blue california
Promise Health Plan

3840 Kilroy Airport Way
Long Beach, CA 90806

January 22, 2025

Subject: Notification of April 2025 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 April 1, 2025.

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, 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 April 2025 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

3.3: Managed Long-Term Services and Supports (MLTSS)

3.3.2: Long-Term Care (LTC)

3.3.2.2: Bed Hold and Leave of Absence

Updated, in boldface type, the following outlined explanation of "acute hospitalization," one of the requirements for bed holds:

The following requirements shall be met:

1. Acute hospitalization for the beneficiary shall be ordered by the attending physician.
    a. **Developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries Blue Shield Promise will authorize up to a total of seven (7) calendar days per hospitalization.**

Updated, in boldface type, the following item in list of definitions for leaves of absence:

Leave of absence is defined as follows for patients who are on approved leave of absence.

1. Developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries: 73 days. **A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.**

Updated, in boldface type, the following bullet in list of reasons for which a leave of absence may be approved:

- Participation by developmentally disabled, developmentally disabled habilitative and developmentally disabled-nursing beneficiaries in an organized summer camp for developmentally disabled persons. **A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.**

3.3.2.3: Continuity of Care

Deleted the following two paragraphs with 2023 language explaining the provision of automatic continuity of care for member SNF placement:

~~Effective January 1, 2023, and through July 1, 2023, for members residing in a SNF and transitioning from Medi-Cal FFS to Medi-Cal managed care, Blue Shield Promise will automatically provide 12 months of continuity of care for the SNF placement. Automatic continuity of care means that if the member is currently residing in a SNF, they do not have to request continuity of care to continue to reside in that SNF. While members must meet medical necessity criteria for SNF services, continuity of care must be automatically applied.~~

~~Following their initial 12-month automatic continuity of care period, members may request an additional 12 months of continuity of care, following the process established by APL 22-032, Continuity of Care for Medi-Cal members Who Transition into Medi-Cal Managed Care, or any superseding APL.~~

3.7: Community Health Worker

Added, in accordance with APL 24-006, "pharmacist," to the list of possible Medi-Cal enrolled providers who can serve as a supervising provider, which employs or otherwise oversees a Community Health Worker (CHW).

Added the language below to clarify billing pathways for CHW services.

For billing, call Blue Shield Promise Customer Care to check eligibility. The following describe the billing pathways for different types of providers billing for CHW services:

- Is member part of Blue Shield Promise Long Term Care? If yes, send bill and recommendation to Blue Shield Promise.
- Is member part of the Blue Shield Promise direct network? If yes, send bill and recommendation to Blue Shield Promise.
- Is member affiliated with a delegated medical group? If yes, send bill and recommendation to the delegated medical group.

Updated, deleted and replaced table which charts CPT codes, CPT descriptions, modifiers and modifier descriptions, in order to add more detail.

Added the following bullets, listing the necessary circumstances for the CHW violence prevention services:

CHW violence prevention services are available to members who meet any of the following circumstances as determined by a licensed practitioner:

- The member has been violently injured as a result of community violence.
- The member is at significant risk of experiencing violent injury as a result of community violence.
- The member has experienced chronic exposure to community violence.

Documentation Requirements

Removed the NPI number as a required field for CHW claims.

3.8: Doula Services

Added the following bullet to the list of Doula Training Pathway criteria:

Training Pathway:

- Doulas are not required to have a certificate from a specific organization as long as they meet the Doula Minimum Qualifications as listed in the DHCS Medi-Cal Provider Manual: Doula Services. Additional information regarding enrollment is available on the Doula Application Information webpage.

Covered Services

Added, in boldface type, the following paragraph detailing covered doula visits:

All visits are limited to one per day, per Member. Only one doula can bill for a visit provided to the same Member on the same day, excluding labor and delivery. One prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. The prenatal visit or postpartum visit billed on the same calendar day as birth can be billed by a different doula.

The extended three-hour postpartum visits provided after the end of pregnancy do not require the member to meet additional criteria or receive a separate recommendation. **The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual provided on separate days.**

Billing Codes and Modifier

Updated, in boldface and strikethrough type, the following informational language concerning the proper billing codes to use:

Doulas should refer to DHCS Medi-Cal Provider Manual for Doula Services for specific billing codes to be used for each covered service~~s and should refer to the Blue Shield Promise Doula Resource Guide for instructions on how to complete the Doula Transaction Log for reimbursement.~~

Updated, in boldface and strikethrough type, the following instructional language explaining how to submit a Doula Visit Detail Log:

How to submit "Doula Visit Detail Log

Doulas should refer to the Doula Resource Guide for instructions on how to complete the Doula Visit Detail Log. Doulas can complete and submit the **log**~~form~~ to the Blue Shield Promise Doula Program office via secured email BSCPromiseDoula@blueshieldca.com.

Section 7: Utilization Management

7.1: Utilization Management Program

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Deleted and replaced with the following language concerning authorization log submission:

Approval/denial data files ("Authorization Logs") must be delivered via Provider Connection at www.blueshieldca.com/providerwebapp/authorization/IPAFileUpload using the IPA9 file layout.

- To initiate the delivery of authorization logs by means of a SFTP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com.
- If an IPA/medical group is currently submitting logs via IPA10 format, no changes are required.

7.1.3: Organization of Health Care Delivery Services

Added the following sub-section which describes Blue Shield Promise's contracted durable medical equipment provider:

Durable Medical Equipment Provider

Blue Shield Promise contracts with Western Drug Medical Supply as the exclusive source for durable medical equipment products for Medi-Cal members. Providers are required to utilize Western Drug Medical Supply for durable medical equipment products. Failure to comply with this requirement will result in denied claims.

Western Drug Medical Supply has agreed to contractual performance standards which include but are not limited to delivery timelines, member satisfaction, and referral source satisfaction to ensure ongoing consistent and high-quality service.

Please refer to Appendix 14 of this manual for a comprehensive list of products that should be obtained through Western Drug Medical Supply and contact details for this vendor.

7.4: Primary Care Physician Scope of Care

7.4.4: California Regulatory Required Programs

Deleted and replaced the entire section, which explains mandatory reporting of specific diseases, with the following:

All Blue Shield Promise providers are required to comply with California state regulations regarding the mandatory reporting of specific diseases and conditions. A list of reportable diseases, the form on which the diseases and conditions should be reported, and reporting instructions can be found on the California Department of Public Health website at www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph110a.pdf.

Please note that a health care provider's failure to report those diseases and conditions mandated by Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, 1364.10 and 1364.11). In addition, failure to report is a citable offense and subject to civil penalty ($250) per Health and Safety Code 105200. Please consult the California Department of Public Health website at www.cdph.ca.gov for additional information about California state regulations regarding the mandatory reporting of specific diseases and conditions and consult with your local county public health departments for county specific mandatory reporting information.

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

7.9.4: Comprehensive Perinatal Services Program (CPSP)

Added the following to list of recommended intervals for routine tests for pregnancy patients:

Time (Weeks Gestation)	Assessment / Service
Initial (as early as possible)	Maternal mental health screening completed at least once during the pregnancy
Initial Postpartum: –within 3 weeks following delivery AND Follow-up Comprehensive visit no later than 12 weeks after birth	Physical exam to include: 14. Screening for maternal mental health completed within the first six (6) weeks of the postpartum period.

7.9.24: Community Supports

Added, in order to align with claims submission processes going live for Community Supports in Q2 2025, the following language explaining the Community Supports claims submission process:

Submission of Claims for Community Supports Reimbursement

Providers of Community Supports services have two options for submitting claims. Claims can be submitted through a Clearinghouse or on paper using the current version of the CMS 1500 form. These methods are described in detail in Section 14.1 Claim Submission.

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

Deleted the CCS Report from the list of required Quarterly Reports.

Section 8: Encounter Data

8.1: Encounter Data - Medi-Cal

8.1.1 Compliance Guidelines

Added the following language explaining claims and encounters for administered drugs:

National Drug Code (NDC)

Blue Shield Promise validates National Drug Codes using the sources noted below. Only submit an NDC if required.

- Department of Health Care Services (DHCS) Medi-Cal Rx Approved NDC List
- US Food and Drug Administration (FDA) 240 National Drug Code Directory

Note: Blue Shield Promise requires claims and encounters reporting Physician Administered Drugs (PADs) to include both the Healthcare Common Procedure Coding System (HCPCS) code and a valid National Drug Code (NDC) for Medi-Cal members.

Services that include the use of 340B Physician Administered Drugs should be reported accurately with the proper procedure code, National Drug Code, drug unit, and drug quantity to Blue Shield Promise. The "UD" modifier must be included in one of the four available modifier positions (2400 SV101-3, 4, 5 or 6) within the electronic transmission (837).

Section 9: Quality Improvement

9.1: Quality Improvement Program

Added, to the Quality Improvement Mission Statement, the following language explaining the review, updating and approval of the quality program goals:
The quality program goals are reviewed and updated on an annual basis and approved by the appropriate committees in May of each year.

Deleted entire subsection, which detailed the individual 2024 Quality Program Goals.

Confidentiality and Conflict of Interest

Deleted and replaced language describing the Quality Management Committee responsibilities, with the following:

The Quality Management Committee is a forum to discuss development, oversight, guidance and coordination of Blue Shield Promise quality activities which require open dialogue and discussion. Members of the Committee may have access to sensitive data to further the Committee goals. Blue Shield Promise employees follow the Code of Conduct when dealing with sensitive data. External Committee members are required to sign a confidentiality statement annually.

Scope (includes but not limited to):

Updated, in boldface and strikethrough type, the following line item, in the list of activities within the scope of responsibilities for the Quality Management Committee sub-committees:

8. Reviewing reports of subcommittees **that report directly to QMC** ~~(Medical Services and Access & Availability, others reporting as necessary)~~.

9.5: Initial Health Appointment (IHA)

Added the following outline, detailing the documentation that should be included for an Initial Health Appointment (IHA):

Handwritten medical records must be signed, dated, and legible. Legibility means the record entry is readable by a person other than the writer.

Documentation of an IHA should include (but is not limited to):

1. Past medical history:
    - Prior major illnesses
    - Prior surgeries
    - Prior hospitalizations
    - Current medications
    - Allergies
    - Age appropriate dietary and feeding status
2. Social history
    - Marital and living arrangements
    - Current employment
    - Occupational history
    - Use of drugs and/or alcohol
    - Level of education
    - Sexual history
3. Mental status exam
4. Diagnoses

Procedure

Added the following line item to the list of monitoring and oversight actions that will be conducted to ensure that newly enrolled members complete an IHA within 120 days of their enrollment date:

6. To ensure that newly enrolled Blue Shield Promise members complete an IHA within 120 days of their enrollment date, Blue Shield Promise will conduct the following monitoring and oversight actions:
    d. Illegible entries on handwritten medical records will be scored as "No", indicating that there was no documentation that specified criteria was included in the IHA.

9.13: Credentialing Program

9.13.4: Credentials Process for IPA/Medical Groups

Updated item 9. with boldface type, as follows:

9. The IPA/medical group must develop and implement policy and procedures describing its credentialing system controls **or Credentialing Information Integrity** and monitoring process. (Applies to paper and electronic processes.)

9.14: Quality Improvement and Health Equity Transformation Program

9.14.1: Health Equity Office and QIHETP Structure

Updated the following bullet points in boldface and strikethrough type below:

The Blue Shield Promise HEART QIHETP governance structure includes the following at a minimum:

- The QIHEC follows internal governance structure policies and procedures to report to the **Medi-Cal Committee of the Board**, ~~Board Quality Improvement Committee (BQIC),~~ who is responsible for the approval of the QIHETP description, work plan, evaluation, and monitoring performance toward QIHETP goals. **The Medi-Cal Committee of the Board reports to the Blue Shield of California Board of Directors via consent agenda.**
- The QIHEC ~~HEO~~ includes participation of a broad range of Network Providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers in the process of the QIHETP development and performance review.

9.14.3: Continuous Quality Improvement

Updated, in boldface type, the following bullet point in list of activities to ensure the identification, evaluation, and reduction of health disparities:

- Deploying mechanisms to continuously monitor, review, evaluate, and improve access to and availability of all Covered Services. The mechanisms must include oversight processes that ensure members are able to obtain Medically Necessary appointments within established standards for time or distance, timely access, and alternative access in accordance with **APL 21-006** and W&I Code sections 14197 and 14197.04.

9.14.7: Network Provider Training

Updated language in boldface type below:

The CHEO will collaborate with Blue Shield Promise staff to ensure that the Network Provider mandatory training includes information on all member rights specified in the DHCS 2024 Managed Care Boilerplate Contract, Exhibit A, Attachment III, Section 5.1 (Member Services), and diversity, equity, and inclusion (DEI) training (sensitivity, diversity, communication skills, and cultural competency training) as specified in the DHCS 2024 Managed Care Boilerplate Contract, Exhibit A, Attachment III, Subsection 5.2.11.C (Diversity, Equity, and Inclusion Training) and detailed in **All Plan Letter (APL) 23-025 DEI Training Program Requirements.**

The mandatory Provider DEI training program requires that all new Subcontractors, Downstream Subcontractors, and Network Providers serving Blue Shield Promise members complete the training within 90 days of their start date. Ongoing DEI training is required for all Subcontractors, Downstream Subcontractors, and Network Providers serving Blue Shield Promise members during times of re-credentialing or contract renewals.

If you have any questions regarding the mandatory DEI Training Program Requirements contact BSPHealthEquity@blueshieldca.com.

9.14.8: Monitoring and Reporting

Added the following bullet point to list of monitoring and reporting activities:

- Blue Shield Promise will report on all Health Equity and Quality Measure Set (HEQMS) measures as set forth by the DMHC ~~APL 22-028 – Health Equity and Quality Measure Set and Reporting Process requirements upon request~~ APL 24-013 – Health Equity and Quality Program Policies and Requirements (6/28/2024).

Section 10: Pharmacy and Medications

10.2: Specialty Pharmaceuticals

Updated, in boldface type, the following bullet point in list of items included in AB 2420:

- injectable medications or blood products used for the treatment of hemophilia, including Hemlibra **and Hympavzi**.

Section 11: Health Education

11.6: Program Resources

11.6.4: Departments in Collaboration with Health Education

Added the following language defining the Health Equity Office:

The Health Equity Office assists the Health Education department to incorporate health equity into strategic planning, program design, and operations.

Section 12: Provider Services

12.6: Provider Network Additions (IPA/Medical Groups)

Deleted and replaced section

Blue Shield Promise maintains the following per submission and notification by contracted IPA/medical groups:

- Primary Care Physicians
- Specialty Care Physicians
- Hospitals
- Urgent Care Centers
- Federally Qualified Health Clinics (FQHC), FQHC Look-alikes (health centers that provide similar services and meet the same performance requirements as FQHCs but do not directly receive federal funding under the Health Center Program), and Indian Health Clinics

The addition of an IPA/medical group provider requires submission of a provider profile to Blue Shield Promise.

Los Angeles county Primary Care Physicians, Specialty Care Physicians, Hospitals and Urgent Care Center additions need to be submitted to Blue Shield Promise Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

Los Angeles county Federally Qualified Health Clinics additions will need to be sent to the IPA/medical groups assigned provider relations representative.

San Diego county Primary Care Physicians, Specialty Care Physicians, Hospitals, Urgent Care Center and Federally Qualified Health Clinics additions need to be submitted to Blue Shield Promise Information & Enrollment Department at BSCProviderInfo@blueshieldca.com.

Medi-Cal enrollment is required to participate in the network. New Provider Orientation (NPO) training completion is a requirement to add providers to the Medi-Cal network.

Section 13: Marketing – Medi-Cal

13.2: Prohibited Conduct

Deleted and replaced the following item in list of prohibited behaviors:

5. Marketing practices that discriminate against members or potential members on the basis of any characteristic protected by federal or state law. Protected characteristics include, without limitation: sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code Section 422.56.

Section 14: Claims

14.1: Claim Submission

Deleted and replaced item B. as follows:

B. Providers must follow the most recently updated Current Procedural Terminology (CPT) coding guidelines, National Drug Code (NDC) for drugs as well as the Healthcare Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, and Department of Health Care Services (DHCS) coding guidelines.

   National Drug Code (NDC)

   Blue Shield Promise validates National Drug Codes using the sources noted below. Only submit a NDC if required:

   - Department of Health Care Services (DHCS) Medi-Cal Rx Approved NDC List
   - US Food and Drug Administration (FDA) 240 National Drug Code Directory

   Note: Blue Shield Promise requires claims and encounters reporting Physician Administered Drugs (PADs) to include both the Healthcare Common Procedure Coding System (HCPCS) code and a valid National Drug Code (NDC) for Medi-Cal members.

   Services that include the use of 340B Physician Administered Drugs should be reported accurately with the proper procedure code, National Drug Code, drug unit, and drug quantity to Blue Promise. The "UD" modifier must be included in one of the four available modifier positions (2400 SV101-3, 4, 5 or 6) within the electronic transmission (837).

Appendices

Appendix 1: Delegation of Utilization Management Responsibilities

Updated cells in the "Delegation of Utilization Management Responsibilities Chart," which details delegated utilization management activity, IPA/group/plan responsibility as it relates to utilization management activity, performance evaluation and corrective action plans.

Appendix 2: Delegation of Credentialing Responsibilities

Updated cell in the Delegation of Credentialing Responsibilities Chart, which details delegated credentialing activity, group and plan responsibility as it relates to credentialing activity and corrective action plans.

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

Definitions

Added "Restricted Knox Keene Plan" to definition of a "Delegated Entity/Specialty Health Plan."

Audits and Audit Preparation

Updated this sub-section, which details the provider's requirements for preparation, documentation and methodology for auditing claims and provider disputes.

Updated, in boldface and strikethrough type, the timelines in a paragraph concerning the provision of audit results, as follows:

Blue Shield Promise will provide the Delegated Entity/Specialty Health Plan with written audit results within ~~30 calendar~~ **10 business** days including an itemization of any deficiencies and whether or not the Delegated Entity/Specialty Health Plan must prepare and submit a formal, written corrective action plan (to be on BSCPHP template provided by the auditor) to include root cause, remediation, and evidence of remediation within ~~14~~10 business days of receipt of audit results. If supporting documentation/evidence is not provided the CAP will be closed as non-compliant.

Appendix 13: HEDIS Guidelines

Updated numerous cells in the "HEDIS Measurements" table, which details HEDIS measures, descriptions of how the measurements will be employed and health standards/criteria.

Appendix 14: Durable Medical Equipment (DME) Supplies Included under Capitation

Added this new appendix which details DME and Medical Supplies included under Capitation.

This page intentionally left blank.