blue california
Promise Health Plan

601 Potrero Grande Dr
Monterey Park, CA 91755

July 25, 2023

Subject: **Notification of October 2023 Updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

Blue Shield Promise is revising the *Blue Shield Promise Health Plan Medi-Cal Provider Manual.* The changes in each provider manual section listed below are effective October 1, 2023.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at www.blueshieldca.com/en/bsp/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 (Manual) is* included by reference 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 or about the revisions that will be published in the October 2023 version of this *Manual*, please contact Blue Shield Promise Provider Services at (800) 468-9935 [TTY 711] 6 a.m. to 6:30 p.m., Monday through Friday.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Section 3: Benefit Plans and Programs

3.2 Managed Long-Term Services and Supports (MLTSS)

3.2.2.4: Long-Term Services and Supports Liaison

Added entire section 3.2.2.4, which describes the activities and training of long-term services and supports liaison.

3.2.2.5: The Preadmission Screening and Resident Review (PASRR) Requirements

Added entire section 3.2.2.5, which describes the PASRR requirements to ensure that members who may be admitted into a nursing facility for a long-term stay be preliminarily assessed for serious mental illness and/or intellectual/developmental disability or related conditions.

3.5 Enhanced Care Management

Added language describing how providers of Enhanced Care Management (ECM) services must submit encounters on the CareConnect platform. The added language also includes a chart of HCPCS codes for ECM services.

Section 6: Grievances, Appeals, and Disputes

6.1: Member Grievances

Added the following language, pursuant to APL 23-006, concerning the revised Independent Medical Review/Complaint Form:

A revised Independent Medical Review/Complaint Form is available in English and the 16 threshold languages on the DMHC website at: https://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx

Added language to notify that Members have the right to request continuation of benefits during a State Fair Hearing.

6.2: Member Appeals Requests

Added language to notify that Members have the right to request continuation of benefits during the appeals process.

Section 7: Utilization Management

Replaced, throughout Section 7, the word "Prevention" with the word "Periodic" to correct acronym for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.

7.4: Authorization and Review Process

7.4.1: Authorization Time Frames

Moved Utilization Management Timeliness Standards chart for the standards for each type of request, from Section 7.4.1 to Appendix 13.

7.4.2: Authorization Validity

Updated language regarding how long an authorization is valid, in boldface type as follows:

Authorizations are generally approved for **180** days with a disclaimer stating that authorizations are valid only if the member is eligible on the actual date of service.

7.5: Emergency Services and Admission Review

7.5.1: Emergency Services

Updated paragraph, in response to AIR R.0180 2024 Readiness, regarding how member eligibility is obtained, after business hours, in boldface type as follows:

For additional support, the on-call nurse has access to the covering physician, or an alternate covering physician, to assist in physician related issues. **A Blue Shield Promise Medical Director or licensed physician acting on behalf of the medical director is available 24 hours a day, seven days a week to assist with access issues. A Blue Shield Promise Medical Director is available should there be a need for a Peer-to-Peer review.** Upon receipt of 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.

7.5.2: Urgent/Emergent Admissions

Updated paragraph, in response to AIR R.0180 2024 Readiness, regarding prior authorizations and emergency room admissions, in boldface type as follows:

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. **Notification can be done by fax at (619) 219-3301 or phone at (800) 468-9935.** PCP admission notification will be sent within 24 hours of the admission. If a provider requests authorization for post-stabilization care, Blue Shield Promise shall render a determination on behalf of a member within 30 minutes of the request.

7.7: Referrals

7.7.5: Continuity of Care

Updated item 3 in list of conditions for which members can request to remain with a terminated/non-contracted provider, as follows:

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.

3. Pregnancy: defined as the three trimesters of pregnancy and the immediate postpartum period, including maternity mental health. Completion of covered services shall be provided for the duration of the pregnancy; the completion of covered services shall not exceed 12 months. The postpartum period begins immediately after childbirth and extends for 12 months.

Added the following item, in accordance with APL 22-032, to list of descriptions of Continuity of Care, 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:

1. Acknowledgment of the Continuity of Care request will be made within the timeframes specified below, advising the Member that the Continuity of Care request has been received, the date of receipt, and the estimated timeframe for resolution. Notification to the Member will be using the Member's known preference of communication or by notifying the Member using one of these methods in the following order: telephone call, text message, email, and then notice by mail:
    - For non-urgent requests, within seven (7) calendar days of the decision.
    - For urgent requests, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than three (3) calendar days of the decision.

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

7.8.7: Comprehensive Perinatal Services Program (CPSP)

Updated bullet point in list of timelines from ACOG's Guidelines for Perinatal Care (8th edition) examination schedule for woman with an uncomplicated pregnancy, as follows:

d. Postpartum, with an initial visit within 3 weeks after delivery and a follow-up visit no later than 12 weeks after delivery.

Updated chart with recommended intervals for routine tests for individual patients during pregnancy

7.8.14: Organ Transplant

Added language explaining that Blue Shield Promise will refer, coordinate, and authorize the delivery of the MOT benefit and all medically necessary services associated with MOTs up to 180 days post-transplant.

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

Removed the following item from list of Quarterly Reports that must be submitted to Blue Shield Promise 45 days after the end of the quarter:

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.

Section 9: Quality Improvement

9.6: Facility Site Review

Updated language explaining where Blue Shield Promise participates in the Site Review Collaborative, as follows:

Blue Shield Promise participates in the Site Review Collaborative in the County where a site(s) is/are located and will accept reviews completed by Certified Site Reviewers from other contracted Health Plans in the same county.

9.6.1: FSR Evaluation

Updated the items in the list of Facility Site Review Evaluation procedures, as follows:

1. New providers will be evaluated by the Provider Information and Enrollment (PIE) team to determine whether a valid FSR exists prior to adding a new IPA relationship to the Blue Shield Promise Medi-Cal provider network.
2. If an FSR cannot be validated, the FSR unit will be notified.
3. An FSR will be conducted by Blue Shield Promise upon receipt of a request from the PIE team prior to any Primary Care Physician's site being added to the provider network.

9.12: HEDIS Measurements

Moved HEDIS Measurements chart to Appendix 14.

9.13: Credentialing Program

Added "credentialing mental health parity regulations" to the list of minimum credentials requirements that the Credentialing Program ensures compliance with.

Updated language concerning the Credentialing Policies and Procedures, as follows:

Policies and procedures are reviewed annually and revised as needed to meet the NCQA, DHCS, DMHC, CMS, L.A. Care, state, federal, and credentialing mental health parity regulatory agencies' requirements.

9.13.1: Credentials Process for Directly Contracted Physicians

Updated language in boldface type below explaining part of the California Participating Physician Application (CPPA) and the Council for Affordable Quality Healthcare (CAQH) application processes:

Upon receipt of a completed application, Blue Shield Promise for Behavior Health/Mental Health/Substance Abuse practitioners/providers will confirm receipt **and completeness** of application within 7 business days and complete review of application within 60 days of receipt.

9.13.4: Credentials Process for IPA/Medical Groups

Updated items 9, 11, 13, and 20 in list of methods Blue Shield Promise will use to assess and monitor credentialing activities, as follows:

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:

9. The IPA/medical group must develop and implement policy and procedures describing its credentialing system controls and monitoring process. (Applies to paper and electronic processes.).
11. The IPA/medical group is required to review all Blue Shield Promise practitioners/ providers sanction activities within the 30 calendar days of the report's release by the reporting entity and report the findings to Blue Shield Promise as Blue Shield Promise practitioners/providers are identified.
13. 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 audits, by the requested due date.
20. At least annually, the delegate acts on all findings from number 9, item 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.

Section 11: Health Education

11.1: Health Education Program

Updated the Health Education Program Purpose, as follows:

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. Educational interventions address health categories and topics that align with findings from Blue Shield Promise's Population Needs Assessment and Department of Health Care Services requirements, including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.

11.2: Scope of the Health Education Program

11.2.1: Member Education

Updated language explaining how to access Health Education materials, as follows:

Accessing Health Education Materials

The HE Department has a variety of materials in threshold languages and alternative formats (e.g., audio CD, Braille, large print, Data CD, materials accessible online, or electronic text files) 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 print materials from the Blue Shield Promise library at www.blueshieldca.com/en/bsp/health-and-wellness/health-education-materials. Providers who are unable to print materials from the library or who want to request materials in non-English, non-Spanish languages or in an alternative format can contact the Blue Shield Promise HE Department.

11.2.3: Selection of Health Education Materials

Updated entire section with information about Promise's commitment to the delivery of quality health promotion and educational materials. This commitment includes developing methods of testing reading levels and health education material standards.

11.2.4: Provider Education

Updated entire section with information about the Health Education Department's commitment to coordinate 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.

11.6: Program Resources

11.6.3: Wellvolution

Updated language about access to Wellvolution programs, in boldface type as follows:

All Wellvolution programs are 100% covered by Blue Shield Promise **and there is no cost to Blue Shield Promise members to enroll in Wellvolution programs**.

11.6.4: Departments in Collaboration with Health Education

Removed statement that the Provider Relations Department also assists in the delivery of materials.

12.7: Provider Network Changes

12.7.7: Change in a Provider's Panel Status

Updated, in support of the annual SB 137 DMHC filing, item 3 in list of events for which the IPA/medical group is required to inform the Plan within 5 business days, as follows:

The IPA/medical group is required to inform the Plan within five (5) business days when either of the following occur:

3. If the one or more of their providers was not accepting new patients and 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 Services Department at (800) 605-2556 (Los Angeles) or (855) 699-5557 (San Diego) TTY 711 for assistance in selecting a new provider. The provider is also to direct the enrollee/potential enrollee to the Department of Managed Care Services (DMHC) to report any provider directory inaccuracy.

Added the following bullet-point to list of methods through which providers can review their information on the Blue Shield Promise website and submit changes to the information listed in the directories:

- Call Blue Shield Promise Member Services at (800) 605-2556 (Los Angeles) or (855) 699-5557 (San Diego).

Updated, in support of the annual SB 137 DMHC filing, information about the Online Interface Form, which is an electronic web form that contains the required provider directory information Blue Shield Promise has on file for the provider, as follows:

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.

A system generated acknowledgment is automatically sent upon submission of an Online Interface Form.

12.11: Provider Directory

Updated, in support of the annual SB 137 DMHC filing, language concerning the Provider Directory and how to access it, as follows:

The Blue Shield Promise provider directory is updated each month. Any member of the public may download a PDF copy of the directory from blueshieldca.com/en/bsp/medi-cal-members/find-provider. A searchable directory is also available online.

To request a printed copy of the directory, please contact Blue Shield Promise in writing at:

Blue Shield of California Promise Health Plan
Customer Care
3840 Kilroy Airport Way
Long Beach, CA 90806

By phone:

- (800) 605-2556 (Los Angeles) [TTY:711]
- (855) 699-5557 (San Diego) [TTY:711]

Or online:

- blueshieldca.com/memberwebapp/bscphp/contact-us-medical

Blue Shield Promise will postmark the printed copy within five (5) business days of the request.

Section 14: Claims

14.7: Electronic Visit Verification (EVV)

Added entire sub-Section 14.7, in compliance with APL 22-014, which explains the requirement to implement electronic visit verification (EVV) for all Medi-Cal personal care services (PCS) and home health care services (HHCS) that are delivered during in-home visits by the provider.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.3: Access to Free Interpretation Services

Updated language concerning language proficiency and certification, in boldface type as follows:

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., **Language Line**) to determine if the candidate is qualified for medical interpreting. **It is recommended that Bilingual staff who rate a 1=Novice or 2=Low Intermediate based on a scale of 1-5 on a language proficiency test use a telephonic or face-to-face interpreter for communicating with members.** This will help avoid possible liability issues due to improper care and will be monitored during the facility site review.

Appendices

Appendix 2: Delegation of Credentialing Responsibilities

Added responsibilities for Mental Health and Substance Use Disorder Providers, to comply with AB 2581, as follows:

Delegated Credentialing Activity	Delegated	IPA/Medical Group Responsibility	Plan Responsibility	Frequency of Reporting/Due Date submitted via email box or Cred Auditor	Plan's Process for Performance Evaluation	Corrective Action if IPA/MG Fails to Meet Responsibilities
XIII. Mental Health and Substance Use Disorder Providers	☐Yes ☐No	Assembly Bill 2581 requires the following procedures be put in place for Mental Health/ Substance Use Disorder providers, effective January 1, 2023: • All Mental Health/Substance Use Disorder providers, upon receipt of a completed application, will receive an application received letter within seven days to verify receipt and inform the applicant whether the application is complete. • All complete Mental Health/Substance Use Disorder provider applications for credentialing will be completed within sixty days.	• Monitor and oversee delegated functions • Establish, publish, and distribute performance standards and guidelines to the IPA/MG • Provide the IPA/MG a substantive evaluation through review and analysis of performance reporting	**Annually:** - CR Program - CR Program Evaluation - CR Activity **Quarterly/ Semi-Annual:** via HICE Reports	• Pre-delegation review • Annual due-diligence audit or Attestation • Quarterly/ focus audits	• Request Corrective Action Plan(s) (CAPs) • Sanctions per IPA's delegation agreement (i.e., CAP deduction from monthly capitation) • Termination of CR delegation if CAP objectives are not achieved.

Appendix 4: Access to Care Standards

Deleted the standard for PCP Adult Preventive Care from Attachment A.

Added the following standard in Attachment A.

Type of Care and Service	Blue Shield Promise Health Plan Standard
Behavioral Health initial appointments with behavioral health physicians	Within ten (10) business days of the request.

Appendix 9: Delegation Oversight Claims, Compliance, IT System Integrity - Auditing and Monitoring

Updated language concerning the process of conducting periodic audits of claims and provider disputes to ensure compliance with regulatory requirements, as follows:

Audits and Audit Preparation

Blue Shield Promise and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield Promise's audit, Blue Shield Promise will send a written notification 60 days prior to the audit that includes the documents the Delegated Entity will need to provide along with the scope of the audit and due dates of when the material needs to be submitted. The documentation includes providing claims universes for each category. An industry standard questionnaire will need to be completed that will provide detailed information about your claims processing operations and internal controls. Also provided is a cover sheet that needs to be completed and attached to each claim sample. Note that the claim sample must include the following from the contract with the provider: the first and last page (signature) of contract, rate sheet from contract e.g., all documentation is required to be submitted with sample claim as noted on the cover sheet.

Blue Shield Promise will provide a notification of the annual audit that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization.

Blue Shield Promise will require a walk through and demonstration of the Delegated Entity's operations. This will include a demonstration of the life of a claim from end to end (mailroom to disposition of payment and/or denial) which will include operational systems and interviews with staff associated with specific functional areas. To assure end to end processes are formally documented Blue Shield Promise requires submission of Policy and Procedures (P&P) noted in the industry standard questionnaire as well as P&Ps requested during the audit claims assessment questions interview on the scheduled audit day. As part of the assessment Blue Shield Promise evaluates that P&Ps are reviewed annually via evidence that they were approved via committee or appropriate authority signature and dated.

If required claims documentation is not received, the audit is incomplete and will be scored as non-compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

Updated language concerning Corrective Action/Follow-up Audits, as follows:

Corrective Action/Follow Up Audits

Blue Shield Promise performs, at a minimum, an annual claims and PDR audit. Follow-up 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 **remediation validation audits** will be performed **based upon outcome of escalation to the Delegation Oversight Committee.** 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 by the date provided by the auditor. Additionally, Blue Shield Promise may perform an unannounced audit dependent upon other indicators.

Newly Contracted Provider Training Oversight Audit

Added language concerning annual audits on the review of Delegated Entities training materials training, as follows:

Annual audits are conducted on the review of Delegated Entities training materials and/or the Delegated Entities website that contains the training materials. The material must be submitted to the Blue Shield Promise Delegation Oversight Compliance Team by February 1st of the following year to BSCProviderTraining@blueshieldca.com.

Appendix 13: Utilization Management Timeliness Standards

Moved Utilization Management Timeliness Standards chart for the standards for each type of request, from Section 7.4.1 to Appendix 13.

Updated entire Utilization Management Timeliness Standards chart, which categorizes the Medi-Cal managed care standards for the types of requests and timelines for decisions and notifications of those decisions.

Appendix 14: HEDIS Guidelines

Updated and ***moved*** HEDIS Measurements chart, created per NCQA Requirements, to Appendix 14.