# Medi-Cal Provider Manual

July 2022

blue california | Promise Health Plan

blueshieldca.com
blueshieldca.com/promise

# Table of Contents

SECTION 6: GRIEVANCES, APPEALS, AND DISPUTES



SECTION 7: UTILIZATION MANAGEMENT

SECTION 9: QUALITY IMPROVEMENT



SECTION 10: PHARMACY AND MEDICATIONS

SECTION 11: HEALTH EDUCATION



SECTION 12: PROVIDER SERVICES

This page intentionally left blank.

# SECTION 1: INTRODUCTION

## Welcome

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

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

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

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

## Blue Shield of California Promise Health Plan

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

## Medi-Cal

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

## Regulatory Agencies

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

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

## Regulatory Requirements for Network Providers

Network providers, defined in 42 CFR Section 438.2 and in the *Medi-Cal Managed Care Contract* (Exhibit E, Attachment 1, Definitions), must:

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

# SECTION 2: MISSION STATEMENT

## Mission

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

This page intentionally left blank.

# SECTION 3: BENEFIT PLANS AND PROGRAMS

## 3.1: Covered Benefits

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

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

The benefit designs associated with the Blue Shield Promise Medi-Cal plans are described in the Member Handbook (also called *Evidence of Coverage).* Providers can view these documents online by visiting the Blue Shield Promise website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/medi-cal-members/plan-documents/member-handbook. To request printed copies of the publications, please contact the Provider Customer Services Department at (800) 468-9935.

## 3.2: Managed Long-Term Services and Supports (MLTSS)

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

Blue Shield Promise providers may refer a Member to the health plan for consideration to receive MLTSS. Each of these programs are subject to their own eligibility criteria, and a submitted referral does not guarantee approval of service. See the Social Services Referral Form which can be accessed on the Blue Shield Promise provider website at blueshieldca.com/promise/providers in the *Forms* section.

MLTSS programs include:

### *3.2.1: 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

#### *3.2.1.1: Accessing CBAS*

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 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 Social Services Referral Form which can be accessed on the Blue Shield Promise provider website in the *Forms* section. CBAS centers will request the member's medical history and physical in addition to an order for CBAS services from the member's PCP to enroll the member for CBAS services.

### *3.2.2: 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 with 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

### *3.2.2.1: Accessing LTC Services*

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 MLTSS/Long-Term Care Department for review (855) 622-2755, fax (844) 200-0121. This form can be accessed on the Blue Shield Promise provider website in the *Forms* section.

Once the LTC referral and physician order for Custodial Care have been received, Blue Shield Promise will notify the referral source of the LTC referral outcome within three (3) calendar days for routine situations and 72 hours for urgent situations. Blue Shield Promise 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 LTC case managers will support the assigned physician with facilitation and coordination of care needs. Blue Shield Promise LTC case managers also conduct regular telephonic and written clinical review of members in the Long-Term Care facility up to every four (4) months.

## 3.3: Long-Term Services and Supports (LTSS)

Additional Long-Term Services and Supports that help members live in the community include In-Home Supportive Services (IHSS) and Multipurpose Senior Services and Programs (MSSP). IHSS and MSSP are services managed and paid by entities outside of Blue Shield Promise.

LTSS programs include:

### *3.3.1: 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.

#### *3.3.1.1: 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 Social Services Department can assist members with the following:

- Coordinating and navigating the IHSS application, assessment, and re-assessment processes
- 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; L.A. County IHSS Application Hotline at (888) 944-4477, San Diego County at (800) 510-2020, Blue Shield Promise Social Services Department at (877) 221-0208 or by completing and submitting the Blue Shield Promise Social Services Referral Form which can be accessed on the Blue Shield Promise provider website in the *Forms* section. Physicians will also need to complete the required IHSS forms and provide members with other documentation to support their need for IHSS.

### *3.3.2: 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. There are five (5) MSSP Providers in LA County and one (1) MSSP provider in SD County who are responsible for determining program eligibility. 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

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

#### *3.3.2.1: Accessing MSSP Services*

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 Social Services Department at (877) 221-0208 or by completing and submitting the Blue Shield Promise Social Services Referral Form.

Los Angeles County MSSP sites:

- Human Services Association
- Huntington Hospital
- Jewish Family Services
- Partners in Care Foundation
- Senior Care Action Network (SCAN)

San Diego County MSSP site:

- Aging & Independence Services

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

## 3.4: Home-Based Palliative Care Program

Blue Shield Promise's Medi-Cal Home-Based Palliative Care Program uses an interdisciplinary team approach that provides tightly integrated, longitudinal in-home palliative care services as well as assessment and provision of medical care in line with the patient's goals. The Program incorporates:

- Treatment decision support,
- Care plan development and shared decision-making, and
- Pain and symptom management.

### *3.4.1: Enrolling/Disenrolling Members in the Home-Based Palliative Care Program*

Member Eligibility

Members with any of the following conditions are eligible for the Palliative Care Program:

- Advanced medical conditions such as congestive heart failure, chronic obstructive pulmonary disease, liver disease, and advanced cancer.
- Children with serious medical conditions.
- The member has started to need visits to the emergency department and hospitalizations.

Member Referral

Members have several ways to learn about and gain referral to the Program.

- Blue Shield Promise runs a monthly report to identify members that qualify for palliative care services. The report algorithm is aligned with the general and disease-specific eligibility criteria that comprise the "minimum eligibility requirement" for the Program.
- Blue Shield Promise members can self-refer to the Program by contacting Blue Shield Promise Customer Care at (800) 605-2556.
- PCPs and Specialists can refer members for a full Palliative Care Program Evaluation by completing the Palliative Care Patient Eligibility Screening Tool form (see Appendix 17) and submitting it to Blue Shield Promise by fax at (323) 889-2109 or secure email at bscphp_palliativecare@blueshieldca.com.

The monthly report, all Program-related calls, and physician referrals are transferred to the Blue Shield Promise Palliative Care Coordinator. This position is responsible for assigning potentially eligible members to contracted palliative care servicing providers for further screening and assessment.

Evaluation of Eligibility and Enrollment

Upon receiving a palliative care referral, Blue Shield Promise will review to confirm member eligibility for the benefit. A Blue Shield Promise contracted palliative care provider will outreach to the member to offer palliative care services. Upon the members acceptance to participate in the palliative care program, the palliative care agency will initiate the start of services and coordinate with Blue Shield Promise as appropriate.

Member Disenrollment

To ensure Blue Shield Promise has an accurate list of members enrolled in the Program, providers must notify Blue Shield Promise within 15 business days of a member's disenrollment from the Program using the Blue Shield Promise Palliative Care Program Patient Disenrollment Form (see Appendix 18). A member may be disenrolled for several reasons, including member's condition improving, member declining services or

member enrolling in hospice services.

Case rate payments for the disenrolled member will be discontinued the month following notification of disenrollment in the program.

### *3.4.2: Covered Services*

Members enrolled in the Medi-Cal Home-Based Palliative Care Program are not charged copays or coinsurance for palliative care services and can receive services including:

- Advanced care planning-related activities.
- Palliative care evaluation (prior to enrollment), and ongoing needs assessment and consultation once the member is enrolled.
- Care plan development incorporating both palliative and curative care, created with the engagement of member and/or member's representative.
- Participation of a palliative care team responsible for providing medical care and psychosocial support for mental, emotional, social, and spiritual well-being.
- Assigned nurse case manager to coordinate medical care.
- Pain and symptom management via medications, physical therapy, and other medically necessary services.
- Mental health and medical social services to help minimize the stress and psychological problems that arise from a serious illness, related conditions, and the dying process.
- Needed services such as: home-based palliative care visits, either in person or via videoconferencing; 24/7 telephonic support; caregiver support; and assistance with transitions across care settings.

Enrollment in the Program will not eliminate or reduce any covered benefits or services. Additionally, it will not affect a member's eligibility to receive services they were eligible for prior to Program enrollment, including home health services.

This page intentionally left blank.

# SECTION 4: MEMBER RIGHTS AND RESPONSIBILITIES

## 4.1: Member Rights and Responsibilities

### Purpose

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

### Policy

It is Blue Shield Promise's policy to provide quality health care to its Members. To assure Members of this commitment, Blue Shield Promise has established these Member Rights and Responsibilities.

Blue Shield Promise requires its Providers to understand and abide by these Member Rights and Responsibilities when providing services to our Members. Providers are informed of Member Rights through the Provider Manual and Provider Newsletters.

Blue Shield Promise informs each Member of these Rights and Responsibilities in Member's *Evidence of Coverage*, which is distributed upon enrollment and annually thereafter.

MEMBER RIGHTS AND RESPONSIBILITIES

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

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

You have the right to be treated well.

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

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

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

You have the right to get a range of services.

- To get family planning services.
- To get preventative health care services.
- To get minor consent services.
- To be treated for sexually transmitted diseases (STDs).
- To get emergency care outside of our network.
- To get health care from a Federally Qualified Health Center (FQHC).
- To get health care at an Indian Health Center.
- To get a second opinion.
- To get interpreter services at no cost. This includes services for the hearing-impaired.
- To get informing information materials in alternative formats and large size print upon request.

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

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

## What are your responsibilities as a health care Member?

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

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

We want you to understand your health plan.

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

This page intentionally left blank.

# SECTION 5: ENROLLMENT

## 5.1: Eligibility

Eligible members must reside within the Blue Shield Promise approved service area and meet the requirements for Medi-Cal benefits. As eligibility may change at any time, providers are required to verify member eligibility at time of service. Eligibility may change at any time, so providers are reminded to check Member eligibility at the time of each visit.

## 5.2: Member Enrollment

The Health Care Options (HCO) Program, under the California Department of Health Care Services (DHCS), is responsible for the process of Member enrollment and disenrollment into and out of Medi-Cal.

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

## 5.3: Member Health Plan Selection

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

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

Individuals in mandatory aid codes who do not select a plan will be defaulted into either of the two plans using a special assignment algorithm. If a Member defaults to

L.A. Care, they will be assigned by HCO to one of the five plan partners. Recipients in voluntary aid codes may choose to be enrolled in a managed care health plan like Blue Shield Promise Health Plan if they so desire.

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

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

## 5.4: Coverage

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

## 5.5: Newborn Coverage

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

## 5.6: Change of Primary Care Physician

### *5.6.1: Member Initiated Change*

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

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

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

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

*5.6.2: Primary Care Physician Initiated Change*

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

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

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

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

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

## 5.7: Eligibility List

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

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

## 5.8: Eligibility Verification

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

Eligibility Status (Class) Codes

01 = Eligible Member - Capitation paid

05 = Member on Hold Status - No Capitation Paid (Call Member Services for possible hold release)

59 = Member on Hold - Pending termination 09 = Member Disenrolled - No Capitation paid

00 = Member Voluntarily Disenrolled - No Capitation paid

99 = Disenrolled Member - No Capitation paid

Dep = Dependent Child-Covered under mother's cap for month of birth and following month

## 5.9: Identification Cards

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

- A welcome letter
- A Member Identification Card with the 24-hour emergency numbers for their primary care physician (PCP)
- Blue Shield Promise Health Plan Member Handbook (*Evidence of Coverage*)
- Reminder card requesting the Member call and make their first (120-day health assessment) appointment.
- Fraud postcard containing phone numbers to report fraud.

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

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

## 5.10: Disenrollment

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

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

## 5.11: Plan Initiated Disenrollment

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

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

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

Reasonable efforts should be made to:

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

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

## 5.12: Transportation

Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) are provided to ensure members have access to their providers. Transportation is offered to and from plan approved locations. Arrangements should be made at least 24 hours prior to the appointment by calling Blue Shield Promise at (877)433-2178 (TTY 711).

NEMT is a covered benefit when a member needs to obtain medically necessary covered services and when prescribed in writing via a Physician Certification Statement form (PCS). Medically appropriate NEMT services via ambulance, litter van, wheelchair van or air are provided when the member's medical and/or physical condition does not allow for transport by ordinary means of public or private transportation.

The PCS form must be completed and submitted before NEMT services can be scheduled and provided to the member. The PCS form includes the components in *DHCS All Plan Letter 17-010 (Revised): Non-Emergency Medical and Non-Medical Transportation Services* and is available to download from the Blue Shield Promise provider website under *Authorization Request Forms* in the *Provider Forms* section. Blue Shield Promise cannot modify an NEMT authorization once the treating physician prescribes the form of transportation.

NMT is a covered benefit for members to obtain medically necessary services, pick up drug prescriptions that cannot be mailed directly to the member, or pick up medical supplies, prosthetics, orthotics, and other equipment. NMT includes round trip transportation by passenger car, taxicab, or other form of public or private conveyance, as well as mileage reimbursement for medical purposes when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets. For private conveyance, a member must attest to Blue Shield Promise in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. Members using a wheelchair may utilize NMT services if they are able to ambulate without assistance from the driver. A PCS form is not required for NMT.

## 5.13: Translation Services/California Relay Services

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

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

This page intentionally left blank.

# SECTION 6: GRIEVANCES, APPEALS, AND DISPUTES

## 6.1: Member Grievances

### Purpose

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

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

### Procedure

Members are encouraged to speak with their IPA/medical group/PCP regarding any questions or concerns they may have. Members may also communicate their concerns directly to Blue Shield Promise Member Services by telephone at (800) 605-2556 (TTY: 711) for Los Angeles County and (855) 699-5557 for San Diego County. Grievances can also be filed by 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*.

Blue Shield Promise will acknowledge receipt of all written formal grievances within five (5) calendar days. Blue Shield Promise will resolve grievances within 30 calendar days and provide a resolution letter to the Member. Providers and IPA/medical groups are required to provide medical records, authorizations, or responses within 7 calendar days of the request in order to resolve the grievance within the regulatory timelines.

If a Member has a grievance against Blue Shield Promise, the Member should first use the Blue Shield Promise grievance process before contacting the Department of Managed Health Care (DMHC). Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to the Member.

Members may also be eligible for an Independent Medical Review (IMR) to provide an impartial review of medical decisions made by a health plan. The IMR will determine the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. See Section 6.3.

If the resolution of the appeal/grievance is not acceptable to the Member, the Member needs assistance with a grievance, or if a grievance has remained unresolved for more than 30 days, the Member has the right to contact the DMHC for assistance at (888) 466-2219 (TTY (877) 688- 9891) or http://www.dmhc.ca.gov. The DMHC is

responsible for regulating health care service plans. Instructions, complaint forms, and IMR application forms are available on the DMHC website.

Medi-Cal Members also have the right to request a State Hearing within 120 calendar days of the Notice of Appeal Resolution (NAR). For more information about State Hearing requests, Members may call the California Department of Social Services (CDSS) at (800) 952-5253 (TTY (800) 952- 8349). The Ombudsman Office of the California Department of Health Care Services (DHCS) is also available to Medi-Cal beneficiaries for help with grievances at (888) 452-8609.

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

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

### Expedited Grievance

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

## 6.2: Member Appeals Requests

The Member Appeals Process is designed to allow members, authorized member representatives or providers to file on their behalf, a complete and timely review within 30 calendar days of Blue Shield's receipt of the request.

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

The definition of an "*Appeal*" is a delay, modification, or denial of services based on medical necessity, or a determination that the requested services was not a covered benefit.

Examples of Appeals are:

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

Appeals can be:

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

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

Standard – Resolved in 30 calendar days.

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

Each Appeal begins the process anew to establish the story including:

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

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

### *6.2.1: Expedited Appeal*

A provider, on behalf of a Member, or a Member may file an expedited appeal to an adverse benefit determination and ask to have it processed expeditiously. Expedited appeals are resolved within 72 hours. This type of appeal is generally used in a continued stay or continued treatment situation, and when indicated based on the critical clinical condition of the Member. The following circumstances may constitute, but are not limited to, an expedited appeal:

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

All requests for expedited appeals will be triaged by licensed personnel to determine whether the appeal meets expedited criteria.

Documentation will be collected and presented to a Medical Director so that the case can be resolved and closed to the Member within 72 hours.

## 6.3: Independent Medical Review

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

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

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

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

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

Independent Medical Review for Experimental/Investigational Procedures

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

Members That Qualify to Request the Experimental & Investigational Review Process

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

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

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

Criteria Determining Experimental/Investigational Status

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

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

## 6.4: Provider Disputes – Claims Processing

Purpose

To establish and maintain a fair, fast and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes in accordance with H&S §1371.37, 1371.38 and 1371.39.

### *6.4.1: Provider Questions, Concerns, and Disputes*

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

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

### *6.4.2: Reconsiderations*

A provider will have the ability to furnish the Blue Shield Promise 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.

*6.4.3: Provider Disputes Policy and Procedure*

Providers may submit a written dispute to the Blue Shield Promise Provider Dispute Department. Disputes may pertain to issues such as post-service authorization or denial of a service; non-payment or underpayment of a claim; or disputes with our delegated entities.

All provider disputes must be submitted in writing. If a provider attempts to file a provider dispute via telephone, Blue Shield Promise staff will instruct the provider to submit the provider dispute to Blue Shield Promise in writing.

All written, formal disputes will be responded to in writing. Upon receipt of the written dispute specifying the issue of concern, the dispute will be entered into the provider dispute database. An acknowledgement letter will be sent to the provider within fifteen working days of receiving the written dispute.

Information about how to file a dispute can be found on the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/disputes-medi-cal. For the Provider Dispute Resolution Request Form, click on *Provider dispute forms* in the *Forms* section.

*6.4.4: First Level Dispute*

A provider may dispute a denial decision made by Blue Shield Promise or one of its IPA/medical groups. To ensure timely processing of a dispute, all pertinent information should be provided at the time of submission. If the dispute is regarding a service that is the financial responsibility of the capitated entity, such as an IPA or Medical Group, please provide a copy of the claim and/or denial of the dispute.

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 received the dispute.

2. All records shall be evaluated by the appropriate Plan personnel who will render a decision. The Blue Shield Promise 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 Dispute - L.A. County*

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 must be filed within 60 working days of receipt of the Blue Shield Promise determination letter. It can also be used when Blue Shield Promise 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 or L.A. Care. If it is sent to Blue Shield Promise, 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 requesting a first-level dispute.
3. A copy of the original documents submitted to Blue Shield Promise.
4. A copy of the first level dispute - denial determination letter.
5. A copy of any other correspondence between Blue Shield Promise 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.

### *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 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

## 7.1: Utilization Management Program

### Mission Statement

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

### Purpose

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

UM provides inpatient utilization management 7 days a week from 8 a.m. to 5 p.m., except for company designated holidays, and after hours to assist with repatriation of members from a non-contracted to a contracted facility.

### Goals

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

### *7.1.1: Physician, Member, and Provider Responsibilities*

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

Additional activities and responsibilities include:

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

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

*7.1.2: UM Reporting Requirements for IPA/Medical Groups*

Weekly Reporting Requirements Authorization Logs -Approval/Denial Data File Requirements for IPA/Medical Groups Only

Approval/denial data files ("Authorization Logs") must be delivered via secure email or SFTP file to Blue Shield Promise. To initiate the delivery of authorization logs by means of a SFTP (Secure File Transfer Protocol) or to obtain the Blue Shield Promise standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com.

Authorization logs must be sent, at minimum, on a weekly basis in order to ensure timely data processing. IPA/medical group approvals, denials and partial denials should be delivered together on one file. If sent via email, the data 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 considered out of compliance, rejected by Blue Shield Promise, and returned to the IPA/medical group for correction and resubmission.

Only shared-risk services for which the IPA/medical group is delegated to perform UM and Blue Shield Promise is responsible for claim adjudication are required on the data file.

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

- Subscriber ID Number
- Patient Last Name
- Patient First Name
- Patient Date of Birth (mm/dd/yyyy)
- Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial)
- Request Type (Inpatient, Service or Medication)
- Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility)

- 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, etc.)
- First date of service or Admit date (mm/dd/yyyy)
- Last date of service or Discharge date (mm/dd/yyyy)
- 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
- Units: Number of procedures, treatments, days, sessions, or visits
- Servicing Provider Name
- Servicing Provider NPI
- Facility Name (if applicable)
- Facility NPI (if applicable)
- Requesting Provider Name
- Requesting Provider NPI
- Authorization or Decision Reference Number
- Blue Shield Promise IPA/medical group Identification Number (i.e., IPxxxxxxxxxx) – (It is highly recommended to include your Blue Shield Promise PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Promise Provider Relations representative.)
- Receipt Request Date (date provider requested authorization from IPA/medical group)
- Decision (Approved, denied, partially denied or void)
- Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.)
- Decision Date (mm/dd/yyyy)
- Discharge Diagnosis (if applicable)
- Discharge Status (i.e., To Home, SNF…., if applicable)

Monthly Reporting Requirements

The following monthly reports are due to Blue Shield Promise by the 15th of the month following the month in which services were rendered or denials made:

Second Opinion Tracking Log – Include all authorizations, modifications, and denial information for second opinion requests. The log must include the reason the second opinion was requested.

Linked Services Log – Include Member name, PCP name, diagnosis, and intervention.

ESRD Log – Include authorization number and category; Member name, DOB, Member ID; PCP, ICD10, CPT and description; requesting provider; referred provider and specialty; place of service and quantity; request type and date, decision, and decision date.

Organ Transplant Log – Include Member name, diagnosis, review plan, date case opened and/or closed, monthly updates, and level.

*7.1.3: Organization of Health Care Delivery Services*

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

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

*7.1.4: Medical Services Committee Structure and Membership*

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

Meetings

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

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

Confidentiality

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

Reports

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

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

*7.1.5: UM Review Process for Appropriateness of Care*

Desk level procedures are utilized by staff for the review process. Benefit algorithms have been developed to allow certain types of referrals to be automatically authorized by the UM coordinators. This process can reduce the number of referrals not requiring clinical expertise for determination. Referrals that involve clinical information and require clinical decisions are routed to the UM Clinician and/or Physician Reviewers.

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

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

| Medi-Cal |
| --- |
| Medi-Cal Guidelines |
| MCG 25th Edition |
| Up to Date |
| Nelson Textbook of Pediatrics |
| National Guideline Clearinghouse |
| Hayes |
| NCCN |
| Blue Shield Promise Health Plan Evidence of Coverage (EOC) |

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

Reviewer Availability

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

*7.1.6: Review Criteria*

The UM Department uses nationally recognized evidenced based review criteria, i.e., MCG 25th Edition, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards, Comprehensive Perinatal Service Program Guidelines, and Title 22. A review of criterion is updated on an ongoing basis.

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

The UM review criteria used to make a determination for a Member's care is available to the requesting provider and the Member upon request either in writing or by contacting Blue Shield Promise UM Department at (800) 468-9935.

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

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

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

## 7.2: Complex Case Management Program

### Mission Statement

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

### Purpose

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

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

*7.2.1: The Role of the Case Manager*

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

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

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

*7.2.2: Case Management in the Ambulatory Setting*

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

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

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

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

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

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

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

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

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

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

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

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

### *7.2.3: Utilization Management (UM) Clinicians in the Inpatient Setting*

Inpatient review is conducted by licensed clinicians who are responsible for the daily utilization review of acute hospital, skilled nursing, psychiatric, and rehabilitation inpatient stays. UM Clinicians interface with the in-house physicians, facility case managers/social services, discharge planners, and the Chief Medical Officer to assure continuity of care in the most appropriate setting. Immediately upon notification of admission they begin the process of case assessment and the coordination of discharge planning with the focus of medical necessity. Additional functions are as follows:

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

## 7.3. Enhanced Care Management

Enhanced Care Management (ECM) is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered. ECM is designed to:

- Improve care coordination;
- Integrate services;
- Facilitate community resources;
- Improve health outcomes; and
- Decrease inappropriate utilization and duplication of services.

To accomplish these goals, ECM will be interdisciplinary, high-touch, person-centered and provided primarily through in-person interactions with Members where they live, seek care, and prefer to access services. Members keep their Medi-Cal plan and PCP, but now have an added layer of services and supports. The six core services included in ECM are:

- Comprehensive care management
- Care coordination (physical health, behavioral health, community-based LTSS)
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social support services

ECM Target Populations

The Department of Health Care Services (DHCS) has identified six (6) mandatory ECM "populations of focus." These populations are listed below:

- Individuals and families experiencing homelessness
- High Utilizers
- Adults with Serious Mental Illness/Substance Use Disorder
- Incarcerated and Transitioning to the Community
- At risk for Institutionalization
- Nursing facility Residents transitioning to the Community

DHCS has provided a phased roll out of ECM in 2022 and 2023. Not all the populations of focus listed above will be eligible as of 1/1/2022.

ECM will be available to Members dually eligible for Medicare and Medicaid if they are enrolled in a Blue Shield Promise plan and otherwise meet criteria. ECM is not available to Cal MediConnect Members since Cal MediConnect already incorporates a higher level of care coordination.

Some members eligible for ECM may also be eligible for Community Supports, (non-benefits) that Blue Shield Promise may offer to eligible Medi-Cal members. For additional information about Community Supports, see Section 7.9.23.

## 7.4: Primary Care Physician Scope of Care

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

OFFICE/CLINIC:

Allergy:

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

Cardiology:

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

Dermatology:

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

Endocrinology:

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

Gastroenterology:

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

General Surgery:

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

Gynecology:

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

Hematology:

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

Infectious Disease:

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

Nephrology:

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

Neurology:

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

Ophthalmology:

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

Orthopedics:

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

Otolaryngology:

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

Podiatry:

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

Pulmonology:

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

Rheumatology:

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

Urology/Nephrology:

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

Vascular:

- Evaluate and treat varicose veins
- Evaluate peripheral vascular disease
- Evaluate carotid bruits
- Diagnose transient ischemic attacks
- Manage intermittent claudication
- Diagnose abdominal aortic/thoracic aneurysm

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

## 7.5: Authorization and Review Process

### *7.5.1: Authorization Time Frames*

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

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

Emergency care: Requires no prior authorization

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

Urgent referrals received by telephone will be either processed immediately by non-clinical staff (based on extension of authority under which certain requests can be administratively approved) or directed to an UM Clinician or to the CMO when mandated, in order to make an immediate decision. The provider will be instructed to follow-up with a faxed copy of the request at a later time, if appropriate

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

Utilization Management Timeliness Standards

(Medi-Cal Managed Care - California)

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

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

| | | Notification Timeframe | |
|---|---|---|---|
| Type of Request | Decision | Initial Notification (Notification May Be Oral and/or Electronic) | Written/Electronic Notification of Denial and Modification to Practitioner and Member |
| | Additional information received<br>• If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.<br><br>Additional information incomplete or not received<br>• If after 28 calendar days from the receipt of the re- quest for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the Member notice of denial. | Practitioner: Within 24 hours of making the decision.<br><br>Member:<br>None specified.<br><br>Practitioner:<br>Within 24 hours of making the decision.<br><br>Member:<br>None specified. | Practitioner:<br>Within 2 working days of making the decision.<br><br>Member:<br>Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.<br><br>Practitioner:<br>Within 2 working days of making the decision.<br><br>Member:<br>Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. |
| Expedited Authorization (Pre-Service)<br>• Requests where provider indicates or the Provider Group /Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function.<br>• All necessary information received at time of initial request. | Within 72 hours of receipt of the request. | Practitioner:<br>Within 24 hours of making the decision.<br><br>Member:<br>None specified. | Practitioner:<br>Within 2 working days of making the decision.<br><br>Member:<br>Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service. |

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

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

| | | Notification Timeframe | |
|---|---|---|---|
| Type of Request | Decision | Initial Notification (Notification May Be Oral and/or Electronic) | Written/Electronic Notification of Denial and Modification to Practitioner and Member |
| Urgent Concurrent review of treatment regimen already in place– (i.e., inpatient, on- going/ ambulatory services).<br><br>OPTIONAL: Health Plans that are NCQA accredited for Me-di-Cal may choose to adhere to the more stringent NCQA standard for concurrent review as outlined. | Within 72 hours of receipt of the request. | Practitioner:<br>Within 72 hours of receipt of the request (for approvals and denials).<br><br>Member:<br>Within 72 hours of receipt of the request (for approval decisions). | Member & Practitioner:<br>Within 24 hours of receipt of the request.<br><br>Note:<br>If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 3 calendar days after the oral notification. |
| Post-Service/ Retrospective Review-<br>All necessary information received at time of request (decision and notification are required within 30 calendar days from request). | Within 30 calendar days from receipt or request. | Member & Practitioner:<br>None specified. | Member & Practitioner:<br>Within 30 calendar days of receipt of the request. |

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

### *7.5.2: Authorization Validity*

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

### *7.5.3: Specialty Referrals*

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

When, in the opinion of the PCP a Member referral to a specialist is indicated, a request shall be submitted to the Member's assigned IPA/medical group's UM Department for review and authorization. Treatment requests for Members assigned to Blue Shield Promise Direct are to be faxed to the Blue Shield Promise UM Department with the exception of services established as no prior authorization required under the direct referral process.

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

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

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

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

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

### *7.5.4: Ancillary Referrals*

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

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

### *7.5.5: Outpatient Services*

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

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

IPA/medical groups are required to submit the approved IPA/medical group authorization requests to the UM Department prior to scheduling the procedures, with the exception of full risk IPA/medical groups.

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

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

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

### *7.5.6: Elective Admission Requests*

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

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

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

## 7.6: Emergency Services and Admission Review

### *7.6.1: Emergency Services*

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

Emergency Care

Blue Shield Promise Members are entitled to access emergency care without prior authorization. However, Blue Shield Promise requires that when an enrollee is stabilized, but requires additional medically necessary health care services, providers must notify Blue Shield Promise within 24 hours of admission.

### Life Threatening or Disabling Emergency

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

### Business Hours

The Blue Shield Promise UM Department is available via telephone from 8:00a.m. to 5:00p.m., Monday thru Friday. In a 911 situation, if a Member is transported to an ED, the ED physician shall contact the Member's PCP (printed on the Member's enrollment card) as soon as possible (post stabilization) in order to give him/her the opportunity to direct or participate in the management of care. If the PCP intends to refer the Member to an ED, the PCP must call the ED to authorize the treatment. The physician's name, date, and time of the authorization will be documented in the ED medical record. If the Member seeks treatment at an ED without prior approval from the PCP, the ED will triage the Member and call the PCP for approval to treat the Member. It is the responsibility of the PCP to grant the authorization for treatment under these circumstances.

### Medical Screening Exam

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

### After Business Hours

After regular Blue Shield Promise business hours, Member eligibility is obtained, and notification is made by calling the 800 number on the Member ID card. The 800 number connects to a 24-hour multilingual information service, which is available to Members as well as to providers. Blue Shield Promise UM Clinicians are available after hours to assist with post-stabilization care transitions. THIS IS NOT A MEDICAL ADVICE SERVICE. In the event that a Member calls for advice relating to a clinical condition that they are experiencing and believe based on their perception that it is urgent/emergent, the Member will be advised to go to the nearest emergency room or to call 911.

The following are some of the key services the on-call UM Clinicians will provide:

- Facilitate urgent/emergent treatment authorization numbers to providers.
- Facilitate Member transfers from emergency departments to contracted hospitals or California Children's Services (CCS) paneled facilities when applicable.
- Arrange facility transfer ambulance transport services.
- Provide providers with network resource information.
- Link Blue Shield Promise contracted physicians to ED physicians when necessary.

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

*7.6.2: Urgent/Emergent Admissions*

Prior authorization is not required for emergency room admissions (see Emergency Services for definition of "emergency"). If the ER post-stabilization results in an inpatient admission, the provider is required to notify Blue Shield Promise within 24 hours of the admission. PCP admission notification will be sent within 24 hours of the admission.

PCP Notification

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

Plan Notification

All contracted per-diem hospitals are responsible to notify inpatient admissions to the Blue Shield Promise UM Department within 24 hours of admission. Upon receipt of the hospital admission notification, the UM Department will respond back to the hospital with a Blue Shield tracking or authorization number within 24 hours of notification.

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

*7.6.3: Concurrent Review*

Blue Shield Promise provides for continual reassessment of all acute inpatient care. Other levels of care, such as partial day hospitalization or skilled nursing care may also require concurrent review at the discretion of Blue Shield Promise. Review may be performed telephonically, through access of a facilities Electronic Medical Record (EMR) or by reviewing clinical records faxed into Blue Shield Promise. Upon admission notification, contracted providers are given approval for the admission day. In addition, an admission notification letter is sent to the documented PCP. Concurrent review is conducted thereafter to ensure medical necessity and the Member's care is delivered in the most appropriate setting. The date of the first concurrent review will generally occur on the second hospital day. The benefit of this process is to identify further discharge planning needs the Member may have due to unforeseen complications and or circumstances.

Clinical information may be obtained from the admitting physician, the hospital electronic medical record, or the hospital Utilization Review (UR) Nurse. The Blue Shield Promise UM Clinician established medical necessity using evidence based clinical guidelines and provides the determination for the request within regulatory turnaround times. If the Member remains an inpatient, further concurrent review will be performed daily. The number of hospital days and level of care authorized are variable and are based on the medical necessity for each day of the Member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the UM Clinician and the CMO.

*7.6.4: Discharge Planning*

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

The goal of the discharge planning process is to follow the Members through the continuum of levels of care until the Member is safely discharged to his/her previous level of care. This approach is performed to ensure continuity of care and optimum outcomes for Blue Shield Promise Members.

Providers are required to notify the Blue Shield Promise UM Clinician of Member discharge within 24 hours of the discharge. The PCP of record is sent a discharge notification letter within 24 hours of notification.

This may be done by one of the following mechanisms:

- Dictated hospital summary note from the Attending Physician.
- Phone call from the Attending Physician.
- Phone call from the Blue Shield Promise UM Case Manager.
- Inpatient Hospital Notification letter sent by the UM Clinician.

*7.6.5: Retrospective Review*

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

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

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

## 7.7: Authorization Denials, Deferrals, and Modifications

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

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

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

- The PCP and/or the requesting provider will be sent a written or electronic confirmation within two (2) working days of the determination.
- The communication to the provider shall include the name and telephone number of the health care professional responsible. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
- The Member will be sent written confirmation within 48 hours of the determination.
- For concurrent care within 72 hours of the request, electronic or written.
- Denial of services rationale includes a reference to the specific clinical guideline that was used to make the determination. Providers and Members can request a copy of the specific criteria set used.
- The disclosure shall be accompanied by the following notice: "The guidelines that were used by Blue Shield Promise for your case are used by the Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need."
- Criteria/guidelines, specific to the care being delivered or requested, will be made available upon request to the provider or Member via phone to the UM Department at (800) 468-9935, via fax to the UM Department at (800) 889-6577, or request via mail to UM Department at Blue Shield Promise Health Plan, 601 Potrero Grande Drive, Monterey Park, CA 91755.

The written notification shall include the following elements:

- The notice to the Member will inform the Member that they may file an appeal concerning the determination using the appeal process (as proscribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process.
- How to initiate an expedited appeal at the time they are notified of the denial.
- The Member's right to, and method for obtaining, a State Fair Hearing.
- The Member's right to represent himself/herself at the State Fair Hearing or to be represented by legal counsel or another spokesperson.

- The name and address of the entity making the determination.
- The State's toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Corporation's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the Member's satisfaction.

Included within the denial letter to Members and providers are the reasons for the denial determination and, if possible, alternative treatments or care. The reason(s) for the denial must be translated into the Member's preferred language.

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

## 7.8: Referrals

### *7.8.1: Second Opinion*

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

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

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

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

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

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

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

*7.8.2: Self-Referable Services (Medi-Cal)*

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

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

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

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

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

*7.8.3: Direct OB/GYN Access*

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

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

1. Referrals must be made to Blue Shield Promise contracted OB/GYN physicians only.
2. Routine and preventive health care services including breast exams, mammograms, and pap tests.
3. Payment for the level of the consultation/follow-up that is indicated on the claim shall be established from the documentation sent along with the claim to substantiate the medical necessity for payment at that level.
4. Any recommended treatments, procedures or surgeries will require prior authorization.
5. Any OB/GYN who is also a PCP will be able to self-refer directly for OB services. Further treatments, procedures, or surgeries will require prior authorization from the Blue Shield Promise UM Department.
6. Any OB/GYN who is a PCP will provide all GYN services, other than prior authorized surgeries and procedures included under the capitated primary care services payment agreement contract.

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 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 has developed a Maternal Mental Health Program to assist participating practitioners and delegated entities in implementing the requirement. Providers may visit the Blue Shield Promise provider website Maternal Mental Health Services Program link at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/maternal-mental-heath-program 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.

*7.8.4: Independent Medical Review*

The independent medical review (IMR) is an expansion of the appeal process. Refer to Section 6.3: Independent Medical Review.

*7.8.5: Continuity of Care*

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

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

Definitions

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

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

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

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

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

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

Procedure

1. Members may file requests with the Plan/IPA/medical group for continuity of care when they are SPD members, newly enrolled converting from Medi-Cal Fee for Service via telephone, facsimile, or by mail.
2. Continuity of care considerations will be made in accordance with the urgency of the Member's condition at the time of such a request.
3. Continuity of care considerations are applicable only to those circumstances when the Member has an acute or serious chronic condition, high risk or late

term pregnancy, terminal illness, care of a newborn up to 36 months, and/or performance of a surgery or other procedure that is authorized by the plan.

4. The timeframe for Members undergoing continued care with a terminated or non- contracted provider is up to 12 months. This timeframe may be extended in order for the Member's care to be transferred safely.
5. If the provider was contracted with the Plan/IPA/medical group and the contract was terminated, the fee will be based on the contractual agreement prior to the termination.
6. If it is a non-contracted provider and there is no agreement between the Plan and the provider, then the Plan/IPA/medical group shall pay the provider similar rates as those paid to similar providers for similar services within a similar geographical region.
7. If the provider does not accept the payment rate, then the Plan/IPA/medical group is not obligated to continue care with the provider.
8. The provider shall be bound to the Plan's contractual requirements for quality assurance, utilization review and credentialing.
9. The Plan will monitor the care provided by requiring the provider to submit ongoing treatment plans, progress notes and other appropriate medical record information.
10. The Plan will coordinate the exchange of the Member's medical record information from the non-contracted/terminated provider to the Plan provider when the Member's condition allows for such a transition.

*7.8.6: Reconstructive Surgery*

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

Definitions

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

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

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

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

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

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

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

Physician Reviewer Evaluation

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

*7.8.7: Standing Referral*

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

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

Provisions for Requesting a Standing Referral

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

Standing referral requests will include:

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

Provisions for Requesting Extended Access to a Specialist

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

Review and Determination

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

Specialist Communication Guidelines to Primary Care Provider

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

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

### *7.9.1: California Children's Services (CCS)*

California Children's Services (CCS) is a Medi-Cal benefit provided by the County. Blue Shield Promise coordinates the benefits for eligible members The CCS Program provides physical habilitation and rehabilitation for children with specified handicapping conditions through CCS certified providers. The program goal is to obtain the medical and allied services necessary to achieve maximum physical and social function for children. Members identified with CCS-eligible conditions are referred to the County CCS program immediately upon identification.

When a Member is identified as meeting the criteria for the CCS Program, the Member/ Member's family or designee is notified in writing and informed they will be contacted by a Blue Shield Promise employee to discuss the CCS Program. For newly enrolled Members, or existing Medi-Cal beneficiaries transitioning to Blue Shield Promise, Blue Shield Promise maintains a process by which a CCS-eligible child or youth may maintain access to CCS providers and receive assistance in coordination with the new PCP. For children/youth with an established relationship with an out-of-network provider and are requesting continuity of care, Blue Shield Promise will follow the health plan benefits eligibility guidelines based on Department of Healthcare Services (DHCS) requirements.

*7.9.1.1 CCS Provider Training*

The CCS Program maintains mechanisms to ensure that all contracted providers are informed of and adhere to the following:

- CCS program eligibility requirements
- The need to identify potentially eligible children
- How to refer to the CCS program

Trainings will occur for all new providers or IPAs in the New Provider Training Material as well as upon request of a provider or IPA. Training opportunities can also be identified during the annual delegation oversight audits. At a minimum, training will occur at least annually in the form of provider updates emails, newsletters, or e-broadcasts via the Blue Shield Provider Connection website. Blue Shield Promise maintains a process to review Blue Shield Promise provider's qualifications for CCS provider panel participation and encourages those qualified to become paneled. Blue Shield Promise also maintains access to a list of those facilities designated with CCS approval, including hospitals and Special Care Centers.

*7.9.1.2 Provider Communications*

Blue Shield Promise is responsible for ensuring the provider network is aware of Members eligible for or receiving services through the CCS program. Blue Shield Promise shall be responsible for generating and distributing, to its IPAs and the Member's PCP, a report of Members identified as being eligible or authorized to receive CCS services received from CCS. Blue Shield Promise will send these reports to its delegated IPAs and contracted providers on a monthly basis. Blue Shield Promise and its delegated IPAs and contracted providers will work with the local CCS office to ensure the member is receiving appropriate medical care and that coordination of care is documented in the member's medical record and/or its delegated IPAs will undertake regular activities, such as review of encounter data necessary to identify members with potential CCS conditions and ensure appropriate referrals to CCS.

*7.9.1.3 CCS Program Referrals*

Initial referrals of members with CCS-eligible conditions are made to the local CCS program by telephone, same-day, or fax. Followed by receipt of supporting medical records, to allow for eligibility determination by the local CCS program. Blue Shield Promise providers are responsible for continuing to provide all medically necessary covered services to the member until CCS eligibility is confirmed.

Once eligibility for the CCS program is established for a member, Blue Shield Promise providers shall continue to provide all medically necessary covered services that are not authorized by CCS. Blue Shield Promise shall ensure the exchange of medical record information, coordination of services and joint case management between the PCP, the CCS specialty providers, and the local CCS program.

If the local CCS program does not approve eligibility, Blue Shield Promise remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, Blue Shield Promise remains responsible for obtaining and paying for the services provided.

Blue Shield Promise's contracted physicians or IPA Health Services staff shall assist in the coordination of care between PCP's, CCS Specialty Providers, and the local CCS program. All members who are referred to CCS or confirmed to have a CCS-eligible condition shall be managed by Case Management. The CCS program authorizes payments to Blue Shield Promise network physicians who currently are members of the CCS panel and to other providers who provided covered CCS to the member during the CCS eligibility determination period who are determined to meet the CCS standards for paneling Blue Shield Promise shall submit information to the CCS program on all providers who have provided services to a member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by Blue Shield Promise or a network physician shall be allowed until the next working day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

*7.9.1.4 CCS Care Management*

The CCS Program will be responsible for case management of all identified CCS-eligible members and authorizes medically necessary care. When a Member meets criteria for the CCS Program, the Member/ Member's family or designee is contacted telephonically by a Blue Shield Promise employee to discuss their condition and enroll them in the CCS Care Management Program. The CCS Program will be responsible for case management of all identified CCS-eligible members and authorizes medically necessary care.

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

*7.9.1.5 CCS Age Out and Transition of Care Coordination Program*

Blue Shield Promise maintains a care coordination program to assist CCS-eligible Members nearing the age of 21 years or who are transition out of CCS due to the completion of CCS services. The age-out program begins once a Member reaches 17 years of age and remains on the CCS report as CCS-eligible Members will receive communication informing them of the available services in assisting the Member/Member's family or designee in planning toward the upcoming transition to an adult care provider. CCS Case Managers are available to assist the family in identifying appropriate options available to the Member, such as specialty services,

specialty hospitals, medications, durable medical equipment, etc. For unmet social needs, Members/Member's families may be referred to a PHP Social Worker for assistance. At 60 days and again at 30 days prior to Member's 21st birthday, Members/Member's families or their designee will receive a call from the Blue Shield Promise Case Manager to ensure the care planning is in process or completed. If the assistance is needed, the Blue Shield Promise Case Manager will assist in locating an appropriate specialist as well as addressing any other needs. For complex care needs requiring specialty services not currently available in-network, the Blue Shield Promise Case Manager will collaborate with the CCS Case Manager, treating specialist or SCC and the Blue Shield Promise Provider Network team to locate and appropriate provider.

*7.9.1.6 CCS Continuity of Care*

For newly enrolled Members or existing Medi-Cal beneficiaries transitioning to Blue Shield Promise, Blue Shield Promise maintains a process by which a CCS-eligible child or youth may maintain access to CCS providers and receive assistance in coordination with the new PCP. For children/youth that has an existing relationship with an out-of-network provider and is requesting continuity of care, Blue Shield Promise will follow the health plan responsibilities identified in the DHCS regulatory requirements.

*7.9.2: Child Health and Disability Prevention Program (CHDP)*

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

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

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

Comprehensive Health History and Physical Examination

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

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

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

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

| | | |
|---|---|---|
| • Abdomen | • Hair | • Nose, Throat |
| • Blood Pressure | • Head Circumference | • Palpation of femoral |
| • Dental | • Heart | • Screen brachial/radial |
| • Ears (Audiometry) | • Height and weight, chest | • Skin |
| • Extremities* | • Lungs | • Spine |
| • Eyes (Vision Testing) | • Mouth, Gums | |
| • Genitals (pelvic exam)* | • Neck | |

*According to periodicity schedules

Tests are to include the following:

- Tuberculin tests
- Cholesterol screening
- STD screening
- Lab testing for anemia, diabetes, and/or urinary tract infection
- Testing for Sickle Cell Trait
- Lead screening (lead level checks at ages 12 months and 24 months, or between 24 months and 72 months when a child has not had a documented lead screening.

California Statutes and Regulations for Lead Screening for Providers Caring for Children 6 Months to 6 Years of Age

California state statutes and regulations impose specific responsibilities on doctors, nurse practitioners, and physician's assistants doing periodic health care assessments on children between the ages of 6 months and 72 months. These providers must provide oral or written anticipatory guidance to a parent or guardian of the child, including, at a minimum, the information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from 6 months of age to 72 months of age. The anticipatory guidance must be provided at each periodic health assessment, starting at 6 months of age until 72 months of age. In the State of California, ''lead screening'' means testing an asymptomatic child for lead poisoning by analyzing the child's blood for concentration of lead. California regulations require a blood lead test at 12 and 24 months, or between 24 months and 72 months when a child has not had a documented lead screening. These provider responsibilities apply to all physicians, nurse practitioners, and physician's assistants, not just Medi-Cal or Child Health and Disability Prevention (CHDP) providers and are only a summary of the provider responsibilities.

The blood lead screening tests may be conducted using either the capillary (finger stick) or venous blood sampling methods. All confirmatory and follow-up blood lead

level testing must be performed using blood samples taken through the venous blood sampling method. While the minimum requirements for appropriate follow-up activities, including referral, case management and reporting, are set forth in the CLPPB guidelines, a provider may determine additional services that fall within the EPSDT benefit are medically necessary.

Network providers are not required to perform a blood lead screening test if either of the following applies:

a) In the professional judgment of the network provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning.

b) If a parent, guardian, or other person with legal authority to withhold consent for the child refuses to consent to the screening.

The network provider must document the reason(s) for not performing the blood lead screening test in the child member's medical record. In cases where consent has been withheld, the network provider must document this in the child member's medical record by obtaining a signed statement of voluntary refusal. If the network provider is unable to obtain a signed statement of voluntary refusal because the parent/guardian withheld consent: 1) refuses or declines to sign it, or 2) is unable to sign it (e.g., service provided via telehealth modality), the network provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's medical record.

Network providers must follow the current California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when conducting blood lead screening tests, interpreting blood lead levels, and determining appropriate follow-up. Refer to https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB for the most current guidelines.

Federal Refugee Guidelines for Lead Screening

Refugee health guidelines for lead screening are as follows. Refer to www.cdc.gov/immigrantrefugeehealth/ for more information.

- Blood lead test all refugee children 6 months to 16 years old at entry to the U.S.
- Within 3 - 6 months post-resettlement, follow-up blood lead tests should be conducted on all refugee children aged 6 months to 6 years, regardless of initial screening blood lead level.
- Within 90 days of their arrival in the United States, evaluate children aged 6 months to 6 years of age should undergo nutritional assessment and testing for hemoglobin or hematocrit levels (e.g., a routine complete blood count with differential).
- Children under 6 months to 6 years should be given a daily multivitamin with iron.

Follow-Up on Conditions Identified During CHDP Exams

Blue Shield Promise will arrange for any medically necessary services identified through a health assessment (or episodic exam). Treatment for these conditions is to be initiated within 60 days after identified need. Medical records must contain a justification regarding the member's condition. The Primary Care Physicians will coordinate continued medical care with the CHDP office.

*7.9.3: Regional Centers*

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

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

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

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

Other applicable factors are that the condition:

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

Factors that do *not* apply:

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

### *7.9.4: Early Prevention, Screening, Diagnosis, and Treatment (EPSDT)*

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

EPSDT Services

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

Requested EPSDT services must meet the following medical necessity criteria:

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

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

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

*7.9.5: Women, Infants, and Children Program (WIC)*

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

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

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

Screening of Nutritional Needs and WIC Eligibility Identification and Referral

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

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

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

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

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

*7.9.6: Comprehensive Perinatal Services Program (CPSP)*

Pregnancy and Postpartum Services

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

Case Coordination Elements

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

Components of Case Coordination

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

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

Multidisciplinary Conditions/Issues

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

Pregnancy Conditions/Issues

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

Postpartum Conditions/Issues

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

Conditions Requiring Medical Referrals

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

Conditions/Issues Requiring Social Work Referrals

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

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

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

Monitoring

To ensure compliance with the CPSP services listed above, Blue Shield Promise will initiate an enhanced Maternal Health Oversight and Monitoring Program that consists of the following functions:

- Blue Shield Promise will notify providers about the program and in-service training will be conducted regarding APL 12-003 and CPSP standards.
- High-volume OB providers will be selected from our eligible OB provider network.
- Selected providers will be sent requests for medical records to be audited or will be notified if Blue Shield Promise will be utilizing the Electronic Medical Record (EMR) system to access the records.
- Medical record reviews/audits will be conducted using an audit tool approved by DHCS per CPSP standards.
- Providers will be notified of the audit results, of any noted trending deficiencies, and of the need for a Corrective Action Plan (CAP).
- Compliance gaps in Blue Shield Promise's provider network will be tracked, trended, and reported in Quality Management Committee meetings.

The Maternal Health Oversight and Monitoring Program is one component of the overall Maternal Health Program, which includes Blue Shield Promise's Quality, Delegation Oversight, and Care Management Programs.

*7.9.7: Family Planning*

Family planning includes the following services:

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

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

- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

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

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

Members may receive care from:

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

7.9.8: Sensitive Services

***"Sensitive services"*** are health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

Benefit Coverage

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

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

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

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

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

Examples of Covered Services:

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

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

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

*7.9.9: Sexually Transmitted Disease (STD)*

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

STD Reporting

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

*7.9.10: Mental Health (Medi-Cal Managed Care)*

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

Behavioral Health Services Access

There are multiple entry paths for Blue Shield Promise members to access behavioral health services. Referrals may be requested by primary care physicians (PCPs), specialty providers, County Departments, Community Based Organizations, case managers and member self- referrals. The Blue Shield Promise contracted MBHO has a toll free 800 number that is available 24/7 for behavioral health service authorization requests. The MBHO number is listed on the member's ID card. Blue Shield Promise also has a toll free 800 number that is available 24/7 for general inquiries, member eligibility verification,

business hour service authorization requests and after hour service authorization requests. After hour requests are coordinated by cross connecting callers to the afterhours Blue Shield Promise on call nurses. The nurses have 24-hour access to Blue Shield Promise physicians for assistance in making any medical necessity determinations that are beyond the nursing scope of practice. The after-hour nurses are educated and trained in coordinating behavioral health service referrals as for all levels of mental health treatment to the appropriate provider network for behavioral health care.

Medi-Cal Managed Care Plan Behavioral Health Benefits and Services

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

Role of Primary Care Physicians

The Primary Care Physician is responsible for:

- Initial Health Assessment (IHA) and Individual Health Education Behavior Assessment (IHEBA) using an age appropriate DHCS approved assessment tool
- Screening for Mental health Conditions
- Offering brief behavioral/counseling intervention(s) to members ages 11 and older, including pregnant women, that provider identifies as having risky or hazardous alcohol or drug use, when a member responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified, in accordance with Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT).
- Trauma screenings: As a clinical best practice, PCPs 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 and the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/aces-screening-initiative.
- Screening for prenatal and postpartum mental health conditions and referrals for mental health services as appropriate. Refer to Section 7.8.3: Direct OB/GYN Access for additional information.
- Referrals for additional assessment and treatment

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

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

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

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

MBHO Behavioral Health Services

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

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

*7.9.11: Vision*

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

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

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

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

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

*7.9.12: Dental*

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

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

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

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

*7.9.13: Organ Transplant*

Blue Shield Promise is required to cover the Major Organ Transplant (MOT) benefit for adult and non-California Children's Services (CCS) eligible pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.

Blue Shield Promise will refer, coordinate, and authorize the delivery of the MOT benefit and all medically necessary services associated with MOTs, including, but not limited to:

- Pre-transplantation assessments and appointments
- Organ procurement costs
- Hospitalization
- Surgery
- Discharge planning
- Readmissions from complications
- Post-operative services
- Medications
- Care coordination

Blue Shield Promise will cover all medically necessary services for both living donors and cadaver organ transplants. Blue Shield will only authorize MOTs to be performed in approved transplant programs located within a Medi-Cal approved Center of Excellence (COE) or hospital that meets the Department of Health Care Services' (DHCS) criteria. Blue Shield Promise must directly refer adult members and authorize referrals to a transplant program that meets Medi-Cal for an evaluation within 72 hours

of a member's PCP or specialist identifying the member as a potential candidate for the organ transplant.

All covered benefits related to the following major organs will be provided for at a Medi-Cal approved COE:

- Bone marrow
- Heart
- Heart-lung
- Liver
- Pancreas
- Small bowel
- Combined liver and small bowel
- Lung
- Simultaneous kidney-pancreas

California Children's Services (CCS) and Transplant

Blue Shield Promise must refer pediatric members to the County CCS program for CCS eligibility determination within 72 hours of the member's PCP or specialist identifying the member as potential candidate for the MOT. Blue Shield Promise will assist in referring and coordinating the delivery of the MOT benefit and all medically necessary services associated with MOT. Blue Shield Promise will not be required to pay for costs associated with transplants that qualify as a CCS-eligible condition. The County CCS program will be responsible for referring the CCS-eligible member to the transplant SCC. Blue Shield Promise will provide case management and care coordination. If the CCS program determines that the member is not eligible for the CCS program, but the MOT is medically necessary, Blue Shield Promise will be responsible for authorizing the MOT.

Authorization Timeframes

CCS MOT Service Authorization Requests (SARs) are typically authorized for one year. Non-CCS Treatment Authorization Requests (TARs) are authorized according to the type of MOT in the table below:

| Transplant | Duration of TAR Authorization |
|---|---|
| Liver with Hepatocellular Carcinoma | 4 Months |
| Cirrhosis | 6 Months |
| Bone Marrow | 6 Months |
| Heart | 6 Months |
| Lungs | 6 Months |
| All else | 1 Year |

*7.9.14: Long Term Care*

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

*7.9.15: Alcohol and Drug*

Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) (Formerly AMSC)

It is the policy of Blue Shield Promise to ensure members 11 years of age and older receive alcohol and drug misuse screenings by their Primary Care Provider (PCP). Consistent with the American Academy of Pediatrics (AAP) Bright Futures initiative, the United States Preventive Services Task Force recommendations, and All Plan Letter (APL) 21-014, PCPs must annually screen members 11 years of age and older for alcohol and drug misuse. Although Blue Shield Promise must provide one alcohol and drug misuse screening per year, additional screenings must be provided when medically necessary. Medical necessity must be documented by the member's PCP.

Screening

PCPs must screen members for unhealthy alcohol and drug use using validated screening tools. Validated screening tools include, but are not limited to:

- Cut Down-Annoyed-Guilty-Eye-Opener Adapted to Include Drugs (CAGE-AID)
- Tobacco, Alcohol, Prescription medication, and other Substances (TAPS)
- National Institute on Drug Abuse (NIDA) Quick Screen for adults
    - The single NIDA Quick Screen alcohol-related question can be used for alcohol use screening.
- Drug Abuse Screening Test (DAST-10)
- Alcohol Use Disorders Identification Test (AUDIT-C)
- Parents, Partner, Past and Present (4Ps) for pregnant women and adolescents
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) for non-pregnant adolescents
- Michigan Alcoholism Screening Test Geriatric (MAST-G) alcohol screening for geriatric population

Brief Assessment

When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools. Validated assessment tools include, but are not limited to:

- NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)
- Drug Abuse Screening Test (DAST-20)
- Alcohol Use Disorders Identification Test (AUDIT)

Brief Interventions and Referral to Treatment

For members with brief assessments that reveal unhealthy alcohol use, brief misuse counseling should be offered. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, must be offered to recipients whose brief assessment demonstrates probable AUD or SUD.

Alcohol and/or drug brief interventions include alcohol misuse counseling and counseling a member regarding additional treatment options, referrals, or services.

Brief interventions must include:

- Providing feedback to the patient regarding screening and assessment results
- Discussing negative consequences that have occurred and the overall severity of the problem
- Supporting the member in making behavioral changes
- Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated

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

Documentation Requirements

Member medical records must include:

- The service provided (e.g., screen and brief intervention)
- The name of the screening tool and the score (unless the screening tool is embedded in the electronic health record)
- The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
- If and where a referral to an AUD or SUD program was made

Compliance with APL 21-014/SABIRT services is subject to audit by Blue Shield Promise, including medical record review. PCPs must maintain documentation of SABIRT services provided to members. When a member transfers from one PCP to another, the receiving PCP must attempt to obtain the member's prior medical records, including those pertaining to the provision of preventive services.

Billing and Documentation

The following HCPCS codes may be used to bill for SABIRT services as outpatient services only:

| HPCPS code | Description | When to Use | Frequency Limit | Notes |
|---|---|---|---|---|
| G0442 | Annual alcohol misuse screening, 15 minutes | Alcohol use screening | 1 per year, per provider | The minimum age has changed from 18 to age 11. |
| H0049 | Alcohol and/or drug screening | Drug use screening | 1 per year, per provider | |
| H0050 | Alcohol and/or drug services, brief intervention, per 15 minutes | Alcohol misuse counseling or counseling regarding the need for further evaluation/treatment | 1 per day, per provider | Brief intervention services may be provided on the same date of services as the alcohol or drug use screen, or on subsequent days. |

Please note that HCPCS codes H0049 and H0050 are reimbursable "by report." An attachment documenting the services delivered must be submitted with claims for H0049 and H0050. For more information, visit the Evaluation & Management (E&M) section of the DHCS Medi-Cal Provider Manual and Blue Shield Promise's SABIRT webpage at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/sbirt-medi-cal.

*7.9.16: Tuberculosis*

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

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

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

*7.9.17: Waiver Program*

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

Members suitable for the Medi-Cal Waiver Program are:

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

*7.9.18: Phenylketonuria (PKU)*

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

Metabolic diseases may be a carve-out benefit and may be covered through

California Children's Services (CCS). Infants and children up to the age of 21 years that are identified as having PKU will be referred by the Plan to CCS for case management.

Medically Necessary Enteral Nutrition Products

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

Requirements for Medical Authorization of Enteral Nutrition Products are:

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

Definitions

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

***"Special food products"*** Is defined as products that are specially formulated to have less than one gram of protein or used in place of normal food products such as

grocery store foods used by the general population.

*7.9.19: Cancer Screening*

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

*7.9.20: Cancer Clinical Trials*

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

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

*7.9.21: AIDS Vaccine Coverage*

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

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

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

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

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

### *7.9.23: Community Supports*

Community Supports are services or settings that Blue Shield Promise may offer in place of services or settings covered under the California Medicaid State Plan that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for health plans to offer and for Members to utilize. Blue Shield Promise may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan. These services are available to eligible Blue Shield Promise Medi-Cal members and provide additional support above and beyond Long Term Care Support Services (LTSS) to enhance Member's care, allowing them to stay in their homes safely and preventing institutionalization. They can also be an additional part of care for members enrolled in Enhanced Care Management (ECM). Community Supports services are available for some Medi-Cal members not enrolled in ECM that need additional support in the community. These services will vary based on a member's needs and Blue Shield Promise's established Community Supports criteria and exclusions.

Blue Shield Promise offers the following Community Supports to eligible Medi-Cal members in Los Angeles and San Diego Counties:

- Asthma Remediation
- Day Habilitation Programs
- Environmental Accessibility Adaptations (Home Modifications)
- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Supportive Meals/Meals/*Medically Tailored Meals (MTM)
    - *Los Angeles County: Medically Tailored Meals Only
    - *San Diego County: Meals and Medically Tailored Meals
- Personal Care & Homemaker Services
- Recuperative Care (Medical Respite)
- Respite (for Caregivers)
- Short-Term Post-Hospitalization Housing
- Sobering Centers

Providers may reference the Community Supports Referral form on the Blue Shield Promise provider website at blueshieldca.com/promise/providers in the *Forms* section to determine a member's eligibility and submit a referral. Although these services are not Medi-Cal benefits, they are subject to Blue Shield Promise's grievance and appeals process in the event a concern arises regarding access to services.

For more information, refer to Appendix 19: DHCS Community Supports Categories and Definitions and Appendix 20: Community Supports Criteria and Exclusion Guide.

## 7.10: Delegated UM Reporting Requirements (IPA/Medical Groups Only)

The purpose of UM reports is to provide ongoing monitoring for delegated UM functions and to ensure that services and decisions rendered by the delegated IPA/medical group are appropriate and meet DHS, DMHC, and Blue Shield Promise standards. All delegated IPA/medical groups must report and submit UM information to Blue Shield Promise as described below. See also Appendix 1: IPA Delegation Matrix.

### Monthly Reporting Requirements

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

1. Authorization Turnaround Time Tracking Report – Include authorization , Member name, requested date, approval date, provider notification date, diagnosis, and requested services.
2. Denials and Modifications – Include all Denial and Modification numbers, Member name, requested date, decision date, provider notification date, and requested services.
3. Denials and Modifications – Include a complete copy of denial/modification letter, authorization/referral, doctor's notes, criteria used, and a copy of the DMHC self-addressed envelope.
4. HIV/ABR Report – Include CIN, Medi-Cal number, Blue Shield Promise ID, IPA/medical group, Mo/Yr diagnosed, Mo/Yr billed, date last billed, Aid Code, and AEVS Verification number.
5. Maternity/Deliveries Admission (MDAR) Report – Maternity and Delivery cases.
6. Managed Care Program Data (MCDP) Report – Includes Continuity of Care (COC) and Out of Network (OON) data. COC report includes total number of PCP/SCP termed, total number of members requesting assistance, and total number of members allowed continuing access to provider and total number of members whose coverage ended while still needing care. OON report includes number of provider OON requests, approved and in progress, and the number of IPA/medical group referrals to OON providers. To be submitted by the 1st of the month following the end of the monthly reporting period.

### Quarterly Reporting Requirements

Reports must be submitted to Blue Shield Promise 45 days after the end of the quarter (May 15th, August 15th, October 15th, and February 15th).

1. UM HICE Work Plan Report – Include, at a minimum, UM activities, trending of utilization activities for under- and over-utilization, Member and provider satisfaction activities and inter-rater reliability activities and improvement.
2. CCS Report – Include data for all CCS cases.

3. Quarterly Supplemental Report – Summary of Referrals, Case Management/Continuity of Care, Linked & Carved Out Services and After-Hours Calls Managed by RN/MD.
4. Dental General Anesthesia Report – Per APL 15-012, Developmental Disability (DD) reporting for dental general anesthesia services provided by a physician in conjunction with dental services for managed care beneficiaries in hospitals, ambulatory medical surgical settings, or dental offices.

Annual Reporting Requirements

Reports must be submitted annually to Blue Shield Promise by February 15th of each calendar year:

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

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

This page intentionally left blank.

# SECTION 8: ENCOUNTER DATA

## 8.1: Encounter Data - Medi-Cal

### Policy and Procedures

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

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

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

If you have EDI questions or if you would like to know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com or call EDI Operations at (800) 480-1221.

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.

### COMPLIANCE GUIDELINES

### Volume of the Data

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

### Quality of the Data

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

### Timeliness of the Data

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

### Complete Submission

Blue Shield Promise will measure encounter submissions based on a rolling year of utilization data.

This page intentionally left blank.

# SECTION 9: QUALITY IMPROVEMENT

## 9.1: Quality Improvement Program

### Mission Statement

Blue Shield Promise's mission is to ensure all Californians have access to high-quality health care at an affordable price. Blue Shield Promise's Quality Program is comprehensive and designed to objectively, systematically, and continuously monitor, evaluate and improve the quality of care and/or services delivered to all Blue Shield Promise Members and Providers. Quality improvement activities are conducted in all areas and dimensions of clinical and non-clinical member care and service. Performance improvement projects and activities are selected and conducted using methodologies and practices that conform to respected health services research entities as well as standards and best practices established by regulatory and accrediting bodies.

### Goals

- Improve the quality and efficiency of health care.
- Improve Members' experiences with services, care, and their own health outcomes.

### Objectives

- Ensure that timely, quality, medically necessary and appropriate care and services that meet professionally recognized standards of practice are available to Members.
- Deliver quality care that enables enrollees to stay healthy, get better, manage chronic illness and/or disabilities and improve and maintain quality of life.
- Ensure our Members are afforded accessible health care by continually assessing the access to care and availability of our network of primary care and specialty providers.
- Implement or improve programs and services that support the elimination of health care disparities in our membership.
- Adhere to National Culturally and Linguistic Appropriate Services (CLAS) standards.
- Ensure the provider network is sufficient to meet the language needs and preferences of the membership.
- Ensure any language spoken by at least 5% of our membership is addressed by languages spoken by our provider network.
- Provide a confidential mechanism of documentation, communication and reporting of Quality Improvement issues and activities to the Quality Management Committee (QMC), Quality Oversight Committee, Board Quality Improvement Committee (BQIC), Compliance Department, and other appropriate involved parties.
- Assess the effectiveness of the Quality Improvement Program across all lines of business and act on opportunities for improvement.
- Ensure that Blue Shield Promise is meeting member cultural and linguistic needs at all points of contact.

- Ensure Members have access to all medically necessary covered services regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.
- Ensure mechanisms are in place to identify and address patient safety issues.
- Maintain an adequate, qualified provider network based on a thorough credentialing process.
- Assure compliance with the quality requirements, standards, and guidelines of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA, and L.A. Care, and escalate issues to the appropriate department.
- Identify potential risk management issues.
- Conduct oversight of all delegated activities, identify opportunities for improvement and ensure action is taken.
- Ensure that mechanisms are in place to support, facilitate and improve continuity and coordination of care.
- Ensure adequate clinical resources are in place to administer the quality program, including a full-time Medical Director whose responsibility is direct involvement in the implementation of the QI activities, in accordance with Title 22 CCR Section 53857.
- Ensure accountability through involvement of the governing body, designation of the Quality Oversight Committee and Quality Management Committee (QMC) with oversight and performance responsibility, delegation of the Medical Director with supervision of QI activities and inclusion of contracting practitioners and providers in the QI process and performance review.
- Effectively interface with all interdisciplinary departments and practices for the coordination of quality improvement activities.

### Scope

The scope of the Quality Improvement Program is to monitor care and service and identify opportunities for improvement of care and services to both our Members and providers/practitioners. This is accomplished by evaluating data, and leading or supporting the identification, investigation, implementation, and evaluation of corrective actions that continuously improve and measure the quality of clinical and administrative service. A formal evaluation of the Quality Improvement Program is performed annually. Specific elements of the Quality Improvement Program include but are not limited to:

- Adverse outcomes/sentinel events
- Medicare Chronic Care Improvement Program (CCIP)
- Credentialing and Re-credentialing
- Clinical measurement and improvement monitoring
- Compliance with regulatory requirements and reporting
- Culturally and Linguistically Appropriate Services Delegation Oversight (Claims, Credentialing and Utilization Management)
- Evidence-based practice guidelines
- High risk and high-volume services

- Facility site reviews
- Initial Health Assessments
- Independent Physician Associations (IPA)/Medical Group Oversight
- Medication Therapy and Management
- Medical record keeping practices
- Member safety
- Member satisfaction/grievances
- Dual Special Needs Plan (DSNP) Model of Care
- Potential Quality Issues
- Peer Review
- Practitioner accessibility and availability
- Practitioner satisfaction/grievances
- Provider Incentives
- Performance Improvement Projects (PIPs)
- Plan-Do-Study-Act (PDSA)

Confidentiality and Conflict of Interest

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

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

No persons shall be involved in the review process of Quality Improvement issues in which they were directly involved. If potential for conflict of interest is identified, another qualified reviewer will be designated. There is a separation of medical/financial decision making and all committee members. Committee chairs and the Chief Medical Officer sign a statement of this understanding.

### *9.1.1: Program Structure Governing Body*

The Blue Shield of California Board of Directors (Board) is ultimately responsible for the Quality Program. Annually, the quality strategy, related goals, and metrics are presented to the Board of Directors (Board) for recommendations. The Board provides oversight on performance against the quality goals, including ensuring compliance and regulatory requirements are met. The Board has delegated oversight of all quality activities to the Board Quality Improvement Committee (BQIC).

### *Committees*

### ***Quality Management Committee (QMC)***

The Quality Management Committee (QMC) is charged with the development, oversight, guidance, and coordination of Blue Shield Promise quality activities. Comprised of a voting membership of network providers, the QMC also assures compliance with accrediting and regulatory quality activities from entities such as DHCS, DMHC, CMS, NCQA, and L.A. Care. The QMC monitors provisions of care, identifies problems, and recommends corrective action, and informs educational opportunities for practitioners to improve health outcomes. Chaired by the Chief Medical Officer or physician designee, the Quality Management Committee reports to the Quality Oversight Committee and meets at least four times per year.

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

- Access and Availability
- Behavioral Health
- Medical Services

Scope ***(includes but not limited to)***:

1. Directing all Quality Improvement activities.
2. Monitoring, evaluating, and directing the overall compliance with the Quality Improvement Program.
3. Annually reviewing and approving the Quality Improvement Program, Work Plan and Annual Evaluation.
4. Reviewing and approving Quality Improvement policies and procedures, guidelines, and protocols. Recommending policy decisions.
5. Reviewing, analyzing, and evaluating Quality Improvement activity.
6. Ensuring practitioner participation in the QI program through planning, design, implementation, and review.
7. Assuring compliance with the requirements of accrediting and regulatory agencies, including but not limited to, DHCS, DMHC, CMS, NCQA and L.A. Care.
8. Developing and approving preventive health and clinical practice guidelines that are based on nationally developed and accepted criteria.

9. Reviewing and evaluating reports of Quality Improvement activities and issues arising from its subcommittees (Behavioral Health, Medical Services, Model of Care and Timely Access & Availability).
10. Developing relevant subcommittees for designated activities and overseeing the standing subcommittee's roles, structures, functions, and frequency of meetings as described in this Program. Ad-hoc subcommittees may be developed for short-term projects.
11. Developing and coordinating Risk Management education for all Health Plan Practitioners and staff.
12. Responsibility for evaluating and giving recommendations concerning audit results, member satisfaction surveys, Practitioner satisfaction surveys, access audits, HEDIS audits and IQIP studies.
13. Responsibility for evaluating and giving recommendations from monitoring and tracking reports, including appeals and grievances, potential quality investigations, member service metrics, Initial Health Assessments and Facility Site Review.
14. Ensuring follow-up, as appropriate.

***Delegation Oversight***

Blue Shield Promise may delegate any or all utilization management (UM), credentialing, and/or claims functions to Independent Practice Associations (IPAs), hospitals, medical groups, or vendors. A pre-delegation assessment is conducted within 12 months of implementing a delegated relationship, to assess the entity's ability to perform the proposed delegated functions.

Blue Shield Promise is ultimately responsible for all care and services provided to its Members directly or through a delegated arrangement. Blue Shield Promise's ongoing delegation oversight activities are directed by the Delegation Oversight Committee (DOC).

Blue Shield Promise ensures all functions delegated by Blue Shield Promise to providers, vendors, or other organizations are performed according to accreditation, regulatory, and Blue Shield Promise requirements. At least annually, Blue Shield Promise reviews the delegate's programs, policies and procedures, and data systems and files, if applicable to the delegated relationship. At least quarterly, delegates are required to submit performance reports, which are reviewed for compliance. Any identified deficiencies require a corrective action plan, which will be monitored until activities are compliant. If needed, additional actions, up to and including de-delegation, are taken for groups that do not correct deficiencies.

### *9.1.2: Standards of Practice*

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

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

Thresholds and targets derived from these standards and norms are:

- Measurable
- Achievable
- Consistent with national/community standards
- Consistent with requirements of regulatory agencies and legal guidelines
- Valuable to the assessment and improvement of quality for Members

Standards are communicated to practitioners through the Plan in a systematic manner that may include:

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

### *9.1.3: Quality Improvement Process*

Blue Shield Promise utilizes a Quality Improvement Process to identify opportunities to improve both the quality of care and quality of service for all Plan Members. Blue Shield Promise adopts and maintains clinical guidelines, criteria, quality screens and other standards against which quality of care, access, and service can be measured.

Blue Shield Promise uses a continuous quality improvement (CQI) process to measure performance, conduct quantitative and qualitative analysis, and assess and identify barriers and opportunities for improvement. Interventions are implemented to improve performance and are remeasured to determine effectiveness of the interventions.

Quality improvement is a data-driven process. Blue Shield Promise uses a variety of data sources to monitor, analyze, and evaluate quality improvement goals and objectives. These data sources include, but are not limited to:

- Quality Screens
- Chronic Care Improvement Plans
- HEDIS
- Plan Do Study Act and Performance Improvement Plan Studies
- Monitors
- Indicators

- Medical Record Audits
- Facility Site Reviews
- Outcome Measures
- Focused Review Studies
- Member satisfaction surveys
- Member grievances and quality of care issues (see more below)
- Practitioner/Provider Satisfaction Surveys
- Access to Care Audits

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 as described in this Provider Manual.

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

- Blue Shield Promise has a comprehensive review system to address potential quality of care issues. A potential quality issue arising from a Member grievance or an internal department is forwarded to the Blue Shield Promise Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including, but not limited to, medical records and a provider written response, if available. The case may then be forwarded to a Blue Shield Promise Medical Director for review and determination of any quality of care issues. A case review may also include a review of the care provided by a like-peer specialist and/or review by the Blue Shield Promise Peer Review Committee.
- During the review process, information is obtained from an IPA/medical group or directly from the involved provider. Upon review completion, dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a request for corrective action or an educational letter outlining opportunities for improvement. Patient safety concerns or patterns of poor care can be considered during Blue Shield Promise re-credentialing activities or reviewed in more detail by the Blue Shield Promise Credentialing Committee and may result in termination from the Blue Shield Promise network.
- Contracted providers are obligated to participate in the quality of care review process and must provide documents, including medical records and corrective action plans upon request. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157.

Quality Studies (HEDIS/PIP/PDSA Focused Review Studies)

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

Credentialing

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

### *9.1.4: Communication of Information*

All Quality Improvement activities are presented and reviewed by the Quality Management Committee. Types of activities, analyses, and/or data may include:

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

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

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

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

### Quality Improvement Program Description and Policies and Procedures

The Quality Improvement Program and its policies and procedures are reviewed at least annually and revised, as needed, to meet the needs of the Plan, its Members, and practitioners/providers; the changing demands of the healthcare industry, and regulatory requirements. The program description, work plan, and annual evaluation are reviewed and approved by the Quality Management Committee and Board Quality Improvement Committee (BQIC). Quality Improvement policies and procedures are reviewed and approved by the Quality Management Committee.

### Annual Work Plan

The Quality Work Plan outlines key activities for the year, and includes any activities not completed during the previous year, unless identified in the Annual Evaluation as issues that are no longer relevant or feasible to pursue. It is reviewed, approved, and monitored regularly by the Quality Management Committee, Quality Oversight Committee, and BQIC.

The Quality Improvement Work Plan is a fluid document and is revised, as needed, to meet changing priorities, regulatory requirements, and identified areas for improvement.

### Annual Program Evaluation

An annual evaluation is conducted each year to assess the quality activities that took place the prior year. The Clinical Quality department coordinates with the business areas responsible for the respective work plan activities to ensure the data collection, assessment of whether goals were met, quantitative and qualitative analysis, and identification of opportunities for improvement and/or corrective action if goals were not met. Any opportunities for improvement and corrective actions inform the subsequent year's Quality Improvement Program and work plan.

The Annual Evaluations are reviewed by the Chief Medical Officer and submitted to the Quality Management Committee, Quality Oversight Committee, and Board Quality Improvement Committee (BQIC) for review and approval.

## 9.2: Quality of Care Focused Studies

### Policy

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

### Procedure

1. Focused review studies will include the following design elements:
    - Objective and reason for topic selection
    - Sampling framework and sampling methodology
    - Data collection criteria and analysis methodology
    - Report of data and/or findings
    - Quantitative/Qualitative analysis
    - Barrier analysis
    - Action plans, as appropriate
    - Reassessment, as appropriate
2. The study will be designed to produce accurate, reliable, and meaningful data in accordance with standards of statistical analysis. The study questions will be framed using information from scientific literature, professional organizations, practitioner/provider representatives, regulatory requirements, and outcome-related data. The practice guidelines/ quality indicators used in the study will be specified, whenever possible. The variables to be collected and analyzed will be defined and derived from the practice guideline/quality indicators.

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

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

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

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

e. Monitoring plan

4. The results, interpretation and action plan will be presented to the Quality Management Committee for review and approval and then forwarded to the Board Quality Improvement Committee.
5. Reports will be made to the Quality Management Committee as required by the action plan.
6. Results will be made available to members and practitioners through newsletters, bulletins, faxes, special mailings, etc., as appropriate.
7. Sources for standards, norms and guidelines pertaining to the measurement of quality of care include, but are not limited to, the following:
   - National Committee of Quality Assurance standards for quality and utilization management.
   - Other independent credentialing, certification, and accreditation organizations, including Department of Health Care Services (DHCS), Centers for Medicare & Medicaid Services (CMS), JCAHO, CMRI, The Quality Commission, AAAHC and URAC.
   - HEDIS Medicare performance standards. Medicare performance standards.
   - Federal Agency guidelines including the Office of Technology Assessment (OTA), Agency for Healthcare Policy and Research (AHCPR), National Institute of Health (NIH), Department of Health and Human Services (DHHS), Center for Disease Control (CDC), and the United States Public Health Services (USPHS).
   - United States Preventive Services Task Force (USPSTF) guidelines.
   - National consensus organization guidelines for clinical practice.
   - Child Health and Disability Prevention (CHDP) program guidelines.
   - Professional specialty service guidelines, including American Academy of Family Practice, American College of Physicians, American Academy of Pediatrics, American College of Obstetrics and Gynecology, and the American Medical Association.
   - English language peer reviewed medical literature.
   - Milliman Care Guidelines.
   - Pharmacology guidelines extracted from the practice standards of the American Society of Hospital Pharmacists (ASHP) and the PDR.
   - Expert opinion.
   - HMO standards for access to ambulatory care.
   - InterQual Severity of Illness/Intensity of Service (ISSI).
   - Commission for Professional Activity Studies (PAS) length of stay norms.

## 9.3: Clinician and Member Satisfaction Surveys

***Clinician Satisfaction Survey***

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.

Member Satisfaction Survey

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

## 9.4: Clinical Practice Guidelines

Policy

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

## 9.5: Initial Health Assessment

Purpose

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

Policy

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

During their Initial Health Assessment, members need to complete an Individual Health Education Behavioral Assessment (IHEBA) also known as a SHA (Staying Healthy Assessment form) in the appropriate age category for them. The IHEBA can help providers identify risky health behaviors in order to promote positive lifestyle changes.

These forms are available on the Blue Shield Promise provider website at blueshieldca.com/promise/provider. Under *tools & information,* click on *health education resources,* then *Health education for Medi-Cal providers.*

In our efforts to coordinate with our providers, Blue Shield Promise conducts outreach to all new Members to ensure timely access to an IHA. Members receive phone calls and letters notifying them of the available service and encouraging them to call their PCP to make an IHA appointment within 120 days of enrollment. Blue Shield Promise also sends a letter to the PCPs notifying them of their newly assigned Member and reminding them of the requirements to conduct a timely IHA.

Please be advised your office may be randomly selected to participate in the IHA medical record review utilizing the IHA Audit Tool. Blue Shield Promise will coordinate with our members and providers as follows:

1. A minimum of three documented attempts must be made to schedule the timely IHA, with at least one phone call and one letter.
2. Notify Members of the importance and availability of IHAs through the Member Telephone outreach, Member letter, EOC, and newsletters.
3. Notify practitioners/providers of the requirement for IHAs through the Provider Manual, newsletters, provider letters, fax blast and telephone.
4. Monitor compliance by Monthly IHA provider file review.

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

Although, there is no specific form, complete documentation of this visit is required to be kept in the Member's medical record. (Age-appropriate physical evaluations templates are available on Blue Shield Promise provider website in the Health Education for Medi-Cal Providers link under IHA). Provision of the assessment or that of a comparable comprehensive assessment needs to be documented in the Member's medical record. These forms are available on the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms.

Health Assessment Services include:

A. Health Assessments for Members under 21 years of age in accordance with AAP/Bright Futures Periodicity Schedule must include, at minimum:

- Practitioners must complete an age-appropriate Staying Healthy Assessment ("SHA") form/ Individual Health Education Behavioral Assessment ("IHEBA") within the initial visit.
- Health and developmental history.
- Review of Organ Systems.
- Psychosocial/Behavioral Assessment.
- Developmental disorder screening at 9th, 18th and 30th month visits
- Blood Pressure before 3 years old for at risk patients, BMI, Height & Weight and (Head circumference from <1-18 months).
- Physical examination, including assessment of physical growth.
- Assessment of nutritional status.
- Hearing and Vision screening, as appropriate.
- Dental assessment to include inspection of mouth, teeth and gums beginning at 12 months of age.
- Immunizations as recommended by ACIP and CDC schedules and reported to California Immunization Registry (CAIR) or San Diego Immunization Registry (SDIR) within 14 days of administration.
- Tuberculosis (TB) risk assessment screening and testing or chest x-ray for positive PPD skin test.
- Tobacco usage assessment.
- HPV Vaccine is recommended by ACIP for girls and boys as young as 9 to 26 years old.
- HIV Screening, as appropriate.
- Intimate Partner Violence screening, as appropriate.
- Nutrition Assessment.
- Obesity Screening.
- Sexual Activity Assessment and contraceptive care.
- Sexually Transmitted Infection (STI) screening on all sexually active adolescents.
- Cervical Cancer Screening, as appropriate.
- Lab tests appropriate to age and sex, including anemia (Hemoglobin/ Hematocrit) starting at age 9-12 months.
- Diabetes risk assessment.
- Blood lead testing at appropriate intervals as well as appropriate reporting and treatment for abnormal levels.

B. Health Assessments for Asymptomatic Members 21 years of age and older must include, at minimum:

- Practitioners must complete an age-appropriate Staying Healthy Assessment (SHA)form/ Individual Health Education Behavioral Assessment ("IHEBA") within the initial visit.
- Complete history and physical examination which includes review of organ systems that includes inspection of ears, nose, mouth, throat, teeth, and gums.
- Height, Weight and Blood Pressure documented.
- Diabetic Screening as part of Cardiovascular risk assessment in adults ages 40 to 70 who are overweight or obese.
- Dyslipidemia screening and calculation of 10-year Cardiovascular Disease (CVD)event risk in adults ages 40 to 75.
- Hepatitis B and Hepatitis C Screening.
- Mammography screening for breast cancer completed every 2 years on all women starting at age 50, concluding at age 75 unless pathology has been demonstrated.
- Cervical Cancer screen (Pap smear) for women beginning at the age 21-65 of first sexual intercourse and once every 3 years, or for women ages 30 to 65 who want to lengthen the screening interval, screening with combination of cytology and human papillomavirus (HPV) co-testing every 5 years.
- Chlamydia screen for all sexually active females through age 26 and older who are determined to be at high-risk for Chlamydia infection.
- Tuberculosis (TB) Risk Assessment – Screen/Test or Chest X-Ray results for positive Mantoux or PPD skin tests.
- Initial and annual assessment of tobacco use for each Member.
- Alcohol Misuse Screening and Behavioral Counseling for all adults at each visit.
- Intimate Partner Violence Screening on women ages 18 and older.
- HIV Screening.
- Sexually Transmitted Infection (STI) Screening.
- Health education and anticipatory guidance appropriate to age and health statistics.
- Colorectal cancer screening done for all adults at age 45 and concluding at age 75 years. Prostate Specific Antigen (PSA) testing for men annually 45 years of age with high risk and ages 50-70 for men with average risk.
- Immunizations administered as recommended by the current ACIP and CDC schedules and reported to California Immunization Registry (CAIR) or San Diego Immunization Registry (SDIR) within 14 days of immunization.

Procedure

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

120 days of enrollment.

2. The Member Handbook, distributed at the time of enrollment, contains both basic information about PCP services and specific information describing the importance of the IHA. It encourages Members to access this service. Members are specifically directed, in their Blue Shield Promise new Member packet, to contact their PCP's office to schedule an IHA.
3. Blue Shield Promise Provider Relations representatives educate contracted practitioners/ providers on the 120-day health assessment requirements. Practitioner/ Provider bulletins and newsletters are used to reinforce awareness of the compliance and tracking process. The IHA is also included in New Provider Training upon contracting with Blue Shield Promise.
4. When a significant health problem, requiring further evaluation or referral, is identified, the PCP will be responsible for scheduling an appointment date for follow-up within 60 days.
5. 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.
6. If a Member refuses an IHA, the refusal must be documented in the medical record or on the eligibility list until the Member comes to the office.

Provider Incentives

Blue Shield Promise is committed to providing supportive services for network providers and has developed an IHA provider incentive program for contracted network providers who perform IHAs for new Medi-Cal enrollees to Promise Health Plan. The IHA provider incentive program rewards Blue Shield Promise network providers for ensuring that every Member who requires an IHA receives the care they need. Eligible providers are eligible for payouts that will be made for every IHA completion demonstrated in Blue Shield Promise data systems via encounter data with a date of service within 120 days of the Member's enrollment at Blue Shield Promise Health Plan.

## 9.6: Facility Site Review

### Overview

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

#### *9.6.1: FSR Evaluation Tools*

### Policy

The Facility Review is a comprehensive evaluation of the Access/Safety, Personnel, Office Management, Clinical Services, Preventive Services, and Infection Control related to your physical location. The reviews are conducted by a Certified Site Review Nurse using the attached tools that have been approved by Blue Shield Promise Medical Directors. Blue Shield Promise will utilize the current DHCS Medical Record Review tool to evaluate readiness and compliance with DHCS requirements. See DHCS Policy Letter 14-004, Attachment A or current version.

### Procedure

1. An FSR will be conducted by Blue Shield Promise upon receipt of a request from Provider Network Administrators or Credentialing prior to any Primary Care Physician's site being added to the practitioner/provider network.
2. The FSR Coordinator will process an FSR for all sites within 60 days of receipt of a request for an FSR or at least 90 days prior to their three-year or annual FSR anniversary date.
3. The FSR will be conducted using the most current review Survey tool as directed by the DHCS and approved by the Blue Shield Promise Medical Directors.

4. Practitioners/Providers for initial credentialing and recredentialing will be contacted a minimum of three (3) times to schedule a mutually agreed upon date and time to conduct the review. If Blue Shield Promise is unsuccessful in contacting a site, an auto-scheduled date will be generated in order to complete the review by the required timelines.
5. The Facility Site Review unit will send a confirmation letter along with a link that contains sample copies of the tools to be used as well as a set of policies and procedures and forms that your office can use to update the office policies and procedures to meet criteria from the Center for Medicare & Medicaid Services and the California Department of Health Care Services.
6. The reviewer will arrive at the scheduled time and conduct the review. The reviewer will be courteous, thorough, and helpful. If a reviewer cannot answer a question, he/she will take the question back to the supervisor or manager of the facility site review staff and will contact the office with the answer.
7. After completing the review, the reviewer will score the facility according to the approved scoring guidelines. Compliance will fall into the following categories:
    - Exempted Pass: 90% and above without deficiencies in Critical Elements, Pharmaceutical or Infection Control sections
    - Conditional Pass 80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical or Infection Control sections
    - Not Pass 79% and below
    - A Corrective Action Plan (CAP) is required for all sites that have a deficiency in a critical element, Pharmaceutical, or Infection Control sections, regardless of score
8. Any CAP considered critical, if required, is due within 10 business days of the date of the review. A non-critical CAP for the rest of the deficiencies will be due 30 days from the date of the review.
9. Blue Shield Promise staff is available to assist practitioners/providers with the review preparation and CAP completion.
10. New Practitioners/Providers sites may request for an educational visit. For those providers who score below 80% will not be admitted to the network until they have corrected all deficiencies and have submitted evidence of corrections to deficiencies found. Such providers must submit evidence in order to be considered for another review and receive a passing score.
11. Practitioners/Providers that score 80 to 89% and do not submit a CAP or CAPS within required time frames will be referred to the Medical Director and Credentialing Committee for further action, which may include but is not limited to: immediate closure of panels to new membership, annual audit and/or termination from the network.

12. Blue Shield Promise and the practitioners/provider's delegated IPA/medical groups will contact practitioners/providers who do not submit their CAP within the required timeframes to offer assistance.
13. Blue Shield Promise follows the DHCS FSR guidelines as written in Policy Letter 14-004, or current version. Additional information, including review requirements and regulatory timelines, are included in this document for review.

### *9.6.2: Facility Review Tool Purpose*

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

Policy

1. Convenient, adequate parking is available, some of which must be accessible to disabled persons or reasonable alternates are in place.
2. The facility is neat, clean, and well organized. Adequate storage space is available so that patient care areas are not unnecessarily cluttered. Electrical wiring is covered and concealed according to building codes. Incandescent bulbs and fluorescent tubes are covered. Floors, walls, and ceilings are in good repair. Lighting is adequate.
3. Waiting areas have sufficient floor space and seating capacity to accommodate the typical patient load.
4. The number of examination and treatment rooms is adequate to accommodate patient needs.
5. There is at least one exam room that can be designated for patients with contagious or infectious diseases.
6. The number of adult, pediatric, and obstetrical examination tables is adequate to meet patient needs.
7. The office hours of operation are available upon request or posted within or outside the office door. Emergency telephone number(s) are updated annually and posted in easily accessible locations to office staff.
8. Policies and procedures for housekeeping must be maintained including specific responsibilities of personnel and a procedure for regularly monitoring completion of specified tasks.

### *9.6.3: Physical Accessibility*

Purpose

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

Policy

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

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

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

Procedures

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

### *9.6.4: Medical Equipment*

Purpose

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

Policy

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

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

Procedures

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

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

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

### *9.6.5: Fire and Earthquake Safety*

Purpose

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

Policy

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

Procedure

1. Current inspection tags are securely attached to extinguishers if a fire inspection has been done within the last 12 months.
2. Regular reviews of fire safety features (e.g., exit signs, evacuation maps, etc.) are scheduled.
3. The written emergency evacuation plan is discussed in new employee orientations and is readily accessible to all staff. The plan is regularly reviewed and updated to reflect changes in the physical plan, changes in safety codes, etc.
4. Evidence of non-medical emergency protocol training is documented and maintained in every employee's file.
5. Response to a Fire
   - Sound the alarm either with the pull alarm station or telephone.
   - If using the telephone, give the location and extent of the fire.
   - Warn others near you.
   - Check doors before opening for heat. If hot, do not open.
   - Open doors slowly and be prepared to close doors quickly.
   - Evacuate all patients and other employees who are in immediate danger.
   - If you have time and there is no immediate danger, close all window and doors in the area.
   - Do not use elevators.
   - Above all, remain calm.
6. Earthquake Safety
   - Assign responsible person(s) to coordinate response to an earthquake.
   - Move away from windows and glass.
   - Take cover under a sturdy desk, table.
   - After the quake, assess damage and check other around you for injury.
   - Provide first aid, if qualified.

Follow instructions to move patients and/or evacuate building.

### *9.6.6: Emergency Equipment and Medications Policy*

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

Procedures

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

### *9.6.7: Infection Control*

Purpose

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

Policy

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

Procedure

***Cleaning of exam rooms, equipment, and surfaces***

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

***Handling and Disposal of Bio-hazardous Waste***

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

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

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

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

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

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

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

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

***Containment and Storage***

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

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

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

118280

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

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

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

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

Autoclave Procedures

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

Cold Sterilization

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

Hand Washing

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

Protective Clothing

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

## 9.7: Medical Records

### *9.7.1: Policy*

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

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

from Blue Shield Promise or from the Pre-Review packet that was received when the Facility Site Review was scheduled.

4. If the practitioner/provider is unwilling to schedule the medical record audit, the FSR Supervisors or QI Director will be notified. If arrangements cannot be made to complete this Medical record Review the practitioner panel may be closed to new Members and the situation is referred to the QI Medical Director and the Credentialing Committee for further action which may include termination from the Blue Shield Promise Health Plan Network.
5. The Review Nurse, will review medical records, using the following rationale: passing or 80% total aggregate score or higher.
6. In order to ensure compliance with Blue Shield Promise standards, Blue Shield Promise will conduct follow-up audits of all practitioners/providers who score less than 80% overall, or in a section of their medical records audit, on their initial or routine medical record review.
7. Survey results will be utilized to conduct practitioner/provider education and as a component to the recredentialing process.

***9.7.2: Procedure***

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

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

### *9.7.3: Guidelines*

Policy

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

Procedure

1. The medical record is a legal document and should be treated as such.
2. The maintenance of the patient medical record is the responsibility of the individual practitioner/provider's office. The medical record should be secure and inaccessible to unauthorized persons in order to prevent loss, tampering, and disclosure of information, alteration, or destruction of the record.
3. A patient's medical record should be easily retrievable at the time of the patient's encounter and for administrative purposes. To accomplish this, there should be a system for tracking the record. Records should be stored in one central location that is inaccessible to unauthorized persons.
4. Inactive medical records must remain accessible for a period of time which meets state and federal requirements (currently five years and to age of majority for minors). Patient medical records may be converted to microfilm or computer disks for long term storage.

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

Section 1. Patient Information (Inside the front cover)

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

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

Adult charts:

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

Pediatric charts (if applicable):

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

Section 3. Laboratory

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

Section 4. XRAY and EKG

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

Section 5. Consult / Referral

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

Section 6. Miscellaneous

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

Confidentiality

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

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

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

Mental Health Care Records

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

## 9.8: Access to Care

Blue Shield Promise requires its providers to comply the standards listed in Appendix 4: Access to Care Standards.

Compliance with these standards is monitored through Member complaints and grievances, PQIs, Member satisfaction surveys, medical record reviews, disenrollments, PCP transfers, and annual Access Surveys and Studies. Blue Shield Promise will ensure that provider contact lists are generated for all provider groups required to be surveyed for the current measurement year.

Blue Shield Promise shall ensure that its provider network is sufficient to provide accessibility, availability, and continuity of covered health care services established by regulatory and accreditation standards.

### Monitoring Access for Compliance with Standards

Access to care standards are reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis. Provider network adherence to access standards is monitored via the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, and after-hours access;
2. Member complaint data – Assessment of Member complaints related to access to care; and
3. Member satisfaction survey – Evaluation of Members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified provider-specific or organizational trends.

### After Hours Care and Emergencies

Primary and specialty care physicians are required to be available to render emergency care to Members 24 hours a day, 7 days a week, either directly or through arrangements for after-hours coverage with an appropriately qualified practitioner/provider. Physicians may provide care in their offices or based on the medical necessity of the case, refer the Member to an urgent or emergency care facility. Blue Shield Promise has a nurse on call to arrange for care if a practitioner/provider is unavailable. If a Member contacts the Plan about an emergency situation, the Plan will direct the Member to an appropriate urgent or emergency care center for immediate assessment and treatment.

## Appointment Scheduling

Each Provider must implement an appointment scheduling system. The following are the minimum standards:

1. The Provider must have an adequate telephone system to handle patient volume. Appointment intervals between patients should be based on the type of service provided and a policy defining required intervals for services. Flexibility in scheduling is needed to allow for urgent walk-in appointments;
2. A process for documenting missed appointments must be established. When a Member does not keep a scheduled appointment, it is to be noted in the Member's record and the Provider is to assess if a visit is still medically indicated. All efforts to notify the Member must be documented in the medical record;
3. When the Provider must cancel a scheduled appointment, the Member is given the option of seeing an associate or having the next available appointment time;
4. Special needs of Members must be accommodated when scheduling appointments. This includes, but is not limited to wheelchair-using Members and Members requiring language translation;
5. A process for Member notification of preventive care appointments must be established. This includes, but is not limited to immunizations and mammograms; and,
6. A process must be established for Member recall in the case of missed appointments for a condition which requires treatment, abnormal diagnostic test results or the scheduling of procedures which must be performed prior to the next visit.

In applying the standards listed above, participating Providers have agreed that they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, gender identity, pregnancy, sex stereotyping, place of residence, socioeconomic status, or status as a recipient of Medicaid benefits. Additionally, a participating Provider or contracted medical group/IPA may not limit his/her practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care. If a PCP chooses to close his/her panel to new Members, Blue Shield Promise must receive thirty (30) days advance written notice from the Provider.

IPA/medical groups are expected to ensure that each practitioner/provider in their network receives and complies with Appendix 4: Access to Care Standards.

Medi-Cal Laws requires organizations to ensure that the network providers offer hours of operation that are no less (in number or scope) than the hours of operation offered to commercial enrollees. If the Provider serves only Medi-Cal recipients, hours offered to Medi-Cal managed care enrollee must be comparable to those for Medi-Cal fee-for service Members.

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 Promise 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.

### *9.8.1: Monitoring Process*

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

### *9.8.2: Subcontracted Network Certification Requirement*

The Department of Health Care Services (DHCS) requires Medi-Cal managed care plans to implement a subcontracted annual network certification process effective July 1, 2021. A subcontracted network is a network which Blue Shield Promise has delegated various functions, including but not limited to; claims, credentialing, financial solvency, and utilization management to entities such as groups, independent provider associations (IPAs), hospitals, and applicable vendors.

The goal of the subcontracted network certification requirement is to ensure managed care plans (MCPs) that delegate the responsibility of providing Medi-Cal covered healthcare services to subcontracted networks meet network adequacy requirements for each subcontracted network. All subcontracted networks will be subject to the same network adequacy standards required of the primary MCP, as outlined in APL 20-003, which include:

- Provider to Member ratios
- Mandatory provider types
- Time and distance standards
- Timely access

The below grid outlines the mandatory provider types:

<table>
<tr><td>Adult primary care physicians (including non-physician medical practitioners)</td><td rowspan="3">Adult and pediatric core specialists:<ul><li>Cardiology/Interventional Cardiology</li><li>Dermatology</li><li>Endocrinology</li><li>ENT/Otolaryngology</li><li>Gastroenterology</li><li>General Surgery</li><li>Hematology</li></ul></td></tr>
<tr><td>Pediatric primary care physicians (including non-physician medical practitioners)</td></tr>
<tr><td>Obstetrician-gynecologists (OB/GYNs)</td></tr>
</table>

| | |
|---|---|
| Adult mental health outpatient providers | • HIV/AIDS Specialists/Infectious Diseases<br>• Nephrology<br>• Neurology<br>• Oncology<br>• Ophthalmology<br>• Orthopedic Surgery<br>• Physical Medicine and Rehabilitation<br>• Psychiatry<br>• Pulmonology |
| Pediatric mental health outpatient providers | |
| Hospitals | |
| Pharmacies | |
| Ancillary Services | |

The full list of network adequacy standards may be found on the DHCS website at Attachment A of APL 20-003.

Subcontracted networks will need to meet network adequacy standards for the scope of services they are contracted to provide. If Blue Shield Promise determines that a subcontracted network will not be certified, we must clearly explain the reason(s) and work with the subcontracted network to ensure that Members within the network would otherwise be able to access appropriate care.

## 9.9: Broken/Failed Appointments

### *9.9.1: Broken/Failed Appointment Follow-up*

Policy

All practitioner/provider offices are required to have in place a procedure for scheduling appointments. Offices are also required to have a policy for assuring timely and efficient recall of patients. DHCS requires that missed/broken appointments must be documented in the medical record the day of the missed appointment and the Member must be contacted by mail or phone to reschedule within 48 hours.

Procedure

The following is a sample "Broken/Failed Appointment" protocol which may be implemented by practitioner/provider offices if no other protocol is currently in place. Blue Shield Promise will monitor its provider network for compliance via oversight activities that may include medical record review, provider surveys and/or review of provider policies.

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

BROKEN/FAILED APPOINTMENTS

BROKEN APPT. DATE: _____

REVIEW DATE: _____

FOLLOW-UP REQ: _____

FOLLOW–UP ASAP: _____

NEW APPT. DATE: _____

PRACTITIONER/PROVIDER SIGNATURE: _____

COMPLETED BY: _____

2. At the end of each day the receptionist will determine which patients failed to keep their appointment by:
   a. Checking the appointment schedule and making a list of all failed appointments.
   b. Gathering the pulled charts which were ready for appointments (Charts are pulled the day before scheduled appointments).
3. Use a progress sheet with the latest date or a new progress sheet and stamp the sheet with the "Broken/Failed Appointment" rubber stamp.
4. Attach the progress sheet to the medical record and forward to the primary care practitioner/ provider.
5. The medical assistant (M.A.) or designated individual will review all charts of those patients who missed an appointment and wait for further orders from the practitioner/provider.
6. The practitioner/provider will review the chart to determine the need for patient recall.
7. The practitioner/provider will complete items 2, 3 and 6 as needed, on the Broken/ Failed Appointment" rubber stamp, using the following guidelines:
   - Item 2 – Write in review data
   - Item 3 – Enter a checkmark if follow-up action is ordered
   - Item 4 – Enter a checkmark if the patient is to return to the clinic as soon as possible
   - Item 6 – Enter signature and title
8. If the patient needs follow-up, the M.A. or designated individual shall try to contact the patient
9. one time by phone. If no results, a recall postcard or letter will be mailed out to the patient's current address of record. A copy will be filed in the chart.
10. Every attempt to contact the patient, with date and time of each attempt, must be documented in the progress notes. Only the following staff may document patient recall activities in the medical record: M.D., P.A., N.P., R.N., L.V.N., or M.A.

11. The M.A. completes items 1, 5 and 7 as needed on the broken/failed appointment stamp using the following guidelines:
    - Item 1 – Enter the date of the broken appointment.
    - Item 5 – Enter the date of the new appointment.
    - Item 6 – Enter date, signature and title of person doing recall activity.
12. The broken/ failed appointment will also be documented in the appointment schedule for tracking purposes.
13. The practitioner/provider is responsible for final decisions concerning a broken/ failed appointment follow-up. Patients being followed for reportable conditions shall also be reported to the local health authority.
14. The administrator or office manager is responsible for:
    a. Assuring that all clinic personnel are aware of their responsibilities under this procedure.
    b. Designating, in conjunction with the Medical Director, the persons responsible for implementing this policy.
    c. Periodically monitoring the performance of staff in carrying out their duties.

## 9.10: Advance Directives

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

## 9.11: Clinical Telephone Advice

Policy

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

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

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

## 9.12: HEDIS Measurements

### Use of Practitioners/Providers Performance Data

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

| Measure | Criteria | Description |
|---|---|---|
| 1. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) | Blue Shield Promise will audit the percentage of Members ages 3 months or older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. | The Member must have a date of service for any outpatient, telephone, observation, e-visit, virtual check-in, or ED visits during the intake period that meets all the following criteria:<br>• Determine all acute bronchitis episode dates.<br>• Test for negative comorbid condition history<br>• Test for negative medication history<br>• Test for negative competing diagnosis |
| 2. Asthma Medication Ratio (AMR) | Blue Shield Promise will audit Members that are 5 – 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. | The Member must be identified as having persistent asthma and have had administered oral medication, inhaler, injection, or intravenous dispensing for asthma. Identify Members that have persistent asthma by a least four asthma medication being dispensed |
| 3. Breast Cancer Screening (BCS) | Blue Shield Promise will audit Members that are age 50–74 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year. | The Member must have at least one (1) bilateral mammogram screen for breast cancer within the past two years. |

| Measure | Criteria | Description |
|---|---|---|
| 4. Cervical Cancer Screening (CCS) | Blue Shield Promise will audit female Members that are 21-64 years of age who were screened for cervical cancer | Members who were screened for cervical cancer screening using either of the following criteria:<br>• Women 21-64 years of age who had cervical cytology performed within the past 3 years.<br>• Women 30-64 years of age who had cervical cytology/ human papillomavirus (HPV) co-testing performed every 5 years. |
| 5. Chlamydia Screening in women (CHL) | Blue Shield Promise will audit the percentage of women who were identified as sexually active and who had at least one test for chlamydia in measurement year. | The Member must have at least one (1) chlamydia test performed during the measurement year. |
| 6. Appropriate Testing for Pharyngitis (CWP) | Blue Shield Promise will audit the percentage of episodes for Members 3 years and older where the Member was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A streptococcus (strep) test for the episode. | A group A streptococcus test (Group A Strep Tests Value Set) in the seven-day period from three days prior to the Episode Date through three days after the Episode Date. |
| 7. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) | Blue Shield Promise will audit the percentage of Members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. | At least one claim/encounter for spirometry (Spirometry Value Set) during the 730 days (2 years) prior to the IESD (Index Episode Start Date) through 180 days (6 months) after the IESD. |
| 8. Pharmacotherapy Management of COPD Exacerbation (PCE) | Blue Shield Promise will audit the percentage of COPD exacerbations for Members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. | Dispensed prescription for systemic corticosteroid (Systemic Corticosteroid Medications List) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date. |

| Measure | Criteria | Description |
|---|---|---|
| 9. Asthma Medication Ratio (AMR) | Blue Shield Promise will audit the percentage of Members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. | The number of Members who have a medication ratio of 0.50 or greater during the measurement year. |
| 10. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) | Blue Shield Promise will audit the percentage of Members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge. | At least 135 days of treatment with beta-blockers (Beta-Blocker Medications List) during the 180-day measurement interval. This allows gaps in medication treatment of up to a total of 45 days during the 180-day measurement interval.<br><br>Assess for active prescriptions and include days supply that fall within the 180-day measurement interval. For Members who were on beta-blockers prior to admission and those who were dispensed an ambulatory prescription during their inpatient stay, factor those prescriptions into adherence rates if the actual treatment days fall within the 180-day measurement interval. |
| 11. Statin Therapy for Patients With Cardiovascular Disease (SPC) | Blue Shield Promise will audit the percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:<br>1. Received Statin Therapy. Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.<br>2. Statin Adherence 80%. Members who remained on a high-intensity or moderate- | The number of members who had at least one dispensing event for a high-intensity or moderate-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events. |

| Measure | Criteria | Description |
|---|---|---|
| | intensity statin medication for at least 80% of the treatment period. | |
| 12. Cardiac Rehabilitation (CRE) | Blue Shield Promise will audit the percentage of Members 18 years and older, who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation or heart valve repair/replacement. Four rates are reported:<br>• Initiation. The percentage of Members who attended 2 or more sessions of cardiac rehabilitation within 30 days after a qualifying event.<br>• Engagement 1. The percentage of Members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event.<br>• Engagement 2. The percentage of Members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event.<br>• Achievement. The percentage of Members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event. | At least 2 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 30 days after the Episode Date (31 total days) (on the same or different dates of service).<br>At least 12 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 90 days after the Episode Date (91 total days) (on the same or different dates of service).<br>At least 24 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service).<br>At least 36 sessions of cardiac rehabilitation (Cardiac Rehabilitation Value Set) on the Episode Date through 180 days after the Episode Date (181 total days) (on the same or different dates of service). |

| Measure | Criteria | Description |
|---|---|---|
| 13. Childhood Immunization Status (CIS) | Blue Shield Promise will audit the percentage of children 2 years of age who had DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV, and flu vaccines by their second birthday. | The Member must have the following immunizations by their second birthday:<br>• 4 diphtheria, tetanus, and acellular pertussis (DtaP)<br>• 4 pneumococcal conjugate<br>• (PCV)<br>• 3 polio (IPV)<br>• 3 haemophilus influenza type B (HiB)<br>• 3 hepatitis B (HepB)<br>• 1 measles, mumps, and rubella (MMR)<br>• 1 chicken pox (VZV)<br>• 1 hepatitis A (HepA)<br>• 2 or 3 rotavirus (RV)<br>• 2 influenza (flu) |
| 14. Lead Screening in Children (LSC) | Blue Shield Promise will audit the percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. | At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday. |
| 15. Controlling Blood Pressure (CBP) | Blue Shield Promise will audit Members that are Age 18 - 85 during the measurement year. They must not have more than a one-month gap in enrollment during the measurement year. | Members who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year. |
| 16. Comprehensive Diabetes Care (CDC) | Blue Shield Promise will audit Diabetic Members that are age 18-75 years of age during the measurement year. There must not be more than a one-month gap in enrollment during the measurement year. | Diabetic Members must have the following done during the measurement year:<br>• Hemoglobin A1c (HbA1c) testing<br>• HbA1c poor control (>9.0%)<br>• HbA1c control (<8.0%)<br>• Retinal eye exam performed<br>• BP control (<140/90 mm Hg) |

| Measure | Criteria | Description |
|---|---|---|
| 17. Kidney Health Evaluation for Patients With Diabetes (KED) | Blue Shield Promise will audit the percentage of Members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year. | Members who received both of the following during the measurement year on the same or different dates of service:<br>• At least one eGFR (Estimated Glomerular Filtration Rate Lab Test Value Set).<br>• At least one uACR identified by both a quantitative urine albumin test (Quantitative Urine Albumin Lab Test Value Set) and a urine creatinine test (Urine Creatinine Lab Test Value Set) with service dates four or less days apart. For example, if the service date for the quantitative urine albumin test was December 1 of the measurement year, then the urine creatinine test must have a service date on or between November 27 and December 5 of the measurement year. |
| 18. Statin Therapy for Patients With Diabetes (SPD) | Blue Shield Promise will audit the percentage of Members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:<br>1. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.<br>2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period. | The number of Members who had at least one dispensing event for a high-intensity, moderate intensity, or low-intensity statin medication during the measurement year. Use all the medication lists below to identify statin medication dispensing events. |

| Measure | Criteria | Description |
|---|---|---|
| 19. Depression Screening and Follow-Up for Adolescents and Adults (DSF) | Blue Shield Promise will audit the percentage of Members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. | The Member must have had the following:<br>• Depression Screening: percentage of Members who were screened for clinical depression using a standardized instrument.<br>• Follow-up on Positive Screen: percentage of Members who received follow-up care within 30 days of screening positive for depression |
| 20. Immunization for Adolescents (IMA) | Blue Shield Promise Members that are 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. | Members must have the following immunizations completed by their 13th birthday:<br>• At least one meningococcal vaccine (MCV) on or between the Member's 11th and 13th birthday<br>• At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine on or between the Member's 10th and 13th birthday<br>• At least two HPV vaccines with different dates of service on or between the Member's 9th and 13th birthday<br>  • There must be at least 146 days between the first and second dose of HPV vaccine<br>  • OR at least 3 HPV vaccines with different dates of service on or between the Member's 9th and 13th birthday |

| Measure | Criteria | Description |
|---|---|---|
| 21. Antidepressant Medication Management (AMM) | Blue Shield Promise will audit the percentage of Members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.<br>1. Effective Acute Phase Treatment. The percentage of Members who remained on an antidepressant medication for at least 84 days (12 weeks).<br>2. Effective Continuation Phase Treatment. The percentage of Members who remained on an antidepressant medication for at least 180 days (6 months). | At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. |
| 22. Follow-Up Care for Children Prescribed ADHD Medication (ADD) | Blue Shield Promise will audit the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed | A follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD. |
| 23. Follow-Up After Hospitalization for Mental Illness (FUH) | Blue Shield Promise will audit the percentage of discharges for Members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. | A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.<br>A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge. |

| Measure | Criteria | Description |
|---|---|---|
| 24. Follow-Up After Emergency Department Visits for Mental Illness (FUM) | Blue Shield Promise will audit the percentage of emergency department (ED) visits for Members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. | A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.<br>A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. |
| 25. Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) | Blue Shield Promise will audit the percentage of acute inpatient hospitalizations, residential treatment, or detoxification visits for a diagnosis of substance use disorder among Members 13 years of age and older that result in a follow-up visit or service for substance use disorder. | • A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 30 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode.<br>• A follow-up visit or event with any practitioner for a principal diagnosis of substance use disorder within the 7 days after an episode for substance use disorder. Do not include visits that occur on the date of the denominator episode. |

| Measure | Criteria | Description |
|---|---|---|
| 26. Follow-Up After Emergency Department Visits for Alcohol and Other Drug Abuse or Dependence (FUA) | Blue Shield Promise will audit the percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:<br>1. The percentage of ED visits for which the Member received follow-up within 30 days of the ED visit (31 total days).<br>2. The percentage of ED visits for which the Member received follow-up within 7 days of the ED visit (8 total days). | A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.<br><br>A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. |
| 27. Pharmacotherapy for Opioid Use Disorder (POD) | Blue Shield Promise will audit the percentage of new opioid use disorder (OUD) pharmaco-therapy events with OUD pharmacotherapy for 180 or more days among Members aged 16 and older with a diagnosis of OUD. | New OUD pharmacotherapy events with OUD pharmacotherapy for 180 or more days without a gap in treatment of 8 or more consecutive days. |
| 28. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) | Blue Shield Promise will audit the percentage of Members 18–64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. | A glucose test (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or an HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year. |

| Measure | Criteria | Description |
|---|---|---|
| 29. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | Blue Shield Promise will audit the percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. | • Blood Glucose: Members who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.<br>• Cholesterol: Members who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.<br>• Blood Glucose and Cholesterol: Members who received both of the following during the measurement year on the same or different dates of service.<br>  • At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).<br>  • At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set). |
| 30. Use of Imaging Studies for Low Back Pain (LBP) | Blue Shield Promise will audit the percentage of Members who had a primary diagnosis of low back pain and did not have an imaging study within 28 days of the diagnosis. | Members that have had a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan). |

| Measure | Criteria | Description |
|---|---|---|
| 31. Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS) | Blue Shield Promise will audit the percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer. | Cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) or an HPV test (High Risk HPV Lab Test Value Set; High Risk HPV Test Result or Finding Value Set) performed during the measurement year. |
| 32. Appropriate Treatment for Upper Respiratory Infection (URI) | Blue Shield Promise will audit the percentage of episodes for Members 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event. | Dispensed prescription for an antibiotic medication from the CWP Antibiotic Medications List on or 3 days after the Episode Date. |
| 33. Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) | Blue Shield Promise will audit the percentage of episodes for Members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. | Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or three days after the Episode Date. |
| 34. Use of Imaging Studies for Low Back Pain (LBP) | Blue Shield Promise will audit the percentage of Members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis. | An imaging study (Imaging Study Value Set) with a diagnosis of uncomplicated low back pain (Uncomplicated Low Back Pain Value Set) on the IESD or in the 28 days following the IESD. |
| 35. Use of Opioids at High Dosage (HDO) | Blue Shield Promise will audit the proportion of Members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days during the measurement year. | The number of Members whose average MME was ≥90 during the treatment period. |
| 36. Use of Opioids from Multiple Providers (UOP) | Blue Shield Promise will audit the proportion of Members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year who received opioids from multiple providers. | Identify all opioid medication dispensing events during the measurement year. Include Members who received opioids from four or more different prescribers during the measurement year. Use the NPI to determine if the prescriber for medication dispensing events was the same or different. |

| Measure | Criteria | Description |
|---|---|---|
| | | Identify all opioid medication dispensing events during the measurement year. Include Members who received opioids from four or more different pharmacies during the measurement year. Use the NPI to determine if the pharmacy for medication dispensing events was the same or different.<br>Identify all opioid medication dispensing events during the measurement year. Include Members who received opioids from four or more different prescribers and four or more different pharmacies during the measurement year (i.e., Members who are numerator compliant for both the Multiple Prescribers and Multiple Pharmacies rates). |
| 37. Risk of Continued Opioid Use (COU) | Blue Shield Promise will audit the percentage of Members 18 years of age and older who have a new episode of opioid use that puts them at risk for continued opioid use. | Use all the medication lists below to identify opioid medication dispensing events for the numerator. Calculate covered days using the instructions in the measure definition. |
| 38. Adults' Access to Preventive/Ambulatory Health Services (AAP) | Blue Shield Promise will audit the percentage of Members 20 years and older who had an ambulatory or preventive care visit. | Medicaid and Medicare: One or more ambulatory or preventive care visits during the measurement year.<br>Commercial: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year. |
| 39. Prenatal and Postpartum Care (PPC) | Blue Shield Promise will audit the percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Women are assessed for timeliness of prenatal care and postpartum care. | For timeliness of prenatal care, the Member must have had a prenatal care visit with a PCP (must include diagnosis of pregnancy) or an OB/GYN and one of the following:<br>• Documentation of pregnancy or referencing pregnancy.<br>• A basic physical obstetrical examination that includes |

| Measure | Criteria | Description |
|---|---|---|
| | | auscultation for fetal heart tone or pelvic exam with obstetric observations or measurement of fundus height.<br>• Evidence that a prenatal care procedure was performed.<br>For postpartum compliance, the Member must have had a visit on or between 7 and 84 days after delivery. |
| 40. Well-Child Visits in the First 30 Months of Life (W30) | Blue Shield Promise will audit the percentage of Members who had the following number of well-child visits with a PCP during the last 15 months.<br>1. Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits.<br>2. Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits. | 1. Six or more well-child visits (Well-Care Value Set) on different dates of service on or before the 15-month birthday.<br>2. Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.<br>The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child. |
| 41. Adolescent Well-Care Visits (WCV) | Blue Shield Promise will audit the percentage of Members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. | One or more well-care visits (Well-Care Value Set) during the measurement year.<br>The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the Member. |
| 42. Frequency of Selected Procedures (FSP) | This measure summarizes the utilization of frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization. | |
| 43. Ambulatory Care (AMB) | This measure summarizes utilization of ambulatory care in the following categories:<br>• Outpatient Visits including telehealth<br>• ED Visits | |
| 44. Inpatient Utilization–General Hospital/Acute Care (IPU) | This measure summarizes utilization of acute inpatient care and services in the following categories:<br>• Maternity<br>• Surgery<br>• Medicine | |

| Measure | Criteria | Description |
|---|---|---|
| | • Total inpatient (the sum of Maternity, Surgery and Medicine) | |
| 45. Mental Health Utilization (MPT) | This measure summarizes the number and percentage of Members receiving the following mental health services during the measurement year:<br>• Inpatient<br>• Intensive outpatient or partial hospitalization<br>• Outpatient<br>• ED<br>• Telehealth<br>• Any service | |
| 46. Antibiotic Utilization (ABX) | This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender:<br>• Total number of antibiotic prescriptions.<br>• Average number of antibiotic prescriptions per Member per year (PMPY).<br>• Total days supplied for all antibiotic prescriptions.<br>• Average days supplied per antibiotic prescription.<br>• Total number of prescriptions for antibiotics of concern.<br>• Average number of prescriptions PMPY for antibiotics of concern.<br>• Percentage of antibiotics of concern for all antibiotic prescriptions.<br>• Average number of antibiotics PMPY reported by drug class:<br>– For selected "antibiotics of concern."<br>– For all other antibiotics. | |
| 47. Plan All-Cause Readmission (PCR) | For Members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. | Count the number of observed IHS among nonoutlier Members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under Count of Observed 30-Day Readmissions. |
| 48. Wight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC) | Blue Shield Promise Members that are 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and physical activity | Members that have had an outpatient visit with a PCP or OB/ GYN during the measurement year with the following documented:<br>• Documentation of BMI Percentile, Height, and Weight<br>• Counseling for nutrition<br>• Discussion of current nutrition behaviors<br>• Checklist indicating nutrition was addressed.<br>• Counseling or referral for |

| Measure | Criteria | Description |
|---|---|---|
| | | nutrition education<br>• Anticipatory guidance for nutrition<br>• Weight or obesity counseling<br>• Counseling for physical activity<br>• Discussion of current physical activity behaviors<br>• Checklist indicating physical activity was addressed.<br>• Counseling or referral for physical activity<br>• Anticipatory guidance specific to the child's physical activity<br>• Weight or obesity counseling |
| 49. Enrollment by Product Line (ENP) | Blue Shield Promise will audit the total number of Members enrolled in the product line, stratified by age and gender. | |
| 50. Enrollment by State (EBS) | Blue Shield Promise will audit the number of Members enrolled as of December 31 of the measurement year, by state. | |
| 51. Language Diversity of Membership (LDM) | Blue Shield Promise will audit an unduplicated count and percentage of Members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials. | |
| 52. Race/Ethnicity Diversity of Membership (RDM) | Blue Shield Promise will audit an unduplicated count and percentage of Members enrolled any time during the measurement year, by race and ethnicity. | |
| 53. Total Membership (TLM) | Blue Shield Promise will audit the number of Members enrolled as of December 31 of the measurement year. | |

## 9.13: Credentialing Program

### Purpose

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

## Scope

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

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

## Objectives

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

## Credentialing Policies and Procedures

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

Credentials Committee

The Credentials Committee is responsible for overseeing the credentialing and recredentialing of all practitioners/providers contracted with Blue Shield Promise. The Medical Director serves as chairman of the Credentials Committee, which is comprised of a multi- specialty panel of practitioners/providers in the Blue Shield Promise network, the Credentialing Manager and any additional physicians as needed, for their professional expertise. However, only physicians have the right to vote in Credentials Committee Meeting. A minimum of three (3) voting Members is considered a quorum. The Credentials Committee meets at least once a month but not less than quarterly. If there is a need, committee will conduct an ad-hoc meeting.

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

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

### *9.13.1: Credentials Process for Directly Contracted Physicians*

The Credentials Committee is responsible for making decisions regarding initial credentialing, recredentialing, and changes to credentials, and inactivation of all directly contracted practitioners/providers.

Blue Shield Promise has adopted the California Participating Physician Application (CPPA)and the Council for Affordable Quality Healthcare (CAQH) applications. The following items are needed to complete the application process.

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

In addition to completing an initial application, the practitioner must provide:

1. A copy of his/her current professional license to practice.
2. A copy of a current and valid DEA certificate (if applicable).
3. A copy of a current malpractice insurance certificate with the practitioner listed as an insured with the minimum required coverage.
4. A current curriculum vitae (CV). Include month and year with no gaps.
5. A copy of board certificate (if applicable).
6. Medicare number, Medi-Cal number and NPI.
7. Physician Supervisory Agreement (for Midlevel only).
8. A copy of the ECFMG certificate (if applicable).
9. A written explanation regarding any sanction activity, malpractice judgments in the last five (5) years or pending claims, restriction of privileges, etc.

Upon receipt of a completed application, Blue Shield Promise will obtain and verify the information in accordance with its policies and procedures. If the required supporting documents are missing or the documents with signature pages are dated more than three months prior to the receipt of a completed application, the Credentialing Department will contact the applicant for the missing information. Failure to submit the information within after the third attempt will be considered a voluntary withdrawal of the application.

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

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

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

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

### *9.13.2: Minimum Credentials Criteria*

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

1. All applicants will meet the following minimum credentialing requirements and submit a comprehensive profile sheet to include:
    a. Name
    b. Professional Title
    c. Office Address
    d. Telephone & Fax Numbers
    e. Office Hours
    f. Provider Type (PCP/Specialist)
    g. Specialty with Board Certification Status or Complete Internship/Residency Training
    h. Languages Spoken by Provider and Staff; includes American Sign Language
    i. Non-English languages spoken by qualified medical interpreter
    j. California Medical License Number. Must hold and maintain a current and unrestricted State medical or professional license.
    k. Hold a current and valid DEA certificate, if applicable.
    l. Tax Identification Number
    m. National Provider Identifier (NPI)
    n. Maintain current hospital privileges in the requested specialty at a Blue Shield Promise contracted hospital. This requirement may be waived only if the physician arranges for another Blue Shield Promise practitioner/provider to provide hospital coverage at a contracted hospital. This arrangement must be documented in writing by the covering physician and submitted to Blue Shield Promise. Exception to this requirement is granted to specialties that do not typically require admitting privileges (i.e., dermatology, pathology, radiology, psychology, and optometry)
    o. Initial Approved/Recredentialed Date
    p. Birth Date
    q. Medi-Cal Number
    r. Gender
    s. Ethnicity
    t. Panel Status:
        1. Accepting new patients
        2. Accepting existing patients
        3. Available by Referral only
        4. Available only through a hospital or facility; or
        5. Not accepting new patients
    u. Email address if permitted by provider via written communication
    v. FQHC or Clinic name

w. If applicable, website URL for each service location

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

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

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

aa. Have no felony convictions.

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

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

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

2. All applicants will meet the following minimum training requirements: Physicians (MD, DO) must be either:

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

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

- 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 American Board of Podiatric Medicine (ABPM) [formerly American Board of Podiatric Orthopedics and Primary Podiatric Medicine ("ABPOPPM")];

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

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

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

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

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

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

physician assistant if:

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

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

### Recredentialing

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

### Credentialing Time Limit

The primary source verifications must be completed, and the provider's attestation must be signed and dated within 180 calendar days prior to the Credentialing Committee decision.

### *9.13.3: Credentials Process for IPA/Medical Groups*

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

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

1. The Credentialing Delegation Oversight Auditor will conduct pre-delegation and annual audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the IPA/medical group's policies and procedures, Credentialing Committee minutes, ongoing monitoring, organizational provider credentialing, sub-delegation oversight activities, quarterly reports, and the IPA/medical group's credentials files, as applicable. The Industry Collaborative Effort (ICE) standardized audit tool will be used to conduct an audit. The audit tool can be found on the ICE website under *Approved ICE Documents.* The IPA/medical group will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, at least two (2) weeks prior to the scheduled audit date.
2. Blue Shield Promise will use one of the following techniques for the file review:
    a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield Promise auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the IPA/medical group. The Blue Shield Promise auditor will audit the files in the order indicated on the file pull list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files.
    b. The NCQA's 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.
3. After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review.
4. To be delegated and to continue delegation for credentialing, IPA/medical groups must meet the minimum standards by scoring at least 95%. If the IPA/medical group scored below 95%, a corrective action plan (CAP) is required. IPA/medical groups

must submit all deficiencies to Blue Shield Promise Credentialing Delegation Oversight Department within 30 days of notification is received. After reviewing the CAP, the IPA/medical group will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.

5. The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements.
6. Delegated credentialing status may be terminated by Blue Shield Promise at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
7. Blue Shield Promise retains the right to approve, suspended and terminate practitioners/ providers or sites based on issues with quality of care.
8. Delegated IPA/medical groups are required to submit a quarterly report for practitioners/ providers credentialing, recredentialing, termination and suspension activities, and quality improvement 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.
9. The IPA/medical group 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, as well as monthly;
   - Member complaints; and
   - Identified adverse events.
10. The IPA/medical group is required to review all Blue Shield Promise practitioners/providers sanction activities within the 30 days of the report issued date and report the finding to Blue Shield Promise as Blue Shield Promise

practitioners/providers are identified.

11. The IPA/medical group is responsible to provide and assist any credentials document needed for investigation and audit which include but not limited to specific information related to a provider's training, action related to any sanctions, etc.
12. The IPA/medical group is required to submit copies of originals files for selected practitioners/providers at the time of regulatory agency oversight audits or at any time requested by the health plan for regulatory oversight audit.
13. The IPA/medical group 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 IPA/medical group 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.
14. The IPA/medical group will be required to sign and abide by the credentialing delegation agreement.

Practitioners/Providers' Rights

Practitioners/Providers shall have the right to:

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

Confidentiality of Credentials Information

All information related to credentialing and recredentialing activities is considered confidential. All credentialing documents are kept in locked file cabinets in the Credentialing Department, which is kept locked when not occupied. Only authorized personnel will have access to credentials files. Practitioners/Providers may access their files in accordance with the established policies. All confidential electronic data will be

access-controlled through passwords. Access will be assigned based on job responsibility, and also on a need-to-know basis. All Credentials Committee Members, guests, and staff involved in the credentialing process will sign a confidentiality agreement at least annually.

Sanction Review

Blue Shield Promise queries the National Practitioner Data Bank, Office of Inspector General, Medi-Cal S&I, SAM, and state licensing agencies at the time of initial and recredentialing to determine if there have been any sanctions placed or lifted against a practitioner/provider. Documentation regarding the identified sanction is requested from the agency ordering the action. If the affected practitioner/provider is directly contracted with Blue Shield Promise, then the practitioner/provider is notified in writing of the action and requested to provide a written explanation of the cause(s) for the sanction and the outcome. If the practitioner/provider is delegated to an IPA/medical group, then the affected IPA/medical group is notified of the sanction activity in writing and requested to provide a written plan of action. This information, along with the documentation and the IPA/medical group's response, is forwarded to the Credentials Committee for review and action.

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

License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the U.S. Drug Enforcement Administration or by an updated copy from the provider. Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

Summary Suspension of a Practitioner's Privileges

- Immediate action will be taken to suspend a practitioner's privileges in the event of a serious adverse event. A serious adverse event is defined as any event that could substantially impair the health or safety of any Member.
- Immediate action will also be taken to suspend a practitioner's privileges in the event the practitioner fails to meet the following minimum credentialing criteria:
    1. The practitioner's license to practice has been revoked, suspended, or under any type of restriction or stipulation, including probation, by the state licensing agency.
    2. The practitioner has been suspended from the Medi-Cal program; however, this does not apply to practitioners who participate in only in the Medicare program.
    3. The practitioner fails to maintain the minimum malpractice liability coverage.
- Should a practitioner/provider fail to meet the minimum credentialing criteria as described above, Blue Shield Promise will allow the practitioner/provider a chance

to correct the deficiency before inactivating the practitioner/provider. Upon knowing that a practitioner/ provider is noncompliant, the Credentialing Department will notify the practitioner/provider immediately in writing of the deficiency. The notification will specify the methods available for correcting the deficiency and the timeframe allowed for the submission, and that failure to correct the deficiency will result in immediate inactivation.

- Any information regarding an adverse event will be forwarded to the QI Department as a potential quality issue (PQI) and handled in accordance with the established policies and procedures.
- The Medical Director has the authority to immediately suspend any or all portions of a practitioner/provider's privileges in the event of a serious adverse event (as defined above). The written notice will include a notice of the practitioner's right to a Fair Hearing. (Please refer to Policy 70.1.3.10 Fair Hearing Plan for detail.)
- A summary suspension of a practitioner's membership or employment is imposed for a period in excess of fourteen (14) days.
- The notice of suspension shall be given to legal department for ratification. In the event of suspension, the practitioner's Members shall be assigned to another practitioner/provider. The wishes of the patient shall be considered, where feasible, in choosing another practitioner/provider.

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

Health Delivery Organizations

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

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

# SECTION 10: PHARMACY AND MEDICATIONS

Effective January 1, 2022, the Department of Health Care Services (DHCS) transitioned Medi-Cal pharmacy services from the Medi-Cal managed care plans to a centralized delivery system. This new centralized delivery system is called Medi-Cal Rx. Magellan is DHCS' contracted pharmacy benefit management vendor that will administer Medi-Cal Rx benefits.

Blue Shield Promise Health Plan will continue to provide medical benefits and support services such as provider network, customer care support, and utilization management as well as appeals and grievances for prescription medications that are covered under the medical benefit.

Blue Shield Promise Health Plan is in compliance with all DHCS and Department of Managed Health Care (DMHC) All Plan Letters (APLs) and requirements related to this carve out.

For questions regarding Medi-Cal Rx pharmacy benefits, policies, and procedures, contact the Medi-Cal Rx Customer Service Center at (800) 977-2273 or visit https://medi-calrx.dhcs.ca.gov/home/.

## 10.1: Pharmaceutical Utilization Management

This program incorporates utilization management to encourage appropriate and cost-effective use of medications. This will apply to drugs billed through medical or institutional claims. The Blue Shield of California Pharmacy & Therapeutics Committee is the governing committee responsible for oversight and approval of policies and procedures pertaining to drug utilization including medication policies that fall under the medical benefit to help us provide quality coverage to our Members.

Review of medication requests for non-FDA approved indications

1. In accordance with Section 1367.21 of the California Health and Safety Code, Blue Shield Promise will not limit or exclude coverage for a drug on the basis that the drug prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
    a. The drug is approved by the FDA;
    b. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition, or for the treatment of a chronic and/or seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is covered by Blue Shield Promise; and,
    c. The drug has been recognized for treatment of that condition by one of the following:

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

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

## 10.2: Specialty Pharmaceuticals

### Purpose

To establish clear policy and procedures for prescribing specialty pharmaceuticals covered under the medical benefit and ensuring reliable access to these medications.

### Policy

As of July 1, 2003, Blue Shield Promise no longer requires a health care service provider to assume or be at financial risk for any item described as a qualifying specialty pharmaceutical covered under the medical benefit. The health care provider is permitted to assume financial risk for these items after making the request in writing at the time of negotiating an initial contract or renewing a contract with Blue Shield Promise.

The items included in AB 2420 are:

- Injectable chemotherapeutic medications and adjunct injectable pharmaceutical therapies for side effects.
- Injectable medications or blood products used for the treatment of hemophilia, including Hemlibra.
- Injectable medications related to transplant services.
- Adult vaccines.
- Self-injectable medications.
- Other injectable medication or medication in an implantable dosage form costing more than $250 per dose.

All medical benefit specialty pharmaceuticals prescribed for Members associated with a non-risk medical group will require prior authorization review that may include requirements for step therapy with preferred drugs or biosimilar agents, and place of service. The Blue Shield Promise Pharmacy Department will conduct the prior authorization review utilizing criteria and guidelines approved by the Blue Shield of California Pharmacy & Therapeutics Committee unless the health care provider has been delegated to perform the prior authorization review.

### Procedure

IPA/Medical Groups Not Retaining Specialty Pharmaceutical Risk and Blue Shield Promise Directly Contracted Physicians

1. In situations where the Member is assigned to an IPA/medical group or a directly contracted physician, where Blue Shield Promise assumes the risk for providing specialty pharmaceuticals, physicians must obtain a prior authorization approval from the health plan regardless of whether they utilize office stock, refer patient to a home infusion provider, direct the Member to an outpatient facility for administration or require the services of a specialty pharmacy vendor.

2. Physicians who plan to prescribe a specialty pharmaceutical will submit a prior authorization request to the Blue Shield Promise Pharmacy Department. Physicians may obtain a prior authorization form by calling the Blue Shield Promise Pharmacy Department.
3. The Blue Shield Promise Pharmacy Department will review the submitted request. All determinations will be based on the Blue Shield Promise prior authorization guidelines, step therapy, site of service requirements and nationally accepted evidence-based guidelines.
4. If additional information is needed to make a final determination, the Pharmacy Department will send a request to the prescribing physician or the primary care physician. Pharmacy personnel will adhere to the HIPAA minimum necessary information requirements.
5. If the prior authorization request is approved the Blue Shield Promise Pharmacy Department will enter a prior authorization override that permits the processing of the prescription drug claim under the medical benefit.
6. The Blue Shield Promise Pharmacy Department will notify the provider, Member, and the specialty pharmacy in writing of the medication approval. Letters of approval will be mailed to the Blue Shield Promise Member and a copy will be faxed to the provider. The specialty pharmacy will receive a faxed copy of the approved prior authorization form and prescription.
7. If the prior authorization request is modified or denied, the Blue Shield Promise Pharmacy Department will notify the Member and the physician in writing.
8. All denials based on insufficient medical necessity will reference the appropriate guidelines utilized when evaluating the prior authorization request. For denials based on treatment of a condition that is not a covered benefit, the denial letter will reference the applicable state or federal regulation.
9. Upon notice of an authorized prescription, the specialty pharmacy will process the prescription in accordance with their dispensing procedures. The dispensing process will include coordination of delivery with the physician, facility, or home infusion provider.
10. The specialty pharmacy will be responsible for verifying ongoing Member eligibility and an IPA/medical group assignment for all new and refill prescriptions. If the Member is no longer eligible with Blue Shield Promise, then subsequent authorizations and dispensing of the specialty pharmaceutical will be based on the procedures established by the newly assigned health plan.
11. In the event that the physician needs to utilize a medication stocked in his/her office, he or she will need to indicate this on the prior authorization form. If the medication and the in-office stock use are approved the physician will receive an approval notice.

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

IPA/Medical Group Retaining Specialty Pharmaceutical Risk

If a Member is assigned to an IPA/medical group that has elected to keep the financial risk for medical benefit specialty pharmaceuticals, Blue Shield Promise will refer the provider and Member to the IPA/medical group for review of the prior authorization request. The IPA/medical group will be expected to conduct the prior authorization review utilizing Blue Shield Promise criteria and guidelines approved by the Blue Shield of California Pharmacy & Therapeutics Committee. Adherence to Blue Shield Promise's medical necessity, site of service and biosimilar first policies is required and will be subject to the delegation audit.

IPA/medical groups are responsible for complying with California Health and Safety Code Section 1367.206(b) and California Insurance Code 10123.201(c)(2) for medically necessary exception requests. IPA/medical groups will approve a medication prior authorization request if:

1. Trial of preferred drugs has been attempted, but caused intolerable side effects, inadequate response achieved, diminished effect, or unable to try due to contraindications.
2. Rationale is submitted by provider that states one of the following:
    a. Preferred drugs are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the Member's known clinical characteristics and history of the Member's prescription drug regimen.
    b. Preferred drugs are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

## 10.3: Reporting

Medi-Cal Pharmacy CALINX claim files are available by the 15th of each month and can be accessed via a secure web portal. Participating Provider Groups that do not have access to these files should email BSCCalinxRx@blueshieldca.com to ask for an access request form. Once the access request form has been submitted and approved, access instructions and additional information will be sent to the requestor.

## 10.4: Drug Storage and Dispensing in Provider Offices

### Policy

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

### Procedure

1. Each site shall maintain and periodically update a set of internal medication/ pharmacy policies and procedures.
2. All medications shall be stored in their original containers. This does not apply to cleaning or antiseptic solutions that may be poured into other dispensing containers.
3. Germicides, disinfectants, test reagents and household cleaning substances shall be stored separately from medications.
4. All multiple dose containers shall be labeled with the date they are originally opened.
5. All medications and related items including sample drugs shall be routinely checked for expired items.
6. All medications shall be discarded, per Title 22 requirements, when they reach their expiration date.
7. Medications shall be stored in a segregated manner according to their route of administration (i.e., oral, injectable, topical).
8. All medications, needles, and syringes are to be stored in an area only to authorized personnel.
9. Medications shall be stored at temperature levels specified by the manufacturer (i.e., room temperature, refrigerated at 35-45 degrees F or frozen at less than 7 degrees F).
10. Controlled substances (Schedule II or III) are to be stored separately from other medications in a securely locked cabinet. Controlled substances shall be inventoried, logged, and controlled. The physician is responsible for the use, storage, and inventory of all controlled substances.
11. Items other than medications that are stored in a refrigerator are kept in a separate compartment from drugs.
12. Medications that are transferred from the original container into another are classified as "re-packaged." The following information is required on the new container: date of re-packaging, initials of re-packager, manufacturer name, and original lot number.

13. Medications shall be prepared in a designated, clean area of sufficient size as to minimize the potential for medication errors.
14. Drugs for emergency use should be stored in a secure, locked area and a location that is accessible in an emergency.
15. A list of contents and expiration dates should be on the outside of the emergency "box."
16. The contents of the emergency "box" should match the contents list.
17. The use and/or dispensing of sample medications are discouraged. If a provider elects to use and/or dispense sample medications, the following standards must be met:
    a. A physician or pharmacist shall be responsible for the storage, inventory, and dispensing of sample medications.
    b. Only a physician or pharmacist shall dispense sample medications. This cannot be delegated to other office staff.
    c. Sample medications shall be logged when received, including the medication name, quantity, manufacturer name, lot number, and expiration date.
    d. Samples may only be dispensed to the provider's own patients.
    e. Samples may not be sold.
    f. Samples must be stored in a secure manner.
    g. If samples are dispensed, they must meet all labeling requirements.
    h. An appropriate entry is made in the patient's medical chart in a similar manner as if a prescription had been written.
    i. Samples may not be used to satisfy prior authorization requirements for trial and failure of a medication.

## 10.5: Access to Pharmaceutical Care and Services

Blue Shield Promise will ensure appropriate Member access to pharmaceutical care or services billed under medical or institutional claims.

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

This page intentionally left blank.

# SECTION 11: HEALTH EDUCATION

## 11.1: Health Education Program

### Purpose

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

### Goals

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

## 11.2: Scope of the Health Education Program

### *11.2.1: Member Education*

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

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

## Health Education Classes

The Blue Shield Promise Health Education (HE) Department or the Blue Shield Promise Utilization Management (UM) Department receives and processes referrals for HE classes and/or other interventions. Blue Shield Promise providers may refer their patients to HE services by completing and submitting the Health Education Referral Form (See Appendix 6: Health Education Referral Form) to the HE Department via fax or mail. Once the referral is received, HE will locate a health education class. If no class is available, HE will send written information to the Member on the requested topic. For referrals to programs with a cost, the provider may submit their referral using a Treatment Authorization Request (TAR) Form to the UM Department, via fax or mail. The PCP will receive documentation of the final outcome for referrals submitted to the HE or UM Departments.

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

The Blue Shield Promise HE Department works with the Outreach Department and Quality Improvement Department to coordinate activities for Blue Shield Promise's involvement in community outreach efforts, health fairs and health screening events.

## Health Education Materials

A variety of brochures and handouts are available to providers and we encourage providers to give them to members at the point of service, at no cost on the Blue Shield Promise website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education-medi-cal

All materials selected are culturally sensitive and linguistically appropriate (refer to Section 17: Culturally and Linguistically Appropriate Services (CLAS) for definitions), and do not exceed the 6th grade reading level as required by the Department of Health Care Services (DHCS) for Members.

## Ordering Health Education Materials

The HE Department has a variety of materials in English, Spanish, and other threshold languages available to Members and providers. Materials in languages other than English are also reviewed for cultural sensitivity and linguistic appropriateness for the target population. Providers may download materials from the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education-medi-cal or contact the Blue Shield Promise HE Department to request a materials order form and materials in an alternative format.

## Member Resources

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

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

In collaboration with L.A. Care, Blue Shield Promise Health Plan develops Preventive Health Guidelines for Adults and Children/Adolescents. These guidelines represent a compilation of recommendations from national and state organizations including the U.S. Department of Health and Human Services, National Institutes of Health, Centers for Disease Control and Prevention, U.S. Preventive Services Task Force, California Department of Public Health, and Los Angeles County Department of Public Health. Preventive Health Guidelines for Adults and Children/Adolescents are available on the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/Sites_Content_EN/bsp/health-wellness/health-education

Members may also call the Health Education Department to request a printed copy of the guidelines. Providers are notified about updates to the guidelines via the Blue Shield Provider Connection website at blueshieldca.com/provider, provider visits, or blast fax. Members are notified about updates to the guidelines via member newsletters.

*11.2.2: Mandated Health Education Topics*

The following health related topics are mandated by the DHCS:

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

*Includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age.

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

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

*11.2.3: Selection of Health Education Materials*

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

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

Methods of Testing Reading Levels of Health Education Material

All member health education materials must be reviewed and tested using an approved tool. The Fry Readability Formula is based on the assessment of three 100-word passages from an article. The average number of syllables and average number of sentences per 100 words are plotted on a grade level graph to determine the approximate grade level. The Flesch-Kincaid Grade level is equivalent to the US grade level of education. It shows the required education to be able to understand a text. These two methods will be used for most materials distributed from Blue Shield Promise.

Health Education Material Standards

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

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

### *11.2.4: Provider Education*

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

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

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

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

## 11.3: Member Education Contractual Requirements

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

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

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

The provider is responsible for providing culturally sensitive and linguistically appropriate health education, prevention, and counseling services to the Member population based on their needs (See Appendix 7: Health Education State Requirements for Providers). Providers are responsible for implementing the Staying Healthy Assessment Tool. (See specifics under Section 11.5.) Providers are strongly encouraged to guide their patients to take increased responsibility for their personal health. The Blue Shield Promise HE Department is responsible for providing all state mandated health education materials and associated services to Members via contracted providers. Also, 24-hour free interpretation services are available to providers with LEP patients needing interpreter services.

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

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

*11.3.2: Monitoring Provisions of Health Education*

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

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

Medical Record Documentation of Health Education Services

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

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

## 11.4: IPA/Medical Group's Responsibility to Health Education

IPAs/medical groups are required to comply with the responsibilities outlined in Sections 11.1 through 11.3 and are required to participate in health education activities that are required by Blue Shield Promise in order to best support health education goals for members.

### 11.5: Staying Healthy Assessment (SHA) Tool

All contracted Primary Care Providers (PCPs) must administer the Staying Health Assessment (SHA) to Medi-Cal managed care members. The goal of the tool is to identify high-risk behaviors of individual plan members, prioritize individual health education needs related to lifestyle, environment, cultural linguistic background, and to assist providers to initiate and document focused health education interventions, referral, and follow-up. PCPs must ensure that the SHA is administered at each age-appropriate category. There are nine separate age categories. The tools have been translated into twelve non-English languages. Providers can access updated Staying Healthy tools at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/ha-medi-cal.

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

- Annual administration of the SHA is highly recommended (not required) for the adolescent and senior groups because behavioral risk factors change frequently during these years.
- The PCP must review the completed SHA with the member and initiate a discussion with the member regarding behavioral risks the member identified in the assessment. Clinic staff members may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.
- If the member refuses to complete the assessment, the refusal should be documented in the medical records.

To implement the SHA electronically, providers must notify the Health Education Department by submitting a completed Electronic SHA Format Notification Form available at https://www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/sites/StreamDocumentServlet?fileName=BSP_2019_SHAformatNotificationForm.pdf.

The following will be continuous throughout the year:

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

## 11.6: Tobacco Cessation Services

Per All Plan Letter (APL) 16-014, providers are required to implement tobacco cessation interventions and a tobacco user identification system into their practices. Providers must:

- Conduct initial and annual assessment of each patient's tobacco use and note this information in patient's medical record
- Offer FDA-approved tobacco cessation medications (for non-pregnant adults)
- Provide counseling using the "5 A's" model or other validated model for treating tobacco use and dependence
- Refer patients to available individual, group, and telephone counseling services
- Offer services for pregnant tobacco users
- Provide interventions to prevent the use of tobacco in children and adolescents

Recommendations on how to identify tobacco users include:

- Add tobacco use as a vital sign in the chart or Electronic Health Records
- Use International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use
- Place a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco
- Record tobacco use in the SHA or other IHEBA
- Record status on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160)

How to Start the Conversation

Provider: Discuss some of the health problems associated with smoking, for example:

"As your health care provider and someone who cares about you and your health, I'd like to help you quit smoking because it's the best thing you can do for your health and anyone who lives with you."

Tobacco Cessation Medications Available to Medi-Cal Patients

In our efforts to help members quit smoking, Blue Shield Promise provides coverage for smoking cessation agents for adults who use tobacco products. Some of these medications require prior authorization, have quantity limits, and are subject to change. Please review the Blue Shield Promise drug formulary for a complete list of available medications.

Providers play a key role in the member's journey in quitting smoking. Please work with your patient to find the best option for quitting smoking such as, referring them to community resources and/or prescribing them tobacco cessation medication. Providers should adhere to the prior authorization requirements such as, following up with requested information from the pharmacy department, and meeting requested deadlines.

To view the policy letter, learn more about the required interventions, find training and patient resources, please visit the Blue Shield Promise provider website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/tobacco-cessation-medi-cal.

## 11.7: Program Resources

### *11.7.1: Health Education Staff*

Health Education and Cultural and Linguistic Senior Manager

The Health Education and Cultural and Linguistic Senior Manager (Senior Manager) works in conjunction with the Chief Medical Officer and other departments to implement health education programs appropriate to identified needs of members and providers. This position reports to the Senior Director of Lifestyle Medicine.

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

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

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

The Health Education Manager

The Health Education Manager reports to the Health Education and Cultural and Linguistic Senior Manager. The Health Education Manager leads and manages health education initiatives and ensures compliance with NCQA, state, federal and L.A. Care requirements.

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

Health Educator

The Health Educator reports to the Health Education and Cultural and Linguistic Senior Manager and the Health Education Manager and works in conjunction with them to implement health education programs appropriate to our member and provider population.

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

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

*11.7.2: Health and Wellness Portal*

The health and wellness portal is an online resource available to Members. The goal of the portal is to increase Members' ability to manage their health by helping them identify their risks via a wellness assessment and connecting them to self-management tools and resources that can help mitigate their risks. Members can also track their health over time on the portal. Some of the tools available on the portal include a health library on topics including physical activity, blood pressure, cholesterol, blood glucose, and nutrition. To access the portal, Members can log on to the Blue Shield Promise website at www.blueshieldca.com/promise/hra and create an account.

*11.7.3: Departments in Collaboration with Health Education*

Cultural and Linguistic Department

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

Quality Improvement

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

Customer Service Department

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

### Provider Relations Department

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

### Outreach Department

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

### Utilization Management

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

This page intentionally left blank.

# SECTION 12: PROVIDER SERVICES

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

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

The following resources are available to providers and staff:

- Provider Relations Representative
- Provider In-Services
- Provider Manual
- Provider Bulletin
- Provider Communication
- Joint Operation Committee (IPA/Medical Groups and Hospitals only)

We encourage providers to make recommendations and suggestions that will better allow us to serve our Members and to improve the processes within our organization through open discussions and meetings.

## 12.1: Provider Manual Distribution

Provider Manuals are distributed to all new IPA/medical groups and hospitals during Joint Operation Committee meetings and for Blue Shield Promise directly contracted providers within ten (10) business days of placing Provider on active status. Blue Shield Promise will request and maintain documented receipt of all Provider Manuals distributed. Provider Manuals are updated annually and/or as required. Updates to the provider manual are made available on the Blue Shield Promise provider website at blueshieldca.com/promise/provider under *Provider Manuals* or print upon request.

## 12.2: Provider Orientations

Orientations are conducted by the Provider Services staff to educate new IPA/medical groups, hospitals, ancillary providers, and Blue Shield Promise directly contracted providers on Plan operations and policies and procedures within ten (10) business days of placing a provider on active status.

### IPA/Medical Group Responsibilities

Blue Shield Promise's contracted IPA/medical groups are responsible for conducting provider training and orientation for its contracted providers within ten (10) business days of placing a provider on active status with the IPA/medical group regardless of their effective status with Blue Shield Promise. IPA/medical groups are required to provide evidence of the 10-day training as requested by Blue Shield Promise. When submitting provider to be added to the network, IPA/medical groups must attest to the completion of a 10-day provider orientation training by providing the training date of completion within submitted provider rosters or provider profiles. New Provider Training Attestation Forms must also be completed for each individual practitioner and IPA/medical group must be prepared to provide a copy of the New Provider Training Attestation Form when requested by Delegation Oversight.

## 12.3: Joint Operation Committee Meetings (IPA/Medical Groups and Hospitals Only)

Joint Operation Committee (JOC) meetings are conducted by the Provider Relations Representative at least annually or as needed to allow monitoring and oversight of delegated responsibilities, ensure effective problem resolution, and maintain ongoing communication between Blue Shield Promise and its contracted IPA/medical groups and hospitals. Blue Shield Promise will maintain documentation of attendees and issues discussed.

## 12.4: PCP Enrollment Limits

A primary care physician (PCP) may be assigned a maximum of 2,000 Members total. When a PCP reaches the enrollment limit, the PCP's panel is closed to new enrollment until the PCP's Membership drops below the maximum level. State regulations require Blue Shield Promise to ensure the network meets the following provider to Member ratios:

- Primary Care Physician 1:2,000
- Capacity is added to PCP when supervising Mid-Level provider up to a max capacity of 1:5,000

A PCP can limit the growth of their enrollment by requesting to close their panel. When a provider closes their panel, the provider is no longer open for the auto assignment default process or Member choice selection. Exceptions may be made for existing Members.

Additionally, Blue Shield Promise has the capability of closing a provider's panel to new patients if the Member experiences access issues, quality issues, or provider has failed a facility site review. The provider's panel will re-open upon an approved corrective action plan (CAP).

## 12.5: Mid-Level Medical Practitioners

The use of Mid-Level Practitioners increases primary and specialty care capacity and Member access to professional services. Relative to primary care, the number of potential assigned Members to a PCP can be increased by 1,000 Members for each mid-level practitioner the PCP supervises to a maximum of 5,000 Members.

PCPs may supervise up to four (4) mid-level practitioners in any combination according to the following state regulated physician supervisor to mid-level provider ratios:

| | |
|---|---|
| Nurse Practitioner | 1:4 |
| Physician Assistant | 1:2 |
| Midwife | 1:3 |

The delegation of specified medical services to mid-level practitioners does not relieve the supervising physician of ultimate responsibility for the welfare of the patient or the actions of the mid-level practitioner.

## 12.6: Provider Network Additions (IPA/Medical Groups)

Blue Shield Promise maintains the following per submission and notification by contracted IPA/medical groups:

- Primary Care Physicians
- Specialty Care Physicians
- Hospitals
- Urgent Care Centers

The addition of an IPA/medical group provider requires submission of a provider profile to the Blue Shield Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

Medi-Cal enrollment is required to participate in the network.

See Section 9.13: Credentialing Program for minimum credentialing data requirements.

## 12.7: Provider Network Changes

Provider network changes include terminations, leave of absences/vacation, enrollment status/restrictions, and changes in IPA/medical group affiliation.

Providers affiliated with Blue Shield Promise through an IPA/medical group must send notification to the IPA/medical group in accordance with their contractual agreement. Notification of changes should be directed to the Provider Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

### *12.7.1: PCP Terminations*

IPA/medical groups and/or Blue Shield Promise directly contracted providers shall send written notification for all provider withdrawals and terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the group is notified and at a minimum of 90 days in advance. Blue Shield Promise cannot guarantee that Members will remain with the same PCP/IPA/medical group due to Member choice.

Blue Shield Promise retains the right to obligate the PCP/IPA/medical group to provide medical services for existing Members until the effective date of Member transfer. When an IPA/medical group fails to designate an appropriate provider, Members will be reassigned as described below:

Blue Shield Promise Directly Contracted Physicians

1. If the terminating PCP practices under a group contract, the Members will remain with the group.
2. If the terminating PCP practices under a solo contract, the Members will be reassigned within the Blue Shield Promise Provider Network.

IPA/Medical Groups

1. If the terminating PCP practices in a Federally Qualified Health Center (FQHC), clinic, or staff model, the Members will remain with the FQHC, clinic, or staff model and will remain with the group.
2. If the terminating PCP is a solo practitioner provider and is currently affiliated with more than one IPA/medical group, the Members will be transferred to follow the PCP to another IPA/medical group that will cause least disruption to a) a hospital and/or b) a specialist panel.
3. If the PCP is administratively terminated by Blue Shield Promise and/or the IPA/medical group for reasons such as, but not limited to suspension of license, malpractice insurance, or Facility Site Review, the Members will remain within the IPA/medical group.
4. If the IPA/medical group wants Members reassigned to specific primary care physicians, the IPA/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.

### *12.7.2: Termination Notification Requirements*

Blue Shield Promise recognizes the importance of timely Member notification prior to the termination of a regularly seen specialist or specialty group. The IPA/medical groups and/or Blue Shield Promise directly contracted providers shall send written notification for all provider withdrawals and terminations to Provider Information & Enrollment at BSCProviderInfo@blueshieldca.com as soon as the Group is notified and at a minimum of 60 days in advance. In accordance with the Department of Health Care Services (DHCS), Blue Shield Promise Members are required to receive at least 30 days' prior notice of an upcoming physician termination, including specialist or specialty group termination.

The specifics of the requirements are as follows:

1. All Blue Shield Promise contracting providers must notify Members seen regularly by a specialist or specialty group whose contract is terminated at least 30 days prior to the effective termination date. The letter to the Member must include notification of the specialist or specialty group's termination, the effective date of termination, and the procedures for selecting or assigning another specialist or specialty group. (Please refer to the Continuity of Care Guidelines in Section 7.8.5 for Members qualifying for continuity of care).
2. Contracting providers must have policies that define Members seen regularly by a specialist or specialty group and which outline the provider's implementation plan for notifying Members of the specialist/specialty group termination, as well as the procedures they may follow to select another specialist. Ways to identify affected Members may include but are not limited to:
    - Number of visits within a specified time period such as two or more cardiac follow-up visits within one year.
    - Repeated referrals for the same type of care over a specified time period such as four referrals for the treatment of diabetes over a two-year period.
    - Receipt of periodic preventive care by the same specialist or specialty group such as a woman receiving an annual well woman exam by the same OB-GYN.
3. If the provider does not provide Blue Shield Promise affected Members with 30 days' advance written notice, the provider is responsible for ensuring the specialist and/or specialty group continues to provide medical services to affected Members until a 30-day advance notice of the termination is given.

### *12.7.3: Blue Shield Promise Oversight*

Blue Shield Promise provides appropriate oversight of each of its contracting providers, including, but not limited to:

- Specialist/Specialty Group Termination Policy and procedures as outlined above;
- Review of Member notification letter regarding specialist/specialty group terminations.

As such, Blue Shield Promise's Delegation Oversight Consultant will review each provider's policy and procedure and member notification letters during its annual delegation audit process.

The specialist termination notification policy and procedure will outline how your organization will:

1. Identify "affected Members" regularly seen by a specialist or specialty group;
2. Inform affected Members of the specialist/specialty group termination; and
3. Assign or direct affected Members to select another specialist or specialty group.

In addition, the provider is required to maintain copies of all notification correspondence between the provider and affected Members.

### *12.7.4: Office Relocation*

IPA/medical groups or Blue Shield Promise directly contracted providers shall send 60-day prior written notification for all office relocations to the BSCProviderInfo@blueshieldca.com email. The PCP/IPA/medical group is responsible for submitting a coverage plan to Blue Shield Promise, if necessary.

PCP that changes office locations will require a facility site review (FSR). The PCP's panel will be closed to new Membership until the new location has successfully completed the FSR review and been enrolled. Once the new site is enrolled and approved, Members will be transferred from the existing site to the new site. If the PCP moves outside of the former office's geographic area, Blue Shield Promise will coordinate with the IPA/medical group to reassign the Members to a new PCP within Blue Shield Promise's access standard of five (5) miles but no more than ten (10) miles. In transferring Members, the provider's location, specialty, and language are taken into consideration. If the IPA/medical group is unable to meet this requirement, Members will be transferred to a provider in the geographic area of the former office location.

### *12.7.5: Provider Leave of Absence or Vacation*

PCPs/IPA/medical groups must provide adequate coverage for providers on leave of absence or on vacation. PCPs/ IPA/medical groups must submit a coverage plan to their appointed Blue Shield Promise Provider Relations Representative for any absences greater than four (4) weeks. Absences over 90 days will require transfer of Members to another Blue Shield Promise PCP.

### *12.7.6: Change in a Provider's IPA/Medical Group Affiliation*

PCPs may change their Blue Shield Promise IPA/medical group affiliation by submitting written notification of the change request to the Provider information & Enrollment that the PCP wishes to change from in accordance with the contractual agreement and with contract regulators.

Blue Shield Promise 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
Email: BSCProviderInfo@blueshieldca.com

### *12.7.7: Change in a Provider's Panel Status*

The IPA/medical group is required to inform the Plan within five (5) business days when either of the following occur:

1. One or more of their providers is not accepting new patients;
2. One or more of their providers previously did not accept new patients and is currently accepting new patients; or
3. If the one or more of their providers was not accepting new patients is contacted by an enrollee/Plan Member or potential enrollee/Plan Member seeking to become a new patient, the Provider shall direct the enrollee/Plan Member or potential enrollee/Plan Member to our Member Service Department at (800) 605-2556 (Los Angeles) or TTY 711 for assistance in selecting a new provider.

Provider Directory Inaccuracies

Providers can review their information on the Blue Shield Promise website and submit changes to the information listed in the directories through the following:

- Submit provider demographic changes on Blue Shield's provider portal, Provider Connection at blueshieldca.com/provider
- Email BSCProviderInfo@blueshieldca.com
- Completing an Online Interface Form

When a report indicating that information listed in the provider directory is inaccurate, Provider Information & Enrollment will verify the reported inaccuracy and, no later than 30 business days following receipt of the report, either verify the accuracy of the information or update the information in the provider directory.

When verifying a provider directory inaccuracy, Blue Shield Promise shall, at a minimum:

1. Contact the affected provider no later than 5 business days following receipt of the report; and
2. Document the receipt and outcome of each report.

Documentation shall include the provider's name, location, and a description of the Blue Shield Promise validation, the outcome, and any changes or updates made to the provider directory.

Blue Shield Promise will terminate a provider upon confirming:

1. Provider has retired or otherwise has ceased to practice;
2. A provider or provider group is no longer under contract with the plan for any reason;
3. The contracting provider group has informed the plan that the provider is no longer associated with the provider group and is no longer under contract with the plan.

Online Interface Form

The Online Interface Form is an electronic web form that contains the required provider directory information Blue Shield Promise has on file for the provider. Providers can notify Blue Shield Promise of changes to their demographic data by completing the Online Interface Form and/or providing an affirmative response to Blue Shield Promise's Outreach Program, through the online interface. The Online Interface Form is available to the following provider types:

4. Practitioners (i.e., physicians and other health professionals such as PT, OT, podiatrist)
5. IPA/medical groups
6. Hospital and Ancillary providers

A system generated acknowledgment is automatically sent upon submission of an Online Interface Form.

### *12.7.8: Network Validation*

1. Quarterly Network Validation
    a. Blue Shield Promise validates the IPA/medical groups provider network quarterly through established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels etc.
2. Bi-annual Network Validation
    a. Blue Shield Promise directly contracted providers validate their data bi-annually. Providers are asked to validate the information and report any changes to their record(s) such as provider terminations, name changes, address changes, open/closed panels etc.
3. Annual Validation

    Hospitals and Facilities validate their data annually through established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, etc.

The validations include the following:

a. Provider Notice:

(1) Instructions to review and submit provider changes within 30 business days.

(2) Instructions on how the plan provider can update the information listed in the provider directory using the online interface.

b. Attestation:

(1) Receipt of network validation

(2) Confirm that the information in the provider directory or directories is current and accurate; or

(3) Update the information required to be in the directory or directories

4. Plan Provider Attestation Requirement:

Blue Shield Promise requires an attestation from plan providers, if an attestation or an update is not received from the plan provider within 30 business days, Blue Shield Promise shall:

a. Verify whether the information is correct or requires updates within 15 business days.

b. Blue Shield Promise shall document the receipt and outcome of each attempt to verify the information.

c. If Blue Shield Promise is unable to verify or update the information, a provide notification informing the provider that in 10 business days the provider will be removed from the provider directory.

5. Removing a Plan Provider:

If no response to the provider notice(s) is received, after the required ten (10) business day notice period, the plan provider shall:

a. Be removed from the provider directory by the next required update; or If provider responds within the 10-business day notice period, plan provider will not be removed.

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.

## 12.8: IPA/Medical Group Specialty Network Oversight

See Section 9.8: Access to Care.

## 12.9: Changes in Management Service Organizations (IPA/Medical Groups Only)

IPA/medical groups must provide a 90-day advance written notification of a change in management service organization (MSO) along with a copy of the executed contract between the IPA/medical group and the new MSO to Blue Shield Promise's Provider Services Director.

The new MSO must meet Blue Shield Promise's pre-contractual criteria. If the new MSO does not meet the criteria, the MSO is responsible for submitting a corrective action plan. Failure of the IPA/medical group / MSO to comply will result in panel closure of all providers.

## 12.10: Provider Grievances

See Section 6: Grievances, Appeals, and Disputes, subsection 6.4: Provider Disputes – Claims Processing.

## 12.11: Provider Directory

The Blue Shield Promise provider directory is updated each month. Any Member of the public may download a PDF copy of the directory from www.blueshieldca.com/promise. A searchable directory is also available online.

The directory lists primary care physicians, specialists, hospitals, vision providers, pharmacies, and Federally Qualified Health Clinics who see Medi-Cal patients. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their appointed contracted IPA/medical group and/or Blue Shield Provider Information & Enrollment department at BSCProviderInfo@blueshieldca.com. Providers may also review their information on the Blue Shield Promise website at www.blueshieldca.com/promise. Blue Shield Promise is committed to ensuring the integrity of the directory.

## 12.12: Prohibition of Billing Members

Each provider agrees that in no event including, but not limited to, nonpayment by the Plan, the Plan's insolvency or the Plan's breach of this agreement shall any Plan Member be liable for any sums owed by the Plan.

A provider or its agent, trustee, assignee, or any subcontractor rendering covered medical services to Plan Members may not bill, charge, collect a deposit or other sum; or seek compensation, remuneration or reimbursement from, or maintain any action at law or have any other recourse against, or make any surcharge upon, a Plan Member or other person acting on a Plan Member's behalf to collect sums owed by Plan.

Should Blue Shield Promise receive notice of any surcharge upon a Plan Member, the Plan shall take appropriate action including but not limited to terminating the provider agreement for cause. Blue Shield Promise will require that the provider give the Plan Member with an immediate refund of such surcharge.

This page intentionally left blank.

# SECTION 13: MARKETING - MEDI-CAL

## 13.1: Introduction

The marketing of managed care services to Medi-Cal beneficiaries is strictly regulated and monitored by Blue Shield Promise Health Plan and the California Department of Health Care Services (DHCS); therefore, Blue Shield Promise Health Plan and its providers must adhere to all regulatory guidelines.

## 13.2: Prohibited Conduct

Prohibited conduct includes but is not limited to:

1. False or misleading claims or representations that include, for example:
    a. A specific health plan is recommended or endorsed by any state or county agency.
    b. The state or county recommends that a Medi-Cal beneficiary enroll in a specific health plan.
    c. A Medi-Cal beneficiary will lose their Medi-Cal benefits or other welfare benefits if he/she does not enroll.
    d. Any representation that office staff is an employee(s) of the state or county.
2. The offering or giving of any form of compensation, reward, or loan to induce enrollment.
3. Making use of any list of Medi-Cal beneficiary names or information obtained originally from confidential state or county data sources.
4. Providing confidential beneficiary information or data sources to health plans or other third-party entities for enrollment purposes.
5. Marketing practices that discriminate against prospective Members based on race, color, marital status, religion, age, sex, national origin, ancestry, gender, gender identity, sexual orientation, disability, language, or medical condition (e.g., pregnancy, disability, etc.).
6. Engaging in any Medi-Cal marketing activity on state or county premises or any other location not authorized in Blue Shield Promise Health Plan's marketing plan or by DCHS.

Blue Shield Promise is responsible for monitoring marketing activities of its providers when such activity relates to Blue Shield Promise and Medi-Cal. Providers must receive approval on all marketing materials containing the Blue Shield Promise Health Plan name and logo prior to use.

In addition to monitoring provider marketing material development, usage, and distribution, Blue Shield Promise shall continuously and closely monitor provider outreach efforts.

Primary care physicians (PCPs) may NOT:

1. Coerce, threaten, or intimidate patients into making a particular health plan or provider selection.
2. Influence patients to change health plan Membership based on financial gain to the PCP.
3. Tell patients that they could lose their Medi-Cal health benefits if they do not choose a particular health plan.
4. Make any reference to competing health plans (e.g., comparing plans in a positive or negative manner) for purposes of encouraging or influencing a patient to enroll or disenroll from a particular health plan based on the PCP's financial interest.
5. Mail complete enrollment forms to HCO on behalf of patients.
6. Photocopy sample enrollment forms with the health plan and PCP names filled in for distribution to patients or to fill in the health plan and PCP names on blank enrollment forms for patients to sign and mail.
7. Use photocopied blank forms or plain-printed enrollment forms. (Only SDHS-supplied forms will be accepted).
8. Have health plan marketers stationed and enrolling in or outside the PCP office.
9. Allow PCP staff to receive any remuneration for marketing or enrolling beneficiaries.

## 13.3: Monitoring Provider Marketing Material Development/Usage/Activity Guidelines

When using the Blue Shield Promise Health Plan name/logo:

1. Providers must submit one (1) set of materials to Blue Shield Promise Health Plan for review and approval prior to use:
    a. If materials are general in nature, and if the provider contracts with more than one health plan, only one (1) set must be submitted to a health plan.
    b. If the materials contain the names or logos of more than one health plan, the contracted provider must submit a set of materials to each health plan mentioned for review and approval.
2. Submitted materials must contain the actual tight clear legible copy. Rough ideas are unacceptable and will not be reviewed.
3. No marketing materials are to be used and/or activities done without prior consent from Blue Shield Promise. This includes general advertising used to reach Medi-Cal beneficiaries, tactical advertising with the Blue Shield Promise Health Plan name and/or logo, and collateral/promotional items such as brochures, pamphlets, pens, etc.

# SECTION 14: CLAIMS

## 14.1: Claim Submission

Blue Shield Promise Health Plan applies the appropriate regulatory requirements related to claims processing.

A. Blue Shield Promise requires that providers submit all encounters electronically and encourage providers to submit all claims and receive payments electronically as well, for faster processing and payment, using electronic data interchange (EDI). To enroll in electronic claim submission, providers can use Office Ally or Change Healthcare. To enroll in electronic encounter submission, providers can use TransUnion or Office Ally.

   Paper claims must be submitted using the current versions of CMS-1450 (UB) and CMS 1500 forms. Paper claims and additional information such as medical records, daily summary charges and invoices must be submitted at the following address to avoid processing and payment delay:

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

B. Providers must follow the most recently updated Current Procedural Terminology (CPT) coding guidelines, National Drug Code (NDC) for drugs as well as the HCFA Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, Department of Health Care Services (DHCS) coding guidelines and those published annually by the Centers for Medicare & Medicaid Services (CMS).

C. Except as required by DHCS, any Medi-Cal Fee Schedule published on or after the fifteenth (15th) of the month will become effective for dates of service on or after the first (1st) day of the month following the month during which such change was published by DHCS. For example, the Medi-Cal Fee Schedule posted in October will be effective November 1.

D. Blue Shield Promise removes deleted HCPCS and CPT codes from its claims payment system. To ensure timely payment, providers are encouraged to only submit currently valid and recognized CPT and HCPCS codes. For drug codes, the CPT or HCPCS and NDC are required for consideration of payment.

E. Providers must ensure all claims submitted to Blue Shield Promise are complete and accurate. Complete claim means a claim or a portion there of, if separable, including attachments and supplemental information or documentation which provides “reasonably relevant information” as defined in Title 28 Section 1300.71 Claims Settlement Practices by Section (a)(10), information necessary to determine payer liability as defined in Section (a)(11); and:

1. For emergency services – legible emergency department reports.
2. All required/mandatory fields in current CMS-1500 form for professional services and UB-04 form for facility services adopted by the National Uniform Billing Committee (NUBC).
3. All required/mandatory fields in current CMS-1500 adopted by the National Uniform Claim Committee (NUCC).
4. Any Medi-Cal designated requirements such as Universal Product Number (UPN) for medical supplies or National Drug Codes (NDC) for pharmacy related claims.

Claims submitted electronically must be HIPAA compliant and meet all requirements for EDI transactions.

F. Claim Filing Limits

1. Medi-Cal claims submissions must meet the following time requirements:
   a. Claims must be submitted within 180 days from the date of service.
   b. Claims submitted beyond 180 days from the date of service will be denied for timely filing unless documentation supporting the reason for delay meets one of the following situations:
      i. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four (4) months after the month of service.
      ii. If a provider has submitted a bill to a liable third party, the provider has one (1) year after the month of service to submit the bill for payment.
      iii. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one (1) year to submit the bill after the month in which the services have been rendered.
      iv. Blue Shield Promise finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.
   c. Claims received after 12th month after month of service will be denied as untimely.

G. Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT)

1. ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. The ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.
2. Providers that are identified as a participant in the Blue Shield Promise provider network must receive the remittance advices and payments electronically for services provided to Blue Shield Promise members.

3. Blue Shield Promise will automatically enroll Blue Shield Promise providers with the clearinghouse Office Ally for their ERA/835 transactions.
4. If a Blue Shield Promise provider would like to enroll their ERA/835 transactions through a different clearinghouse, please see below for approved clearinghouses (not an inclusive list). Providers will need to send a completed ERA form indicating the clearinghouse selection. If a clearinghouse is not selected, providers will automatically be assigned to Office Ally.

| Approved Clearinghouse | Website | Phone Number |
|---|---|---|
| Office Ally | https://cms.officeally.com | (360) 975-7000 |
| Change Healthcare | https://www.changehealthcare.com | (866) 817-3813 |
| Allscripts | https://www.allscripts.com | (800) 334-8534 |
| Trizetto Provider Solutions | http://www.trizettoprovider.com | (888) 550-5637 |
| Navicure | https://www.navicure.com | (770) 342-0800 |

5. To enroll in ERA/EFT, providers must download the enrollment form from the Blue Shield Promise provider website at blueshieldca.com/promise/provider and follow these steps:
   a. On the home page, click on *Working with us.*
   b. Scroll to the bottom of the page to the box labeled *Manage electronic claims and encounters* then click on the link *learn more about electronic claims.*
   c. Scroll down to *Sign up for electronic remittance advice and electronic payments* and click on *Read enrollment instructions.*
   d. Click on *Sign up for ERA* in the box labeled *Electronic Remittance Advice.*
   e. Click on the link *ePayments Provider Authorization Form.* This form also includes the enrollment for electronic funds transfer (EFT).

      Enrollment forms must be faxed to the number listed on the form at (866) 276-8456. For questions regarding the ERA enrollment process, please email EDI_PHP@blueshieldca.com.

## 14.2: Claims Processing Overview

A. Blue Shield Promise makes every effort to ensure claims that are Blue Shield Promise financial responsibility are paid, denied, or contested within 30 calendar days of receipt. At least 90% of claims that are Blue Shield Promise financial responsibility to pay are processed within 30 calendar days of receipt or 95% within 45 working days.

- Receipt dates are based on when Blue Shield Promise receives the claim the first time.

B. Misdirected Claims

1. Claims that are financial responsibility of the IPA/medical group or Full Risk Hospitals are forwarded to the appropriate payer within 10 working days.
2. Billing Providers receive notices from Blue Shield Promise identifying the responsible payers.

C. Reimbursement Rates

1. To be eligible for payment, the claim must be complete and accurate.
2. Contracted providers are paid at contracted rate.
3. Non-contracted providers are paid at Medi-Cal established rates.

D. Interest payments are applied to complete claims that are not paid within 45 working days. Interest is paid for the period of the time that the payment is late.

1. Emergency services – The greater of $15 for each month period or 15% per annum; or
2. All other complete claims - 15% per annum or daily rate of 0.000411.
3. Interest payments are not made for claims where additional information is received after the original claim payment or denial, claims denied due to untimely filing and later paid because evidence of timely prior filing to the incorrect payer is submitted, or claim denied due to untimely filing is paid because information about a good cause for the delay is accepted.

E. Balance Billing

Providers must not balance bill members for any covered/authorized services. Title 22, Section 51002 of the California Code of Regulations states "a provider of service under the Medi-Cal program shall not submit to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service."

F. Overpayment Recovery

Blue Shield Promise 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.

G. Emergency Claims

Emergency claims are paid without prior authorization. Legible emergency department reports must be submitted when billing with ER level 5. ER level 5 are forwarded and reviewed by a physician. Physician reviewer determines whether or not service meets the requirements of emergency level 5.

H. Family Planning and Sensitive Services Claims

Claims for family planning and sensitive services (such as abortion, sexually transmitted diseases, HIV testing, and counseling) do not require authorizations.

Claims for sterilization services must be submitted with completed and signed DHCS Consent Form (PM 330 Form). Claims submitted without the form will be rejected and not be paid. Claims will be paid upon receipt of completed and signed PM 330 Form.

I. Inpatient Hospital Claims – Emergency Admission

In the event emergency admission is not authorized prior to member's discharge, medical records must be submitted with the claims in order to determine medical necessity and avoid delay on payments. Claims with medical records are forwarded by Claims Department to Utilization Management ("UM") to determine appropriate level of care and medical necessity. Upon completion of UM's review, claims are processed and paid according to approved and authorized service.

J. Inpatient Hospital Claims – Elective Admission

All elective inpatient admissions require prior authorization. Prior authorization, bed type and days billed versus pre-certification are verified for inpatient claims. Claims are paid according to authorized level of care. Lack of prior authorization will result in payment denials.

K. Outpatient and Other Claims

Ambulatory services, outpatient surgeries, ancillary, and specialty services require prior authorization. Claims for these services without prior authorization will result in payment denials.

Some services are established as no prior authorization required under the direct referral process.

L. Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services for which provider is reimbursed pursuant to the APG payment rate. Incidental procedure services and supplies are considered included in a global procedure charge(s). A list of incidental procedures is provided in Appendix 14.

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.

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, the Plan may ask a hospital to submit medical records such as Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report, and Implant Log. The Plan 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

## 14.3: Coordination of Benefits (COB)

Medi-Cal is considered a payer of last resort. Other coverage should be billed as the primary. When billing Plan, submit the primary payer's explanation of benefits (EOB) or remittance advice (RA) with the claim.

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.

1. If a member has OHC, provider should consider OHC plan as the Member's primary health plan.
2. 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.
3. Blue Shield Promise shall remain the secondary health plan and payer of last resort for Medi-Cal eligible members.
4. 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.

## 14.4: 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, the member's designated medical group, or Independent Practice Association (IPA) 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, the Plan, the medical group, or the IPA 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, the member's designated medical group or the IPA 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 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 medical group or IPA, in writing, within ten (10) days of any recovery obtained.

## 14.5: Claims Status Inquiry

Providers may verify receipt of claims within 15 days of submission to Blue Shield Promise by calling (800) 468-9935 ext. 3, by checking Blue Shield's provider portal at blueshieldca.com/provider, or by submitting an EDI 276 claim inquiry request. Please allow for the appropriate processing timeframes when obtaining claim status. To enroll and setup EDI 276/277 claim inquiries, please contact your clearinghouse or software vendor. If available, claim status transactions may be integrated into your practice management system.

## 14.6: Claims Compliance and Monitoring

Please see Appendix 16: Claims Compliance and Monitoring for Blue Shield Promise claims requirements for Delegated Entities.

# SECTION 15: ACCOUNTING

## 15.1: Financial Ratio Analysis (IPA/Medical Groups Only)

The Accounting Department is responsible for the accurate financial reporting of capitation and claims expense transactions. The Managed Care Finance Department is responsible for data generation and timely payment of capitation.

IPA/medical groups must submit year-end financial statements audited by an independent certified public accountant firm within 150 calendar days after the close of the fiscal year to Blue Shield Promise and the Department of Managed Health Care (DMHC) (regulator). On a quarterly basis, financial statements must be submitted to DMHC within 45 calendar days after the quarter ends.

IPA/medical groups must estimate and document, on a quarterly basis, the organization's liability for incurred but not reported (IBNR) claims using a lag study, an actuarial estimate, or other actuarial firm certified methodology and calculation.

IPA/medical groups shall maintain at all times:

- A positive working capital (current assets net of related party receivables less current liability).
- A positive tangible net equity as defined in regulation 1300.76(e).
- A cash to claims ratio as defined in regulation 1300.75(f).
- A claims timeliness requirement as defined in regulation SB260.

## 15.2: Capitation Payment

The Managed Care Finance Department is responsible for sending the monthly capitation payments to its contracted IPA/medical groups. Capitation payments are made no later than the 10th of each month for Medi-Cal San Diego and no later than the 13th for Medi-Cal Los Angeles or within 10 days from receipt of revenue from DHCS or L.A. Care.

Capitation reports and eligibility reports are posted on a secured site or what is widely known as a Secure File Transfer Protocol ("SFTP") server. These reports are available to the IPA/medical groups no later than the 10th of each month. Each IPA/medical group is responsible for coordinating with Blue Shield Promise on how to access the SFTP server. For security measures, only two individuals per IPA/medical group are issued a username and password to access this site. Any changes to the IPA/medical group's contact person will require a new password or PGP key. IPA/medical groups must request and fill out a new PGP Key Form and submit to their assigned Provider Relations Representative.

This page intentionally left blank.

# SECTION 16: REGULATORY, COMPLIANCE, AND ANTI-FRAUD

## 16.1: Anti-Fraud Policy and Program

State and federal agencies have increased investigations based on health care fraud and abuse laws and enforcement against providers and enrollees who violate these laws. State and federal authorities have in recent times prosecuted numerous healthcare providers for various fraudulent practices, and also mandated health care service Plans to establish anti-fraud programs.

Following this mandate and resultant industry trends, Blue Shield Promise Health Plan has developed an aggressive Compliance and Anti-Fraud Program that includes voluntary disclosure to appropriate agencies of alleged cases of fraud and abuse. Provider cooperation is essential for the success of anti-fraud and abuse efforts and as a provider of health care services to Blue Shield Promise Health Plan Members, we would like to draw your attention to this program and request your cooperation.

Health care fraud includes, but is not limited to, knowingly making, or causing to be made any false or fraudulent claim for payment of a health care benefit. Thus, any intentional deception or misrepresentation that a provider, Member, employee, supplier, or other entity makes knowing that such action could result in an unauthorized payment, benefit, denial, or other illegal action would be classified as health care fraud.

There are two ways in which providers can cooperate in Blue Shield Promise Health Plan's antifraud and abuse efforts:

1. Review practices related to services to Blue Shield Promise Members to ensure that:
    a. Fee-for-service bills, if any, accurately describe the actual services performed and duplicate billing is avoided.
    b. Fee-for-service bills are not generated for capitated services.
    c. Members are not billed for covered services except for applicable co-payments.
    d. Co-payments, when applicable, are collected.
    e. Encounter data is reported accurately.
    f. Providers participate in Blue Shield Promise Health Plan utilization reviews to detect and review underutilization in a capitated environment.
    g. Blue Shield Promise Health Plan is informed about renewals and changes to all licenses and other credentials.
    h. Diagnoses and medical necessity are stated accurately, and accurate medical records are maintained.
    i. Full cooperation is demonstrated in transferring Members to Plan hospitals when medically appropriate.
    j. Any marketing efforts for enrollment as Blue Shield Promise Members are within legal limits.

2. Report any fraud and abuse or suspicious activity that may come to your attention to the Special Investigation Unit Hotline at (855) 296-9092, anonymously. Such instances include:
    a. Any illegal or improper solicitations or offers made to you by Blue Shield Promise employees.
    b. Any illegal or improper solicitations or offers made to you regarding services to Blue Shield Promise Members by other providers.
    c. Any attempts by patients to use a Medi-Cal card or Blue Shield Promise identity cards belonging to another.

If the matter relates to Medi-Cal services, providers may also call the State of California, Department of Health Services Medi-Cal Fraud Hotline at (800) 822-6222, email stopmedicalfraud@dhcs.ca.gov, or go to https://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

## 16.2: 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.

## 16.3: 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.

# SECTION 17: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Purpose

To ensure that Members receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices, and preferred language, at every medical and non-medical encounter.

Procedure

Blue Shield Promise Health Plan has adopted a CLAS Policy which is consistent with the National Standards for CLAS. Contracts between Blue Shield Promise and IPA/medical groups, providers, hospitals, and ancillary providers include a provision requiring them to participate in and comply with the performance standards, policies, procedures, and programs established from time to time by the local initiative, and Plan with respect to cultural and linguistic services including without limitation, attending training programs, and collecting and furnishing cultural and linguistic data to the local initiative, and Plan. IPA/medical groups will educate and communicate cultural and linguistic requirements, policies, procedures, and programs to their contracted providers on an ongoing basis.

## 17.1: **Blue Shield Promise Health Plan and Subcontractor's Responsibility in** the Provision of CLAS

Blue Shield Promise and its subcontractors will fully comply with federal and state regulations, DHCS, L.A. Care, and DMHC contract requirements relating to CLAS. Blue Shield Promise does not delegate overall responsibility for culturally and linguistically appropriate services provided to plan Members to IPA/medical groups and other providers.

CLAS areas that Blue Shield Promise Health Plan will be responsible for include:

1. Hiring a cultural and linguistic specialist responsible for CLAS.
2. Developing policies and procedures on CLAS related topics and requirements and ensuring access to Members' CLAS data is protected and only accessible by approved parties.
3. Sharing eligible individual Member data on language needs with providers.
4. Identifying LEP Members and communicating information to IPA/medical groups.
5. Providing information on language patterns of Blue Shield Promise Members.
6. Sharing providers' race and/or ethnicity upon Member's request.
7. Updating language capability of physicians and clinic staff in the provider directory.

8. Informing Members of their rights to: Interpreting services at no cost; not use family Members, including minors, or friends for interpreting; request an interpreter during discussions of medical information and explanations of plans of care; receive translated subscriber materials in threshold languages and in alternative format (i.e., Braille, audio, and large print); and file a complaint or grievance if their cultural and/or linguistic needs are not met.
9. Contracting, coordinating, and covering the cost of face-to-face and American Sign Language (ASL) interpreting services requested by IPA/medical groups, providers, and Members.
10. Contracting, coordinating, and covering the cost of 24-hour/7-day telephonic interpreting services when requested by IPA/medical groups, providers, and Members.
11. Developing protocol on how IPA/medical groups, providers, and clinic staff can access to free interpreting services through Blue Shield Promise.
12. Developing and distributing resources, tools, and materials to IPA/medical groups (e.g., signs, language ID cards, etc.).
13. Assessing and monitoring the effectiveness of linguistic services.
14. Contracting with a qualified translation company to translate written enrollment and Member informing materials in the threshold languages including the *Evidence of Coverage* (EOC) booklet, Provider Directory, Marketing Materials, Form Letters (denial letters, complaint and grievance materials, medical care reminders, and other legal documents). Then sharing these translated materials with the IPA/medical groups.
15. Conducting or subcontracting with qualified agencies or qualified facilitators to provide cultural competency and cultural diversity training courses for, health plan staff, IPA/medical groups, providers, and clinic staff.
16. Conducting an annual analysis on the Blue Shield Promise's provider network capacity and Members' needs. When gaps and/or barriers are identified, develop, and implement improvement opportunities to meet Member needs.
17. Working with the QI Department to address CLAS related grievances presented by Members and IPA/medical groups and explore opportunities for improvement.
18. Communicating and disseminating CLAS information and requirements, and cultural competency training opportunities to IPA/medical groups and providers on an ongoing basis.
19. Monitoring and overseeing CLAS programs and compliance with IPA/medical groups.
20. Maintaining a committee that oversees Multicultural Distinction and CLAS oversight and approve related documentation. Blue Shield Promise Members will serve as active committee Members.

CLAS areas that IPA/medical groups will be responsible for include:

1. Designating a person responsible for CLAS and including responsibilities in job description. CLAS function is reflected in the organizational chart.
2. Identifying Member language on monthly eligibility list sent to providers.
3. Updating Provider Directory to include language capability of providers and clinic staff.
4. Distributing signs to contracted providers on the availability of free interpreter services for LEP Members and ensuring signs are posted at key points of contact.
5. Having appropriate telephone numbers and protocol to access interpreting services through the IPA/medical group or Health Plan.
6. Ensuring access to free interpreting services to LEP and hard-of-hearing or deaf Members on a 24-hour/7-day basis.
7. Educating and informing providers and clinic staff on how to access interpreting services.
8. Providing and/or promoting cultural competency training to providers and clinic staff.
9. Making Member-informing materials available to LEP Members in the threshold languages and ensuring quality translation and cultural and linguistic appropriateness of materials. Informing providers and clinic staff what materials are available at Blue Shield Promise and how to get them, including materials for Members with disabilities (e.g., audio, Braille, large print, materials accessible online, or electronic text files).
10. Having procedures for handling CLAS-related complaints made at the clinic and IPA/medical group sites and logging grievances with CLAS-related issues.
11. Educating providers and clinic staff on the need to maintain a language capability form, certification of language proficiency or interpreting training, or similar documentation on file for bilingual staff, and staff providing interpreting services to Members.
12. Educating providers and staff on the process, and availability of CLAS Community resources/ agencies. A list of resources/agencies must be kept on file and can be obtained from Blue Shield Promise.
13. Including CLAS related questions in "Provider Satisfaction Survey" and analyzing these results to identify patterns of CLAS related problems for corrective action (optional).
14. Having written policies and procedures covering the above subjects.
15. Documenting all education of CLAS information and its dissemination to contracted providers, as well as retaining copies of agendas, sign-in sheets, handouts/materials from provider cultural competency trainings attended.

16. Translating the Notice of Action (NOA) and Notice of Appeal Resolution (NAR), including the clinical rationale, into the Member's preferred language.

## 17.2: Identification of Limited English Proficient (LEP) Members

Cultural competency and linguistic capability in managed care is critically important to allow Blue Shield Promise to meet the needs of our culturally and linguistically diverse population. Language is a medium used in every step of the health care system, from making appointments to understanding instructions and asking questions.

Definitions:

***"Limited English proficient (LEP) Members"*** are those Members that cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

***"Threshold Languages"*** are primary languages spoken by limited English proficient (LEP) population groups meeting a numeric threshold of 3,000 or five percent (5%) of the eligible beneficiaries, whichever is lower. The Department of Health Care Services (DHCS) designates threshold languages in each county. Languages spoken by a population of eligible LEP beneficiaries residing in a county, who meet the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes, are also considered threshold languages for a county.

The following eleven threshold languages have been identified by DHCS for Los Angeles County: English, Spanish, Chinese (Cantonese and Mandarin), Arabic, Armenian, Cambodian/Khmer, Korean, Farsi, Filipino/ Tagalog, Vietnamese, and Russian.

For San Diego GMC, the threshold languages are Arabic, English, Spanish, Tagalog Vietnamese, Farsi, and Chinese. (Sources: http://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/LanguageAssistance.aspx )

***"Materials in Alternative Formats"*** are information and materials that can be used by Members with disabilities (e.g., audio, Braille, large print, materials accessible online, or electronic text files). This includes health education materials and information on how to access health plan services.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and IPA/medical groups will assess their Member population's language preference distributions to determine special needs and develop appropriate plans and services.
2. Blue Shield Promise will provide a monthly new Member eligibility list to IPA/medical groups and providers, which will include the primary language spoken by each Member. IPA/medical groups and providers may use the eligibility list as a tool to track their LEP Members.
3. Blue Shield Promise and subcontractors will ensure Members are routinely given opportunities to declare their need for culturally and linguistically appropriate services (e.g., when making an appointment, during Initial Health Assessment, on arrival, and in the exam room, etc.). Providers and clinic staff should record each Member's primary language in their medical chart.

## 17.3: Access to Free Interpretation Services

It is the responsibility of Blue Shield Promise and subcontractors to provide access to interpreter services, 24 hours a day, seven days a week, at no cost, to LEP and hard-of-hearing Members when they access health care services.

Blue Shield Promise and its subcontractors must not require or suggest that LEP, hard-of-hearing, or deaf Members provide their own interpreters or use family Members or friends as interpreters. The use of such persons may compromise the reliability of medical information and could result in a breach of confidentiality or reluctance on the part of beneficiaries to reveal personal information critical to their situations. Minors should not interpret for adults.

If, after being notified of the availability of interpreters, the Member elects to have a family Member or friend serve as an interpreter, providers may accept the request. However, the use of such an interpreter should not compromise the effectiveness of services nor violate the beneficiary's confidentiality.

Providers MUST document the request or refusal of language interpreting services by an LEP, hard-of-hearing, or deaf Member in the Member's medical record. This will be monitored during facility site reviews and medical records review audits.

Providers and clinic staff shall follow Blue Shield Promise protocol for requesting interpreting services to access telephonic, or face-to-face interpreting services for LEP, American Sign Language, hard-of-hearing, or deaf Members.

Providers and bilingual staff providing interpreting services MUST maintain an "Employee Language Skill Self-Assessment" form, certification of language proficiency or interpreting training on file.

Bilingual staff providing medical interpreting services are encouraged to take a language proficiency test by a qualified agency (e.g., Pacific Interpreters) to determine if the candidate is qualified for medical interpreting. Bilingual staff with limited bilingual

capabilities or who rate "POOR" on a language proficiency test should not provide interpreting services to Members and are required to use telephonic interpreting service or schedule a face-to-face interpreter for Blue Shield Promise Members. This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.

*17.3.1: Posting of Signs at Key Medical and Non-Medical Points of Contact*

Signs informing Members of their right to request free interpreting services should be clearly posted at each provider office (i.e., reception area, waiting room, exam room). Blue Shield Promise and IPA/medical groups are responsible for ongoing distribution of signs/posters to the providers. To obtain signs/posters, please contact the Cultural and Linguistic Department.

*17.3.2: Proficiency of Interpreters*

Blue Shield Promise and its subcontractors will ensure that limited English proficient (LEP), hard-of-hearing, or deaf Members have equal access to healthcare services through the provision of high-quality interpreting and linguistic services as appropriate for medical, pharmaceutical, and non-medical encounters in the Member's spoken language 24 hours a day, seven (7) days per week. This includes American Sign Language (ASL) interpreting services.

Definitions:

***"Medical interpreter"*** is a qualified bilingual staff Member, or contracted interpreter, who possesses conversational fluency in both the target language and English, and the ability to interpret medical terms (e.g., physiology, symptoms, common disease names and processes, clinical procedures, instructions and treatment plans and consent forms, etc.) in English and the target language of the LEP Member.

***"Non-medical interpreter"*** is a bilingual staff Member, or contracted interpreter, with conversational fluency in both the target language and English and provides assistance to Members for administrative services (i.e., Member Orientation, scheduling appointments, non-clinical consent forms, Customer Care).

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and its subcontractors will use the 24-hour/7-day over-the-phone interpreting service as a supplement to in-person interpretation. Subcontractors may rely on Blue Shield Promise to access interpreting services by following the interpreting services protocol. (Please refer to Section 17.2.)
2. Documentation of linguistic competency of individuals providing interpreting services at Blue Shield Promise or the IPA/medical group must be on file. Documents may include:
    a. Written or oral assessment of bi-lingual skills.
    b. Documentation of years served as interpreter/translator.
    c. Successful completion of appropriate training programs.
    d. Confidentiality agreement or verification of confidentiality clause in contract signed by interpreter through agency.
    e. Other relevant documents signifying interpreter/translator capability (e.g., out of state certificate or license).
3. All interpreter services vendors who perform interpreting duties must sign a confidentiality agreement with Blue Shield Promise and its subcontractors.
4. Blue Shield Promise will retain reports of all monitoring systems for interpreting services. Monitoring can include a record of performance measures (i.e., written and/or oral testing of bilingual skills, attendance of relevant training programs and number of years interpreting, etc.); log of 24-hour telephonic interpreting services; analysis of grievances and complaint logs regarding communication or language problems; and interpreting service satisfaction questions included in the annual Member and provider satisfaction survey.
5. IPA/medical groups should document interpreting services utilization and maintain on file. Documentation may include a log of 24-hour telephonic interpreting services and/or number of over-the-phone and face-to-face interpreting services requests received from contracted providers.
6. Blue Shield Promise and its IPA/medical groups may subcontract with interpreting services agencies to determine the qualifications of its interpreters used at provider sites.

## 17.4: Cultural Competency Training

Blue Shield Promise values diversity as an integral component of our organization and will promote the achievement of a cultural competent organization. Blue Shield Promise views cultural competency as a responsibility at both the organizational and individual level.

Cultural competency training is designed to assist in the development and enhancement of interpersonal and intra-cultural skills to improve communication, access, and services, and to more effectively serve our diverse membership including Seniors and People with disabilities (SPD).

Definitions:

***"Culture"*** is a dynamic and evolving process comprised of a group's learned patterns of behavior, values, norms, and practices.

***"Cultural competency"*** is an increased working knowledge of how behaviors, values, norms, practices, attitudes and beliefs of disease, preventative practices and treatment affect medical and non-medical encounters.

***"Organizational cultural competency"*** is the ability of an organization to adapt to diversity and actively apply knowledge of culture and linguistic issues in serving our diverse membership for improved access and health outcomes.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise and its subcontractors will provide and/or promote opportunities for ongoing cultural competency and cultural diversity trainings to providers and staff.
2. Providers and staff are strongly encouraged to attend cultural awareness/ competency training programs that are offered through L.A. Care, Blue Shield Promise Health Plan, IPA/medical groups, or other cultural awareness/competency training agencies.
3. Blue Shield Promise and its subcontractors will retain copies, if available, of training curriculum, documentation of attendance, and schedule of training dates.
4. Blue Shield Promise and its subcontractors will keep a list of cultural resource materials used during a training program.

## 17.5: Translation of Member-Informing and Health Education Materials

Written informing documents provide essential information to Members about access and usage of services. It is the responsibility of Blue Shield Promise and the IPA/medical group to provide culturally and linguistically appropriate informing materials to Members in the threshold languages determined by the Department of Health Care Services (DHCS) and at a 6th grade reading level or below.

Member informing materials include but not limited to:

- Member Handbook
- Welcome packets
- Provider directory
- Access and availability of linguistic services
- Marketing materials
- Member surveys
- Member Newsletters
- Grievance and fair hearing process
- Form letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits, including clinical rationale.

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

1. Blue Shield Promise will send the Member Handbook and Welcome Packets in all threshold languages to LEP members as determined by monthly enrollment information. A tracking system will include documenting materials sent out to Members in the different languages, types of materials, and volume.
2. Blue Shield Promise and its IPA/medical groups will have common letters (i.e., denials letter, informed consent, etc.) available in the language(s) that is commonly encountered based on Health Plan and IPA/medical group membership; or a system to provide Members the opportunity to receive these documents in their preferred languages. Blue Shield Promise will forward to the IPA/medical group translated Member-informing materials and available health education materials.
3. A qualified translator will complete all translations. Memorandum of Understanding (MOU) contracts and information on the agencies' qualifications should be on file at Health Plan and IPA/medical groups.
4. Blue Shield Promise and its IPA/medical groups will use, at a minimum, the following translation process to ensure quality translation of written Member informing materials and health education materials:
    a. The document needing translation will be submitted to the "qualified translator" for translation. A "*qualified translator*" is a person with a formal education in English, with the ability to read, write and understand the target language and with knowledge of, and experience with, the culture of the intended audience.

The following three steps are done when translating a source document into the target language: translation, editing, and proofreading. Each step is performed by a different linguist. Once the translation is complete, the requesting department will receive an email from the vendor containing the translation.

## 17.6: CLAS Related Grievances

Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to LEP persons that are limited in scope or lower in quality than those provided to others. An individual's participation in a federally funded program or activity may not be limited on the basis of LEP.

Therefore, a Blue Shield Promise Health Plan Medi-Cal Member has the right to file a grievance if their cultural and/or linguistic needs are not met. Providers and clinic staff should know how to handle and forward CLAS related grievances presented by a patient at their office. (See Section 6: Grievances, Appeals, and Disputes.) CLAS related grievances presented to Blue Shield Promise Health Plan will be handled by following these steps:

1. The Grievance Unit receives Member and provider grievances and determines if the case has a CLAS related issue.
2. Blue Shield Promise's Grievance Department will resolve the issue with the Member whenever possible.
3. If a Member or provider grievance is classified or coded to have cultural and/or linguistic issues, the case will be forwarded to the Cultural and Linguistic Department.
4. The Cultural and Linguistic (C&L) specialist will investigate, follow-up, and resolve the issue with the provider and/or office staff involved with the case.
5. The Cultural and Linguistic specialist may collaborate with the Grievance, Utilization Management, Quality Management, and Provider Network Operations (PNO) Departments, when necessary.
6. A copy of the actions taken will be kept on file with the Grievance Department, PNO, and Cultural and Linguistic Departments.
7. The Cultural and Linguistic specialist will keep statistics of CLAS related grievances for trends, and statistical information will be reviewed by the CLAS manager.

## 17.7: Referrals to Culturally Appropriate Community Resources and Services

1. Blue Shield Promise will distribute to providers the CLAS Community Resource Directory consisting of culturally and linguistically appropriate education and counseling services on topics such as domestic violence, counseling, cultural adaptation resource, elder care, interpreter resources, etc. during site visits, mailings, trainings, etc. Providers, clinic staff, and Members can also access the CLAS Community Directory from the Blue Shield Promise provider website at blueshieldca.com/promise/provider. This directory can also be obtained by contacting the CLAS Department.
2. Providers should document all referrals in the Member's medical chart.
3. Blue Shield Promise has a closed loop system in place to monitor those Members being referred to CLAS Community Resources and Services. The CLAS referral request form can be faxed to the Blue Shield Promise Health Plan CLAS Department. Once the Member is referred, the provider will be informed of the Member's participation to the program in an effort to encourage further follow up.
4. Providers should maintain all information provided in the Member's medical record.

## 17.8: IPA/Medical Group Monitoring and Reporting Requirements

In order to assess the ability of an IPA/medical group to appropriately conduct CLAS, the IPA/medical group will be assessed at least annually thereafter by the Cultural and Linguistic Department. Blue Shield Promise will also educate the providers of their direct responsibility in complying with federal regulations relating to CLAS and the provision of services to Limited English Proficient (LEP), hard-of-hearing, or deaf Members.

1. The Blue Shield Promise CLAS auditor will review, at a minimum, the following documents:
    - IPA/medical group policies and procedures on CLAS.
    - LEP identification and recording process.
    - Access to interpreting services including staff knowledge of handling interpreter needs.
    - Signs posted and other communication tools used to meet needs of LEP and hard-of- hearing or deaf Members.
    - Recording requests/refusals for interpreting services in medical charts.
    - Documentation on promotion and/or attendance of CLAS Training for providers and staff.
    - Materials made available to LEP Members in the threshold languages.
    - Provider satisfaction surveys conducted by the IPA/medical group.
    - IPA/medical group procedures for handling CLAS related complaints made at clinic and IPA sites.
    - Access to CLAS Community Resources and Services, the referral process for referring Members to CLAS Community Resources and Services, and how providers are informed of the need to record the referrals in the Member's medical chart.
    - Documentation on dissemination/communication of CLAS related information to providers and staff.

    Some of the items above will be reviewed by Blue Shield Promise, Facility, Medical Records, QM/UM, and Health Education review staff whose reviews will be coordinated with the Cultural and Linguistic Department.

2. The CLAS monitoring review tool will be used by the Blue Shield Promise CLAS auditor. This monitoring tool will be provided to the IPA/medical group.

3. Blue Shield Promise will provide guidance and educational opportunities to the IPA/medical groups for those sections that do not meet section criteria(s) within 30 days of receiving notice of the review. Blue Shield Promise criteria for monitoring are based on federal and state regulations and contract requirements on Culturally and Linguistically Appropriate Services (CLAS).

Blue Shield of California Promise Health Plan Participating IPA/Medical Group

Delegation of Utilization Management Responsibilities

This Participating Independent Physician Association / Medical Group Delegation of Utilization Management Responsibilities Agreement ("Agreement") is made and entered into on <<Date>> by and between BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN, a California corporation ("PLAN"), and <<Contract Entity Name>> ("Medical Group").

Medi-Cal

| Delegated UM Activity | Delegated | IPA/Medical Group Responsibility | Plan Responsibility | Frequency of Reporting/Due Date | Plan's Process for Performance Evaluation | Corrective Action if IPA/MG Fails to Meet Responsibilities |
|---|---|---|---|---|---|---|
| I. UM Program | ☐Yes ☐No | Develop, implement, and submit to Plan the UM Program outlining structure, accountability, scope, adoption of criteria, processes and other regulatory and NCQA components of UM function. | • Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting | Annually:<br>-UM Program<br>-UM Program Evaluation<br>-UM Workplan<br>Quarterly/Semi-Annual:<br>UM Updates (Coalition/ICE Report) | • Pre-delegation review<br>• Annual due-diligence audit | • Request Corrective Action Plan(s) (CAPs)<br>• Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)<br>• Termination of UM delegation if CAP objectives are not achieved. |

| | | | | | | |
|---|---|---|---|---|---|---|
| II.<br>Outpatient specialty referrals<br><br>Routine/Urgent Pre-service and retrospective review that result in an approval or denial of services | □Yes □No | • Conduct review utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage<br>• Adhere to regulatory turnaround time standards for decision making<br>• Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations)<br>UM determinations are tracked/ monitored through UM Committee | • Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting | Monthly:<br>-Approval logs<br>-Denial logs<br>-Denial letters including patient clinical information<br><br>Quarterly/Semi-Annual: UM Updates (Coalition/ ICE Report) | Pre-delegation review<br>• Annual due-diligence audit Quarterly/ focus audits | • Request Corrective Action Plan(s) (CAPs)<br>• Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)<br>• Termination of UM delegation if CAP objectives are not achieved. |
| III.<br>Outpatient/ ambulatory procedure referrals – Professional component<br><br>Routine/Urgent Pre-service and retrospective review that result in an approval or denial of services | □Yes □No | Conduct review utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage Adhere to regulatory turnaround time standards for UM decision making Use Blue Shield Promise-approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations) UM determinations are tracked/monitored through UM Committee<br>Contact Plan within 24 hours for tracking number | • Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting | Monthly:<br>-Approval logs<br>-Denial Logs<br>-Denial letters including patient clinical information<br><br>Quarterly/Semi-Annual: UM Updates (Coalition/ICE Report) | • Pre-delegation review<br>• Annual due-diligence audit<br>• Quarterly/ focus audits | • Request Corrective Action Plan(s) (CAPs)<br>• Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)<br>• Termination of UM delegation if CAP objectives are not achieved. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | for facility portion of referral (Shared Risk only) | | | | |
| IV. A. (Shared Risk) Inpatient hospitalization, SNF, and Acute Rehab. Routine/Urgent Pre-service, retrospective and concurrent review that result in an approval or denial of services | ☐ Shared responsibility<br><br>☐ Delegated responsibility<br><br>☐ N/A IPA/MG has no responsibility under this section | • Forward and coordinate all requests involving inpatient services to Plan UM Dept<br>• Conduct review Utilizing Plan approved evidence-based UM criteria and Blue Shield Promise Evidence of Coverage<br>• Adhere to regulatory turnaround time standards for UM decision making<br>• Use Blue Shield Promise approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations)<br>• Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider<br>• Report any acute stay over 6 days to Blue Shield Promise for coordination of care<br>• UM determinations are tracked/monitored through UM Committee | • Conduct UM review<br>• for inpatient services<br>• Forward information pertaining to the concurrent review to the delegate, if available<br>• Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting | • Not applicable<br>Weekly submission of authorization and denial log including full/partial denials (for claims processing)<br><br>Monthly<br>Denial Logs<br>Denial letters including patient clinical information<br>Quarterly/ Semi-Annual:<br>UM Updates (Coalition/ ICE Report) | • Not applicable<br>• Pre-delegation review<br>• Annual due-diligence audit<br>• Quarterly/ focus audits | • Not applicable<br>• Request Corrective Action Plan(s) (CAPs)<br>• Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)<br>• Termination of UM delegation if CAP objectives are not achieved. |

| | | | | | | |
|---|---|---|---|---|---|---|
| IV. B.<br>(Full Risk/ Global)<br>Inpatient Hospitalization, SNF, and Acute Rehab.<br><br>Routine/Urgent Pre-service, retrospective and concurrent review that result in an approval or denial of services | ☐Yes ☐No<br><br>☐ N/A<br>IPA/MG has no responsibility under this section | • Conduct review Utilizing Plan approved evidence-based UM criteria and Plan Evidence of Coverage<br>• Adhere to regulatory turnaround time standards for UM decision making<br>• Use Plan approved UM determination notice templates, including appeals language (i.e., NOA, Organization Determinations)<br>• Continue the care until treating provider has been notified of group's decision, and care plan has been agreed upon by the treating provider.<br>• UM determinations are tracked/monitored through UM Committee | • Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting | Monthly<br>-Approval logs<br>-Denial logs<br>-Denial letters including patient clinical information<br><br>Quarterly/ Semi-Annual:<br>UM updates (Coalition/ ICE Report) | • Pre-delegation review<br>• Annual due-diligence audit<br>• Quarterly/ focus audits | • Request Corrective Action Plan(s) (CAPs)<br>• Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation)<br>• Termination of UM delegation if CAP objectives are not achieved. |

| | | | | | | |
|---|---|---|---|---|---|---|
| V. Linked Services | □Yes □No | Identify the following and report number of cases to Blue Shield Promise:<br>• CCS<br>• DOT for TB<br>• ESRD<br>• Waiver Programs (home care, HIV/AIDS, etc.)<br>• Transplants<br>• Mental Health<br>• Drug/Alcohol<br>• Hospice<br>• Custodial (Long Term Care)<br>• EPSDT Supplemental Services<br>• HCBS for DDS<br>• DDS/EI/ES<br>Identify the need for Long-Term Services and Supports (LTSS) and refer to:<br>• CBAS<br>• IHSS<br>• MSSP<br>• LTC | • Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting<br>• Review and coordinate all LTSS services | Monthly Logs<br><br>Quarterly:<br><u>For LA County Only:</u><br>Submit to Plan using Plan approved Quarterly Supplemental Report form. | • Pre-delegation review<br>• Annual due-diligence audit<br>• Quarterly/ focus audits | • Request Corrective Action Plan(s) for elements of non-compliance Sanction per<br>• IPA's delegation agreement (i.e., CAP deduction from monthly capitation)<br>• Termination of delegation if CAP objectives are not achieved within agreed timeframe. |
| VI. A. Complex Case Management | □Yes □No | Identify and refer members for Complex Case Management Coordinate member care with the Plan | • Provide complex case management services to members meeting Plan criteria. | Not applicable | Not applicable | Not applicable |

| | | | | | | |
|---|---|---|---|---|---|---|
| VI. B.<br>Basic Case Management | □Yes □No | Provide basic case management to members not eligible for Plan Complex Case Management and Disease Management Programs. | • Provide assistance to delegate when needed<br>• Monitor and oversee delegated functions<br>• Establish, publish, and distribute performance standards and guidelines to the IPA/MG<br>• Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting | Monthly Logs<br><br>Quarterly:<br>For LA County Only: Submit to Plan using Plan approved Quarterly Supplemental Report form. | • Pre-delegation review<br>• Annual due-diligence audit<br>• Quarterly/ focus audits | • Request Corrective Action Plan(s) for elements of non-compliance<br>• Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation<br>• Blue Shield Promise may conduct discretionary review to<br>• re-measure former areas of non-compliance<br>• Termination of delegation if CAP objectives are not achieved within agreed timeframe. |

| | | | | | | |
|---|---|---|---|---|---|---|
| VII. Member Communica-tions | □Yes □No | • Ensure member communications adhere to all regulatory standards<br>• Obtain approval for all Member Communications from Plan prior to distribution to members | • Ongoing evaluation of Member<br>• Communication according to regulatory standards<br>• Provide regulatory updates to the delegate as they become available | Ongoing | • Pre-delegation review<br>• Annual due-diligence audit<br>• Quarterly/ focus audit | |
| VIII. Member Appeals/ Grievances | □Yes □No | • Evidence of communication stating requests for appeals are forwarded to Plan upon receipt or per Blue Shield Promise guidelines | • Review and resolve all appeals and grievances within established timeframes | Not applicable | Not applicable | Not applicable |
| IV. Evaluation of New Technology | □Yes □No | Not applicable | • Plan evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health procedures | Not applicable | Not applicable | Not applicable |

Blue Shield of California Promise Health Plan will share Member experience and Clinical Performance data with Practitioners and Providers when requested. Requests should be submitted via email to your delegation coordinator.

The Plan and Medical Group agree to accept the terms of the above.

| Blue Shield of California Promise Health Plan | | | <<Contract Entity Name>> | |
|---|---|---|---|---|
| ("Plan") | | | ("Medical Group") | |
| By: | | | By: | |
| Name: | | | Name: | |
| Title: | | | Title: | |
| Date: | | | Date: | |

# Request for Release of Mental Health Care Information

(Practitioner/Provider/Clinic)

_____

(Address) (Phone)

_____

1. PATIENT INFORMATION

_____

Patient Last name, First name, Middle Initial Date of birth Former name, if any

2. REQUESTING ENTITY

(Name) _____

(Address) _____

(Phone) _____

3. REASON FOR REQUEST

I request the following mental health information regarding the above patient's outpatient treatment with a psychotherapist (as defined by Section 1010 of the California Evidence Code). Please be specific:

4. INTENDED USE OF INFORMATION

This information will be used for:

0 Further medical care 0 Payment of insurance claim 0 Other
0 Applying for insurance 0 Vocational rehab evaluation 0 Disability determination
0 Legal investigation

5. TIMEFRAME FOR USE AND DESTRUCTION

This information will be kept for:

0 30 days 0 60 days 0 90 days 0 Other – Specify

Justification for timeframes longer than 90 days _____

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY

All mental health information obtained will remain confidential and will be used solely for the purpose(s) described in #4 above and for no other purpose.

Signature of requestor_____Date _____

For Clinic Use Only:

Date Received_____ I. D Provided_____

Date Released_____ Processed by_____

0 Sent by mail 0 Picked up in person

# Notification of Extension for Use of Mental Health Care Information

(Practitioner/Provider/Clinic) _____

(Address) _____

_____

(Phone)_____

PATIENT INFORMATION:

Patient's last name _____ First name _____ M.I. _____

Date of birth / Former name, if any _____

REQUESTING ENTITY:

(Name)

_____

(Address)

_____

(Phone)

_____

INTENDED USE OF INFORMATION:

This information will be used for:

_____

_____

EXTENSION TIMEFRAME REQUESTED AND DESTRUCTION:

We request an extension for use of this information for:

0 30 days 0 60 days 0 90 days 0 Other–Specify

Reason for Extension:

_____

_____

_____

Prior to, or not less than three days after, the prescribed timeframe all mental health information obtained, and any copies made subsequently, will be destroyed or disposed of, caused to be destroyed or returned to the originator in a manner that preserves the confidentiality of the information contained therein.

CONFIDENTIALITY

All mental health information obtained will remain confidential and will be used solely for the purpose(s) described above and for no other purpose.

Signature of requestor_____

Date: _____

For Clinic Use Only:

Date Received_____ I.D. provided _____

Date Released_____ Processed by _____

- ☐ sent by mail
- ☐ picked up in person

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Access to Care Standards

ATTACHMENT A

| Type of Care and Service | Blue Shield Promise Health Plan Standard |
|---|---|
| Emergency Services | Immediately, 24 hours a day, 7 days a week. |
| PCP Urgent Care Services without prior authorization | Within forty-eight (48) hours of the request. |
| PCP (and OB/GYN) Urgent Care with prior authorization (including referrals made by a physician to another physician) | Within ninety-six (96) hours of the request. |
| PCP (and OB/GYN) Routine or Non-Urgent Care Appointments | Within ten (10) business days of the request. |
| PCP Adult Preventive Care | Within twenty (20) business days of the request. |
| Specialist Urgent Care without prior authorization | Within forty-eight (48) hours of the request. |
| Specialist Urgent Care with prior authorization | Within ninety-six (96) hours of the request. |
| Specialist Routine or Non-Urgent Care | Within fifteen (15) business days of the request. |
| OB/GYN Specialty Care | Within fifteen (15) business days of the request. |
| Behavioral Health routine and follow-up visits with non-physician practitioners | Within ten (10) business days of the request. |
| Routine and follow-up visits with behavioral health physicians | Within fifteen (15) business days of the request. |
| Behavioral Health Urgent Care Visits | Within forty-eight (48) hours of the request. |
| Behavioral Health Non-life-threatening emergency | Within six (6) hours of the request. |
| Routine or Non-Urgent Care Appointment for Ancillary Services | Within fifteen (15) business days of the request. |
| Children's Preventive Period Health Assessments (Well-Child Preventive Care) Appointments | Within seven (7) working days of the request. |
| After Hours Care | 24 hours/day; 7 day/week availability |

| Type of Care and Service | Blue Shield Promise Health Plan Standard |
|---|---|
| Initial Health Assessment for a New Members (under eighteen (18) months of age) | Within one-hundred-twenty (120) days of the enrollment. |
| Initial Health Assessment for a New Members (over eighteen (18) months of age) | Within one-hundred-twenty (120) days of the enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP). |
| Maternity Care Appointments for First Prenatal Care | Within ten (10) business days of the request. |
| Office Wait Time to be Seen by Physician (for a scheduled appointment) | Should not exceed thirty (30) minutes from the appointment time. All PCPs are required to monitor waiting times and adhere to this standard. |
| After-Hour Instruction for Life-Threatening Emergency (when office is closed) | Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911." |
| Physician Response Time to After-Hour Phone Message, Calls and/or Pages | Within thirty (30) minutes of call, message and/or page. A clear instruction on how to contact the physician or the designee (on-call physician) must be provided for Members. |

BLUE SHIELD OF CALIFORNIA PROMISE HEALTH PLAN

Long Term Services and Support Access to Care Standards

ATTACHMENT B

| Criteria | Standard |
|---|---|
| Skilled Nursing Facility | Skilled Nursing Facility services will be available within 5 business days of request. |
| Intermediate Care Facility/ Developmentally Disabled (ICF-DD) | ICF-DD services will be available within 5 business days of request. These services are provided by Skilled Nursing Facilities and Nursing Facilities (LTC) where 24-hour nursing services are provided. |
| Community Based Adult Services (CBAS) | Meeting appointment time requirements based upon the population density of counties serviced within the required wait times for appointment. |

This page intentionally left blank.

blue california | Promise Health Plan

# PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

**Plan/Medical Group Name:** Blue Shield of California Promise Health Plan
**Plan/Medical Group Fax#:** (323) 889-6254 or (866) 712-2731
**Plan/Medical Group Phone#:** (877) 792-2731

**Urgent or Non-Urgent:** _____

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request.
**Information contained in this form is Protected Health Information under HIPAA.**

| **Patient Information** | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | MI: | Phone Number: | |
| Address: | City: | | State: | Zip Code: | |
| Date of Birth: | ☐Male ☐Female | Circle unit of measure Height (in/cm): _____ Weight (lb/kg):_____ | | Allergies: | |
| Patient's Authorized Representative (if applicable): | | Authorized Representative Phone Number: | | | |
| **Insurance Information** | | | | | |
| Primary Insurance Name: | | Patient ID Number: | | | |
| Secondary Insurance Name: | | Patient ID Number: | | | |
| **Prescriber Information** | | | | | |
| First Name: | Last Name: | | Specialty: | | |
| Address: | City: | | State: | Zip Code: | |
| Requestor (if different than prescriber): | | Office Contact Person: | | | |
| NPI Number (individual): | | Phone Number: | | | |
| DEA Number (if required): | | Fax Number (in HIPAA compliant area): | | | |
| Email Address: | | | | | |
| **Medication / Medical and Dispensing Information** | | | | | |
| Medication Name: | | | | | |
| ☐ New Therapy ☐Renewal ☐ Step Therapy Exception Request<br>If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates): | | | | | |
| How did the patient receive the medication?<br>☐ Paid under Insurance _____ Prior Auth Number (if known): _____<br>☐Name: Other (explain): | | | | | |
| Dose/Strength: | Frequency: | Length of Therapy/#Refills: | Quantity: | | |
| Administration:<br>☐Oral/SL ☐Topical ☐Injection ☐IV ☐Other: | | | | | |
| Administration Location: ☐ Patient's Home ☐ Long Term Care<br>☐ Physician's Office ☐ Home Care Agency ☐Other (explain): _____<br>☐Ambulatory Infusion Center ☐Outpatient Hospital Care _____ | | | | | |

blue california | Promise Health Plan

# PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

| Patient Name: | ID#: |
|---|---|

**Instructions:** Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step therapy exception request.

**1. Has the patient tried any other medications for this condition?** ☐**YES (if yes, complete below)** ☐**NO**

| **Medication/Therapy** (Specify Drug Name and Dosage) | **Duration of Therapy** (Specify Dates) | **Response/Reason for Failure/Allergy** |
|---|---|---|
| | | |

| **2. List Diagnoses:** | **ICD-10:** |
|---|---|
| | |

**3. <u>Required clinical information</u> - Please provide all relevant clinical information to support a prior authorization or step therapy exception request review.**

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐Attachments

**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification**: _____ **Date**: _____

**Confidentiality Notice**: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents.

**Plan/Insurer Use Only:** Date/Time Request Received by Plan/Insurer:_____ Date/Time of Decision_____

Fax Number: (  ) _____

☐Approved ☐Denied Comments/Information Requested: _____

blue california
Promise Health Plan

# Health Education Referral Form

Complete sections A-C.

Fax to 323-889-5407.

## A. Patient Information

| Please verify patient's current address and phone number. | | |
|---|---|---|
| Name: | | Date of referral: |
| BSC Promise Member ID #: | | Phone number: |
| DOB: | Sex: ☐M ☐F | Language: ☐E ☐S ☐Other: |
| Address: | City: | Zip Code: |
| If patient is a minor, please provide name and language of parent/legal guardian.<br>Name: | | Language: ☐E ☐S ☐Other: |
| Notes: | | |

## B. Service Requested

☐ class ☐ one-to-one counseling * ☐ health education material ☐ support group

* Referrals for one-to-one nutrition counseling with an RD should be sent to patient's IPA/Medical Group.

| | | | | |
|---|---|---|---|---|
| Topic | ☐ Age-Specific Ant. Guidance ** | ☐ CKD | ☐ Immunizations | ☐ Physical Activity |
| | ☐ Asthma | ☐ COPD | ☐ Injury Prevention | ☐ Stress Management |
| | ☐ Complimentary & Alternative Medicine | ☐ Diabetes | ☐ Nutrition | ☐ Substance Abuse |
| | ☐ Breastfeeding | ☐ Family Planning | ☐ Obesity | ☐ Tobacco Cessation |
| | ☐ CHF | ☐ HIV/STD Prevention | ☐ Parenting | ☐ Unintended Pregnancy |
| | ☐ Cholesterol | ☐ Hypertension | ☐ Perinatal/Pregnancy | ☐ Other: |
| | ** including information that children can be harmed by exposure to lead | | | |

## C. Provider Information

| | |
|---|---|
| Provider name: | |
| Person completing referral (if other than provider): | |
| Phone number: | Fax number: |

| BSC Promise Health Education use only | |
|---|---|
| Referral Outcome | |
| Provider Notification Date: | |

This page intentionally left blank.

# HEALTH EDUCATION STATE REQUIREMENTS FOR PROVIDERS

To access an electronic copy of this sheet, please visit:
https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/health-education-medi-cal

Please review the following Department of Health Care Services (DHCS) requirements for health education. If you need clarification on any of the requirements, please call or e-mail the Health Education Department at BlueShieldofCAHealthEducation@blueshieldca.com.

## Health Education Services

Document referrals to health education services in your patient's medical record. Health education services include classes, individual counseling, and support groups.

## Health & Wellness Portal

Please encourage your Blue Shield of California Promise Health Plan members to use our Health & Wellness portal at www.blueshieldca.com/promise/hra. The goal of the portal is to increase members' ability to manage their health by helping them identify their risks and connecting them to self-management tools and resources that can help mitigate their risks. Members can also track their health over time on the portal. Some of the tools available on the portal include a health library on various topics including physical activity, blood pressure, cholesterol, blood glucose, and nutrition. A few words from you can increase the likelihood that they will use the site.

## Patient Education Materials

All health education materials you provide to your Medi-Cal patients need to be between 2nd and 6th grade reading level. Additionally, these materials need to be medically accurate, culturally sensitive, and linguistically appropriate. We provide you with materials that meet these requirements. They have been reviewed by one of the Medi-Cal managed plans. To order materials, please call the Health Education Department to request an order form. If you are contracted with Blue Shield of California Promise Health Plan through an IPA, please call your IPA Health Education Coordinator to order materials. You may also download materials from our website at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/Sites_Content_EN/bsp/health-wellness/health-education. Materials are available in county threshold languages and in alternative formats.

## Health topics mandated by California DHCS:

| | |
|---|---|
| ► Age Specific Anticipatory Guidance, including information that children can be harmed by exposure to lead | ► Diabetes |
| ► Alcohol and substance abuse | ► Family planning |
| ► Asthma | ► HIV/STD prevention |
| ► Breastfeeding | ► Hypertension |
| ► Complementary and alternative medicine | ► Immunizations |
| ► Injury prevention | ► Perinatal |
| ► Lead poisoning prevention | ► Physical Activity |
| ► Nutrition | ► Tobacco prevention and cessation |
| ► Obesity | ► Unintended pregnancy |
| ► Parenting | |

County Threshold Languages

| | English | Arabic | Armenian | Chinese | Farsi | Khmer | Korean | Russian | Spanish | Tagalog | Vietnamese |
|---|---|---|---|---|---|---|---|---|---|---|---|
| LA | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| SD | ✓ | ✓ | | | | | | | ✓ | ✓ | ✓ |

Initial Health Assessment (IHA)

According to the DHCS Policy Letter 08-003, a newly enrolled member must schedule an IHA appointment within 120 days of enrollment. Providers are required to make a minimum of three documented attempts to schedule the IHA, with at least one phone call and one letter. In conjunction with the IHA, members need to complete the SHA in their appropriate age category. Blue Shield of California Promise Health Plan (BSCPHP) coordinates with our providers and members to ensure and encourage members and providers to schedule an IHA appointment. On a monthly basis, BSCPHP and your contracted Medical Group/IPA sends contracted providers a list of new members who are due to complete an IHA.

Your office may be randomly selected to participate in the IHA Medical Record Review utilizing the IHA Audit Tool. For more information and to access the audit tool, please refer to the following resource:

- https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/ha-medi-cal

Staying Healthy Assessment Tool

In 2014, DHCS released the new Staying Healthy Assessment (SHA) via Policy Letter 13-001, which outlines the requirements for the Staying Healthy Assessment. Providers are required to use the new SHA forms, which are available in English, Spanish, Arabic, Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Russian, Somali, Tagalog and Vietnamese. For implementation and documentation requirements please view the narrated provider training presentation at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms/ha-medi-cal. There you can also download the SHA forms. To request the use of an alternative IHEBA or to implement the SHA electronically, call the health education department at one of your contracted Medi-Cal plans to request approval.

Remember, a few words of advice from you can have a significant impact on changing your patients' high-risk behavior.

Breastfeeding Promotion

The American Academy of Pediatrics (AAP) supports breastfeeding as the optimal form of nutrition for infants. We encourage you to support this position by continuing to promote breastfeeding services to your patients. Also, please continue to refer your Medi-Cal patients to WIC.

Infant Formula Logos

Please do not distribute infant formula samples, educational materials or promotional materials with formula logos to Medi-Cal patients, as per MMCD Policy Letter 98-10.

Manual Breast Pumps

Breast pumps are available for breastfeeding patients. We encourage you to promote this benefit to your patients. For more information, please call the Utilization Management Department.

NEW! -Blood Lead Screening

As of November 2020, DHCS All Plan Letter (APL) 20-016 supersedes APL 18-017. The APL 20-016 states that at each child's periodic health assessment (PHA), from six to 72 months of age, providers must provide oral or written anticipatory guidance to the child's parent or guardian, which "includes information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age."

To help you provide this guidance to your patients, we have posted a patient education brochure on lead poisoning prevention at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/Sites_Content_EN/bsp/health-wellness/health-education.

For more information and/or specifics on All Plan Letter 20-016, please visit the DHCS website: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-016.pdf or call our Provider Customer Care Department at 800-468-9935, 8:00 a.m. – 5:00 p.m., Monday through Friday.

Tobacco Cessation Services
Per All Plan Letter (APL) 16-014, providers are required to implement tobacco cessation interventions and a tobacco user identification system into their practices. Providers must:

- Conduct initial and annual assessment of each patient's tobacco use and note this information in patient's medical record
- Offer FDA-approved tobacco cessation medications (for non-pregnant adults)
- Provide counseling using the "5 A's" model or other validated model for treating tobacco use and dependence
- Refer patients to available individual, group, and telephone counseling services
- Offer services for pregnant tobacco users
- Provide interventions to prevent the use of tobacco in children and adolescents

Some recommendations to identify tobacco users are:

- Add tobacco use as a vital sign in the chart or Electronic Health Records
- Use International Classification of Diseases (ICD)-10 codes in the medical record to record tobacco use.
- Place a chart stamp or sticker on the chart when the beneficiary indicates he or she uses tobacco
- Record tobacco use in the SHA or other IHEBA
- Record status on the Child Health and Disability Prevention Program Confidential Screening/Billing Report (PM160)

How to Start the Conversation
"As your health care provider and someone who cares about you and your health, I'd like to help you quit smoking because it's the best thing you can do for your health and anyone who lives with you".
Provider: Discuss some of the health problems associated with smoking.

To view the policy letter, learn more about the required interventions, and find training and patient resources, please visit https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/tobacco-cessation-medi-cal.

Please contact the health education department if you would like us to schedule a tobacco cessation program specialist to come to your office to help you implement processes that will make it easier for you to identify, counsel and provide resources for your patients that smoke.

Smoking Cessation Agents available to Medi-Cal patients
In our efforts to help members quit smoking, Blue Shield of California Promise Health Plan (BSCPHP) provides coverage for smoking cessation agents for adults who use tobacco products. Some of these medications require prior authorization, have quantity limits and are subject to change. Please review our drug formulary for a complete list of available medications: https://dsthealth.adaptiverx.com/web/pdf?key=8F02B26A288102C27BAC82D14C006C6FC54D480F80409B68FF2C13F77B385C1B.

Providers play a key role in the member's journey in quitting smoking. Please work with your patient to find the best option for quitting smoking such as, referring them to community resources and/or

prescribing them tobacco cessation medication. Providers should adhere to the prior authorization requirements such as, following up with requested information from the pharmacy department and meeting requested deadlines.

Medi-Cal Diabetes Prevention Program

Blue Shield Promise Medi-Cal patients who are at risk for type 2 diabetes now have access to the Medi-Cal Diabetes Prevention Program (Medi-Cal DPP) as a preventive service. This program is at no cost to Medi-Cal patients. The program is based on National Institutes of Health randomized controlled trial and has been found to greatly reduce the progression of pre-diabetes to type 2 diabetes.* These services are delivered by trained lifestyle coaches in community settings and via online platforms by organizations recognized by the Centers for Disease Control and Prevention (CDC). The focus of the program is making personal changes including improved nutrition and active living.

Eligibility criteria for the program are:

- Blue Shield Promise Medi-Cal member, 18 years and older and
- BMI greater or equal to 25, if not self-identified Asian (or if self-identified Asian, 23 or greater) and
- Not be pregnant and
- No previous diagnosis of type 1 or type 2 diabetes and
- Blood test value within the past year:
    - HgbA1c value: 5.7 - 6.4% or
    - Fasting plasma glucose of 100 - 125mg/dL or
    - Oral glucose tolerance test between140 - 199 mg/dL or
- Have previous clinical diagnosis of gestational diabetes or
- Take the prediabetes risk test and receive a screening result of high risk for type 2 diabetes

If your Blue Shield Promise Medi-Cal patient meets the eligibility criteria for the DPP, please ask your patient to call Solera Health at 866-692-5059 (TTY:711) or visit https://www.solera4me.com/bluepromisemedical.

Providers play an influential role in a member's overall health. By recommending this program to qualifying members, you are providing them with a powerful way to change their lifestyle and reduce their chance of progressing to type 2 diabetes. Enrolling in the Medi-Cal DPP offers patients an opportunity to take an active role in their health and potentially avoid the need for medication.

*https://www.cdc.gov/diabetes/prevention/prediabetes-type2/preventing.html

# Request/Refusal Form for Interpretive Services

Patient name:

_____

Primary language:

_____

☐ Yes, I am requesting interpretive services.
Language(s): _____

☐ No, I prefer to use my family or friend as an interpreter.

☐ No, I do not require interpretive services.

☐ Not Applicable.

Please explain: _____

_____

_____
Patient Signature

_____
Date

Please place this form in the patient's medical record.

Request/Refusal English

This page intentionally left blank.

# Formulario Para Solicitar/Rechazar Servicios de Intérprete

Nombre del paciente: _____

Idioma preferido: _____

☐ Si, necesito servicios de intérprete.
Idioma(s): _____

☐ No, Prefiero utilizar un familiar o amistad como intérprete.

☐ No, requiero servicios de intérprete.

☐ No, me corresponde.

Por favor explique: _____

_____
Firma del paciente

_____
Fecha

Please place this form in the patient's medical record.

This page intentionally left blank.

blue california | Promise Health Plan

# PROTOCOL FOR HOW TO ACCESS INTERPRETING SERVICES

## (Face-to-Face, Over-the-Phone & American Sign Languages)

### Why does Blue Shield of California Promise Health Plan provide Free Interpreting Services?

Federal Law requires that health care providers who see government program recipients provide free language assistance to limited English proficient (LEP) and hard-of-hearing or deaf persons. In order for you to meet this legal requirement, Blue Shield of California Promise Health Plan is providing Over-the-Phone, Face-to-Face and American Sign Language (ASL) interpreting services at no cost to Blue Shield of California Promise Health Plan providers and members.

### When is Over-the-Phone Interpreting Services recommended?

- When you identify a patient as being limited English proficient (LEP) and the patient is already present at the office, telephone interpretation should be used immediately to avoid any delay in service.
- Telephone interpretation is available 24 HOURS A DAY, 7 DAYS A WEEK.
- When a LEP patient requests it.

### DURING BUSINESS HOURS:

**1. Call Blue Shield of California Promise Health Plan Customer Care Department**

Medi-Cal (All counties).....1-800-605-2556
(TTY: 711), 8:00 a.m. to 6:00 p.m.

Cal-Medi Connect (All counties).....1-855-905-3825
(TTY: 711), 8:00 a.m. to 8:00 p.m.

OR

**2. Call Pacific Interpreters**

Alameda (ACCESS CODE: 845311) **1-877-904-8195**
Los Angeles (ACCESS CODE: 840609) **1-877-904-8195**
San Diego (ACCESS CODE: 838600) **1-877-904-8195**
San Francisco (ACCESS CODE: 845310) **1-877-904-8195**
San Joaquin (ACCESS CODE: 842613) **1-877-904-8195**
Santa Clara (ACCESS CODE: 841676) **1-877-904-8195**
Stanislaus (ACCESS CODE: 842615) **1-877-904-8195**
Texas (ACCESS CODE: 846273) **1-877-904-8195**
Beacon Health Options (ACCESS CODE: 80082804) **1-877-904-8195**

### AFTER BUSINESS HOURS:

**1. Call Pacific Interpreters**

All counties (ACCESS CODE: 828201)
1-877-904-8195

- A Pacific Interpreters Member Services Agent will ask for the following information:
  - ACCESS CODE
  - Member's First & Last Name & Blue Shield of California Promise Health Plan ID#
  - Language Needed
  - Is this a Medi-Cal or Cal-Medi Connect Member?

**2. If your office has After Hours Answering Services:** Ensure that their staff can speak languages other than English; please ensure that they know how to connect to an interpreter over the telephone.

**3. If your office has On-Call Physicians/Nurses:** Ensure that they know how to connect to an interpreter over the telephone.

**4. If your office has an answering machine:** Let the patients know that they need to call Pacific Interpreters.

blue california | Promise Health Plan

# PROTOCOL FOR HOW TO ACCESS INTERPRETING SERVICES

## (Face-to-Face, Over-the-Phone & American Sign Languages)

**When are Face-to-Face and American Sign Language interpreting services recommended?**

- To explain complex medical condition or education (i.e. medical diagnosis, treatment options, insulin instructions, etc.) to a LEP or a hard-of-hearing or deaf member.
- When a LEP patient requests it.

  All requests must be made with an advance notice (3 business days). Please contact Blue Shield of California Promise Health Plan Customer Care Department for further assistance:

  Medi-Cal 1-800-605-2556
  Cal-Medi Connect 1-855-905-3825

Please contact Blue Shield of California Promise Health Plan Member Services Department at least 48 Hours in advance if the appointment has been CANCELLED or RESCHEDULED.

**When is California Relay Service (TTY/Telecommunication Device for Deaf - TDD) recommended?**

- When your office staff need to communicate with the hard-of-hearing or deaf patients, please call California Relay Service:

  English 1-888-877-5379
  Spanish 1-888-877-5381

- When your hard-of-hearing or deaf patients need assistance to call your office or Blue Shield of California Promise Health Plan, please dial:
  1-800-735-2929 (Los Angeles) or 711
  1-866-461-4288 (San Diego)

**PLEASE KEEP IN MIND:**

1. Always document the member's preferred language in the member's medical record.
2. Always document the request or refusal of interpreting services in the member's medical record.
3. Always post an "Interpreting Services sign" at key medical and non-medical points of contact.
4. Please discourage patients from using friends and family members as interpreters unless the member requests it after being informed about the availability of the free interpreter services.

# CULTURAL & LINGUISTICALLY APPROPRIATE SERVICES REFERRAL REQUEST FORM

Providers: Complete sections A-C and fax to the Cultural & Linguistics Department at (323) 889-5407

## A. Patient Information

| | | | |
|---|---|---|---|
| Member Name: | | Gender | ☐ Female ☐ Male ☐ Other |
| Member Address: | | City: | |
| Zip Code: | Phone: ( ) | DOB: | Language Spoken: |

## B. Provider Information

| | | |
|---|---|---|
| Requested by: | | Date of Request: |
| Provider Name: | Phone: ( ) | Fax: ( ) |
| Finding: | | |
| Comments: | | |

## C. Referral Information

Service Requested

| | | | |
|---|---|---|---|
| ☐ Social Service | ☐ Support Group | ☐ Community Based Organization (CBO) | ☐ Other: |

Topic

| | | | | |
|---|---|---|---|---|
| ☐ African American | ☐ Parenting Classes | ☐ Cultural Transition | ☐ Stress/Depression | ☐ Youth/Teen |
| ☐ Asian/Pacific Islander | ☐ ESL Classes | ☐ HIV/STD | ☐ Interpreter Services | ☐ Visually Impaired |
| ☐ Hispanic/Latino | ☐ Sexuality Issues | ☐ Domestic Violence | ☐ Employment Service | ☐ Hard of Hearing |
| ☐ Armenian/Russian | ☐ Adoption/Foster Care | ☐ Citizenship | ☐ Immigration/Legal Assistance | |
| ☐ Other: | | | | |

Comments:

## D. Service Information

| | | |
|---|---|---|
| Title of Program: | Date: | Time: |
| Program Location: | | |
| Address: | City: | Zip Code: |
| Program Contact: | Phone: ( ) | |

| | |
|---|---|
| ☐ Unable to contact Member<br>☐ Member was contacted on: _____ | ☐ Will attend program<br>☐ Refused program |

Instructions/Comments:

## E. Follow-Up

| | | |
|---|---|---|
| ☐ Member attended program | ☐ Member did not attend program | ☐ Information not available |

Comments:

C&L Department Phone#: (323) 827-6030
Fax#: (323) 889-5407

This page intentionally left blank.

# Provider Request to Terminate Patient/Provider Relationship

| PROVIDER INFORMATION | |
|---|---|
| Name (First and Last): | |
| Address: | |
| Phone: | License #: |
| IPA/Medical Group: | |

| PATIENT INFORMATION | |
|---|---|
| Name (First and Last): | |
| DOB: | SSN: |
| | Member ID: |

Reasons for terminating patient/provider relationship:

Please give specific dates and instances of the issues you have had with this member:

What actions have you taken to resolve the issues between the member and you?

_____

_____

_____

Currently identified medical conditions requiring immediate or ongoing treatment:

_____

_____

_____

_____

It is very important to document any non-compliant behavior by the member in the member's medical records. Please provide Blue Shield Promise Health Plan with all the documentation from the member's medical records which supports your claims. You must document your actions taken to attempt to resolve these issues with the member.

Please provide the completed form and supporting documentation to the Clinical Quality Review Department using one of the following options:

- Email: promisehealthplanqualityreview@blueshieldca.com
- Fax: (323) 323-765-2702
  ***(Note: Email or fax preferred)***
- Mail:
  Blue Shield Promise Health Plan
  Clinical Quality Review Department
  601 Potrero Grande Drive, 3rd Floor Saturn Building
  Monterey Park, CA 91755

I hereby attest that the above information is true and accurate to the best of my knowledge at this time. I also hereby attest that this request is based solely on my concern that I cannot effectively and appropriately treat the medical needs of this patient because of the above given reasons and that this request is not based on any financial motives.

Signed: _____

Date: _____

# Reimbursement for Ambulatory Surgery Center Services

Reimbursement for ambulatory surgery center (ASC) services is based on the ASC's contractual agreement in effect at the time services are rendered. To receive payment, ASCs must properly identify services provided by submitting a completed UB 04 (or successor), or other HIPAA-compliant claim form and include all applicable codes (Revenue, CPT/HCPCS, modifiers) for each service. Revenue Codes should be appropriate for the bill type.

Plan periodically reviews, and makes appropriate updates to, procedure listings based on industry standards. Updated listings are provided electronically and available upon request.

In calculating allowed amounts, Plan may round the figure to the nearest whole dollar.

## I. Outpatient Surgical Services Reimbursed at APG Payment Rate

The Plan has implemented a payment system for outpatient surgical services that classifies ambulatory procedures into related groups. The groups are based on the relative resource needs (costs) for that group of procedures. The core of this payment system is the CPT-specific coding. ASCs must bill with appropriate revenue codes, CPT/HCPCS codes and modifiers in order to receive applicable payment. Plan reimburses ASCs for outpatient surgical services using the APG Payment Schedule.

In the event your listing contains groupers not included in your payment schedule, reimbursement will be issued at the applicable rate for ungrouped surgical procedures. If you have not received the fee schedule CD, contact your Plan Network Manager, who will provide you with a copy.

### A. Example of Reimbursement Calculation

| SURGICAL SERVICES<br>APG PAYMENT SCHEDULE<br>CALCULATION EXAMPLE | |
|---|---|
| Formula | ASC Payment = (APG Grouper (corresponding APG Weight)) x (APG Payment Rate) |
| Example Assumptions | • Revenue code billed is 0360<br>• CPT code billed is 10021<br>• CPT code 10021 is assigned to Grouper 001<br>• Grouper 001 has a weight of 0.2000<br>• Hospital's negotiated value of APG at 1.0000 (APG Payment Rate) is $1,000 |
| Total Case Rate Payment = 0.2000 x $1,000 =<br>(The case rate payment may be rounded to the nearest whole dollar.) | $200 |

This page intentionally left blank.

# List of Incidental Procedures for APG Payment Rate

| CPT | DESCRIPTION |
|---|---|
| 10004 | Fna bx w/o img gdn ea addl |
| 10006 | Fna bx w/us gdn ea addl |
| 10008 | Fna bx w/fluor gdn ea addl |
| 10010 | Fna bx w/ct gdn ea addl |
| 10012 | Fna bx w/mr gdn ea addl |
| 10036 | Perq dev soft tiss add imag |
| 11045 | Deb subq tissue add-on |
| 11046 | Deb musc/fascia add-on |
| 11047 | Deb bone add-on |
| 11103 | Tangntl bx skin ea sep/addl |
| 11105 | Punch bx skin ea sep/ addl |
| 11107 | Incal bx skn ea sep/addl |
| 15772 | Grfg autol fat lipo ea addl |
| 15774 | Each additional 25cc |
| 15777 | Acellular derm matrix implt |
| 19030 | Injection for breast x-ray |
| 19082 | Bx breast add Lesion strtctc |
| 19084 | Bx breast add Lesion US imag |
| 19086 | BX breast add lesion MR imag |
| 19281 | Perq device breast 1st imag |
| 19282 | Perq device breast ea imag |
| 19283 | Perq dev breast 1st strtctc |
| 19284 | Perq dev breast add strtctc |
| 19285 | Perq dev breast 1st US imag |
| 19286 | Perq dev breast add US imag |
| 19287 | Perq dev breast 1st mr guide |
| 19288 | Perq dev breast add mr guide |
| 20501 | Inject sinus tract for x-ray |
| 20700 | Prep and insert drug deliv dev |
| 20701 | Removal (deep) |
| 20702 | Prep and insert drug deliv dev |
| 20703 | Removal (intramedullary) |
| 20704 | Prep and insert drug deliv dev |
| 20705 | Removal (intra-articular) |
| 20932 | Osteoart algrft w/surf & b1 |
| 20933 | Hemicrt intrclry algrft prtl |
| 20934 | Intercalary algrft compl |
| 20985 | Cptr-asst dir ms px |
| 21116 | Injection, jaw joint x-ray |
| 22552 | Addl neck spine fusion |
| 22853 | Insj Biomechanical Device |
| 22854 | Insj Biomechanical Device |
| 22859 | Insj Biomechanical Device |
| 22868 | Insj Stablj Dev W/dcmprn |
| 22870 | Insj Stablj Dev w/o Dcmprn |
| 23350 | Injection for shoulder x-ray |
| 24220 | Injection for elbow x-ray |
| 25246 | Injection for wrist x-ray |

| CPT | DESCRIPTION |
|---|---|
| 27093 | Injection for hip x-ray |
| 27095 | Injection for hip x-ray |
| 27369 | Njx Cntrst kne arthg/ct/mri |
| 27648 | Injection for ankle x-ray |
| 31627 | Navigational bronchoscopy |
| 31649 | Bronchial valve remov init |
| 31651 | Bronchial valve remov addl |
| 32506 | Wedge resect of lung add-on |
| 32507 | Wedge resect of lung diag |
| 33508 | Endoscopic vein harvest |
| 33866 | Aortic hemiarch graft |
| 35572 | Harvest femoropopliteal vein |
| 36000 | Place needle in vein |
| 36005 | Injection ext venography |
| 36010 | Place catheter in vein |
| 36011 | Place catheter in vein |
| 36012 | Place catheter in vein |
| 36013 | Place catheter in artery |
| 36014 | Place catheter in artery |
| 36015 | Place catheter in artery |
| 36100 | Establish access to artery |
| 36140 | Establish access to artery |
| 36160 | Establish access to aorta |
| 36200 | Place catheter in aorta |
| 36215 | Place catheter in artery |
| 36216 | Place catheter in artery |
| 36217 | Place catheter in artery |
| 36218 | Place catheter in artery |
| 36245 | Place catheter in artery |
| 36246 | Place catheter in artery |
| 36247 | Place catheter in artery |
| 36248 | Place catheter in artery |
| 36251 | Ins cath ren art 1st unilat |
| 36252 | Ins cath ren art 1st bilat |
| 36253 | Ins cath ren art 2nd+ unilat |
| 36254 | Ins cath ren art 2nd+ bilat |
| 36299 | Vessel injection procedure |
| 36400 | Bl draw < 3 yrs fem/jugular |
| 36405 | Bl draw < 3 yrs scalp vein |
| 36406 | Bl draw < 3 yrs other vein |
| 36410 | Non-routine bl draw > 3 yrs |
| 36416 | Capillary blood draw |
| 36474 | Endovenous Mchnchem Add-On |
| 36481 | Insertion of catheter, vein |
| 36500 | Insertion of catheter, vein |
| 36510 | Insertion of catheter, vein |
| 36591 | Draw blood off venous device |

| CPT | DESCRIPTION |
|---|---|
| 36592 | Collect blood from picc |
| 36600 | Withdrawal of arterial blood |
| 36620 | Insertion catheter, artery |
| 36625 | Insertion catheter, artery |
| 37247 | Trluml Balo Angiop Addl Art |
| 37249 | Trluml Balo Angiop Addl Vein |
| 37252 | Intravasc us noncoronary 1st |
| 37253 | Intravasc us noncoronary addl |
| 38200 | Injection for spleen x-ray |
| 38790 | Inject for lymphatic x-ray |
| 38792 | Identify sentinel node |
| 38794 | Access thoracic lymph duct |
| 38900 | Io map of sent lymph node |
| 42550 | Injection for salivary x-ray |
| 44701 | Intraop colon lavage add-on |
| 47001 | Needle biopsy, liver add-on |
| 49327 | Lap ins device for rt |
| 49400 | Air injection into abdomen |
| 49412 | Ins device for rt guide open |
| 49424 | Assess cyst, contrast inject |
| 49427 | Injection, abdominal shunt |
| 50606 | Endoluminal bx urtr rnl plvs |
| 50684 | Injection for ureter x-ray |
| 50690 | Injection for ureter x-ray |
| 50705 | Ureteral embolization/occl |
| 50706 | Balloon dialate urtrl strix |
| 51600 | Injection for bladder x-ray |
| 51605 | Preparation for bladder xray |
| 51610 | Injection for bladder x-ray |
| 51701 | Insert bladder catheter |
| 51702 | Insert temp bladder cath |
| 54230 | Prepare penis study |
| 55300 | Prepare, sperm duct x-ray |
| 58340 | Catheter for hysterography |
| 61781 | Scan proc cranial intra |
| 61782 | Scan proc cranial extra |
| 61783 | Scan proc spinal |
| 62284 | Injection for myelogram |
| 62290 | Inject for spine disk x-ray |
| 62291 | Inject for spine disk x-ray |
| 64634 | Destroy c/th facet jnt addl |
| 64636 | Destroy l/s facet jnt addl |
| 64643 | Chemodenerv 1 extrem 1 - 4 ea |
| 64645 | Chemodenerv 1 extrem 5/> ea |
| 66990 | Ophthalmic endoscope add-on |
| 68850 | Injection for tear sac x-ray |
| 69990 | Microsurgery add-on |
| 78808 | Iv inj ra drug dx study |
| 92973 | Percut coronary thrombectomy |

| CPT | DESCRIPTION |
|---|---|
| 92974 | Cath place, cardio brachytx |
| 93462 | L hrt cath trnsptl puncture |
| 93463 | Drug admin & hemodynmic meas |
| 93561 | Cardiac output measurement |
| 93562 | Cardiac output measurement |
| 93563 | Inject congenital card cath |
| 93564 | Inject hrt congntl art/grft |
| 93565 | Inject l ventr/atrial angio |
| 93566 | Inject r ventr/atrial angio |
| 93567 | Inject suprvlv aortography |
| 93568 | Inject pulm art hrt cath |
| 93571 | Heart flow reserve measure |
| 93572 | Heart flow reserve measure |
| 95940 | Ionm in operating room 15 min |
| 95941 | Ionm remote/>1 pt per hour |
| 96904 | Whole body photography |
| 96934 | Rcm celulr subcelulr img skn |
| 96935 | Rcm celulr subcelulr img skn |
| 96936 | Rcm celulr subcelulr img skn |
| 0042T | Ct perfusion w/contrast, cbf |
| 0054T | Bone surgery using computer |
| 0055T | Bone surgery using computer |
| 0095T | Each additional interspace |
| 0098T | Each additional interspace |
| 0198T | Ocular blood flow measure |
| 0290T | Laser inc for pkp/lkp recip |
| 0348T | Rsa spine exam |
| 0349T | Rsa upper extr exam |
| 0350T | Rsa lower extr exam |
| 0356T | Insrt drug device for iop |
| 0397T | Ercp w/optical endomicroscpy |
| 0437T | Impltj Synth Rnfcmt Abdl Wal |
| 0439T | Myocrd Contrast Prfuj Echo |
| 0444T | 1st Plmt Drug Elut OC Ins |
| 0445T | Sbsqt plmt Drug Elut OC Ins |
| 0466T | Insj ch wal respir eltrd/ra |
| 0471T | Oct skn img acquisj i&r addl |
| 0513T | Esw integ wnd hlg ea addl |
| 0514T | Intraop vis axis id pt fixj |
| 0523T | Ntrapx c ffr w/3d funcil map |
| 0602T | Transdermal GFR Measurements |
| 0603T | Transdermal GFR Monitoring |
| 0604T | Rem Oct Rta Dev Stup&Edu |
| 0605T | Rem Oct Rta Tech Sprt Min 8 |
| 0615T | Eye Mvmt alys w/o Calbrj I&R |
| A4337 | Incontinent rectal insert |
| A4435 | 1 pc ost pch drain hgh output |
| A4555 | Ca tx e-stim electr/transduc |

| CPT | DESCRIPTION |
|---|---|
| A4650 | Implant radiation dosimeter |
| A7027 | Combination oral/nasal mask |
| A9575 | Inj gadoterate meglumi 0.1ml |
| A9581 | Gadoxetate disodium inj |
| A9582 | Iodine I-123 iobenguane |
| A9583 | Gadofosveset trisodium inj |
| C1822 | Gen, neuro, hf, rechg bat |
| C5272 | Low cost skin substitute app |
| C5274 | Low cost skin substitute app |
| C5276 | Low cost skin substitute app |
| C5278 | Low cost skin substitute app |
| C9254 | Inj, lacosamide |
| C9359 | Porous purifi colgn matrx bone vd filler |
| C9363 | Skin sub,(meshd wound matrx) |
| C9364 | Porcine implnt (permacol) |
| C9756 | Fluorescence lymph map w/icg |
| E0766 | Elec stim cancer treatment |
| G2211 | Complex e/m visit add on |
| G2212 | Prolong outpt/office visit |
| G2213 | Initiat med assist tx in er |
| L8604 | Inject bulk agent,dextranomer acid,1ml |
| Q4100 | Skin substitute, NOS |
| Q4101 | Apligraf skin sub |
| Q4102 | Oasis wound matrix skin sub |
| Q4103 | Oasis burn matrix skin sub |
| Q4104 | Integra BMWD skin sub |
| Q4105 | Integra DRT skin sub |
| Q4106 | Dermagraft skin sub |
| Q4107 | Graftjacket skin sub |
| Q4108 | Integra matrix skin sub |
| Q4110 | Primatrix skin sub |
| Q4111 | Gammagraft skin sub |
| Q4112 | Cymetra allograft |
| Q4113 | Graftjacket express allograf |
| Q4114 | Integra flowable wound matri |
| Q4115 | Alloskin skin sub |
| Q4116 | Alloderm skin sub |
| S9433 | Medical food oral 100% nutr |

This page intentionally left blank.

# List of Office-Based Ambulatory Procedures for APG Payment Rate

| CPT | DESCRIPTION |
|---|---|
| 10021 | Fna w/o image |
| 10040 | Acne surgery |
| 10060 | Drainage of skin abscess |
| 10080 | Drainage of pilonidal cyst |
| 10120 | Remove foreign body |
| 10160 | Puncture drainage of lesion |
| 11000 | Debride infected skin |
| 11055 | Trim skin lesion |
| 11056 | Trim skin lesions, 2 to 4 |
| 11057 | Trim skin lesions, over 4 |
| 11200 | Removal of skin tags |
| 11201 | Remove skin tags add-on |
| 11300 | Shave skin lesion |
| 11301 | Shave skin lesion |
| 11302 | Shave skin lesion |
| 11303 | Shave skin lesion |
| 11305 | Shave skin lesion |
| 11306 | Shave skin lesion |
| 11307 | Shave skin lesion |
| 11308 | Shave skin lesion |
| 11310 | Shave skin lesion |
| 11311 | Shave skin lesion |
| 11312 | Shave skin lesion |
| 11313 | Shave skin lesion |
| 11719 | Trim nail(s) |
| 11720 | Debride nail, 1-5 |
| 11721 | Debride nail, 6 or more |
| 11730 | Removal of nail plate |
| 11740 | Drain blood from under nail |
| 11765 | Excision of nail fold, toe |
| 11900 | Injection into skin lesions |
| 11901 | Added skin lesions injection |
| 11921 | Correct skin color defects |
| 11922 | Correct skin color defects |
| 11950 | Therapy for contour defects |
| 11951 | Therapy for contour defects |
| 11952 | Therapy for contour defects |
| 11954 | Therapy for contour defects |
| 11980 | Implant hormone pellet(s) |
| 11981 | Insert drug implant device |
| 11982 | Remove drug implant device |
| 12001 | Repair superficial wound(s) |
| 12002 | Repair superficial wound(s) |
| 12004 | Repair superficial wound(s) |
| 12011 | Repair superficial wound(s) |
| 12013 | Repair superficial wound(s) |
| 12014 | Repair superficial wound(s) |

| CPT | DESCRIPTION |
|---|---|
| 12015 | Repair superficial wound(s) |
| 15783 | Abrasion treatment of skin |
| 15786 | Abrasion, lesion, single |
| 15787 | Abrasion, lesions, add-on |
| 15788 | Chemical peel, face, epiderm |
| 15789 | Chemical peel, face, dermal |
| 15792 | Chemical peel, nonfacial |
| 15793 | Chemical peel, nonfacial |
| 16000 | Initial treatment of burn(s) |
| 16020 | Treatment of burn(s) |
| 16025 | Treatment of burn(s) |
| 16030 | Treatment of burn(s) |
| 17000 | Destroy benign/premlg lesion |
| 17003 | Destroy lesions, 2-14 |
| 17004 | Destroy lesions, 15 or more |
| 17106 | Destruction of skin lesions |
| 17107 | Destruction of skin lesions |
| 17108 | Destruction of skin lesions |
| 17110 | Destruct lesion, 1-14 |
| 17111 | Destruct lesion, 15 or more |
| 17250 | Chemical cautery, tissue |
| 17340 | Cryotherapy of skin |
| 17360 | Skin peel therapy |
| 17380 | Hair removal by electrolysis |
| 17999 | Skin tissue procedure |
| 19000 | Drainage of breast lesion |
| 19001 | Drain breast lesion add-on |
| 20500 | Injection of sinus tract |
| 20526 | Ther injection, carp tunnel |
| 20527 | Inj dupuytren cord w/enzyme |
| 20550 | Inj tendon sheath/ligament |
| 20551 | Inj tendon origin/insertion |
| 20552 | Inj trigger point, 1/2 muscl |
| 20553 | Inject trigger points, =/> 3 |
| 20555 | Place ndl musc/tis for rt |
| 20560 | Needle insert w/o inj 1 or 2 mscl |
| 20561 | Needle insert w/o inj 3 or more |
| 20600 | Drain/inject, joint/bursa |
| 20605 | Drain/inject, joint/bursa |
| 20606 | Drain/inj joint/bursa w/us |
| 20610 | Drain/inject, joint/bursa |
| 20611 | Drain/inj joint/bursa w/us |
| 20612 | Aspirate/inj ganglion cyst |
| 20615 | Treatment of bone cyst |
| 20950 | Fluid pressure, muscle |
| 20974 | Electrical bone stimulation |
| 20979 | Us bone stimulation |

| CPT | DESCRIPTION |
|---|---|
| 24640 | Treat elbow dislocation |
| 24650 | Treat radius fracture |
| 25500 | Treat fracture of radius |
| 25530 | Treat fracture of ulna |
| 25560 | Treat fracture radius & ulna |
| 25600 | Treat fracture radius/ulna |
| 25622 | Treat wrist bone fracture |
| 25630 | Treat wrist bone fracture |
| 25650 | Treat wrist bone fracture |
| 26010 | Drainage of finger abscess |
| 26340 | Manipulate finger w/anesth |
| 26341 | Manipulat palm cord post inj |
| 26600 | Treat metacarpal fracture |
| 26641 | Treat thumb dislocation |
| 26670 | Treat hand dislocation |
| 26700 | Treat knuckle dislocation |
| 26720 | Treat finger fracture, each |
| 26725 | Treat finger fracture, each |
| 26740 | Treat finger fracture, each |
| 26750 | Treat finger fracture, each |
| 26755 | Treat finger fracture, each |
| 26770 | Treat finger dislocation |
| 27200 | Treat tail bone fracture |
| 27220 | Treat hip socket fracture |
| 27256 | Treat hip dislocation |
| 27899 | Leg/ankle surgery procedure |
| 28430 | Treatment of ankle fracture |
| 28450 | Treat midfoot fracture, each |
| 28470 | Treat metatarsal fracture |
| 28475 | Treat metatarsal fracture |
| 28490 | Treat big toe fracture |
| 28495 | Treat big toe fracture |
| 28510 | Treatment of toe fracture |
| 28515 | Treatment of toe fracture |
| 28530 | Treat sesamoid bone fracture |
| 28540 | Treat foot dislocation |
| 28570 | Treat foot dislocation |
| 28600 | Treat foot dislocation |
| 28630 | Treat toe dislocation |
| 28660 | Treat toe dislocation |
| 29000 | Application of body cast |
| 29010 | Application of body cast |
| 29015 | Application of body cast |
| 29035 | Application of body cast |
| 29040 | Application of body cast |
| 29044 | Application of body cast |
| 29046 | Application of body cast |
| 29049 | Application of figure eight |

| CPT | DESCRIPTION |
|---|---|
| 29055 | Application of shoulder cast |
| 29058 | Application of shoulder cast |
| 29065 | Application of long arm cast |
| 29075 | Application of forearm cast |
| 29085 | Apply hand/wrist cast |
| 29086 | Apply finger cast |
| 29105 | Apply long arm splint |
| 29125 | Apply forearm splint |
| 29126 | Apply forearm splint |
| 29130 | Application of finger splint |
| 29131 | Application of finger splint |
| 29200 | Strapping of chest |
| 29240 | Strapping of shoulder |
| 29260 | Strapping of elbow or wrist |
| 29280 | Strapping of hand or finger |
| 29305 | Application of hip cast |
| 29325 | Application of hip casts |
| 29345 | Application of long leg cast |
| 29355 | Application of long leg cast |
| 29358 | Apply long leg cast brace |
| 29365 | Application of long leg cast |
| 29405 | Apply short leg cast |
| 29425 | Apply short leg cast |
| 29435 | Apply short leg cast |
| 29440 | Addition of walker to cast |
| 29445 | Apply rigid leg cast |
| 29450 | Application of leg cast |
| 29505 | Application, long leg splint |
| 29515 | Application lower leg splint |
| 29520 | Strapping of hip |
| 29530 | Strapping of knee |
| 29540 | Strapping of ankle and/or ft |
| 29550 | Strapping of toes |
| 29580 | Application of paste boot |
| 29581 | Apply multlay comprs lwr leg |
| 29700 | Removal/revision of cast |
| 29705 | Removal/revision of cast |
| 29710 | Removal/revision of cast |
| 29720 | Repair of body cast |
| 29730 | Windowing of cast |
| 29740 | Wedging of cast |
| 29750 | Wedging of clubfoot cast |
| 29799 | Casting/strapping procedure |
| 30300 | Remove nasal foreign body |
| 30901 | Control of nosebleed |
| 31231 | Nasal endoscopy, dx |
| 31298 | Nasal sinus endoscopy surgical |
| 31502 | Change of windpipe airway |

| CPT | DESCRIPTION |
|---|---|
| 31575 | Diagnostic laryngoscopy |
| 32550 | Insert pleural catheter |
| 32552 | Remove lung catheter |
| 32553 | Ins mark thor for rt perq |
| 32562 | Lyse chest fibrin subq day |
| 36430 | Blood transfusion service |
| 36465 | Inj noncompounded foam sclerosant |
| 36466 | Inj noncompounded foam sclerosant |
| 36593 | Declot vascular device |
| 36598 | Inject rad eval central venous device |
| 36680 | Insert needle, bone cavity |
| 40800 | Drainage of mouth lesion |
| 40804 | Removal, foreign body, mouth |
| 40830 | Repair mouth laceration |
| 41019 | Place needles h & n for rt |
| 42280 | Preparation, palate mold |
| 42400 | Biopsy of salivary gland |
| 42809 | Remove pharynx foreign body |
| 43752 | Nasal/orogastric w/stent |
| 43753 | Tx gastro intub w/asp |
| 43754 | Dx gastr intub w/asp spec |
| 43755 | Dx gastr intub w/asp specs |
| 43756 | Dx duod intub w/asp spec |
| 43757 | Dx duod intub w/asp specs |
| 43761 | Reposition gastrostomy tube |
| 44705 | Prepare fecal microbiota |
| 45520 | Treatment of rectal prolapse |
| 46600 | Diagnostic anoscopy |
| 46601 | Diagnostic anoscopy |
| 46900 | Destruction, anal lesion(s) |
| 46916 | Cryosurgery, anal lesion(s) |
| 50391 | Instll rx agnt into rnal tub |
| 50686 | Measure ureter pressure |
| 51100 | Drain bladder by needle |
| 51700 | Irrigation of bladder |
| 51705 | Change of bladder tube |
| 51720 | Treatment of bladder lesion |
| 51736 | Urine flow measurement |
| 51741 | Electro-uroflowmetry, first |
| 51784 | Anal/urinary muscle study |
| 51792 | Urinary reflex study |
| 51797 | Intraabdominal pressure test |
| 51798 | Us urine capacity measure |
| 53621 | Dilate urethra stricture |
| 53660 | Dilation of urethra |
| 53661 | Dilation of urethra |

| CPT | DESCRIPTION |
|---|---|
| 53860 | Transurethral rf treatment |
| 54050 | Destruction, penis lesion(s) |
| 54056 | Cryosurgery, penis lesion(s) |
| 54200 | Treatment of penis lesion |
| 54235 | Penile injection |
| 54240 | Penis study |
| 54250 | Penis study |
| 55000 | Drainage of hydrocele |
| 55920 | Place needles pelvic for rt |
| 56820 | Exam of vulva w/scope |
| 56821 | Exam/biopsy of vulva w/scope |
| 57100 | Biopsy of vagina |
| 57150 | Treat vagina infection |
| 57156 | Ins vag brachytx device |
| 57160 | Insert pessary/other device |
| 57170 | Fitting of diaphragm/cap |
| 57420 | Exam of vagina w/scope |
| 57421 | Exam/biopsy of vag w/scope |
| 57452 | Exam of cervix w/scope |
| 57455 | Biopsy of cervix w/scope |
| 57505 | Endocervical curettage |
| 58100 | Biopsy of uterus lining |
| 58110 | Biopsy of uterus lining add on |
| 58300 | Insert intrauterine device |
| 58301 | Remove intrauterine device |
| 58321 | Artificial insemination |
| 58322 | Artificial insemination |
| 58323 | Sperm washing |
| 59020 | Fetal contract stress test |
| 59025 | Fetal non-stress test |
| 59050 | Fetal monitor w/report |
| 59051 | Fetal monitor/interpret only |
| 59200 | Insert cervical dilator |
| 59412 | Antepartum manipulation |
| 59425 | Antepartum care only |
| 59430 | Care after delivery |
| 59899 | Maternity care procedure |
| 60100 | Biopsy of thyroid |
| 60300 | Aspir/inj thyroid cyst |
| 64405 | N block inj, occipital |
| 64445 | N block inj, sciatic, sng |
| 64454 | Inj Aa&/Strd Gen Nrv Brnch w/img |
| 64455 | N block inj, plantar digit |
| 64611 | Chemodenerv saliv glands |
| 64615 | Chemodenerv musc migraine |
| 64616 | Chemodenerv musc neck dyston |

| CPT | DESCRIPTION |
|---|---|
| 64617 | Chemodenerv muscle laryny EMG |
| 64624 | Dest neurolytic agt gen nrv w/img |
| 64632 | N block inj, common digit |
| 65205 | Remove foreign body from eye |
| 65210 | Remove foreign body from eye |
| 65220 | Remove foreign body from eye |
| 65222 | Remove foreign body from eye |
| 65430 | Corneal smear |
| 65778 | Cover eye w/membrane |
| 65779 | Cover eye w/membrane stent |
| 67500 | Inject/treat eye socket |
| 67505 | Inject/treat eye socket |
| 67515 | Inject/treat eye socket |
| 67700 | Drainage of eyelid abscess |
| 67800 | Remove eyelid lesion |
| 67805 | Remove eyelid lesions |
| 67810 | Biopsy of eyelid |
| 68040 | Treatment of eyelid lesions |
| 68200 | Treat eyelid by injection |
| 68400 | Incise/drain tear gland |
| 68761 | Close tear duct opening |
| 69000 | Drain external ear lesion |
| 69020 | Drain outer ear canal lesion |
| 69090 | Pierce earlobes |
| 69200 | Clear outer ear canal |
| 69209 | Remove impacted ear wax uni |
| 69210 | Remove impacted ear wax |
| 69220 | Clean out mastoid cavity |
| 90867 | Tcranial magn stim tx plan |
| 90868 | Tcranial magn stim tx deli |
| 92132 | Cmptr ophth dx img ant segmt |
| 92133 | Cmptr ophth img optic nerve |
| 92134 | Cptr ophth dx img post segmt |
| 92537 | Caloric vstblr test w/rec |
| 92538 | Caloric vstblr test w/rec |
| 93050 | Art pressure waveform analys |
| 93464 | Exercise w/hemodynamic meas |
| 97597 | Active wound care/20 cm or < |

| CPT | DESCRIPTION |
|---|---|
| 97598 | Active wound care > 20 cm |
| 0071T | Focused ultrasnd abl,uterine leiomyomata |
| 0072T | Total leiomyomata vol,200cc tissue |
| 0207T | Clear eyelid gland w/heat |
| 0213T | Njx paravert w/us cer/thor |
| 0214T | Njx paravert w/us cer/thor |
| 0215T | Njx paravert w/us cer/thor |
| 0216T | Njx paravert w/us lumb/sac |
| 0217T | Njx paravert w/us lumb/sac |
| 0218T | Njx paravert w/us lumb/sac |
| 0219T | Plmt post facet implt cerv |
| 0220T | Plmt post facet implt thor |
| 0221T | Plmt post facet implt lumb |
| 0222T | Plmt post facet implt addl |
| 0272T | Interrogate crtd sns dev |
| 0273T | Interrogate crtd sns w/pgrmg |
| 0278T | Tempr |
| 0331T | Heart symp image plnr |
| 0332T | Heart symp image plnr spect |
| 0378T | Visual field assmnt rev/rprt |
| 0379T | Vis field assmnt tech suppt |
| 0419T | Dstrj Neurofibroma Xtnsv |
| 0420T | Dstrj Neurofibroma Xtnsv |
| 0465T | Supchrdl njx rx w/o supply |
| 0474T | Insj aqueous drg dev io rsvr |
| 0529T | Interrog dev eval iims ip |
| 0530T | Removal complete iims |
| 0551T | Tprnl balo cntnc dev adjmt |
| 0563T | Evac meibomian glnd heat bilat |
| 0566T | Autol cell impt adps tiss njx implt knee uni |
| 0588T | Rev or remvl isdns post tib nrv |
| C8929 | Transthoracic Echo, w or w/o contrst followd with |
| C8930 | Transthoracic Echo, w or w/o cntrst followd inc record |

# Claims Compliance and Monitoring

A Supplement to the ***Blue Shield Promise Medi-Cal Provider Manual***

**July 2022**

## Claims Compliance and Monitoring

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 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*.

## Claims Compliance Audit Review Process

Paid and Denied Claims: Verify that all claims are finalized within 30 calendar days at 90% and 99% at 90 calendar days (Title 19 Social Security Act 1902 (37)) and within 45 working days (CCR, Title 28, Section 1371.35 (a)) from the date of receipt of claim.

Interest and Penalty: Applies to paid claims, adjustments, and Provider Disputes (CCR Title 28 Section1300.71(i)).

Interest is applicable for contracted and non-contracted providers claims paid later than the statutory deadline. Interest must be paid beginning with the first day after deadline through the day the payment/check is mailed.

Interest is due on adjustments found in favor of the provider (in whole or in part) when the Delegated Entity was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15 percent annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below.

To avoid a mandated $10.00 per claim penalty, the interest must be paid "automatically." Automatically means that the full amount of interest warranted must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due. (CCR Title 28 Section 1300.71(i)).

If the interest amount is less than $2.00, the interest may be paid on that claim along

with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included. (CCR Title 28 Section 1300.71 (a)(b)).

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Acknowledgement: The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of receipt and paper claims within 15 working days of receipt. Acknowledgement should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic delivery. Acknowledgement must be in the same manner as the claim was submitted or provided by electronic means, by phone, website, or another mutually agreed upon accessible method of notification. (CCR Title 28 Section 1300.71(c)).

Adjustments: Claims where additional monies are being paid on a previously paid or zero paid claim. (CCR Title 28 1300.71 (d)).

Contested Claim: A contested claim is defined as a claim or portion thereof that is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims must be adjudicated within 45 working days of the received date to be considered compliant. (CCR Title 28 Sections 1300.71 (d) and (h)).

Provider Denial: Provider Denial is a denial in which the provider must write off the claim and the member is not liable. These are separate from contested claims. A Delegated Entity may deny a claim or portion thereof, by notifying the provider, in writing, that the claim is denied within forty-five (45) working days after the date of receipt. (CCR Title 28 Section 1300.71 (d) and (h)).

Timely Filing: The Department of Managed Health Care enacted regulations related to claims settlement and dispute resolution practices. Timeframes for filing claims for contracted and non-contracted providers are as follows. (CCR Title 28 Section 1300.71(b)(1)).

Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.

Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed.

AB 1324: (Health and Safety Code Section 1371.8; CCR Section 1300.71 (a)(8)(T)). Blue Shield Promise validates that Delegated Entities pay incurred services if the specific service was pre-authorized or referred, even if the member is later found to be ineligible for any reason, when the provider of service relied on the authorization or referral in good faith and validated the eligibility of the member prior to service being rendered. If the Delegated Entity has an approved authorization and service has not been rendered, the delegated entity needs to formally rescind the authorization by sending a notice to the authorized rendering provider and to the member.

Direct Referral – if the service does not require a physical/paper/electronic referral, AB1324 does not affect these services and the claim may be denied.

Accurate and Clear Written Explanation (Specific to Denying, Adjusting and Contesting Claims): The EOB/EOP must contain data that is the same as what was submitted on the claim: the member financial liability (if applicable), same denied date as indicated in claim system, denial rights, the reason why the claim was denied, contested or adjusted and must include where to file a provider dispute including Provider Dispute timely filing requirements to be within 365 days from the last claim action. The EOB/EOP should include procedures for obtaining dispute forms, instructions for filing the dispute, and a mailing address. For Non-Contracted providers the Delegated Entity needs to provide payment methodology. (Title 28 1300.71.38(b) Time Period for Submission) (Title 28 1300.71.38(b) Notice to Provider of Dispute Resolution Mechanism.)

Provider Dispute Resolution (PDR): Section 1300.71.38 CCR, Title 28. The Delegated Entity shall establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. Time Period for Resolution and Written Determination requires that a Delegated Entity must resolve each provider dispute within 45 working days after the date of receipt of the provider dispute. Provider Disputes must be in writing and include the following:

a. Provider Name.
b. Provider Identification Number.
c. Provider Contact Information.
d. Clearly identify the disputed item.
e. Date of Service (DOS).
f. A clear explanation of bases for provider's feeling that the payment, request for overpayment return, request for additional information, contest, denial, or adjustment is correct.

Misdirected/Forwarded Claims: Regulations require the Delegated Entity to forward misdirected claims to the responsible payor within ten (10) working days of receipt. Blue Shield Promise requires that Delegated Entities forward these claims and disputes directly to the financially responsible entity, if known, otherwise deny to the provider with a remit message informing the provider the delegate is not financially responsible for processing of the claim. The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office

boxes, or designated claims processor or to the plan's contracted Delegated Entity for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim. If a Management Service Organization (MSO) that manages several delegated entities receives a claim from one of their post office boxes and it loads the claim into the wrong delegated entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct delegated entity's claim system. (Title 28 Section 1300.71(a)(8)(B) & Section 1300.71(b)(3)).

Family Planning/Sensitive Services: Members have the right to access family planning services through any family planning provider without prior authorization. Health Plan shall inform its Members in writing of their right to access any qualified family planning provider without prior authorization in its Member Services Guide. Health Plan shall ensure the provision of Minor Consent Services for individuals under the age of 18. Minor Consent Services shall be available within the provider network and members shall be informed of the availability of these services. Minors do not need parental consent to access these services. (WIC Section 14105.181).

a. 90% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims from practitioners within 90 days from the date of receipt. (Title 42 Section 447.75).
b. 95% of all clean claims from practitioners, who are individual or group practice or who practice in shared health facilities within 45 working days after the date of receipt of the claim. (CCR Title 28 Section 1300.71 (g)).
c. Claim paid at Medi-Cal rate or appropriate clinic rates per SB 94.

Check Clearing: Blue Shield Promise accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. As evidence that the check has been mailed by the Delegated Entity can provide a check mail log that has been signed by a Principal Officer or CFO who is attesting to checks being mailed on the dates reported. Blue Shield Promise will confirm the date the check or electronic transfer was charged cleared to the Delegated Entity's bank account during the audit process. Blue Shield Promise requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield Promise requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. This attestation can be requested from your assigned claims delegation oversight auditor.

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.

### 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. For submission of newly contracted providers, you are required to submit the date the newly contracted provider completed training, a signed attestation from your organization provider training team, as well as a signed attestation from the newly contracted provider that list the material that was trained to and the date the provider completed the training. For more information on how to submit the signed attestation, please see Section 12.2.

### 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, monitoring of regulatory compliance, auditing for internal controls and conflicts of interest. This oversight is performed either via shared audit through ICE or individually on an annual basis.

### 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.

## Claims Delegate Reporting Instructions

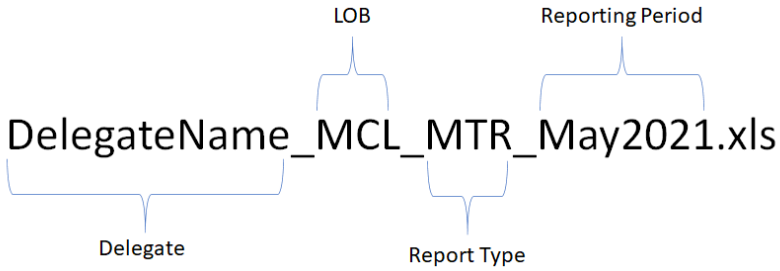
Please email reports to the following contacts:

| Report Type | Contact |
|---|---|
| Disclosure of Emerging Claim Deficiencies | ClaimsDelegateReport@blueshieldca.com |
| **Report Type** | **Contact** |
| MTR | ClaimsDelegateReport@blueshieldca.com |
| PDR | ClaimsDelegateReport@blueshieldca.com |
| Principal Officer Form | ClaimsDelegateReport@blueshieldca.com |

Report files should be named to identify the Group, LOB, Report Type, and Reporting Period. Following this naming convention will uniquely identify the report and help streamline the reporting process.

| File Naming Convention | Description |
|---|---|
| Delegate | The delegated entity's name or an acronym which represents the group. |
| LOB | Medi-Cal (MCL) |
| Report Type | Disclosure of Emerging Claim Deficiencies (DECD)<br>MTR (MTR)<br>PDR (PDR)<br>Principal Officer Form (POF) |
| Reporting Period | Identify the period being reported on e.g., Jan2021, 2021Q1, etc. |

Below is an example of the file name for the Medi-Cal MTR report for group "DelegateA", covering the month of May 2021.



Reports

Please review all the Monthly/Quarterly report requirements. Please submit the Excel/Word report in addition to the signed document. Reports that do not meet reporting standards or have issues will be returned with a request to correct the inconsistencies. Prompt submission is expected to ensure timely reporting.

### *1. Disclosure of Emerging Claim Deficiencies*

In accordance with the California Code Regulation (Title 28, Section 1300.71- Claims Settlement Practices), delegated entities that report claims deficiencies, must complete a Disclosures of Emerging Claims Payment Deficiencies form. The delegated entity will identify the reason for such reported deficiencies by selecting series of check mark boxes, which explain the lack or thereof compliance during the reporting period.

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

| Line of Business (LOB) | Due Date | Report Template (double click icon) |
|---|---|---|
| Medi-Cal | Claims Settlement Practice reports are submitted quarterly. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day.<br><br>• Q1 report due April 30th<br>• Q2 report due July 31st<br>• Q3 report due October 31st<br>• Q4 report due January 31st of the following year. |  <br>AB1455 Claims Settlement Practices |

## 2. *MTR (Medi-Cal)*

Claims must be processed within 30 calendar days and 45 working days.

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

| Line of Business (LOB) | Due Date | Report Template (double click icon) |
|---|---|---|
| Medi-Cal | Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day.<br><br>At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day.<br><br>• January report due February 15th<br>• February report due March 15th<br>• Q1 report due April 31st<br>• April report due May 15th<br>• May report due June 15th<br>• Q2 report due July 31st<br>• July report due August 15th<br>• August report due September 15th<br>• Q3 report due October 31st<br>• October report due November 15th<br>• November report due December 15th<br>• Q4 report due January 31st of the following year |  <br>ICE_Claims_Medi-Cal_MoQtr_Final__040121_ |

### 3. *PDR (Commercial and Medi-Cal)*

For quarterly reports, the delegated payer's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

| Line of Business (LOB) | Due Date | Report Template (double click icon) |
|---|---|---|
| Commercial and Medi-Cal | At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day.<br>• Q1 report due April 31st<br>• Q2 report due July 31st<br>• Q3 report due October 31st<br>• Q4 report due January 31st of the following year |  <br>ICE_Claims_ComQtrProvDisputesReport.xls |

### 4. *Principal Officer Form*

The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

| Line of Business (LOB) | Due Date | Report Template (double click icon) |
|---|---|---|
| All LOBs | Reports are due by the end of September each year (annually).<br>Also, submit updated reports whenever changes occur to Principal Officer(s) at the delegated entity. |  <br>PrincipalOfficerForm.docx |

# Palliative care services screening criteria for program participation

| Member information | | | |
|---|---|---|---|
| Member name | | Member ID# | |
| Date of birth | | Evaluation date | |
| **Referring party information** | | | |
| Provider name | | Organization name | |
| Address | | | |
| City | | State | ZIP code |
| Phone number | | Email | |

For a plan member to be considered for participation in the Home-Based Palliative Care Program, the plan member must meet the following palliative care eligibility screening requirements.

| Section 1: | Eligibility criteria for all members |
|---|---|
| **1.a. General eligibility criteria**<br>The member must meet all of the general eligibility criteria.<br>(If the member is younger than 21 years old, also see Section 2 for broader pediatric eligibility criteria.) | ☐ Is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures.<br>☐ Has an advanced illness, as defined in Section 1.b below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.<br>☐ Death within a year would not be unexpected based on clinical status.<br>☐ Has received appropriate patient-desired medical therapy **OR** is a member for whom patient-desired medical therapy is no longer effective. The member is **NOT** in reversible acute decompensation.<br>☐ The member and, if applicable, the family/member-designated support person, agrees to:<br>o Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and<br>o Participate in Advance Care Planning discussions. |
| **1.b. Disease-specific eligibility criteria**<br>The member must meet at least one of the four disease-specific eligibility criteria.<br>(If the member is younger than 21 years old, also see Section 2 for broader pediatric eligibility criteria.) | ☐ **Congestive heart failure (CHF): Must meet (a) AND (b)**<br>a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned **OR** meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher.<br>b. The member has an ejection fraction of less than 30% for systolic failure **OR** significant co-morbidities.<br>☐ **Chronic obstructive pulmonary disease (COPD): Must meet (a) OR (b)**<br>a. The member has a forced expiratory volume (FEV) of 1 less than 35% of predicted **AND** a 24-hour oxygen requirement of less than 3 liters per minute.<br>b. The member has a 24-hour oxygen requirement of greater than or equal to 3 liters per minute.<br>☐ **Advanced cancer: Must meet (a) AND (b)**<br>a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia.<br>b. The member has a Karnofsky Performance Scale score less than or equal to 70% **OR** has failure of two lines of standard of care therapy (chemotherapy or radiation therapy). |

| | |
|---|---|
| **1.b. Disease-specific eligibility criteria (cont'd)** | ☐ **Liver disease: Must meet (a) AND (b) combined or (c) alone**<br>a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, an international normalized ratio (INR) greater than 1.3.<br>b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices.<br>c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score of greater than 19.<br>☐ **Cerebral vascular accident/stroke:**<br>a. Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia.<br>☐ **Chronic kidney disease (CKD) or end-stage renal disease (ESRD).**<br>☐ **Severe dementia or Alzheimer's disease.**<br>☐ **Other (fill in):** |

If the member does not meet the above eligibility requirements and is younger than 21 years old, proceed to Section 2.

| **Section 2:** | **Pediatric palliative care eligibility criteria** |
|---|---|
| **2.a. General eligibility criteria**<br>The member must meet all the general eligibility criteria. | ☐ The member is under the age of 21.<br>☐ The family and/or legal guardian agrees to the provision of pediatric palliative care services. |
| **2.b. Disease-specific eligibility criteria:**<br>The member must meet at least one of the four life-threatening diagnosis criteria. | ☐ Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease).<br>☐ Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy).<br>☐ Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta).<br>☐ Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms). |
| **Servicing provider** | **Home-Based Palliative Care Program status** |
| Indicate member program status: | ☐ Member is enrolled in the program. *(Enter enrollment date):*<br>☐ Member did not agree to enroll in the program.<br>☐ Member did not qualify for enrollment in the program.<br>☐ Member enrolled in hospice. |
| **PCP/Specialist** | |

☐ I am referring the member to Blue Shield of California for a full Palliative Care Service Evaluation.

# Palliative Care Program Patient Disenrollment Form

To ensure we have an accurate list of members enrolled in the Palliative Care Program, please use this form to notify Blue Shield Promise within 15 business days of a member's disenrollment from the Program.

Member Information:

| |
|---|
| Member name: |
| Member ID: |
| Member date of birth: |
| Disenrollment date: |

Provider Information:

| |
|---|
| Your name: |
| Organization name: |
| Address: |
| Phone: |
| Email: |

Reason for Disenrollment:

| | |
|---|---|
| Please enter the reason for disenrollment: | ☐ Member enrolled in hospice<br>☐ Member is deceased<br>☐ Member condition improved<br>☐ Member is no longer enrolled with Blue Shield Promise<br>☐ Other: _____ |

Please fax the completed form to (323) 889-2109 or secure email to BSCPHP_PalliativeCare@blueshieldca.com.

This page intentionally left blank.

# DHCS Community Supports Categories and Definitions

## Asthma Remediation

*Description:* Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

## Day Habilitation Programs

*Description:* Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

## Environmental Accessibility Adaptations (Home Modifications)

*Description:* Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

## Homelessness[1]

*Definition:*

- An individual or family who lacks adequate nighttime residence
- An individual or family with a primary residence that is a public or private place not designed for our ordinarily used for habitation
- An individual or family living in a shelter
- An individual existing an institution to homelessness[2]
- An individual or family who will imminently lose housing in next 30 days[3]
- Unaccompanied youth and homeless families and children and youth defined as homeless under other Federal statutes
- Victims fleeing domestic violence

---

[1] DHCS definition; this definition is based on HUD definition of homeless with modification as noted below.

[2] If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.

[3] The timeframe for an individual or family who will imminently lose housing has been extended from 14 (HUD definition) to 30 days.

Housing Tenancy and Sustaining Services

*Description:* This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Housing Transition Navigation Services

*Description:* Housing Transition Navigation services assist Members with obtaining housing.

Housing Deposits

*Description:* Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board.

Meals/Medically Tailored Meals

*Description:* Meals delivered to the home: Meals provided immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

Medically Tailored Meals: Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases. Medically Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD), reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and/or side effects to ensure the best possible nutrition-related health outcomes.

Nursing Facility Transition/Diversion to Assisted Living Facilities

*Description:* Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible. For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADL). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board.

Community Transition Services/Nursing Facility Transition to a Home

*Description:* Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization. They are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that does not constitute room and board.

## Personal Care & Homemaker Services

*Description:* Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Includes services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who otherwise could not remain in their homes.

## Recuperative Care

*Description:* Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

## Respite

*Description:* Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

## Short-Term Post-Hospitalization Housing

*Description:* Short-Term Post-Hospitalization housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential alcohol or drug abuse recovery or treatment facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of state plan services.

Sobering Centers

*Description:* Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services and homeless care support services.

# Community Supports Criteria and Exclusion Guide

Community Supports Services and Eligibility Criteria Checklist
Blue Shield Promise Health Plan
Los Angeles County

This guide provides information for both General (Section A) and Service-Specific (Section B) criteria for Community Supports (CS) under CalAIM.

## A. GENERAL CRITERIA AND EXCLUSIONS

| General Criteria for Community Supports (CS) Referrals: |
|---|
| ☐ Active Medi-Cal with Blue Shield Promise at the time of request for referral. |
| ☐ Documentation of member's written or verbal consent for the CS referral. |
| **General Exclusions:** |
| ☐ Member is receiving a similar or program and a referral for CS would be duplication of services. |
| ☐ If member is in facility-based care at the time of referral, the earliest start of Community Supports, if member meets eligibility criteria, will be at the time of discharge from the facility. |
| ☐ Member is unable to contact within 1 business day from the time of referral (Member can be re-referred at a later date, if appropriate). |

## B. SERVICE-SPECIFIC CRITIERA AND EXCLUSIONS

| Environmental Accessibility Adaptations (Home Modifications) |
|---|
| Description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization. EAAs also include asthma remediation. |
| Eligibility Criteria (must meet all criteria): |
| ☐ Individuals at risk for institutionalization in a nursing facility. |
| ☐ Order from the member's current primary care physician or other health specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. |
| ☐ Member owns, rents, leases, or occupies the home where services are needed. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). |
| ☐ Member has received a physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following: |
| ☐ An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member; |
| ☐ B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member *and reduces the risk of institutionalization*. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and |
| ☐ A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy. |
| ☐ A home visit has been conducted to determine the suitability of any requested equipment or service. |

| Exclusion Criteria: |
|---|
| ☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.<br>☐ Member has exceeded the total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.<br>☐ EAAs do not include aesthetic embellishments.<br>☐ Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).<br>☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. |

| Housing Deposits |
|---|
| Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. |
| Eligibility Criteria: |
| ☐ Enrolled in and receiving housing navigation through Homeless and Housing Supports Services (HHSS); and<br>☐ Currently in the process of moving into permanent housing; and<br>☐ Unable to meet requested housing deposit expenses. |
| Exclusion Criteria: |
| ☐ Not currently enrolled in HHSS.<br>☐ Receiving housing deposit resources from a duplicate program.<br>☐ Already living in permanent housing at the point of request, but reasonable accommodation could be considered.<br>☐ Not moving into permanent housing setting.<br>☐ Previously received housing deposit services from Blue Shield Promise Health Plan or other Medi-Cal Managed Care plans. Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. |

## Housing Tenancy and Sustaining Services

Description: This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Eligibility Criteria: Members must meet one criterion from the Homeless criteria AND one from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members participating in Permanent Supportive Housing):

| Homeless Criteria: | High Utilizer/High Acuity Criteria: |
|---|---|
| Member must meet <u>one</u> of the following statuses:<br>☐ Member who received Housing Navigation Community Supports prior to entering housing; or<br>☐ Member who met the HUD definition of homelessness[1] prior to entering housing and has been housed for less than six months; or<br>☐ Member who has exited from an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and has been housed for less than six months; or<br>☐ Member who met HUD chronic homelessness[2] definition prior to entering housing and has been housed for less than two years. | ☐ Member is eligible or enrolled in ECM homeless population of focus; or<br>☐ Member has two or more chronic conditions*; or<br>☐ Member is a high utilizer, defined as:<br>☐ 7 or more Emergency Department visits in prior 12-month period; or<br>☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or<br>☐ Total health care costs of at least $50,000 in prior 12-month period |

<u>OR</u>

☐ Member is participating in a publicly funded permanent supportive housing resource or program** in Los Angeles County.

### Exclusion Criteria:

☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.
☐ Member is enrolled in a duplicative housing navigation or tenancy services program.
☐ Member declines services.
☐ Member has previously received Tenancy Services (limit of a single duration in the individual's lifetime; services may be approved one additional time with documentation as to what conditions have changed to demonstrate why services would be more successful on the second attempt).

*Any 2 of the following conditions: asthma, coronary artery disease (includes stroke and heart attack/MI), chronic/congestive heart failure, chronic obstructive pulmonary disease (includes emphysema), dementia, diabetes, hypertension, epilepsy, chronic liver disease (includes Hepatitis B and Hepatitis C), traumatic brain injury, bipolar disorder, major depressive disorder, psychotic disorder (includes schizophrenia), alcohol use disorder, chronic kidney disease, other serious mental illness, other substance use disorders, any cancer under treatment, except basal cell carcinoma (skin cancer), HIV, Lupus, and rheumatoid arthritis.
**Permanent Supportive Housing resources include programs to provide housing linked to supportive services in project-based or scattered site settings, and may include licensed residential facilities, or shared housing if part of an ongoing County, City, or other government program.

[1] HUD Definition of Homelessness
[2] HUD Definition of Chronic Homelessness

<table>
<tr><th colspan="2">Housing Transition Navigation Services</th></tr>
<tr><td colspan="2">Description: Housing Transition Navigation services assist beneficiaries with obtaining housing</td></tr>
<tr><td colspan="2">Eligibility Criteria: Members must meet <u>one</u> criterion from the Homeless criteria AND <u>one</u> from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members successfully matched for Permanent Supportive Housing):</td></tr>
<tr><td>Homeless Criteria:</td><td>High Utilizer/High Acuity Criteria:</td></tr>
<tr><td>Member must meet <u>one</u> of the following homeless statuses:<br>☐ Member who meets the HUD definition of homelessness; or<br>☐ Member is exiting an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and would become homeless immediately upon release: or<br>☐ Member who meets HUD definition of chronic homelessness.</td><td>☐ Member is eligible or enrolled in ECM homeless population of focus; or<br>☐ Member has two or more chronic conditions*; or<br>☐ Member is a high utilizer, defined as:<br>☐ 7 or more Emergency Department visits in prior 12-month period; or<br>☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or<br>☐ Total health care costs of at least $50,000 in prior 12-month period</td></tr>
<tr><td colspan="2"><u>OR</u><br>☐ Member is matched to a publicly funded permanent supportive housing resource or program** in Los Angeles County.</td></tr>
<tr><td colspan="2">Exclusion Criteria:</td></tr>
<tr><td colspan="2">☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.<br>☐ Member is enrolled in a duplicative housing navigation or tenancy services program.<br>☐ Member declines services.</td></tr>
</table>

| Meals/Medically Tailored Meals (MTM) |
|---|
| Description: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases. Medically Tailored meals are approved by a Registered Dietitian (RD) that reflect appropriate dietary therapy based on evidence-based nutrition practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes. |
| Eligibility (Population Subset) Criteria: Includes the following populations: |
| - Individuals aged 18 and over with Diabetes who have an HbA1c level equal to or greater than eight percent that are taking insulin greater than 200 units per 24-hour period, U500, or 3 or more oral anti-diabetes medications or non-insulin injectables; and<br>  - Have 2 or more inpatient hospitalizations in the prior 12 months with diabetes as primary or secondary diagnosis; or,<br>  - Have had 2 or more ED visits in the prior 12 months, with diabetes as primary or secondary diagnosis, or<br>- Individuals aged 18 and over with Chronic Kidney Disease (CKD) stage 3 and 4; and<br>  - Have 2 or more inpatient hospitalizations in the prior 12 months with CKD as primary or secondary diagnosis; or,<br>  - Have had 2 or more ED visits in the prior 12 months, with CKD as primary or secondary diagnosis. |
| - Individuals aged 40 and over with Congestive Heart Failure (CHF); and<br>  - Have 2 or more inpatient hospitalizations in the prior 12 months with CHF as primary or secondary diagnosis; or,<br>  - Have had 2 or more ED visits in the prior 12 months, with CHF as primary or secondary diagnosis. |
| Exclusion Criteria: |
| - Any of the following health conditions: Gestational Diabetes, Cancer, HIV, Dependence on Renal Dialysis, End-Stage Renal Disease (ESRD); or<br>- Member is currently in another MTM program; or<br>- Member does not have access to cold food storage; or<br>- Member is in Hospice; or<br>- Member is in Skilled Nursing Facility; or<br>- Member is incarcerated. |

| Personal Care & Homemaker Services |
| --- |
| Description: Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes. |
| Eligibility Criteria (must meet at least one of the following): |
| - Individuals at risk for hospitalization or institutionalization in a nursing facility; or<br>- Individuals with functional deficits and no other adequate support system; or<br>- Individuals approved for In-Home Supportive Services.<br><br>Eligibility criteria can be found at http://www.cdss.ca.gov/In-Home-Supportive-Services. |
| Exclusion Criteria: |
| This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Members must be referred to the In-Home Supportive Services program when they meet referral criteria. If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period. Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding. |

## Recuperative Care (Medical Respite)

Description: Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

### Eligibility Criteria:

In order to qualify, Members must:

- Be an active, homeless BSC Promise Medi-Cal or CMC member; and
    a. Homeless is defined as…
        i. Members who meet the HUD definition of homelessness or
        ii. Members who are exiting an institution (such as jail, hospital, or SNF) after more than 90 days and would become homeless immediately upon release
- Is post-hospitalization or post-skilled nursing facility; and
- Have one of the following:
    b. A defined home health skilled need, such as:
        i. Physical therapy, occupational therapy, or speech therapy
        ii. Ongoing IV antibiotics
        iii. Wound Care

OR

- Be in the midst of, or in need of, an outpatient treatment that if interrupted or delayed would cause undue harm.

### Exclusion Criteria:

Members are not eligible if any of the following apply:

- Member is unable or unwilling to independently complete ADLs; except for short-term or limited assistance consistent with recuperative care facility capabilities;
- Member is dependent for medication administration;
- Member is incontinent of bladder and/or bowel and unable to self-care with adult briefs and/or other incontinence supplies;
- Member is gravely disabled;
- Members must be medically and psychiatrically stable enough that hospitalization or a different higher level of care (such as an LTACH or a residential treatment center) is not required;
- Member is cognitively impaired (e.g., needs constant supervision and monitoring and /or re-direction and verbal cues for basic functions/ADLs);
- Member has been recently combative, aggressive and/or threatening towards staff or other individuals;
- Member has a peripherally inserted central catheter ("PICC Line") and is on IV medications depending on other factors, e.g. type of medication administered, mobility, safety of Member and other guests, etc. Decisions about placement of Members with a PICC Line will be decided on a case-by-case basis;
- Member is unable to live independently in housing and/or needs licensed care, such as skilled nursing, 24/7 care and supervision, medication administration, Adult Residential Facility (ARF) / Residential Care Facility for the Elderly (RCFE), a.k.a. Board & Care services, or etc.;
- Member has tested positive for Covid-19 within the last 10 days and/or is still exhibiting symptoms;
- Active Tuberculosis/C-DIFF/MRSA of sputum (possibly of wound) or other communicable/contagious condition(s) may be a disqualifier;
- Members are generally ineligible with limited exceptions if member is oxygen dependent, has stage 3 or 4 decubitus, is actively detoxing or is quadriplegic. Decisions about placement of Members with these needs will be decided on a case-by-case basis.

| Short-Term Post-Hospitalization Housing |
|---|
| Description: Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential Alcohol or Drug Abuse Recovery or Treatment facility, residential mental health treatment facility, correctional facility, nursing facility or recuperative care. |
| Eligibility Criteria (must meet all criteria): |
| Member is homeless.<br>1 or more IP admission within 6 months from time of referral or at significant risk of hospitalization if not housed.<br>No identified family or other housing supports. |
| Exclusion Criteria: |
| Already housed.<br>In a duplicate program/receiving housing through alternative community support/program.<br>Member exhausted the maximum lifetime amount (not to exceed 6 months). |

| Respite Services |
|---|
| Description: Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. |
| Eligibility Criteria (must meet all criteria): |
| Eligible individuals include those who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.<br>Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in California Children's Services or Genetically Handicapped Persons Program (GHPP), and members with Complex Care Needs. |
| Exclusion Criteria: |
| In the home setting, these services, in combination with any direct care services the member is receiving, can provide up to 24 hours per day of care. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the limit of 336 hours per calendar year can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit. This service is only provided to avoid placements for which the Medi-Cal managed care plan would be responsible. Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding. |

| Sobering Centers |
|---|
| Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.<br><br>Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services. |
| Eligibility Criteria (must meet all criteria): |
| □ Individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail.<br>□ Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms).<br>□ Individuals may not be receiving duplicative support from other State, local, or federally funded programs. |
| Exclusion Criteria: |
| □ Member is determined by medical and/or legal personnel to be transported to the ER or jail.<br>□ Member required services beyond 24 hours.<br>□ Individuals may not be receiving duplicative support from other State, local, or federally funded programs. |

| Day Habilitation |
|---|
| Description: Day Habilitation Programs are provided in a Member's home or an out-of-home, non- facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management. |
| Eligibility Criteria (must meet one criteria): |
| □ Member experiencing homelessness, per HUD definition; or<br>□ Member exited homelessness and entered housing in the last 24 months; or<br>□ Member is at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program. |
| Exclusion Criteria: |
| □ Member declines services.<br>□ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. |

| Asthma Remediation |
| --- |
| Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. |
| Eligibility Criteria (must meet all criteria):<br>• Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services;<br>• Member or their caregiver owns, rents, leases, or occupies the home where services are to be delivered;<br>• Member's current licensed health care provider has submitted order specifying the requested remediation(s) for the Member*;<br>• Member has a brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective*;<br>• A home visit has been conducted to determine the suitability of any requested remediation(s) for the Member*. |
| Exclusion Criteria:<br>• If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.<br>• Member has exceeded the total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.<br>• Services are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.<br>• Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. |

*Referring individual must provide written evidence when submitting the Referral.

Community Supports Services and Eligibility Criteria Checklist
Blue Shield Promise Health Plan
San Diego County

This guide provides information for both General (Section A) and Service-Specific (Section B) criteria for Community Supports (CS) under CalAIM.

## A. GENERAL CRITERIA AND EXCLUSIONS

| General Criteria for Community Supports (CS) Referrals: |
|---|
| ☐ Active Medi-Cal with Blue Shield Promise at the time of request for referral. |
| ☐ Documentation of member's written or verbal consent for the CS referral. |
| **General Exclusions:** |
| ☐ Member is receiving a similar or program and a referral for CS would be duplication of services. |
| ☐ If member is in facility-based care at the time of referral, the earliest start of Community Supports, if member meets eligibility criteria, will be at the time of discharge from the facility. |
| ☐ Member is unable to contact within 1 business day from the time of referral (Member can be re-referred at a later date, if appropriate). |

## B. SERVICE-SPECIFIC CRITIERA AND EXCLUSIONS

| Environmental Accessibility Adaptations (Home Modifications) |
|---|
| Description: Environmental Accessibility Adaptations (EAAs, also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization. EAAs also include asthma remediation. |
| Eligibility Criteria (must meet all criteria): |
| ☐ Individuals at risk for institutionalization in a nursing facility. |
| ☐ Order from the member's current primary care physician or other health specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. |
| ☐ Member owns, rents, leases, or occupies the home where services are needed. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.). |
| ☐ Member has received a physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:<br>☐ An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;<br>☐ An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member *and reduces the risk of institutionalization*. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item; and<br>☐ A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy. |
| ☐ A home visit has been conducted to determine the suitability of any requested equipment or service. |

| Exclusion Criteria: |
|---|
| ☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.<br>☐ Member has exceeded the total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.<br>☐ EAAs do not include aesthetic embellishments.<br>☐ Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).<br>☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. |

| Housing Deposits |
|---|
| Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board. |
| Eligibility Criteria: |
| ☐ Enrolled in and receiving housing navigation through Homeless and Housing Supports Services (HHSS); and<br>☐ Currently in the process of moving into permanent housing; and<br>☐ Unable to meet requested housing deposit expenses. |
| Exclusion Criteria: |
| ☐ Not currently enrolled in HHSS.<br>☐ Receiving housing deposit resources from a duplicate program.<br>☐ Already living in permanent housing at the point of request, but reasonable accommodation could be considered.<br>☐ Not moving into permanent housing setting.<br>☐ Previously received housing deposit services from Blue Shield Promise Health Plan or other Medi-Cal Managed Care plans. Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. |

<table>
<tr><th colspan="2">Housing Tenancy and Sustaining Services</th></tr>
<tr><td colspan="2">Description: This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.</td></tr>
<tr><td colspan="2">Eligibility Criteria: Members must meet one criterion from the Homeless criteria AND one from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members participating in Permanent Supportive Housing):</td></tr>
<tr><td>Homeless Criteria:</td><td>High Utilizer/High Acuity Criteria:</td></tr>
<tr><td>Member must meet <u>one</u> of the following statuses:<br>☐ Member who received Housing Navigation Community Supports prior to entering housing; or<br>☐ Member who met the HUD definition of homelessness[3] prior to entering housing and has been housed for less than six months; or<br>☐ Member who has exited from an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and has been housed for less than six months; or<br>☐ Member who met HUD chronic homelessness[4] definition prior to entering housing and has been housed for less than two years.</td><td>☐ Member is eligible or enrolled in ECM homeless population of focus; or<br>☐ Member has two or more chronic conditions*; or<br>☐ Member is a high utilizer, defined as:<br>☐ 7 or more Emergency Department visits in prior 12-month period; or<br>☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or<br>☐ Total health care costs of at least $50,000 in prior 12-month period</td></tr>
<tr><td colspan="2"><u>OR</u><br>☐ Member is participating in a publicly funded permanent supportive housing resource or program** in San Diego County.</td></tr>
<tr><td colspan="2">Exclusion Criteria:</td></tr>
<tr><td colspan="2">☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.<br>☐ Member is enrolled in a duplicative housing navigation or tenancy services program.<br>☐ Member declines services.<br>☐ Member has previously received Tenancy Services (limit of a single duration in the individual's lifetime; services may be approved one additional time with documentation as to what conditions have changed to demonstrate why services would be more successful on the second attempt).</td></tr>
</table>

*Any 2 of the following conditions: asthma, coronary artery disease (includes stroke and heart attack/MI), chronic/congestive heart failure, chronic obstructive pulmonary disease (includes emphysema), dementia, diabetes, hypertension, epilepsy, chronic liver disease (includes Hepatitis B and Hepatitis C), traumatic brain injury, bipolar disorder, major depressive disorder, psychotic disorder (includes schizophrenia), alcohol use disorder, chronic kidney disease, other serious mental illness, other substance use disorders, any cancer under treatment, except basal cell carcinoma (skin cancer), HIV, Lupus, and rheumatoid arthritis.
**Permanent Supportive Housing resources include programs to provide housing linked to supportive services in project-based or scattered site settings, and may include licensed residential facilities, or shared housing if part of an ongoing County, City, or other government program.

[3] HUD Definition of Homelessness
[4] HUD Definition of Chronic Homelessness

## Housing Transition Navigation Services

Description: Housing Transition Navigation services assist beneficiaries with obtaining housing

Eligibility Criteria: Members must meet one criterion from the Homeless criteria AND one from the High Utilizer/High Acuity criteria (High Utilizer/High Acuity criteria may be waived for members successfully matched for Permanent Supportive Housing):

| Homeless Criteria: | High Utilizer/High Acuity Criteria: |
|---|---|
| Member must meet one of the following homeless statuses:<br>☐ Member who meets the HUD definition of homelessness; or<br>☐ Member is exiting an institution (such as jail, hospital, or SNF) after more than 90 days and was HUD homeless prior to entering an institution and would become homeless immediately upon release: or<br>☐ Member who meets HUD definition of chronic homelessness. | ☐ Member is eligible or enrolled in ECM homeless population of focus; or<br>☐ Member has two or more chronic conditions*; or<br>☐ Member is a high utilizer, defined as:<br>☐ 7 or more Emergency Department visits in prior 12-month period; or<br>☐ 2 or more Inpatient visits and/or short-term skilled nursing facility in prior 12-month period; or<br>☐ Total health care costs of at least $50,000 in prior 12-month period |

OR

☐ Member is matched to a publicly funded permanent supportive housing resource or program** in San Diego County.

Exclusion Criteria:

☐ Member is unable to live independently in housing and/or needs higher level care, such as skilled nursing.
☐ Member is enrolled in a duplicative housing navigation or tenancy services program.
☐ Member declines services.

## Medically Supportive Food/Meals
(Food to support health-related situations for 4 to 12 weeks. Services approved on a month-to-month basis)

Description: Meals delivered to the home: immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.

Eligibility Criteria (Member must meet at least one criteria):

☐ Recent discharge from the hospital or other inpatient healthcare facility and not physically able to obtain meals or prepare meals on their own after discharge.
☐ Newly diagnosed illness.
☐ Experiencing a health crisis.
☐ Documented need for nutritional food support to avoid exacerbation of a health crisis condition or episode (example Major organ transplant).

Exclusion Criteria:

☐ Member has adequate caregiver support in place to obtain and prepare meals after discharge or other.
☐ Member is enrolled in other meal programs (e.g., lives at and Independent Living Facility (IILF) which provides more than 7 meals per week to residents).
☐ Unsheltered individuals or without stable housing for the duration of service.
☐ Members with extreme food allergies.

## Medically Tailored Meals (MTM)

Description: Meals provided to the member at home that meet the unique dietary needs of those with chronic diseases. Medically Tailored meals are approved by a Registered Dietitian (RD) that reflect appropriate dietary therapy based on evidence-based nutrition practice guidelines to address a medical diagnosis, symptoms, allergies, medication management and side effects to ensure the best possible nutrition-related health outcomes.

Eligibility Criteria (Member must meet all criteria):

- ☐ Must have Chronic Heart Failure (CHF), Diabetes (uncontrolled), Chronic Kidney Disease (CKD) diagnosis (stages 3-5 or on Dialysis), Cancer, Human Immunodeficiency Virus (HIV).
- ☐ If member has two or more qualifying conditions, must specify only one ICD Code for the primary reason for referral.
- ☐ Inpatient/SNF hospitalization or ER visit within the last 12 months.
- ☐ Must have life expectancy of more than 1 year.
- ☐ No Income requirement.

Exclusion Criteria:

- ☐ Life expectancy less than 1 year.
- ☐ Homeless or no stable housing in last 3 months.
- ☐ No to low motivation to actively participate in program – can explore other meals programs.
- ☐ Member is enrolled in other meal programs (ex: lives at ILF and provided more than 7 meals per week to residents).
- ☐ Members with extreme food allergies

## Personal Care & Homemaker Services

Description: Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management. Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

Eligibility Criteria (must meet at least one of the following):

- ☐ Individuals at risk for hospitalization or institutionalization in a nursing facility; or
- ☐ Individuals with functional deficits and no other adequate support system; or
- ☐ Individuals approved for In-Home Supportive Services.

Eligibility criteria can be found at http://www.cdss.ca.gov/In-Home-Supportive-Services

Exclusion Criteria:

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Members must be referred to the In-Home Supportive Services program when they meet referral criteria. If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period. Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

| Recuperative Care (Medical Respite) |
|---|
| Description: Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing |
| Eligibility Criteria (must meet all criteria): |
| ☐ Adult (18 years of age or older) and homeless.<br>☐ Acute medical or psychiatric problem requiring short-term medical respite care with an identifiable end point of care for discharge.<br>☐ Medically and behaviorally stable (not a risk to self/others, appropriate for group setting).<br>☐ Independent in Activities of Daily Living (mobility, transfer, toileting, feeding, dressing) and not known to be fall-risk.<br>☐ Able to independently administer medications.<br>☐ Agreeable to admission and receiving care from Recuperative Care staff.<br>☐ Be willing to comply with medical recommendations and treatment plan goals.<br>☐ Bladder and bowel continent.<br>☐ Have scheduled subspecialty follow-up appointments as indicated. |
| Exclusion Criteria: |
| ☐ Unable to perform ADLS independently.<br>☐ Active Tuberculosis (TB).<br>☐ Fecal and/or urinary incontinence without management plan *(Member must have the ability to independently to change themselves etc.).*<br>☐ Unstable medical or psychiatric conditions that require an inpatient level of care.<br>☐ Dangerous to self or others; unable to live in a group environment.<br>☐ Demonstrated history of using alcohol or illicit drugs onsite at a residential program, hospital, SNF, or similar program.<br>☐ IV hydration (*Individuals requiring IV antibiotics must be able to self-administer or the hospital must arrange a Home Health Nurse come to the Recuperative Care housing*).<br>☐ Contagious air-borne respiratory illness.<br>☐ Substance use- not onsite or abstain depending on RCU.<br>☐ In a duplicate program/receiving housing services through alternative Community Supports/Program. |

| Short-Term Post-Hospitalization Housing |
|---|
| Description: Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute, psychiatric or Chemical Dependency and Recovery hospital), residential Alcohol or Drug Abuse Recovery or Treatment facility, residential mental health treatment facility, correctional facility, nursing facility or recuperative care. |
| Eligibility Criteria (must meet all criteria): |
| ☐ Member is homeless.<br>☐ 1 or more IP admission within 6 months from time of referral or at significant risk of hospitalization if not housed.<br>☐ No identified family or other housing supports. |
| Exclusion Criteria: |
| ☐ Already housed.<br>☐ In a duplicate program/receiving housing through alternative community support/program.<br>☐ Member exhausted the maximum lifetime amount (not to exceed 6 months). |

| Sobering Centers |
|---|
| Description: Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (alcohol and/or drug) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.<br><br>Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, and homeless care support services. |
| Eligibility Criteria (must meet all criteria): |
| ☐ Individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail.<br>☐ Individuals aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms).<br>☐ Individuals may not be receiving duplicative support from other State, local, or federally funded programs. |
| Exclusion Criteria: |
| ☐ Member is determined by medical and/or legal personnel to be transported to the ER or jail.<br>☐ Member required services beyond 24 hours.<br>☐ Individuals may not be receiving duplicative support from other State, local, or federally funded programs. |

| Day Habilitation |
| --- |
| Description: Day Habilitation Programs are provided in a Member's home or an out-of-home, non- facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management. |
| Eligibility Criteria (must meet one criteria): |
| ☐ Member experiencing homelessness, per HUD definition; or<br>☐ Member exited homelessness and entered housing in the last 24 months; or<br>☐ Member is at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program. |
| Exclusion Criteria: |
| ☐ Member declines services.<br>☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. |

| Asthma Remediation |
|---|
| Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. |
| Eligibility Criteria (must meet all criteria):<br>☐ Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services;<br>☐ Member or their caregiver owns, rents, leases, or occupies the home where services are to be delivered;<br>☐ Member's current licensed health care provider has submitted order specifying the requested remediation(s) for the Member*;<br>☐ Member has a brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective*;<br>☐ A home visit has been conducted to determine the suitability of any requested remediation(s) for the Member*. |
| Exclusion Criteria:<br>☐ If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.<br>☐ Member has exceeded the total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.<br>☐ Services are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.<br>☐ Services shall not replace services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. |

*Referring individual must provide written evidence when submitting the Referral.

This page intentionally left blank.