blue california
Promise Health Plan

April 22, 2022

Subject: **Notification of July 2022 Updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medi-Cal Provider Manual.* The changes listed in the following provider manual sections are effective July 1, 2022.

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

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

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

If you have any questions regarding this notice about the revisions that will be published in the July 2022 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships & Network Management

TBSP12568 (4/22)

Section 5: Enrollment

5.7: Eligibility List

Added *"Member Language" to the eligibility file.*

5.12: Transportation

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

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 web site 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.

Section 6: Grievances, Appeals, and Disputes

6.4.4: First Level Dispute

Added *the following language:*

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.

Section 7: Utilization Management

Updated *the term "Case Manager" to "UM Clinician" throughout entire section.*

7.1: Utilization Management Program

Added *language to indicate that UM now 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.*

7.2.3: Case Management in the Inpatient Setting

Changed *section title to* **7.2.3 Utilization Management (UM) Clinicians in the Inpatient Setting**.
Updated *the following UM clinician functions in boldface and strikethrough type below:*

- Interface **frequently** ~~daily~~ 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.
- **Provide after-hours support to assist with member repatriation from a non-contracted to a contracted facility.**

Utilization Management Timeliness Standards chart

Updated *the following timeframes:*

Type of Request	Decision	Notification
Urgent Concurrent review of treatment regimen already in place (i.e., inpatient, on-going, ambulatory services).	Within 72 hours of receipt of the request	Practitioner and member within 72 hours of receipt of the request.

7.6.1: Emergency Services

Emergency Care

Updated *language in boldface and strikethrough type below:*

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.** ~~prior to, or at least during, the time of rendering these services. Blue Shield Promise wishes to assess the appropriateness of care and assure that this care is rendered in the proper venue.~~

After Business Hours

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

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

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

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.

7.6.3: Concurrent Review

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

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

Added *the following language:*

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.

7.7: Authorization Denials, Deferrals, and Modifications

Update *language in boldface type below:*

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:

- For concurrent care within ~~24~~ **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.** ~~A disclosure of the specific utilization review criterial/guideline or benefit provision used as a basis for the denial will be sent to the Member and the provider.~~

7.9.2: Child Health and Disability Prevention Program (CHDP)

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

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

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

Updated *the following refugee health guidelines:*

- 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 six years should be given a daily multivitamin with iron.

7.9.8: Sensitive Services

Updated *the definition of Sensitive Services as follows:*

"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.

7.9.13: Organ Transplant

Removed *"kidney" from the list of covered major organ transplant benefits to align with DHCS requirements. As minor organ transplants, kidney transplants are not the responsibility of Blue Shield Promise unless they are performed at the same time as a major organ transplant.*

7.9.23: Community Supports

Updated *the program description for clarification and* ***added/updated*** *the following services:*

- Asthma Remediation
- Day Habilitation Programs
- Sobering Centers (LA and San Diego Counties)

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

Moved *the Managed Care Program Data (MCDP) Report under the monthly report section(now due the 15th of the month) and* ***deleted*** *both the Medical Exemption Request (MER) Denial Report (MMDR) and the Out of Network Reports.*

Section 10: Pharmacy and Medications

10.2: Specialty Pharmaceuticals

IPA/Medical Group Retaining Specialty Pharmaceutical Risk

Added *language below:*

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

Section 11: Health Education

Removed *Section 11.3.2: IPA/Medical Group Provision of Health Education and replaced it with the following new section:*

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.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.1: Blue Shield Promise Health Plan and Subcontractor's Responsibility in the Provision of CLAS

CLAS Areas that Blue Shield Promise Health Plan Will be Responsible For

Clarified *that over-the-phone interpreting services are available 24 hours a day, 7 days a week. Face-to-Face and American Sign Language (ASL) interpreting services are available during business hours and will be scheduled as requested.*

Appendices

Appendix 4: Access to Care Standards

Updated *the following standards:*

Type of Care and Service	Blue Shield Promise Health Plan Standard
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.
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.

Appendix 19: DHCS Community Supports Categories and Definitions

Updated *definitions.*

Appendix 20: Community Supports Criteria and Exclusion Guide

Updated *appendix to include an eligibility criteria checklist for Los Angeles County and one for San Diego County.*