blue california
Promise Health Plan

3840 Kilroy Airport Way
Long Beach, CA 90806

April 23, 2025

Subject: **Notification of July 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 July 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 July 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)

3.3.2.1: Accessing LTC Services

Added the following language regarding an authorization request for Medi-Cal long-term care, in accordance with the MC 171 Requirement:

A Blue Shield Promise authorization request for Medi-Cal long-term care must be submitted on our long-term care treatment authorization request (LTC TAR) form, along with the information listed below, to request an initial approval.

1. Face sheet
2. Name of physician(s)
3. State treatment authorization request
4. Preadmission screening resident review (PASARR)
5. Durable Power of Attorney (DPOA) and/or Delegation of Parental Authorization (DOPA), if any
6. Interdisciplinary team meeting notes
7. Medication list
8. Specialty list
9. Minimum DATA SET Assessment
10. Current history and physical or physician's progress notes
11. Medi-Cal Long-Term Care Facility Admission and Discharge Notification (MC 171)
12. Certification for Special Treatment Program Services form HS231, if requesting intermediate care facility/developmentally disabled (ICF/DD)

3.7: Community Health Worker

3.7.1 Asthma Preventive Services

Deleted and replaced, to come into alignment with APL 24-006, this entire section and subsection, which delineates community health workers' duties, requirements, qualifications and services.

3.10: Street Medicine

3.10.5: Provider Billing and Reimbursement

Updated, in strikethrough type, the following language explaining how a Street Medicine provider bills for services:

Street Medicine Providers rendering services to Blue Shield Promise eligible individuals are to bill Blue Shield Promise based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street Medicine Providers must comply with the billing provisions for Street Medicine Providers as applicable in FFS, including but not limited to, the Medi-Cal Provider Manual. For the Provider to be reimbursed for Street Medicine Services, the

Provider must bill using ~~diagnosis code Z59.02 (Unsheltered Homelessness) and~~ Place of Service Code 27 (Outreach Site/Street).

3.11: Non-Specialty Mental Health Services (Medi-Cal Managed Care)

Added, in accordance with the CoHC initiative Payment Integrity Project, the following language explaining the policy to deny payment of Psychotherapy add-ons, when coupled with specific high-level E/M codes:

Payment Integrity Policy:

Blue Shield Promise will deny payment of Psychotherapy add-on codes 90833, 90836 and 90838, when billed with the high-level E/M codes 99204, 99205, 99214 or 99215, for the same member, by the same provider and on the same date of service, as it is unlikely that the combined time for both services would be significant enough to allow separate reimbursement.

Section 6: Grievances, Appeals, and Disputes

6.1: Member Grievances

Updated, in boldface type, the following paragraph explaining the provider protocol after receiving a member grievance:

Procedure

Members are encouraged to speak with their IPA/medical group/PCP regarding any questions or concerns they may have. **If the PCP, IPA/Medical group receives any member grievance, within 48 hours, they are required to forward to the Health Plan all records and member interaction details related to the grievance supporting the Plan's timely resolution of the grievance.**

6.2: Member Appeals Requests

Added the following language explaining the provider protocol after receiving a member appeal:

If the PCP, IPA/Medical group receives any member appeal, within 48 hours, they are required to forward to the Health Plan all records and member interaction details related to the appeal supporting the Plan's timely resolution of the appeal.

Section 7: Utilization Management

7.8: Referrals

7.8.3: Direct OB/GYN Access

Updated, in boldface type, the following language explaining a provider's requirement to provide mental health screening during pregnancy:

Providers may visit the Blue Shield Promise provider website Maternal Mental Health Services Program link at https://www.blueshieldca.com/en/bsp/providers/programs/maternal-mental-health-program to view information on required frequency of maternal mental health screenings, approved screening tools, and the appropriate codes to submit with encounters data once the screening has occurred. **Blue Shield Promise must ensure that providers conduct at least one mental health screening during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings as necessary.**

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

7.9.6: Sensitive Services

Added, in accordance with AB 2843, the following language, which defines "sensitive services.":

Sensitive Services

"Sensitive services" are health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, intimate partner violence, and rape or sexual assault.

7.9.12: Organ Transplant

Updated, in strikethrough type, the following language concerning MOT benefit delivery:

Blue Shield Promise will refer, coordinate, and authorize the delivery of the MOT benefit and all medically necessary services associated with MOTs ~~up to 180 days post-transplant~~ including, but not limited to:

- Care coordination
- Discharge planning
- Hospitalization
- Medications
- Organ procurement costs
- Post-operative services
- Pre-transplantation assessments and appointments
- Readmissions from complications
- Surgery

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

Updated, in boldface and strikethrough type, the following list of delegated UM reporting requirements:

Monthly Reporting Requirements

Reports due to Blue Shield Promise by the 15th of the month following the month in which services were rendered or denials made, and include the following:

1. Authorization Turnaround Time Tracking Report – Include authorization, member name, requested date, approval date, provider notification date, diagnosis, and requested services.
2. ~~Denials and Modifications – Include all Denial and Modification numbers, member name, requested date, decision date, provider notification date, and requested services.~~
3. Denials and Modifications – Include a complete copy of denial/modification letter, authorization/referral, doctor's notes, criteria used, and a copy of the DMHC self-addressed envelope. **Ensure the file contains the member's name, requested date, provider notification date, and requested services.**

9.3: Clinician and Member Satisfaction Surveys

Deleted and replaced the summary to include the expanded areas assessed by the Clinician Satisfaction survey.

9.5: Initial Health Appointment (IHA)

Updated, in boldface and strikethrough type, the following bullet points in list of services that an IHA must include:

- Obesity Screening. **Children and adolescents ages 6 and older with a high BMI should be provided with or referred to comprehensive, intensive behavioral interventions.**
- Cervical Cancer screen (Pap smear) for women beginning at the age 21-65 ~~of~~ **or** first sexual intercourse and once every 3 years, or for women ages 30 to 65 who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) co-testing every 5 years.
- Immunizations administered as recommended by the current ACIP and CDC schedules and reported to California Immunization Registry (CAIR**2**) within 14 **calendar** days of immunization.

Updated, in boldface and strikethrough type, the following items in list of IHA procedures:

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:
    c. Blue Shield Promise will notify PCPs of the requirement to schedule IHAs for newly enrolled members within 120 days of enrollment through the Blue Shield Promise Provider Manual, provider newsletters, Provider Connection, provider websites and **fax blasts**~~, and telephone calls.~~
    ~~d. Blue Shield Promise will provide monthly eligibility lists to the PCPs notifying them of their newly assigned members and reminding them of the requirements to conduct a timely IHA.~~
5. To ensure that newly enrolled Blue Shield Promise members obtain an IHA within 120 days of their enrollment date, PCPs are responsible for the following actions:
    a. ~~Upon receiving an updated eligibility list from~~ Blue Shield Promise~~,~~ PCP offices are required to contact new members by email, letter, and/or telephone to assess the current need for an IHA, and to schedule an IHA for the member within the required 120 days of enrollment, if warranted.

9.13: Credentialing Program

Updated, in boldface and strikethrough type, the following bullet point in list of Credentials Committee responsibilities:

The responsibilities of the Credentials Committee include but are not limited to:

- Review and recommend actions for all network practitioners/providers identified with sanction activities from **a**~~the~~ state licensing agency, Preclusion list, Medi-Cal Suspended and Ineligible list, **the System Award for Management (**SAM**)**, ~~CHHS (Medi-Cal Enrollment)~~ and **the Office of Inspector General (**OIG**)**.

9.13: Credentialing Program

9.13.1: Credentials Process for Directly Contracted Physicians

Added the following non-discrimination language:

Applications include questions/fields regarding the practitioner's race, ethnicity and language, and providing the information is optional. Applications include a statement that the organization does not discriminate or base credentialing decisions on the applicant's race, ethnicity or language.

Updated, in boldface and strikethrough type, Number 4 in list of additional items that must be provided in the application process for directly contracted physicians:

In addition to completing an initial application, the practitioner must provide:

4. **Work history, which covers the most recent five (5) years as a health professional. Documentation should include month and year for each position with no gaps in employment or include an explanation for any gaps greater than six (6) months. Work history can be documented on the credentialing application or on a curriculum vitae (CV)**. ~~A current curriculum vitae (CV) for the previous 5 years as a health professional. Include month and year with no gaps or written explanation of any discrepancy or gaps greater than 6 months.~~

Updated, in boldface and strikethrough type, the following language explaining the application process for directly contracted physicians:

~~Upon receipt of a completed application~~, Blue Shield Promise **will confirm receipt and completeness of**~~or~~ Behavior Health/Mental Health/Substance Abuse practitioners/providers**'** ~~will confirm receipt and completeness of~~ application within 7 business days and complete **the** review ~~of application~~ within 60 days~~of receipt~~ Blue Shield Promise will obtain and verify the information in accordance with its policies and procedures. If the required supporting documents are missing or the documents with signature pages are dated more than three months prior to the receipt of a completed application, the Credentialing Department will contact the applicant for the missing information. Failure to submit the information after the third attempt will be considered a voluntary withdrawal of the application.

~~An initial facility site review/medical record review of all PCP offices are required prior to inclusion into the Blue Shield Promise network. This will be a structured visit, in accordance with the QI facility site review and medical record procedures. The FSR must be conducted prior to the initial credentialing decision and every three (3) years thereafter.~~

Upon completion of the credentialing verification process, a report summarizing each applicant's credentials is forwarded to the Credential**ings** Committee **Chair or Credentialing Committee** for review and action. If the Committee recommends denial, limitation, suspension, or termination of membership based on a medical disciplinary cause or reason, the practitioner shall be entitled to a formal hearing pursuant to the Fair Hearing policy. The Fair Hearing policy does not apply to mid-level practitioners **except as required by applicable laws**.

~~A report of the Credentialing activity is forwarded to the Quality Management Committee for approval.~~ The Credentialing Committee's approval date is considered as the final credentialing approval date. **Practitioners are notified of the credentialing decision within thirty (30) calendar days.**

The Quality Management Committee receives reports on credentialing activities on a quarterly basis.

9.13.2: Minimum Credentials Criteria

Deleted and replaced a large section of language delineating how providers will be credentialed and recredentialed.

Updated, in boldface type, the following sentence concerning minimum credentials criteria:

Credentialing Time Limit

The primary source verifications must be completed **within 120 calendar days**, and the provider's attestation must be signed and dated within 180 calendar days prior to the Credentialing Committee decision.

Deleted and replaced a large section of language concerning the protection of the confidentiality of credentialing information, researching to determine whether or not sanctions have been placed against providers, reviewing and monitoring sanctions, monitoring the practitioner for license, DEA, and malpractice insurance expiration dates and administrative disciplinary actions.

Updated, in boldface and strikethrough type, Item C, which explains the recredentialing process for ICF-DD Homes:

C. Re-credentialing is to occur every **three**~~two~~ years through re-submission of an ICF/DD Attestation. If an ICF/DD Home has a change to any requirement attested to between the years ICF/DD Homes are to be re-credentialed, an ICF/DD Home must report that change to their MCPs along with any required documentation within 90 days of when the change occurred.

9.13.3: Specialty Credentialing Specifications

Updated, in strikethrough type, the following bullet point in a list of appropriately trained personnel who can offer PCP services:

- OB/GYN practitioners ~~with at least one year of a stateside rotating internship in primary care medicine and attest to practicing primary care medicine for the last 5 years.~~

9.13.4: Credentials Process for IPA/Medical Groups and delegated entities

Deleted and replaced this entire section which details IPA/medical groups' and delegated entities' credentialing processes, recredentialing standards, corrective action plans, credentialing quarterly reports, protection of credentialing information integrity, credentialing documentation, policies against fraudulent updates, audits analysis and processing of member complaints.

Updated this entire section which details IPA/medical groups' and delegated entities' credentialing processes, recredentialing standards, corrective action plans, credentialing quarterly reports, protection of credentialing information integrity, credentialing documentation, policies against fraudulent updates, audits analysis and processing of member complaints.

Section 12: Provider Services

12.2: Provider Orientations

Updated, in boldface and strikethrough type, the following paragraph discussing orientations for providers:

Orientations are conducted by the Provider Services staff to educate new IPA/medical groups, hospitals, ancillary providers, and Blue Shield Promise directly contracted providers on Plan operations and policies and procedures within t**hirty**~~en~~ (**3**~~1~~0) business days of placing a provider on active status. Direct network providers must have completed training before entering provider into Blue Shield Promise network and/or provider directory. Training must have been conducted within the past **24**~~12~~ months of being added to the Medi-Cal network. If the provider is not available for an in-person orientation, the New Provider Orientation (NPO) will be conducted telephonically, WebEx, or via a self-directed online module.

Updated, by replacing 10 days/business days with 30 days/business days, throughout paragraph discussing IPA/medical groups' responsibilities to conduct orientation and training for providers, within 30 business days.

Section 13: Marketing – Medi-Cal

13.3: Monitoring Provider Marketing Material Development/Usage/ Activity Guidelines

Updated, in compliance with the L.A. Care audit CAP, the following number items in the list of activities providers are required to do when using the Blue Shield Promise Health Plan name/logo, in boldface type:

1. Providers must submit one (1) set of materials**, including a reading level assessment,** to Blue Shield Promise for review and approval prior to use **through the appropriate Medical Group or Independent Physicians Association (IPA) Administrator or health plan contract administrator:**

4. **The Blue Shield Promise and regulatory review and approval process may take 90 days or more to complete.**

Section 14: Claims

14.2: Claims Processing Overview

Added, in accordance with AB 2843, the following language explaining claims submission restrictions for specific "sensitive services.":

Claims submitted for services related to rape and/or sexual assault are excluded from any cost sharing (pursuant to AB 2843). Blue Shield Promise is prohibited from requiring that a police report be filed, for charges to be brought against the assailant, or for an assailant to be convicted; to provide the covered services.

Added the following item number to list of readmissions that are excluded from 30-day readmission review:

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

7. Readmission claims billed with discharge status code 07, indicating member left against medical advice.

Section 15: Financial

15.3: Medical Loss Ratio Requirements for Subcontractors and Downstream Contractors

Updated, in accordance with APL 24-018 Medical Loss Ratio (MLR) Requirements, the entire section to discuss Blue Shield's policy to comply with all applicable laws and regulations for subcontractors and downstream contractors and establish standards for reporting and remittance.

Section 17: Culturally and Linguistically Appropriate Services (CLAS)

17.8: IPA/Medical Group Monitoring and Reporting Requirements

Deleted, replaced and updated this entire section discussing medical groups' requirement to participate in Cultural and Linguistics activities, Blue Shield Promise's commitment to monitor documents, Blue Shield Promise's responsibility for provider education and medical groups' responsibility to submit reports.

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 cells 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 4: Access to Care Standards

Updated, in boldface type, the following cell in chart that details standards for care access, based on type of care, compared to the Blue Shield Promise standard for that type of care:

Type of Care and Service	Blue Shield Promise Health Plan Standard
After-Hour Instruction for Life-Threatening Emergency (when office is closed)	Life-threatening emergency instruction should state: "If this is a life-threatening emergency, hang up and dial 911 **or go to the nearest emergency room."**

Appendix 10: Community Supports Eligibility Criteria and Restrictions/Limitations Guide Definitions

Updated, deleted and replaced, in accordance with Community Supports: Select Service Definition Updates: https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-February-2025-Service-Definition-Updates.pdf, language in the "Community Supports Services and Eligibility Criteria and Restrictions/Limitations Guide ." Updates were made to the introductory paragraph, Section B "Medically Tailored Meals/Medically-Supportive Food," Section B "Asthma Remediation," Section B "Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities" and Section B "Community Transition Services/Nursing Facility Transition to a Home."