blue california
Promise Health Plan

July 29, 2022

Subject: **Notification of October 2022 Updates to the *Blue Shield Promise Health Plan Cal MediConnect Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Cal MediConnect Provider Manual.* This manual is for providers participating in the Blue Shield Promise Cal MediConnect program. The changes listed in the following provider manual sections are effective October 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 Cal MediConnect 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 Cal MediConnect Provider Manual* is referenced in the agreement between Blue Shield of California Promise Health Plan (Blue Shield Promise) and those Cal MediConnect providers contracted with Blue Shield Promise. If a conflict arises between the *Blue Shield Promise Health Plan Cal MediConnect 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 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

TBSP 12834 (7/22)

UPDATES TO THE OCTOBER 2022
BLUE SHIELD PROMISE HEALTH PLAN CAL MEDICONNECT MANUAL

Section 2: Credentialing

2.11: Credentials Process for IPA/Medical Groups

Added the following to the list of items that the **pre-**delegation and annual oversight audits will include:

Credentialing systems, security controls, policies, and system control monitoring processes.

Section 3: Member Services

3.3.3.4: First Level Appeal

Added the following language:

To ensure timely processing of a dispute, all pertinent information should be provided at the time of submission; if the dispute is regarding a service that is the financial responsibility of the capitated entity, such as an IPA/medical group, please provide a copy of the denied claim explanation of benefits and/or denial of the dispute.

Section 4: Eligibility and Enrollment

4.2.1: Member Initiated Change

Removed language indicating the Enrollment Unit processes PCP changes. All member-initiated changes are completed by Customer Care.

4.3: Eligibility List

Added "Member Language" to the Eligibility List.

Section 5: Utilization Management

5.1: Utilization Management Program

Deleted and ***replaced*** the section as follows:

The role of the Utilization Management (UM) Department is to ensure consistent delivery of high-quality health care services to our Members through Blue Shield of California Promise Health Plan affiliated providers. Health care services are provided through full and shared risk networks structured to provide a continuum of care. The UM Department functions include authorization of the facility component for inpatient and outpatient procedures, home health, inpatient concurrent reviews, discharge planning, and retrospective reviews. UM Concurrent Review provides inpatient utilization management 5 days a week. from 8 a.m. to 5 p.m., except for company designated holidays, and after business hours call 7 days a week to assist with repatriation of members from a non-contracted to a contracted facility.

For Promise Health Plan members who are enrolled with a delegated IPA/medical group, referrals for specialty care, diagnostic testing and other ancillary providers are reviewed by the IPA/medical group. For Promise Health Plan members who are not enrolled with a delegated IPA/medical group, referrals for specialty care, diagnostic testing and other ancillary providers do not require a formal referral as long as the provider is a Promise Health Plan contracted provider. For questions regarding to whom you should submit a referral request, please contact Blue Shield Promise Customer Service.

Blue Shield Promise makes Utilization Management (UM) decisions only on appropriateness of care and service, based on the current Evidence of Coverage and the community standard of care. Blue Shield Promise does not reward practitioners or other individuals for issuing denials of coverage or care. There are no financial incentives that would encourage UM decision makers to make decisions that would result in underutilization of services.

Blue Shield Promise Health Plan contracted IPA/medical groups may only utilize Blue Shield Promise approved criteria as listed below. IPA/medical groups must first use either CMS Local Coverage Determinations (LCD) or CMS National Coverage Determination (NCD) for medical necessity determination. If an NCD or LCD is not available for the service being requested, the IPA/medical group may use one of the other guidelines listed below to establish whether a service is reasonable and necessary. The following is a complete list of the Blue Shield Promise approved guidelines or sources that may be utilized for issuing approvals, denials, or modifications. IPA/medical group/MSO Internal Policy or guidelines should not be used for any medical necessity determination of services fora Blue Shield Promise member. All benefit denials should either reference a CMS source or the Blue Shield Promise Health Plan Explanation of Coverage (EOC).

Blue Shield Promise Health Plan Approved Guidelines	
CMS Local Coverage Determinations (LCD)	National Guideline Clearinghouse
CMS National Coverage Determinations (NCD)	Hayes
MCG 25th Edition	NCCN

These criteria alone cannot ensure consistent UM decision making across the organization. Blue Shield Promise recognizes that individual needs and/or circumstances may require flexibility in the application of the Plan's review process.

Blue Shield Promise Health Plan uses nationally recognized evidence-based clinical criteria to make UM decisions. Criteria utilized to determine requests for service are available upon request by contacting (800) 468-9935.

5.2.3: Specialty Referrals

Added language in boldface below:

When, in the opinion of the PCP a Member referral to a specialist is indicated, **and the member is enrolled with a medical group/IPA,** a request shall be submitted to the Member's assigned IPA/medical group's UM Department for review and authorization except for services established as no prior authorization required under the direct referral process. **When, in the opinion of the PCP, a Member referral to a specialist is indicated and the member is directly managed by Blue Shield Promise, no referral is required if the specialist is in the Blue Shield Promise participating provider network. All out of network services require prior authorization approval.**

5.2.5: Outpatient Services

Added language in boldface below:

Ambulatory services and outpatient surgery procedures require authorization by the Member's assigned IPA/medical group's UM Department. **If the Member is not enrolled in an IPA/medical group, Blue Shield Promise will review the request.**

5.2.6: Elective Admission Requests

Added language in boldface below:

All elective inpatient admissions require an authorization by the Blue Shield Promise UM Department. Requests for elective inpatient admissions should be submitted to the Member's assigned IPA/medical group's UM Department. These requests will then be forwarded to the Blue Shield Promise UM Department for final authorization. **If the Member is not enrolled in an IPA/Medical group, Blue Shield Promise will review the request.**

5.3.1: Emergency Care

Deleted and ***replaced*** the section as follows:

Blue Shield Promise Members are entitled to access emergency care without prior authorization. However, Blue Shield Promise requires that when an enrollee is stabilized, but requires an inpatient admission for further care, additional medically necessary health care services, providers must notify Blue Shield Promise within 24 hours of admission.

5.3.3: Business Hours

Added language in boldface and ***removed*** language in strikethrough below:

Blue Shield Promise UM Department is available via telephone from 8:00 a.m. to 5:00 p.m., Monday through Friday **and on call after hours 7 days a week to assist with repatriation of out of network or out of area ER admissions**. ~~In a 911 situation~~, If a Member is ~~transported~~ admitted to an ERD, the ERD physician shall contact the Member's PCP (printed on the Member's enrollment card) as soon as possible (post stabilization) to give him/her the opportunity to direct or participate in the management of care.

5.3.5: After Business Hours

Removed the following items from the list of key services that the on-call UM Clinician will provide:

- Act as a liaison to PCPs, specialists, and other providers to ensure timely access and the coordination of follow-up care for Member's post emergency care.
- Arrange facility transfer ambulance transport services.
- Assist Members with non-emergent transportation services for weekend appointments when needed.
- Provide network resource information to Members and providers.
- Assist in pharmacy issues.

5.3.7: Concurrent Review

Deleted and ***replaced*** the section as follows:

Blue Shield Promise provides for continual reassessment of all acute inpatient care. Other levels of care, such as partial day hospitalization or skilled nursing care, may also require concurrent review at the discretion of Blue Shield Promise.

Reviews are conducted telephonically, using a facilities Electronic Medical Record (EMR) system or by reviewing faxed clinical documents. An authorization is given for the initial admission day, then concurrently thereafter, contingent on the condition that the inpatient care day has been determined to satisfy criteria for that level of care for that day.

Clinical information may be obtained from the admitting physician, the hospital EMR, faxed clinical documents or the hospital Utilization Review (UR) Nurse. The UM Clinician will compare the clinical presentation to pre-established clinical guideline. If the criteria are satisfied, an appropriate number of days will be authorized for that stay. If the Member remains inpatient, further concurrent review will be performed per the established internal guidelines or Physician Advisors direction. The number of hospital days and level of care authorized are variable and are based on the medical necessity for each day of the Member's stay. This is done through criteria sets and guidelines, provider recommendations, and the discretion of the CMO.

5.3.8: Discharge Planning

Deleted and ***replaced*** the section as follows:

The purpose of discharge planning is to identify, evaluate and coordinate the discharge planning needs of Blue Shield Promise Members when hospitalized. Discharge planning will begin on the day of admission for unscheduled inpatient stays. The review process will include chart review, data collection, and review of the care plan by the attending physician and other Members of the healthcare team. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process.

The goal of the discharge planning process is to follow the Members through the continuum of levels of care until the Member is safely discharged to home, with the goal of reducing adverse events and preventable admissions. The PCP of record is sent a discharge notification letter within 24 hours of notification. This approach is performed to ensure continuity of care and optimum outcomes for Blue Shield Promise Members.

5.4: Direct Access to Women's Health Services

Added language in boldface below:

Blue Shield Promise provides for direct access to women's health services for routine and preventive health care services such as annual well woman exams. These services must be provided by a Gynecologist within either the IPA/medical group network **if the member is enrolled with an IPA/medical group or Blue Shield Promise if the member is not enrolled with an IPA/medical group**. These services do not require prior authorization. Any treatments, procedures or surgeries that are recommended as a result of this evaluation will require prior

authorization from the IPA/medical group **if the member is enrolled with an IPA/medical group or Blue Shield Promise if the member is not enrolled with an IPA/medical group**.

Blue Shield Promise Transitional Care Management Program

Updated language to clarify that the Transitional Care Management Program applies to Cal MediConnect Members. It previously stated that this program applied to Special Needs Plan (SNP) members.

Model of Care – Cal MediConnect

Updated language to clarify that the Model of Care applies to Cal MediConnect Members. It previously stated that this program applied to Special Needs Plan (SNP) members.

Section 6: Pharmaceutical Management

6.1: Medication Therapy Management Program

Updated language in boldface below:

- Have **three** of the following conditions:
    - Chronic Heart Failure (CHF)
    - Diabetes
    - Hypertension
    - Osteoporosis
    - Respiratory Disease
- Receive **eight** or more different covered Part D maintenance medications monthly

6.2: Pharmaceutical Quality Assurance

Updated/added the following items to the list of items, for which pharmaceutical claims may be electronically reviewed:

- Incorrect drug dosage or duration of drug therapy
- Drug-Disease or drug-allergy contraindications
- Over-utilization and under-utilization

Section 7: Quality Improvement

7.1: Quality Improvement Program

Updated the goals and objectives of the Quality Improvement Program to align with current processes.

7.1.1: Program Structure Governing Body - Quality Management Committee

Removed Behavioral Health from list of committees reporting to the Quality Management Committee. ***Updated*** the scope of the Quality Management Committee to align with current processes.

7.9: HEDIS Measurements

Updated HEDIS measurements to align with 2022 NCQA standards.

Section 8: Encounter Data

8.1: Encounter Data – Cal MediConnect

Updated contact information for Cal MediConnect Encounter Data, as follows:

If you have EDI questions or if you would like to know how to submit using a clearinghouse, please email EDI_PHP@blueshieldca.com or call EDI Operations at (800) 480-1221.

If you have any other encounter submission related questions, please email EPE@blueshieldca.com.

COMPLIANCE GUIDELINES

Monthly Submission

Added the following language regarding expectations of monthly data submissions:

Volume of the Data

It is important to comply with encounter submission requirements and to report all services to meet established encounter data quantity targets.

Quality of the Data

Data acceptance rate shall not be less than 95% of all data submitted. The IPA/medical group is responsible to correct the rejections and re-submit the corrections to Blue Shield Promise.

Timeliness of the Data

Encounter data shall be submitted to Blue Shield Promise within one hundred eighty (180) calendar days from Date of Service ("DOS") in which care was rendered.

Complete Submission

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

Capitation/Penalties of Performance

Blue Shield Promise will provide an Encounter Performance Summary Report to the IPA/medical group on a regular basis and will use to evaluate the encounter data quality performance. Submission requirements can be found in the Blue Shield Promise Companion Guides.

Encounter submission performance goals as outlined in the Encounter Performance Summary Report are as follows:

Timeliness

Cal MediConnect: 65% received within 180 days from the date of service.

Accuracy

A compilation of the initial monthly file submission and any subsequently corrected data for the same file name must be 95% accurate. The IPA/medical group is responsible to correct the rejections and re-submit the corrections to Blue Shield Promise.

Blue Shield Promise imposes a penalty on any Capitated Provider who fails to meet the timeliness and accuracy requirements, per the provider's base agreement, if applicable.

If, by the fifteenth (15th) day following the expiration of the thirty days, the encounter data has not been submitted, Blue Shield Promise shall deduct a monthly capitation as stated in the provider's base agreement, if applicable, for each month the IPA/medical group is late, inaccurate, incomplete, or otherwise non-compliant with the requirements. A corrective action plan (CAP) will be issued to allow provider to identify steps for correction. If a CAP is not cured for three consecutive months following the issue date, or there is no substantial improvement within this time period, the Plan shall review notice for possible move to termination.

At the request of Blue Shield Promise, the IPA/medical group will need to provide primary source verification data upon request to support encounter data validation activities.

Additionally, when encounter data does not meet the submission requirements each month, Blue Shield Promise may request a Corrective Action Plan (CAP) from the Provider to remedy the problem, as follows:

1. Blue Shield Promise sends a letter to the Provider requesting a CAP. The letter details the following:
    a. The months that the encounter data did not meet the requirements.
    b. The dates when the encounter data was due to Blue Shield Promise.
    c. The file names for all encounter data files that did not meet the requirements.
    d. The reasons the encounter data did not meet the requirements, whether it be timeliness, accuracy, or a combination of the two (2).
    e. The date the CAP is due to Blue Shield Promise.
    f. Request for submission of accurate and complete encounter data for the timeframes in question.
2. The Capitated Provider must submit a CAP to Blue Shield Promise within thirty (30) days from the date of the CAP Request letter. The CAP must include the following:
    a. The name of the person responsible for implementing the CAP.
    b. A list of specific actions to be taken to ensure that encounter data meets the submission requirements.
    c. Completion dates for each of the corrective actions.
    d. An accurate and complete encounter data file.

3. Blue Shield Promise sends the Capitated Provider a letter of acceptance or rejection of the CAP within thirty (30) days of receipt of the CAP.
    a. Blue Shield Promise includes the specific reasons for rejection of any CAP.
    b. Any rejected CAP must be resubmitted within fifteen (15) days to Blue Shield Promise.
    c. Timeframes can be altered at the discretion of Blue Shield Promise depending on specific circumstances.
4. Capitated Providers who fail to submit an acceptable CAP within the required timeframes and/or accurate and complete encounter data, shall be subject to be frozen to new enrollment and to capitation deductions in accordance with the terms of the Provider Agreement. Blue Shield Promise shall provide thirty (30) days written notice prior to the capitation deduction. Capitation deduction shall be retroactive to the date of non-compliant encounter data submission. The enrollment freeze and capitation deduction shall remain in effect until such time that the CAP and/or encounter data is approved and meets standards.

The responsibility for Encounter Data reporting as outlined above continues until all services rendered during the timeframe of the provider's agreement have been reported.

Section 9: Claims

9.2: Claims Processing Overview

G. Emergency Claims

Deleted the following language as it is no longer applicable.

ER level 5 are forwarded and reviewed by a physician. Physician Reviewer determines whether or not service meets the requirements of emergency level 5.

L. Incidental Procedures

Updated language in boldface/strikethrough below:

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services. Incidental procedure services and supplies are considered included in **Ambulatory Patient Groups (APG) rates** ~~a global procedure charge(s)~~**.**

9.5: Third Party Liability (TPL)

Deleted "~~Plan and the Hospital facility~~" and ***replaced*** it with "**DHCS has**" language concerning the DHCS having the right to recover costs of benefits paid for treatment of the injury or illness.

Section 11: Health Education

11.2.1: Health Education Classes

Removed the following language as it is no longer valid:

For Providers Contracted with an IPA/Medical Group - Please contact the health education coordinator at your affiliated IPA/medical group to order health education materials.

Section 12: Culturally and Linguistically Appropriate Services (CLAS)

12.1: Provider Responsibility in the Provision of CLAS

V. Translation of Member-Informing and Health Education Materials

Noted that translation of member-informing and Health Education Materials are also available in alternative formats which include large print, braille, Data CD, audio CD, web-accessible, or electronic text files.

Appendix 5: Claims Compliance and Monitoring

Claims Monitoring Review Process

Deleted **and** ***replaced*** the section as follows:

In 2023, Blue Shield Promise will conduct oversight and monitoring of claims and PDR run out.

Blue Shield Promise audits include review of Delegated Entity's claims and PDR processing according to regulatory and contractual requirements, including but not limited to Section 42 CFR 447.45 as noted in the Cal MediConnect Program three-way Contract (Medicare, Medi-Cal Program). The three-way 2019 Cal MediConnect Contract between the Health Plan, Department of Health Care Services (DHCS), and Centers for Medicare & Medicaid Services (CMS) is located on the CMS website. See Sections 5.1.9 - 5.1.9.2 and 5.1.10.1. These requirements include but are not limited to timeliness of payment/denial of non-contracted provider claims, member denials, re-openings, adjustments, misdirected/forwarded claims, provider disputes, etc. **This applies to run out claims and PDRs.**

Claims Delegate Reporting Instructions

Updated required reporting and noted that reports must be submitted until run out is complete.