August 3, 2020

«Contract Entity Name»
«Attention»
«Address» «Suite»
«City» «STATE» «Zipcode»

Subject: Notification of October 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 in the following provider manual sections are effective October 9, 2020.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at https://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 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 October 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

TBSP11200 (8/20)
Section 9: Quality Improvement

**Added** the following section outlining a new DHCS requirement for Medi-Cal managed health care plans to implement a subcontracted network certification process. This mandate is outlined in APL 20-003, dated 2/27/20. A link to the APL communication is below.

### 9.9.3: 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>
<thead>
<tr>
<th>Adult primary care physicians (including non-physician medical practitioners)</th>
<th>Adult and pediatric core specialists:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric primary care physicians (including non-physician medical practitioners)</td>
<td>Cardiology/Interventional Cardiology</td>
</tr>
<tr>
<td>Obstetrician-gynecologists (OB/GYNs)</td>
<td>Dermatology</td>
</tr>
<tr>
<td>Adult mental health outpatient providers</td>
<td>Endocrinology</td>
</tr>
<tr>
<td>Pediatric mental health outpatient providers</td>
<td>ENT/Otolaryngology</td>
</tr>
<tr>
<td>Hospitals</td>
<td>Gastroenterology</td>
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<tr>
<td>Pharmacies</td>
<td>General Surgery</td>
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<tr>
<td>Ancillary Services</td>
<td>Hematology</td>
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<td>HIV/AIDS Specialists/Infectious Diseases</td>
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<td>Nephrology</td>
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<td>Orthopedic Surgery</td>
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<td>Physical Medicine and Rehabilitation</td>
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<td>Psychiatry</td>
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<td></td>
<td>Pulmonology</td>
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</tbody>
</table>
**9.9.3: Subcontracted Network Certification Requirement** (cont’d.)

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.

**Section 14: Claims**

**14.1: Claims Submission**

Section 14.1 Claims Submission has been deleted and replaced with the following language:

Blue Shield Promise Health Plan applies the appropriate regulatory requirements related to claims processing.

A. 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 clearinghouses are listed on Provider Connection at blueshieldca.com/provider in the Claims section under How to submit claims or by contacting the EDI Department at (800) 480-1221.

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 - BSC PHP
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 Health Plan 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 thereof, 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.

If claims are being submitted electronically, claims must be HIPAA compliant and meet all requirements for EDI transactions. If you have electronic claim submission questions or if you would like instructions on how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com.

F. Claim Filing Limits

1. Medi-Cal claims submissions must meet the following time requirements:
   i. Claims must be submitted within 180 days from the date of service.
   
   ii. 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:

      a. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four (4) months after the month of service.

      b. 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.

      c. 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.

      d. Blue Shield Promise finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.

   iii. Claims received after 12th month after month of service will be denied as untimely.