blue california
Promise Health Plan

3840 Kilroy Airport Way
Long Beach, CA 90806

July 24, 2024

Subject: **Notification of October 2024 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* (Manual). The changes in each provider manual section listed below are effective October 1, 2024.

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 in the *Provider manuals* section under *policies & guidelines*.

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 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 2024 version of this Manual, please contact Blue Shield Promise Provider Customer 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: Basic Population Health Management (BPHM)

Inserted this new sub-section and its accompanying sub-sections, regarding the Basic Population Health Management (BPHM), which is a comprehensive package of services and supports, intended for members to have access to improved health outcomes and overall wellbeing.

Renumbered all sub-sections, throughout Section 3, starting with Sub-section 3.2.

3.5: Home-Based Palliative Care Program

3.5.1: Enrolling/Disenrolling members in the Home-Based Palliative Care Program

Updated the language discussing eligibility process and referral oversight, to the following:

…All of the above processes and referrals are overseen by the Blue Shield Palliative Care Team.

Evaluation of Eligibility and Enrollment.

Upon receiving a palliative care referral, the Blue Shield Palliative Care Team will review to confirm member eligibility for the benefit…

Updated language detailing the "notification of enrollment" timeline, in boldface type, as follows:

Enrolling a Member

A notification of enrollment must be emailed to the Blue Shield email BSCPalliativeCare@blueshieldca.com listed below within three (3) **business** days of a member's enrollment.

3.8: Doula Services

Updated, in accordance with APL 24-003, the "Description of Doula Services" paragraph which describes services offered by doulas to members, in boldface type and strikethrough, as follows:

Description of Doula Services

Doulas are birth workers who provide health education, advocacy, and physical, emotional, and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal period) including support during miscarriage, stillbirth, and abortion **in accordance with APL 24-003**

Doula services encompass health education, advocacy, and physical, emotional, and nonmedical support provided before, during and after childbirth or end of a pregnancy, including throughout the postpartum period. **Doula services also include personal support for beneficiaries' families.**

Added the following paragraph, explaining how a member can be eligible for a recommendation for doula services:

Recommendation for Doula Services

A Member would meet the criteria for a recommendation for doula services if they are pregnant, or were pregnant within the past year, and would either benefit from doula services or they request doula services. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.

Updated paragraph explaining the doula claims process, to the following:

Claims and Billing

Doula providers have four options for submitting claims. Claims can be submitted through a Clearinghouse or on paper using the current version of the CMS 1500 forms. These methods are described in detail in Section 14.1 Claims Submission.

Doula providers can submit claims by logging on to Blue Shield's Provider Portal at www.blueshieldca.com/provider and navigating to the Claims section, then Submit via SympliSend. Providers can submit digital paper claims, itemization requests, and digital correspondence related to previously processed or in process claims using SympliSend.

Doula providers can also submit a Doula Transaction Log which is detailed below.

Added the following paragraph explaining the proper and accurate documentation of doula services:

Documentation of Services Rendered

Blue Shield Promise requests the provision of Covered Doula Services be documented and coded accurately. Documentation must accurately reflect the Covered Doula Services provided to Blue Shield Promise Members during the claim submission period. Plan will only reimburse for Covered Doula Services. In addition to information documented and coded on the claim, Doula must comply with DHCS submission requirements for other information regarding services rendered. A "Doula Visit Detail" form can be found on the Blue Shield Promise provider portal and will be updated, as necessary.

How to submit "Doula Visit Detail" Form

Doulas can complete and submit the form to the Blue Shield Promise Doula Program office via secured email BSCPromiseDoula@blueshieldca.com.

3.10: Street Medicine

3.10.1: Street Medicine Definition

Updated language that defined "Street Medicine," according to previous APL 22-023 to reflect that "Street Medicine" was currently defined according to APL 24-001, which superseded the previous APL 22-023.

Section 7: Utilization Management

7.1: Utilization Management Program

7.1.1: Physician, Member, and Provider Responsibilities

Added the following bullet point to list of additional activities and responsibilities of the PCP coordinating the entire spectrum of care:

All members may select or will be assigned to a Primary Care Physician (PCP). The PCP coordinates the entire spectrum of care for assigned members. This includes direct provision of all primary healthcare services, including preventive health services.

Additional activities and responsibilities include:

- Ensure providers have accurate contact information for the member and all network providers involved in the member's case.

7.4: Primary Care Physician Scope of Care

7.4.2. Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA)

Updated language about recommending BHT/ABA services, in "strikethrough" text, as follows:

To recommend BHT/ABA services for a member, an ABA Recommendation Form ~~or Comprehensive Diagnostic Evaluation~~ completed by a physician or psychologist, should be faxed to 844-283-3298 and our Behavioral Health Treatment team will coordinate a referral and provide authorization to obtain services.

7.8: Referrals

7.8.2: Self-Referable Services (Medi-Cal)

Updated language concerning the list of services that will be covered without prior authorization, in "strikethrough" and "boldface" text, as follows:

The following list includes services that ~~when performed by the PCP,~~ will be covered without prior authorization.

Description
Abortion Services **[in accordance with APL 24-003]**
Family Planning
HIV Testing
Sensitive Services for Minors (12 yrs. of age and older if sexually active)
Sexually Transmitted Diseases (STDs) Treatment

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

7.9.16: Phenylketonuria (PKU)

Updated language about the provider sending enteral nutrition products in "boldface" type, as follows:

Medically Necessary Enteral Nutrition Products **shall be sent from the pharmacy provider to the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (Magellan)**

Deleted language describing the medical authorization process for enteral nutrition products, due to the fact that services for enteral nutrition are reviewed by Medi-Cal Rx.

Section 9: Quality Improvement

9.8: Access to Care

9.8.2: Subcontracted Network Certification Requirement

Added the following language about subcontractor network assessments, to include new APL 23-006 requirements:

Subcontracted network will be assessed on a minimum biannual basis. Upon completing the review of subcontractor assessments, Blue Shield Promise will provide a CAP notification letter to each subcontractor found non-compliant with the subcontracted network certification requirements, outlining the deficiencies and specific issues of noncompliance that the subcontractor must address. Subcontractors must provide an initial CAP response, no later than 30 calendar days after the issuance of the CAP notification letter, that details a plan of action, including policies, and sets forth steps the subcontractor will take to correct the deficiencies identified.

Subcontractors have six months to correct all deficiencies during which time must provide Blue Shield Promise with monthly status updates that demonstrate action steps the Subcontractors is undertaking to address the CAP. Blue Shield Promise may impose sanctions, or other appropriate enforcement actions, for failure to comply with Network Adequacy All Plan Letter 23-006 and access standards at the end of the six-month CAP period. If monetary sanctions are to be imposed by DHCS, Blue Shield Promise will consider imposing monetary sanctions on subcontractors.

Blue Shield Promise has requirements for delegated entities which address frequency and time frame of reporting of provider data used in the network adequacy indicators with subcontractors. Subcontractors are required to validate their provider network quarterly though established validation processes and methodologies requesting they verify the network for any changes, such as provider terminations, name changes, address changes, open/closed panels etc., outlined in Section 12.7 of this manual.

9.14: Quality Improvement and Health Equity Transformation Program

Added new subsection, describing Blue Shield Promise's commitment to the delivery of quality and equitable health care services, through the Quality Improvement and Health Equity Program (QIHETP).

9.15: Reporting of Provider Preventable Conditions

Added new subsection, in accordance with APL 17-009, superseding APL-16-011, along with updated guidance, detailing the requirement to submit Provider Preventable Conditions (PPC) reporting through DHCS's secure online system.

Section 10: Pharmacy and Medications

10.1: Pharmaceutical Utilization Management

Removed the Prescription Drug Prior Authorization form from Appendix 5 and ***added*** language to this section instructing providers where to access the form on the Blue Shield Promise Provider Portal, as follows:

To view for the Prescription Drug Prior Authorization or Step Therapy Exception Request form, go to Blue Shield Promise's Provider Portal at

https://www.blueshieldca.com/en/bsp/providers/policies-guidelines-standards-forms/provider-forms and click on *Authorization request forms.*

Deleted and replaced the following bullet point in list of manners by which a drug can be recognized for treatment of a condition in "strikethrough" and bold type:

c. The drug has been recognized for treatment of that condition by one of the following:
    - American Hospital Formulary Service Drug Information.
    - Two peer-reviewed articles from major medical journals supporting the proposed off-label use as safe and effective.
    - For chemotherapy and biologic agents:
        - ~~IBM Micromedex DRUGDEX~~ **Lexi-Drugs**

Section 12: Provider Services

12.7.10: Telehealth

Added extensive language describing the Health Care Services' (DHCS) policy on Covered Services offered through Telehealth modalities, as outlined in the DHCS Medi-Cal Provider Manual at Medicine: Telehealth.

Section 14: Claims

14.2: Claims Processing Overview

Deleted the following item describing the reimbursement rates for home therapy hemodialysis, in "strikethrough" type:

~~5. Effective June 1, 2021, home therapy hemodialysis HCPC Code S9335 and home therapy peritoneal disease HCPC S9339 became Medi-Cal benefits.~~

~~(i) HCPCs S9335 and S9339 do not have established Medi-Cal rates, therefore, per Medi-Cal guidelines published in bulletin 563, Blue Shield Promise will reimburse for these HCPCs equivalent to in-center dialysis code Z6004 at the rate of $141.31 until Medi-Cal establishes rates for one or both codes.~~

~~(ii) Contract specific rates for these codes will supersede the Medi-Cal allowable amount.~~

Section 16: Regulatory, Compliance, and Anti-Fraud

16.1: Anti-Fraud Policy and Program

Added the following paragraph, defining healthcare fraud:

Healthcare fraud refers to the act of intentionally deceiving or misleading a healthcare provider, insurer, or government healthcare program for financial gain.

Potential fraud refers to the possibility or likelihood of fraudulent activities occurring in a particular situation or context. It indicates the presence of conditions or factors that could enable fraudulent behavior to take place, even if fraud has not yet been detected or proven. Potential fraud may involve suspicious activities, irregularities, or vulnerabilities that could be exploited by individuals seeking to commit fraud for personal gain or advantage.

All reported allegations deemed potential fraud upon initial review will be reported to regulatory agencies.

Appendices

Appendix 3: Delegation of Claims Processing Responsibilities

Updated the "Delegation of Claims Processing Responsibilities" Chart, which details delegated claims activity, group responsibility as it relates to claims activity, plan responsibility as it relates to claims activity, the claims reporting procedures, and the claims improvement process.

Appendix 5: Prescription Drug Prior Authorization Form

Removed entire Appendix 5

Renamed Appendix 5 from "Prescription Drug Prior Authorization Form" to "Reimbursement for Ambulatory Surgery Center Services."

Renumbered all appendices, starting from the new Appendix 5 "Reimbursement for Ambulatory Surgery Center Services."

Appendix 8: Delegation Oversight Claims, Compliance, IT System Integrity - Auditing and Monitoring

Claims, Compliance, IT System Integrity Oversight Audit Review Process

Audits and Audit Preparation

Added the following language concerning a contracted delegated entity's responsibility to demonstrate their annual oversight and monitoring process:

For a Blue Shield Promise Contracted Delegated Entity that is a Limited/Restricted Knox Keene or Specialty Health Plan, that has contractually sub-delegated any functions, they must demonstrate their annual oversight and monitoring process. Audit preparation would include submission of policies and procedures along with audit results and any supporting documentation and CAPs.

Claims, Compliance, IT System Integrity Oversight Audit Review Process

Payment Accuracy

Updated paragraph describing what payment accuracy includes, to the following:

Payment Accuracy

Payment accuracy includes: (1) proper payment of interest, (2) proper use of reasonable and customary rates and/or appropriate Medi-Cal fee schedule for services rendered to non-contracted providers, (3) applying appropriate contract rates fee schedules as demonstrated by submitted documentation or shared via audit webinar, and (4) system configuration. All four criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Appendix 11: 2024 Actuarial Cost

Updated calendar years throughout Appendix 11 and ***updated*** the table paragraph discussing how projected cost is calculated, to the following:

Actuarial Methodology
The projected utilization rates were developed based on actual encounters for each type of service. The projected unit cost and allowed pmpm costs were developed based on actual fee-for-service incurred claims adjusted for contract scope. Appropriate trend factors were used to estimate claims for calendar year 2023. The overall pmpm was reconciled to Blue Shield overall capitation paid in the year 2022 and trended to 2024.