February 26, 2020

Subject: Notification of May 2020 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 on the following pages are effective May 1, 2020.

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

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

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

If you have any questions regarding this notice about the revisions that will be published in the May 2020 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Hugo Florez
Vice President, Provider Network Management
Promise Health Plan and PPO Specialty Networks

TBSP 10892 (2/20)
Section 8: Encounter Data

8.1: Encounter Data – Medi-Cal

**Added** complete submission measurements as follows:

**Complete Submission**

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

8.2: Encounter Data Contact Requirement

**Removed** the data contact requirement from the manual as it is no longer required.

Section 9: Quality Improvement

9.9.1 Access to Care Standards

**Noted** that the Access to Care Standards can be found in Appendix 7 or online at the Blue Shield Promise provider portal at https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/policies-guidelines-standards-forms.

9.14 Credentialing Program

**Added** Certified Nurse Midwife (CNW) to list of practitioners that credentialing is required for.

9.14.1 Minimum Credentials Criteria

**Removed** the following language from minimum training requirements for MDs and DOs as it no longer applies. Providers must have training in the Specialty requested.

aa. A specialist provider applying as primary care provider must complete at least one-year stateside training in primary care medicine (Internal Medicine or Family Practice);

bb. A primary care provider applying as a specialist must complete at least one year of specialized training (not in primary care medicine) in the United States and provide two letters of recommendation from other primary care physicians.

cc. An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine. If an OB/GYN has completed at least one year of specialized training (not in primary care medicine) in the United States and he/she may substitute two (2) letters of recommendation from other primary care physicians for one year of primary care training.

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

- Podiatrists (DPM) are required to be either board certified by a Board recognized by the American Podiatric Medical Association (e.g., American Board of Foot and Ankle Surgery (ABFAS) [formerly American Board of Podiatric Surgery (“ABPS”)]) or the American Board of Podiatric Medicine (ABPM) [formerly American Board of Podiatric Orthopedics and Primary Podiatric Medicine (“ABPOPPM”)].
9.14.2: Credentials Process for Participating Provider Group (PPG)

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

a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield Promise auditor will provide a list of 30 initial files and 30 recredentialing files to be reviewed at the audit to the PPG. 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 credentialing or recredentialing since the last annual audit, the organization audits the universe of files rather than a sample.

Section 12: Provider Services

12.4: Provider Affiliations

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

12.6: Provider Network Additions (Participating Provider Group “PPG”)

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

12.7.4: Change in a Provider’s PPG Affiliation

Removed the requirement that the PCP send a separate notification of change in affiliation to Blue Shield Promise. This request needs to be sent to the PPG only.

12.7.5: Provider Panel Status

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

12.7.6: Network Validation

Removed language indicating general acute care hospitals shall be exempt from the network validation requirements. The network validation process does apply to general acute care hospitals.
14.1: Claims Submission

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

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

*Updated* the paper claim mailing address to:

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

14.2: Claims Processing Overview

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

L. Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services. Incidental procedure services and supplies are considered included in a global procedure charge(s). A list of incidental procedures is provided in Appendix 19.

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 the 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.
14.2: Claims Processing Overview (cont’d.)

Facility Compliance Review (FCR) (cont’d.)

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

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

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

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

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

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 the Plan, submit the primary payer’s explanation of benefits (EOB) or remittance advice (RA) with the claim.

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 the Plan for benefits paid from any recovery received from the third party;

4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party’s agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Respond to information requests regarding the claim against the third party and notify the Plan and the medical group or IPA, in writing, within ten (10) days of any recovery obtained.
14.6: Claims Oversight and Monitoring – Participating Provider Groups

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

Blue Shield Promise is dedicated to ensuring that claim functions delegated to Participating Provider Groups (“PPG”) are processed in accordance with regulatory requirements and contractual provisions. Blue Shield Promise monitors PPG’s monthly and quarterly claims processing timeliness via the PPG’s submission of the monthly/quarterly timeliness report. Additionally, Blue Shield Promise monitors the PPG’s provider dispute resolution process via submission of the PPG’s quarterly M-CAL Qtr ProvDisp Rpt. Both report templates are located on the ICE website under Approved ICE documents. Blue Shield Promise performs at the minimum annual claims and PDR audits. Follow-up/focused audits will be scheduled by the assigned auditor if the PPG fails the annual/subsequent audit(s) or, if applicable, as a result of the DMHC Audit Findings based upon their requirement of the PPG to file a corrective action plan (CAP) with each PPG’s contracted health plan. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators. Blue Shield Promise audits include review of PPG’s claims and PDR processing according to contractual and regulatory requirements, including but not limited to California Title 28 (1300.71 and 1300.71.38), California Health & Safety Section 1371 and various state bills – AB1324, SB 94, etc. These requirements include but are not limited to timeliness of claims processing (denials, adjustments, payment), misdirected/forwarded claims timeliness, accuracy of denials/contesting, payment of family planning claims, etc.

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

Appendices

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

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

Appendix 10: Health Education State Requirements for Providers

Updated the Health and Wellness member portal URL to http://www.blueshieldca.com/promise/hra.

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

Appendix 18: Reimbursement for Outpatient Services

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

Appendix 19: List of Incidental Procedures

This appendix lists billable CPT codes for incidental procedures.

Appendix 20: List of Office-Based Ambulatory Surgery Procedures

This appendix lists billable CPT codes for ambulatory surgery procedures.