blue california
Promise Health Plan

3840 Kilroy Airport Way
Long Beach, CA 90806

October 16, 2024

Subject: **Notification of January 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 January 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 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 January 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

3.2: Basic Population Health Management (BPHM)

3.2.8: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Medi-Cal for Kids & Teens / PHM for Children

Added the words "Medi-Cal for Kids & Teens" to the title and language of this entire section, which explains the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, per DHCS APL 23-005, which requires that all references to EPSDT include the member program name "Medi-Cal for Kids & Teens."

3.6: Enhanced Care Management

Deleted section **Submission of Encounter Data for Enhanced Care Management** and replaced with the following:

Submission of Claims for Enhanced Care Management Reimbursement

Providers of ECM 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.

3.7: Community Health Worker

Updated, in boldface type, the following partial paragraph explaining the minimum requirements that CHWs must complete, per APL 24-006, released in May 2024 that supersedes APL 22-016 for the Community Health Worker Services Benefit:

In addition to one of the pathways described below, CHWs must complete a minimum of six hours of additional relevant training annually**, which can be in the core competencies or specialty area**…

Updated paragraph explaining a supervising provider's oversight of CHWs, per APL 24-006, as follows:

Supervising Provider Requirements and Qualifications

A supervising provider is an enrolled Medi-Cal provider employing or otherwise overseeing the CHW, with whom Blue Shield Promise contracts. The supervising provider ensures that CHWs meet the qualifications listed above, oversees CHWs and the services delivered to Blue Shield Promise Members, and submits claims for services provided by CHWs. The supervising provider must be a licensed provider, a hospital, including the emergency department, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

The supervising provider is not required to have a licensed provider on staff in order to contract with Blue Shield Promise to bill for CHW services…

Updated the following sub-section explaining the recommendation requirement for CHW services, per APL 24-006, in boldface type:

Member Eligibility Criteria for CHW Services

CHW services require a written recommendation submitted to Blue Shield Promise via the Community Health Worker Referral Form. Written recommendations will be sent to Blue Shield Promise Social Service Department via fax at (844) 742-1152 by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. **For CHW services rendered in the Emergency Department, the treating Provider may verbally recommend CHWs to initiate services and later document the recommendation in the member's medical record of the Emergency Department visit. The recommending licensed provider does not need to be: 1) Enrolled in Medi-Cal, 2) A network provider with Blue Shield Promise, or 3) Employed by the supervising provider.** Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists. **The required recommendation can be provided by written recommendation placed in the member's record or a standing recommendation by Blue Shield Promise based on eligibility criteria for CHW services as described in this manual.**

Updated the following paragraph discussing a supervising provider's submission of CHW services, per APL 24-006, in boldface type and strikethrough:

Claims for CHW services must be submitted by the Supervising Provider with allowable current procedural terminology **(CPT)** codes and modifier(s) as outlined below. CHW services must be reimbursed through a CHW Supervising Provider in accordance with its provider contract ~~unless reimbursed directly through Blue Shield Promise if the CHW is a contracted Medi-Cal enrolled provider~~...

Inserted entire sub-section with information about how tribal clinics can bill for CHW services and Blue Shield having policies for a billing pathway for supervising providers, in accordance with APL 24-006.

Updated the following paragraph explaining the procedure for obtaining multiple or ongoing CHW services, per APL 24-006, in boldface type and strikethrough:

Plan of Care

For Blue Shield Promise Members who need multiple ongoing CHW services or continued CHW services after a) 12 units of service within one year from initial CHW preventative service date or b) when exceeding the daily maximum units of four (4) units per day, a written care plan must be written by one or more individual licensed providers, **with the exception of services provided in the emergency department. Licensed providers** ~~which~~ may include the recommending provider and other licensed providers affiliated with the CHW Supervising Provider. **The provider ordering the plan of care does not need to be the same provider who initially recommended CHW services or the supervising provider for CHW services...**

Renumbered sections, starting with 7.9.17, as three new sections were added.

7.1: Utilization Management Program

7.1.2: UM Reporting Requirements for IPA/Medical Groups

Added the following bullet point in list of criteria by which authorization logs must be sent:

- Approval/denial data files ("Authorization Logs") must be delivered via Provider Connection Portal (www.blueshieldca.com/providerwebapp/authorization/IPAFileUpload) using IPA9 file format or Secure File Transfer Protocol (SFTP) file to Blue Shield using the IPA10 file layout.

Deleted and ***replaced*** the required data elements that must appear on the Authorization Log.

7.1.6: Review Criteria

Added "Inpatient Readmissions" to the list of Blue Shield Promise Utilization Management Program functions.

7.4: Primary Care Physician Scope of Care

7.4.1: Early Periodic, Screening, Diagnostic, and Treatment (EPSDT)/Medi-Cal for Kids & Teens

Added the words "Medi-Cal for Kids & Teens" to the acronym "EPSDT" or the acronym "EPSDT" to the words "Medi-Cal for Kids & Teens," throughout this section, per DHCS APL 23-005, which requires that all references to EPSDT include the member program name "Medi-Cal for Kids & Teens."

7.4.3: Child Health and Disability Prevention Program (CHDP)

Deleted and ***replaced*** this section, which details the CHDP Program, which provides low-income children under 21 years of age complete health assessments for the early detection and prevention of disease and disability.

7.7: Authorization Denials, Deferrals, and Modifications

Updated, in boldface type, the following bullet point in list of provisions, according to which the plan will send notifications of authorization request determinations, according to a regulatory requirement:

Blue Shield Promise or the delegated IPA/medical group will send written notification of an authorization request denial, deferral, and/or modification to the member, the member's PCP, and/or attending physicians according to the provisions below:

- The PCP and/or the requesting provider will be **notified within 24 hours of determination; and** sent a written or electronic confirmation within two (2) working days of the determination.

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

7.9.4: Comprehensive Perinatal Services Program (CPSP)

Updated numerous cells within the CPSP chart, which delineates recommended intervals for routine tests for patients during pregnancy, based on weeks of gestation and assessment/service.

Removed "CHDP" from bullet point in list of conditions/issues requiring Social Work Referrals.

7.9.17: Enteral Nutrition

Added, renumbered and ***updated*** this entire new section, explaining how medically necessary enteral nutrition products shall be sent from the pharmacy provider to the Medi-Cal Rx vendor in boldface type, as follows:

Medically Necessary Enteral Nutrition Products shall be sent from the pharmacy provider ~~to~~ **are primarily reviewed and authorized by** the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (Magellan). **However, the service may be provided through the medical benefit through an authorization process when the Medi-Cal Rx approved List of Enteral Nutrition Products does not meet the member's needs. Medical necessity must be documented for products not covered through the Medi-Cal Rx benefit.**

7.9.18: Cancer Screening

Removed language discussing how prior authorization is not required for biomarker testing and ***placed*** it into renumbered Section 7.9.19 (Biomarker Testing).

7.9.19: Biomarker Testing

Added this entire renumbered section, which explains Biomarker Testing and its coverage.

7.9.20: Pharmacogenomic Testing

Added this entire renumbered section, which explains Pharmacogenomic Testing and its coverage.

7.9.21: Cancer Clinical Trials

Added the following language and bullet points to this renumbered Section, discussing prior authorization documentation for Cancer Clinical Trials:

Submitted prior authorization documentation of medical necessity should include the "Medicaid Attestation Form on the Appropriateness of the Qualifying Clinical Trial" for authorization of the clinical trial. The attestation form must include the following information:

- The member's name and client identification number;
- The national clinical trial number;
- A statement signed by the principal investigator attesting to the appropriateness of the qualified clinical trial; and
- A statement signed by the provider attesting to the appropriateness of the qualified clinical trial.

Section 8: Encounter Data

8.1: Encounter Data - Medi-Cal

8.1.1 Compliance Guidelines

Added the following language explaining Federally Qualified Health Centers' (FQHCs) participation in Alternate Payment Methodology (APM) programs:

Federally Qualified Health Centers (FQHCs)

Federally Qualified Health Centers (FQHCs) participating in Alternate Payment Methodology (APM) program must conform with the Department of Health Care Services (DHCS) FQHC APM Program Guide for Encounter Data.

Section 9: Quality Improvement

9.1: Quality Improvement Program

Added the following bullet point to list of objectives to reach the goal of delivering an exceptional quality program:

2024 Quality Program Goals

Objectives:

- Meet or exceed the minimum performance requirements in all quality metrics and performance standards under the Alternative Payment Model (APM) for enrolled Federally Qualified Health Centers (FQHC).

9.1.3: Quality Improvement Process

Removed the following data sources from list that Blue Shield Promise uses to uses to monitor, analyze, and evaluate quality improvement goals and objectives:

- Centers for Medicare & Medicaid Service (CMS) Core Measures
- Dental Quality Alliance Measure (DQA)
- Clinical Action Registry Report

9.5: Initial Health Appointment (IHA)

Updated the following bullet points in list of items that an IHA includes, as follows:

A. Health Assessments for members under 21 years of age in accordance with the AAP/Bright Futures Periodicity Schedule must include, at a minimum:
   - Documented referral to the Women, Infants, and Children (WIC) Program for breastfeeding, postpartum women, or parent/guardian of children under the age of 5 years.

B. The IHA Health Appointments for Asymptomatic members 21 years of age and older must include, at a minimum:
   - Mammography screening for breast cancer is completed every 2 years on all women starting at age 40 and continuing through age 74 unless pathology has been demonstrated.

- Intimate Partner Violence (IPV) Screening and the provision of ongoing support services for anyone who screens positive.
- Health education and anticipatory guidance appropriate to age and health statistics.
    - Documented referral to the Women, Infants, and Children (WIC) Program for breastfeeding, postpartum women, or parent/guardian of children under the age of 5 years.

Updated following items in list of manners by which Blue Shield Promise will coordinate with providers to ensure that members receive an IHA, in strikethrough and boldface type:

Procedure

4. To ensure that newly enrolled Blue Shield Promise members obtain an IHA with their new PCP within 120 days of enrollment, Blue Shield Promise will coordinate with our members and providers as follows:
    a. Blue Shield Promise will make ~~a minimum of two documented attempts, with at least one phone call and one written attempt,~~ **reasonable attempts** to contact each new member to schedule the timely IHA.
9. If a new member cancels an IHA or does not show up for the IHA ~~, at least 3 outreach attempts to the member must be conducted by~~ the PCP **must make reasonable attempts to contact the member** to reschedule the appointment. All PCP outreach to the member must be documented in the member's medical record.
10. Blue Shield Promise will monitor PCP documentation of the PCPs compliance with the requirement for the PCP to make ~~at least 3 outreach~~ **reasonable** attempts to **contact** a new member ~~within 48 hours of a new member canceling or not showing~~ **who has cancelled or did not show** up for an IHA, via randomized medical record reviews conducted on a quarterly basis.

9.6: Facility Site Review

9.6.1: FSR Evaluation

Replaced item numbers 13 and 14 regarding CAP requirements with the following.

Procedure

13. Blue Shield Promise Facility Site Review Unit will follow the established CAP timeline for CAP notification and completion as outlined in DHCS APL 22-017, or most current version.
14. Providers that do not come into compliance with review criteria and CAP requirements within the established timelines may be removed from the network. Their members may also be expeditiously reassigned to other network providers.

9.7: Medical Records

9.7.1: Policy

Removed the reference to DHCS Policy Letter 14-004, Attachment B and DHCS All Plan Letter 22-017 or the most current version.

9.7.2: Procedure

Added number 10 and ***replaced*** item numbers 11 through 18 regarding CAP requirements with 13 and 14 below:

10. Practitioners/providers that score below 80% in the FSR or MRR for two consecutive reviews must score a minimum of 80% for both FSR and MRR in the next review. Sites that don't score a minimum of 80% will be removed from the network for a period of three years, and the provider's members will be appropriately reassigned.

13. Blue Shield Promise Facility Site Review unit will follow the established CAP timeline for CAP notification and completion as outlined in DHCS APL 22-017, or most current version.

14. Providers that do not come into compliance with review criteria and CAP requirements within the established timelines may be removed from the network. Their members may also be expeditiously reassigned to other network providers.

9.7.3: Medical Record Review Categories

Added "Risk Assessment" to requirements for **IV. Pediatric Preventive Criteria** and **V. Adult Preventive Criteria.**

9.8: Access to Care

9.8.2: Subcontracted Network Certification Requirement

Added "Doulas" to the grid listing mandatory provider types that subcontracted networks must have in order to meet network adequacy requirements for the subcontracted network.

9.12: HEDIS Measurements

Updated, in boldface type, the following paragraph explaining the use of performance data for quality improvement activities:

Use of Practitioners/Providers Performance Data

Practitioners and providers will allow Blue Shield Promise to use performance data for quality improvement activities (e.g., HEDIS, clinical performance data). Providers are expected to meet or exceed the 50th percentile for all DHCS Managed Care Accountability Set (MCAS). **If the contracted provider is a Federally Qualified Health Center (FQHC) enrolled in the Alternative Payment Model (APM) program, the FQHC is expected to meet or exceed the thresholds for minimum performance set forth by the APM program specifications.** Blue Shield Promise will also share member experience and Clinical Performance data with practitioners and providers when requested. Requests should be submitted via email to your Quality Program Manager.

Blue Shield Promise can assist providers in improving performance on quality measures. Various tools and resources are available, including **Clinical Action Registry Report and our** HEDIS tip sheets. To obtain these resources and for the most current descriptions and list of HEDIS and MCAS measures, contact your Quality Program Manager.

9.13: Credentialing Program

Added, under Scope, Chiropractors and Doulas to list of practitioners who are required to be credentialed.

9.13.2: Minimum Credentials Criteria

Updated, in boldface type, the following paragraph discussing license renewals:

License renewals are verified with the licensing board within 30 days of the expiration date. The DEA renewals are verified from the U.S. Drug Enforcement Administration or by an updated copy from the provider **In scope practitioners that are required to have a DEA and do not currently prescribe would be required to submit documentation that they do not prescribe and provide a covering physician who can subscribe on their behalf. If the practitioner states in writing they do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances, they are therefore not required to have a DEA certificate but must describe their process for handling instances when a patient requires a controlled substance.** Malpractice insurance renewals are verified by an updated copy of the certificate from the provider.

Blue Shield Promise will adhere to the California Business and Professional Codes requirements for submitting 805 and 805.01 reports to the Medical Board of California and to the Healthcare Quality Improvement Act of 1986 for reporting to the National Practitioner Data Bank and to the State Medical Board.

Added "Ambulatory Surgery Centers" to the list of health delivery organizations (HDO) that Blue Shield Promise will re- evaluate, prior to contracting with them, and at least every three (3) years thereafter.

9.13.3: Specialty Credentialing Specifications

Added language detailing the requirements to meet for practicing as a doula, which include eligibility requirements and alternative learning "Pathways."

Section 10: Pharmacy and Medications

10.2: Specialty Pharmaceuticals

Updated several items in list of procedural activities involved with prescribing specialty pharmaceuticals, in boldface type below:

Procedure

IPA/Medical Groups Not Retaining Specialty Pharmaceutical Risk and Blue Shield Promise Directly Contracted Physicians

2. Physicians who plan to prescribe a specialty pharmaceutical will submit a prior authorization request to the Blue Shield Promise Pharmacy Department. Physicians may obtain a prior authorization form by calling the Blue Shield Promise. **The completed prior authorization form should be faxed to (866) 712-2731.**
5. The Blue Shield Promise Pharmacy Department will notify the provider, member, and the specialty pharmacy in writing of the medication approval. Letters of approval will be mailed to the Blue Shield Promise member and a copy will be faxed to the provider. The **servicing provider or** specialty pharmacy will receive a faxed copy of the approved prior authorization form.
9. If applicable, **the servicing provider or** specialty pharmacy will be responsible for verifying ongoing member eligibility and an IPA/medical group assignment for all new and refill

prescriptions. If the member is no longer eligible with Blue Shield Promise, then subsequent authorizations and dispensing of the specialty pharmaceutical will be based on the procedures established by the newly assigned health plan.

10. Approval notices for specialty pharmaceuticals will include the specific medication NDC (National Drug Code) and the HCPCS (Health Care Common Procedure Coding System). All claims should be billed utilizing the appropriate NDC code **and JW modifier indicator single dose container drug waste as appropriate.** A manual HCFA 1500 claim with NDC, HCPCS, **and or JW modifier** may be subsequently submitted to Blue Shield Promise for reimbursement.

Section 14: Claims

14.2: Claims Processing Overview

Added the following items in list of claims processing activities and ***re-lettered*** remaining items:

K. Inpatient Hospital Claims – Readmissions

Blue Shield Promise does not allow separate reimbursement for inpatient claims that have been identified as a readmission to the same hospital within 30 days of discharge for the same, similar, or related condition unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Blue Shield Promise views repeat, non-separately reimbursable, and planned readmissions as part of a single episode of care, for which only one DRG (Diagnosis Related Group)/Per diem payment is issued. Both the initial admission and the subsequent readmission are considered fully covered by the payment made for the first admission.

The following readmissions are excluded from 30-day readmission review:

1. Transfers from out-of-network to in-network facilities.
2. Transfers of patients to receive care not available at the first facility.
3. Readmissions that are planned for repetitive or staged treatments, such as cancer, chemotherapy, or staged surgical procedures.
4. Admissions to Skilled Nursing Facilities, Long Term Acute Care Facilities, and Inpatient Rehabilitation Facilities.
5. Obstetrical readmissions.
6. Readmissions greater than 30 days from the date of discharge from first admission.

M. Alternate Payment Methodology (APM) Program

Federally Qualified Health Centers (FQHCs) participating in Alternate Payment Methodology (APM) program must conform with the DHCS FQHC APM Program Guide for Claims Data.

Section 16: Regulatory, Compliance, and Anti-Fraud

16.5: Sensitive Health Information

Added, in compliance with AB 352, this entire new section, which explains health information-standards for the storage and sharing of specified sensitive services records.

Under California's existing Reproductive Privacy Act and the Confidentiality of Medical Information Act (CMIA), individuals have a fundamental right to privacy regarding their reproductive/medical decisions. Unauthorized disclosure of medical information is generally prohibited. California Assembly Bill 352 (AB 352) introduced significant changes to how Health Insurance Companies, Managed Health Care Organizations and their downstream/related entities are required to handle sensitive health information, including but not limited to reproductive health, abortion, and transgender services.

AB 352 expands the previously existing privacy requirements, specifying that on or before July 1, 2024, electronic health record (EHR) systems that store such information are required to adhere to additional provisions regarding medical information related to gender-affirming care, abortion and abortion-related services, and contraception ("sensitive services.").

Specifically, EHR systems that collect and store data on behalf of providers and other organizations are required to:

- Ensure limited user access to all medical information, such that, specific medical information related to sensitive services is only accessible to the parties that are authorized to access that specific information.
- Prevent disclosure, access, transfer, transmission, or processing of sensitive services medical information to any person or entities outside of California.
- Segregate and differentiate any medical information related to sensitive services in a patient's record.
- Automatically disable access to any segregated medical information related to sensitive services by individuals and entities in any other state.

By law, Blue Promise and providers must comply with these requirements. As such, Blue Shield Promise expects that providers have systems and processes in place to address data sharing/disclosure requirements.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.4: Cultural Competency and Health Equity Training

Updated and ***added*** the following language regarding free provider trainings in Cultural Awareness:

Additional free provider trainings and webinars are available on our Cultural Awareness and Linguistics Program webpage at www.blueshieldca.com/en/bsp/providers/programs/cultural-linguistics.

Update Your Information

Easily and securely update your information on Blue Shield's provider portal, Provider Connection at www.blueshieldca.com/provider. If you have not already registered for an account on Provider Connection, click on *Log In/Register* at the top right of the screen and follow the prompts to set up your new account. Once you have created an account, you can share your race, ethnicity, and language information with us by navigating to the *Provider & Practitioner Profiles* section under the *Account Management* heading at the top. This information helps us understand and support our members' specific needs and preference within our network and is displayed on our *Find a Doctor* webpage.

Added, in compliance with SB 923 Gender Affirming Care, the following item in list of Blue Shield Promise Health Plan and Subcontractor responsibilities:

Blue Shield Promise Health Plan and Subcontractor responsibilities include:

5. Beginning January 2025, all contracted providers will be required to complete training on advancing health equity and will cover a variety of topics, including implicit bias, culturally and linguistically appropriate practices, diversity, equity, and inclusion, gender-affirming care, and more. This training will meet mandated requirements and will be reviewed annually to determine if there are any updated mandates. Once the training is finalized, a link to access the training will be provided to you.

Appendices

Appendix 2: Delegation of Credentialing Responsibilities

Updated numerous cells in the Delegation of Credentialing Responsibilities Chart, which details delegated credentialing activity, IPA/group/plan responsibility as it relates to credentialing activity, performance evaluation and corrective action plans.

Appendix 4: Access to Care Standards

Deleted and ***replaced*** the Long-Term Services and Support Access to Care Standards Attachment B with the following:

Provider Type	Timely Access Standard by County Size			
	Rural	Small	Medium	Dense
Skilled Nursing Facility	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request
Subacute Care Facility	Within 14 calendar days of request	Within 14 calendar days of request	Within 7 business days of request	Within 5 business days of request

Appendix 13: HEDIS Guidelines

Updated the HEDIS Measurements Chart, which details treatment measures, treatment description and treatment criteria.