blue california
Promise Health Plan

January 4, 2022

Subject: **Notification of January 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 January 1, 2022.

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

You may also request a PDF version of the revised *Blue Shield Promise Health Plan 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 January 2022 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

TBSP12385 1/22

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

Section 3: Benefit Plans and Programs

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

Updated *references to Palliative Care appendices. The Palliative Care Patient Eligibility Screening Tool form is now Appendix 17 and the Blue Shield Promise Palliative Care Program Patient Disenrollment Form is now Appendix 18.*

Section 5: Enrollment

5.1 Eligibility

Deleted *the following language:*

The State's Automated Eligibility Verification System (AEVS) is the ultimate determination of eligibility, while L.A. Care provides ultimate determination of plan partner assignment for members residing in LA County. Blue Shield Promise provides the ultimate determination of eligibility for San Diego Members.

5.2 Member Enrollment

Updated *the language to indicate the enrollment and disenrollment process is for Medi-Cal and that the referenced contracted plans are in Los Angeles.*

5.9 Identification Cards

Updated *language to clarify materials will be furnished to new members within 7* ***calendar*** *days of enrollment.*

Deleted *provider directory from list of materials furnished to new members.*

Section 6: Benefit Plans and Programs

6.1 Member Grievances

Updated *language to clarify how the Plan responds to a member's grievance.*

Added *language in boldface type below:*

Providers and IPA/medical groups are required to provide medical records, authorizations, or responses within 7 calendar days of the request **(or sooner in the case of expedited grievances)** in order to resolve the grievance within the regulatory timelines.

6.3 Independent Medical Review

Deleted and replaced *"180 days" with "six (6) months" in reference to the period during which an enrollee may request an IMR.*

Added *the following language:*

Members are eligible for an independent medical review if the member has not presented the disputed health care service for resolution by the Medi-Cal fair hearing process. Reviews shall be conducted in accordance with the statutes and regulations of the Medi-Cal program.

Section 7: Utilization Management

7.1 Physician, Member, and Provider Responsibilities

Updated *language to clarify members either may select a PCP and or otherwise be assigned to one.*

7.2.2: Case Management in the Ambulatory Setting

Updated *language regarding a benefit evaluation for organ transplants, as follows:*

Organ Transplant benefits for recipient and Living Donor including Organ transplant evaluation.

7.3. Enhanced Care Management

Added *the following language:*

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.

7.7 Authorization Denials, Deferrals, and Modifications

Added *language to indicate the written notification of an authorization request denial, deferral, and/or modification may be sent by either Blue Shield Promise* ***or the delegated IPA/medical group****.*

Added *the following language:*

The reason(s) for the denial must be translated into the Member's preferred language.

7.8.1: Second Opinion

Added *the following as a reason for a second opinion:*

If the member was not approved for an organ transplant program.

7.9.10: Mental Health (Medi-Cal Managed Care)

Updated *the following language in boldface type in the "Role of Primary Care Physicians" subsection:*

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

***Added** the following language in boldface type:*

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.

7.9.13: Organ Transplant

*This subsection has been **deleted and replaced** as follows:*

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
- Kidney
- Liver
- Pancreas
- Small bowel
- Combined liver and small bowel
- Lung
- Simultaneous kidney-pancreas

California Children Service (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

7.9.15: Alcohol and Drug

*This subsection has been **deleted and replaced** as follows:*

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 MCPs 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.

Added *subsection 7.9.23: Community Supports.*

7.9.23: Community Supports

Community Supports are optional services (non-benefits) that Blue Shield Promise may offer to eligible Medi-Cal members. These services can provide support to members above and beyond Long Term Care Support Services (LTSS) to enhance and support 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). Furthermore, community supports services are also 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 criteria. Although these services are not Medi-Cal benefits, members can file a grievance and/or appeal in the event they are not satisfied with access to a Community Supports service(s).

Blue Shield Promise offers the following Community Supports to eligible Medi-Cal members in Los Angeles and San Diego Counties, as of 1/1/2022:

- 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 (San Diego only)

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.

Section 9: Quality Improvement

9.1.1: Program Structure Governing Body

Deleted *the following language in boldface type:*

Blue Shield Promise ensures all functions delegated by Blue Shield Promise to providers, vendors, or other organizations, **either first tier, downstream or related entities (FDRs),** are performed according to accreditation, regulatory, and Blue Shield Promise requirements.

9.5: Initial Health Assessment

Updated *language to clarify only eligible providers may receive payouts under the IHA provider incentive program.*

9.8: Access to Care

This subsection has been ***deleted and replaced*** *as follows and remaining sections have been renumbered:*

Blue Shield Promise requires its providers to comply with 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 Health Plan 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 manage care enrollee must be comparable to those for Medi-Cal fee-for service members.

9.9.1: Broken/Failed Appointment Follow-up

Updated *language to clarify DHCS requires missing/broken appointments to be documented and members must be contacted for rescheduling within 48 hours.*

Section 10: Pharmacy and Medications

Added *the following language describing the Medi-Cal Rx carve out.*

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/.

Removed *subsections that no longer apply due to the Medi-Cal Rx carve out.*

Section 12: Provider Services

12.7: Provider Network Changes

Deleted *the following language:*

All provider terminations require a minimum of 90-day advance written notification.

12.7.2: Specialist/Specialty Group Termination Notification Requirements

This subsection has been ***renamed*** *to "Group Termination Notification Requirements".*

Deleted *the following language:*

Because Blue Shield Promise does not assign members to specialist physicians/specialty groups, but rather relies on the provider to coordinate the Member's specialty care arrangements, the responsibility to notify the member of upcoming specialist terminations rests with the provider.

12.8: IPA/Medical Group Specialty Network Oversight

Deleted *reference to subsection 9.8.3.*

12.11: Provider Directory

Deleted *the following language:*

New enrollees receive a printed copy of the directory as part of the Medi-Cal welcome kit.

Section 13: Marketing - Medi-Cal

13.1: Introduction

Deleted *the following language:*

Marketing is critical to the success of Blue Shield Promise Health Plan and plays a vital role in:

- Creating awareness
- Building credibility to achieve enrollment growth and retention
- Educating Members about managed care

Blue Shield Promise providers and staff are in a position to greatly influence the choices beneficiaries/patients make regarding their Medi-Cal managed health care. Providers may encounter patients who request guidance in choosing a plan and completing an enrollment form. Providers may assist patients with the completion of the enrollment form when patients bring the form to the provider's office. Providers are not allowed to have blank, partially completed, or completed Health Care Options (HCO) forms in their offices for patient signature nor are providers allowed to mail completed enrollment forms for patients.

13.3: Method for Members to Change Health Plans and Doctors

This subsection has been ***deleted*** *and remaining sections have been* ***renumbered.***

Section 14: Claims

14.2: Claims Processing Overview

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

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

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

Updated *the language in subsection H (Family Planning and Sensitive Services Claims) to clarify that DHCS Consent Form (PM 330 Form) is required with claims for sterilization services.*

Added *language in boldface type to subsection 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.

14.6: Claims Compliance and Monitoring

Renumbered *the Claims Compliance and Monitoring appendix to Appendix 16.*

Section 16: Regulatory, Compliance, and Anti-Fraud

Added *subsection 16.2 (False Claims Act) and renumbered remaining sections:*

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.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

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

Added *the following to list of CLAS areas IPA/medical groups are responsible for:*

Translating the Notice of Action (NOA) and Notice of Appeal Resolution (NAR), including the clinical rationale, into the Member's preferred language.

17.5: Translation of Member-Informing and Health Education Materials

Added *language in boldface type to list member informing materials:*

Form letters containing information regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of services or benefits, **including clinical rationale.**

Appendices

Appendix 4: Access to Care Standards

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

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	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.
Routine or Non-Urgent Care Appointments with a Behavioral Health Provider	Within ten (10) working days 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
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.

Appendix 8: Notification to Providers – Marketing Restrictions and Necessary Approvals

*This appendix has been **deleted** and remaining appendices have been **renumbered.***

Appendix 14: List of Incidental Procedures

*This title of this appendix has been **updated** to List of Incidental Procedures for APG Payment Rate.*

Appendix 15: List of Office-Based Ambulatory Procedures

*This title of this appendix has been **updated** to List of Office-Based Ambulatory Procedures for APG Payment Rate.*

***Added** the following new appendices:*

Appendix 19: DHCS Community Supports Categories and Definitions

Appendix 20: Community Supports Criteria and Exclusion Guide