Blue Shield of California
Promise Health Plan

Nursing Facilities Reference Guide

A reference guide for nursing facility providers

April 2024

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Purpose

Blue Shield of California Promise Health Plan (Blue Shield Promise) provides this Nursing Facilities Reference Guide as a resource for nursing facility providers.

Verifying Member Eligibility

Providers may register and verify eligibility using the Blue Shield Promise's provider website at www.blueshieldca.com/en/bsp/providers. Eligibility may also be verified by contacting Blue Shield Promise Provider Customer Service at (800) 468-9935.

Access to the Blue Shield Promise Website

Contracted providers have access to the Blue Shield Promise's provider website at www.blueshieldca.com/en/bsp/providers. Non-contracted providers may access the portal (part of the website that requires login) by registering and establishing a username and password. To register, contact Blue Shield Promise Provider Customer Service at (800) 468-9935.

Skilled Nursing Benefit Period

Medicare defines the Skilled Nursing Facility (SNF) Benefit Period (Benefit Period) as up to one hundred (100) days of post-acute inpatient skilled nursing level of care. Such Benefit Period resets to the maximum of one hundred (100) days after the Member has had at least sixty (60) consecutive days lapse without either an acute inpatient admission and/or post-acute skilled nursing facility day.

Determining Responsible Party for Authorization and Payment

Please contact the Medi-Cal Long-Term Services and Supports Department at (855) 622-2755 for questions about authorization and payment responsibilities.

Submitting Long-Term Care Prior Authorization Requests to Blue Shield Promise

Long-term care is a continuous admission exceeding the month of admission and the entire following month. Long-term care is covered for eligible Med-Cal patients at a nursing facility or sub-acute facility.

Blue Shield Promise uses two types of long-term care authorization forms:

- Custodial Long-Term Care (LTC) Authorization Request Form for prior authorization for long-term care services in a nursing facility. This is submitted from the facility to Blue Shield Promise.
- Authorization Form for Medi-Cal Long-Term Care that comes from the provider to Blue Shield Promise.

For Blue Shield Promise Medi-Cal members in Los Angeles and San Diego counties, please complete the appropriate authorization form and submit it to Blue Shield Promise Medi-Cal Long-Term Services and Supports Department via fax to:

- Long-Term Care Authorization Request Form (844) 200-0121
- Long-Term Care Ancillary Services Request Form (323) 889-6577

The forms can be downloaded from Blue Shield Promise's provider website at www.blueshieldca.com/en/bsp/providers in the *policies & guidelines* section, under "*Forms for authorizations, referrals and more.*"

Authorization requests must be submitted to Blue Shield Promise within 24 hours of admission to the nursing facility, or within five (5) business days of new eligibility assignment. Blue Shield Promise will review the authorization request to certify that the patient meets Medi-Cal criteria for long-term care services.

Blue Shield Promise will respond to authorization requests within three (3) calendar days. Initial authorizations for service and equipment approvals will have an effective period of up to four (4) months, depending on care service type. Reauthorizations will typically have an effective period of up to four (4) months.

Authorizations for Medi-Cal long-term care, if screened and determined to meet criteria, will typically be issued for a period of four (4) months after the initial period. Exceptions are based on medical review and may deem a longer or shorter duration.

Submitting Initial Long-Term Care for Prior Authorization Requests to Blue Shield Promise

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.

The LTC TAR form should be faxed to (844) 200-0121 and Ancillary Services Request to (323) 889-6577 for Blue Shield Promise members in both Los Angeles and San Diego counties.

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)
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)

Treatment Authorization Request Data and Existing Authorizations

Blue Shield Promise will receive the treatment authorization request (TAR) information from the state open to Medi-Cal long-term care nursing facility residents as part of the historical utilization data. Blue Shield Promise will honor all existing authorizations from the state automatically for three months if an existing TAR from the state is provided and a long-term authorization is coordinated.

Authorization Processes for Short-Term Skilled Care

Short-term skilled care is time-limited admission to a nursing facility or sub-acute facility to accommodate the completion of a treatment plan for rehabilitation or continuation of medical acute care services.

For short-term skilled care, please contact the assigned IPA/medical group or Blue Shield Promise Provider Customer Service at (800) 468-9935 and follow the prompts to reach the Authorizations Department. Skilled authorization requests will be approved based on Centers for Medicare & Medicaid Services (CMS) and Medi-Cal guidelines.

Medicare Short-term Skilled Care and Medi-Cal Short-term Skilled Care

Authorization and payment are dependent upon where the risk lies.

- A shared risk IPA/medical group is responsible for issuing authorizations pertaining to all covered services and the provider is responsible to bill Blue Shield Promise for facility charges.
- Full risk IPA/medical group is responsible for issuing authorizations for all covered services. The provider is responsible for billing the full risk hospital partner for facility charges.

Medi-Cal Long-term Care

All member authorizations and payments are to be administered by Blue Shield Promise.

Medi-Cal Long-term Care with Medicare Part B

Blue Shield Promise is responsible for issuing authorizations and for payment for covered services. Medi-Cal long-term care residents are not assigned to IPA/medical groups and care is not delegated to an IPA/medical group.

Authorizations for Ancillary Services

Some ancillary services require prior authorization. Please complete the Skilled Nursing Facility Service Authorization request form on the Blue Shield Promise website to request authorization.

If a Medicare Part A nursing facility is delegated to the IPA/medical group, and the patient qualifies for Medi-Cal long-term care level of care, then Blue Shield Promise becomes responsible for authorization and payment of Medi-Cal long-term care services if the Medi-Cal is also assigned to Blue Shield Promise Health Plan. Please contact the Blue Shield Promise Medi-Cal Long-Term Care Services Department at (855) 622-2755 for questions about authorization and payment responsibilities.

Provider Dispute Resolution

If there is a dispute between the IPA/medical group and the health plan for responsibility of payment, Blue Shield Promise is responsible for resolving disputes between the IPA/medical group and the health plan.

For Medi-Cal, the dispute must be resolved within 45 working days after notification of the dispute. Blue Shield Promise will issue a written determination stating the pertinent facts and explaining the reasons for the determination within 45 working days after the date of receipt of the dispute.

For Medicare, the dispute must be resolved within 60 calendar days after notification of the dispute. Blue Shield Promise will issue a written determination stating the pertinent facets and explaining the reasons for the determination within 60 calendar days after the date of receipt of the dispute.

Training

Blue Shield Promise staff is available to provide orientation and training on authorization procedures to all contracted facilities. Please contact Blue Shield Promise Provider Customer Service at (800) 468-9935 regarding Members in both Los Angeles and San Diego counties.

Claims

Claim Submission/Claim Filing Limits

A facility may submit claims as frequently as desired. Timeframes for claims submission are as follows:

- Medicare claims must be submitted within one (1) calendar year after the date of service.
- Refer to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual* for Medi-Cal Claim Filing Limits.

Additional documentation is not required from the nursing facility in order to pay a claim if all services billed have been previously authorized and all required billing codes (i.e., RUG, accommodation, and revenue) are submitted.

A claim must be submitted using form UB-04 or successor form. The information listed below is required in addition to provider, patient, and other applicable fields:

- Bill type: 21X
- Statement Dates: date of service being billed
- Admission Date: "from" date of service being billed
- SOC: use value code fields

Paper Claim:

- Field 39a with code "23", enter SOC amount for covered services in the Amount field
- Field 40a with code "66", enter SOC amount for non-covered services in the Amount Field

Electronic (837I:5010):

- Loop 2300 AMT01, qualifier "F5" for SOC amount for covered services
- Loop 2300 AMT01, qualifier "A8" for SOC amount for non-covered services
- Enter the appropriate revenue code on Field 42.
- Enter the revenue code description on Field 43.
- Enter one of the following on Field 44 as applicable: HCPCS/Rates/HIPPS CODE of UB-04.
- Enter accommodation days or the number of days of care by revenue code on Field 46 (Serv Units).
- Enter the total charges on Field 47. Total charges should reflect the Medi-Cal or contracted rates multiply by the quantity.

- Enter Estimated Amount Due on Field 55. This is the difference between the Total Charges and other deductions such as SOC.
- Enter the authorization number on UB-04 Field 63 (Authorization Code).
- Enter the accommodation code on Field 39, with value code 24. The accommodation code can be entered in cents format in the corresponding amount field.
    - Paper claim example: Accommodation Code 01, enter as ".01"
    - Electronic (837I:5010) – Loop 2300 NTE01, qualifier "UPI" and with text entered as follows: "Accommodation XX" (XX being the code such as 01, 03, etc.)

Billing Codes

Medicare

For a standard inpatient nursing facility, skilled nursing services, days 1-100 within a Benefit Period, use Revenue Code 0022 (UB-04 Field 42) with corresponding HIPPS/RUG codes (UB-04 Field 44).

The Benefit Period shall reset to the maximum of 100 days after the member has had at least sixty (60) consecutive days lapse without either an acute inpatient admission and/or post-acute nursing facility day.

Medi-Cal

If contracted reimbursement rates are based on different skilled nursing levels, use the revenue codes listed below.

SNF level	Revenue Code
1	191
2	192
3	193
4	194
5	199

Patient Status Codes Crosswalk

The UB-04 patient status code is required to bill Long-term care claims. Below is a crosswalk from the LTC patient status code to the UB-04 patient status code.

Effective for dates of service prior to 2/1/2024

LTC Patient Status Code	LTC Patient Status Description	UB-04 Patient Status Code	MUST BILL WITH UB Patient Status Description
00	Still under care	30	Still a patient
01	Admitted	09	Admitted as inpatient to this hospital
02	Expired	20	Expired
03	Discharged to acute hospital	70	Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this code list
04	Discharged to home	01	Discharged to home or self-care (routine discharge)
05	Discharged to another LTC facility	84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission
06	Leave of absence to acute hospital (bed hold)	30	Still a patient
07	Leave of absence to home	30	Still a patient
08	Leave of absence to acute hospital/discharged	05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
09	Leave of absence to home/discharged	06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
10	Admitted/expired	09	Admitted as inpatient to this hospital
11	Admitted/discharged to acute hospital	09	Admitted as inpatient to this hospital
12	Admitted/discharged to home	09	Admitted as inpatient to this hospital
13	Admitted/discharged to another LTC facility	09	Admitted as inpatient to this hospital
32	Transferred to LTC status in same facility	84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission

Effective for dates of service on and after 2/1/2024

LTC Patient Status Code	LTC Patient Status Description	UB-04 Patient Status Code	MUST BILL WITH UB Patient Status Description
04	Discharged To Home	01	Discharged to Home or Self Care (Routine Discharge)
03	Discharged To Acute Hospital	02	Discharged/transferred to a Short-Term General Hospital for Inpatient Care
05	Discharged To Another LTC Facility	03	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in Anticipation of Skilled Care

11	Admitted/Discharged To Acute Hospital	04	Discharged/transferred to a Facility that Provides Custodial or Supportive Care
01	Admitted	05	Discharged/transferred to a Designated Cancer Center or Children's Hospital
02	Expired	06	Discharged/transferred to Home Under Care of an Organized Home Health Service Organization in Anticipation of Covered Skilled Care
07	Leave Of Absence To Home	09	Admitted as an Inpatient to this Hospital
00	Still Under Care	20	Expired
06	Leave Of Absence To Acute Hospital (Bed Hold)	30	Still Patient
08	Leave Of Absence To Acute Hospital/Discharged	40	Expired at home
09	Leave Of Absence To Home/Discharged	41	Expired in a Medical Facility
10	Admitted/Expired	42	Expired – Place Unknown
12	Admitted/Discharged To Home	43	Discharged/transferred to a Federal Health Care Facility
13	Admitted/Discharged To Another LTC Facility	50	Hospice – Home
32	Transferred To LTC Status In Same Facility	51	Hospice – Medical Facility (Certified) Providing Hospice Level of Care
		61	Discharged/transferred to a Hospital-Based Medicare Approved Swing Bed
		62	Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital
		63	Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH)
		64	Discharged/transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare
		65	Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
		66	Discharged/transferred to a Critical Access Hospital (CAH)
		70	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

Long-Term Care Acronyms

Accom.	Accommodation
Amt	Amount
DD	Developmentally Disables
DD-CN	Developmentally Disabled/Continuous Nursing
DD-H	Developmentally Disabled/Habilitative
DD-N	Developmentally Disabled/Nursing
DP	Hospital Distinct Part
DP/NF-B	Distinct Part Nursing Facility Level B
ICF	Intermediate Care Facility
ICF/DD	Intermediate Care Facility Developmental Disability Program
ICF/DD-H	Intermediate Care Facility Developmental Disability Habilitative
ICF/DD-N	Intermediate Care Facility Developmental Disability Nursing
NF	Free-Standing Nursing Facility
NF A	Nursing Facility Level A
NF B	Nursing Facility Level B
Non-DD	Non-Developmentally Disabled

Effective for dates of service prior to 2/1/2024

NF-B Adult Sub-Acute		
Description	**Revenue Code**	**Accommodation Code**
Hospital DP/NF-B – Ventilator dependent	199	71
Hospital DP/NF-B-Non-ventilator dependent	199	72
Free-standing NF-B – Ventilator dependent	199	75
Free-standing NF-B non-ventilator-dependent	199	76

Effective for dates of service **on or after 2/1/2024**

NF-B Adult Sub-Acute		
Description	**Revenue Code**	**Accommodation Code**
NF-B Adult Subacute, Hospital DP/NF-B – Non-Ventilator Dependent, Regular Services	190	72
NF-B Adult Subacute, Hospital DP/NF-B – Ventilator Dependent, Regular Services	190	71
NF-B Adult Subacute, Free-Standing – Ventilator Dependent, Regular Services	190	75
NF-B Adult Subacute, Free-Standing – Non-Ventilator Dependent, Regular Services	190	76

Effective for dates of service prior to 2/1/2024

NF-B Pediatric Sub-Acute

Description	Revenue Code	Accommodation Code
Hospital DP/NF-B- Supplemental rehabilitation therapy services	199	83
Hospital DP/NF-B Ventilator weaning services	199	84
Hospital DP/NF-B Ventilator dependent	199	85
Hospital DP/NF-B Non-ventilator rate	199	86
Free-standing NF-B – Ventilator dependent	199	91
Free-standing NF-B – Non-ventilator dependent	199	92
Free-standing NF-B Supplemental Rehabilitation therapy services	199	97
Free-standing DP/NF-B – Ventilator weaning services	199	98

Effective for dates of service on or after 2/1/2024

NF-B Pediatric Sub-Acute		
Description	**Revenue Code**	**Accommodation Code**
NF-B Pediatric Subacute, Hospital DP/NF-B – Supplemental Rehabilitation Therapy Services	199	83
NF-B Pediatric Subacute, Hospital DP/NF-B – Ventilator Weaning Services	199	84
NF-B Pediatric Subacute, Hospital DP/NF-B – Ventilator Dependent, Regular Services	190	85
NF-B Pediatric Subacute, Hospital DP/NF-B – Non-Ventilator Dependent, Regular Services	190	86
NF-B Pediatric Subacute, Free-standing NF-B – Ventilator Dependent Services, Regular Services	190	91
NF-B Pediatric Subacute, Free-standing NF-B – Non-Ventilator Dependent Services, Regular Services	190	92
NF-B Pediatric Subacute, Free-standing NF-B – Supplemental Rehabilitation Therapy Services	199	97
NF-B Pediatric Subacute, Free-standing NF-B – Ventilator Weaning Services	199	98

Effective for dates of service prior to 2/1/2024

Long-Term Non-Skilled Care (Custodial)		
Description	**Revenue Code**	**Accommodation Code**
NF-B Regular	160	01
NF-B Rural swing bed program	160	04
NF-B Special treatment program-mentally disordered	169	11
NF-A Regular	160	21
Rehabilitation program - mentally disordered	169	31
ICF Developmental Disability Program	160	41
ICF/DD-H 4-6 Beds	160	61
ICF/DD-H 7-15 Beds	160	65
ICF/DD-N 4-6 Beds	160	62
ICF/DD-N 7-15 Beds	160	66

Effective for dates of service on or after 2/1/2024

Long-Term Non-Skilled Care (Custodial)		
Description	**Revenue Code**	**Accommodation Code**
NF-B Regular, Regular Services [Distinct Part]	101	01
NF-B Rural Swing Bed Program, Regular Services	101	04
NF-B Regular, Regular Services [Free-standing]	101	07
NF-B Special Treatment Program – Mentally Disordered, Regular Services	1001	11
NF-A Regular, Regular Services	101	21
NF-A Rehabilitation Program – Mentally Disordered, Regular Services	1001	31
ICF/DD, Regular Services [1 To 59 Bed Capacity]	101	41
ICF/DD, Regular Services [60 Or More Bed Capacity]	101	42
ICF/DD-H, 4–6 Beds, Regular Services	101	61
ICF/DD-H, 7–15 Beds, Regular Services	101	65
ICF/DD-N, 4–6 Beds, Regular Services	101	62
ICF/DD-N, 7–15 Beds, Regular Services	101	66

Effective for dates of service prior to 2/1/2024

Bed Hold– Maximum of 7 days per Hospitalization		
Description	**Revenue Code**	**Accommodation Code**
Hospital DP/NF-B - Ventilator dependent	185	73
Hospital DP/NF-B - Non-ventilator dependent	185	74
Free Standing NF-B Vent Dependent	185	77
Free Standing NF-B Non -Vent Dependent	185	78
NF-B Regular	185	02
NF-A Regular	185	22

Effective for dates of service on or after 2/1/2024

Bed Hold– Maximum of 7 Days per Hospitalization		
Description	**Revenue Code**	**Accommodation Code**
NF-B Adult Subacute, Hospital DP/NF-B – Ventilator Dependent, Bed Hold	185	73
NF-B Adult Subacute, Hospital DP/NF-B -- Non-Ventilator Dependent, Bed Hold	185	74
NF-B Adult Subacute, Free-standing – Ventilator Dependent, Bed Hold	185	77
NF-B Adult Subacute, Free-Standing – Non-Ventilator Dependent, Bed Hold	185	78
NF-B Regular, Leave Days, Non-DD Patient [Distinct Part]	180	02
NF-A Regular, Leave Days, Non-DD Patient	180	22

Effective for dates of service prior to 2/1/2024

Bed Hold (Pediatrics) – Maximum of 7 Days per Hospitalization		
Description	**Revenue Code**	**Accommodation Code**
Hospital DP/NF-B - Ventilator dependent	185	87
Hospital DP/NF-B - Non-ventilator dependent	185	88
Free-standing NF-B - Ventilator dependent	185	93
Free-standing NF-B - Non-ventilator dependent	185	94

Effective for dates of service on or after 2/1/2024

Bed Hold (Pediatrics) – Maximum of 7 Days per Hospitalization		
Description	**Revenue Code**	**Accommodation Code**
NF-B Pediatric Subacute, Hospital DP/NF-B – Ventilator Dependent, Bed Hold	185	87
NF-B Pediatric Subacute, Hospital DP/NF-B – Non-Ventilator Dependent, Bed Hold	185	88
NF-B Pediatric Subacute, Free-standing NF-B – Ventilator Dependent Services, Bed Hold	185	93
NF-B Pediatric Subacute, Free-standing NF-B – Non-Ventilator Dependent Services, Bed Hold	185	94

Effective for dates of service prior to 2/1/2024

Leave of Absence (Adult) – Maximum 18 Days per Calendar Year		
Description	**Revenue Code**	**Accommodation Code**
Hospital DP/NF-B – Ventilator dependent	180	79
Hospital DP/NF-B – Non-ventilator dependent	180	80
Free-standing NF-B – Ventilator dependent	180	81
Free-standing NF-B – Non-ventilator dependent	180	82

Effective for dates of service on or after 2/1/2024

Leave of Absence (Adult) – Maximum 18 Days per Calendar Year		
Description	**Revenue Code**	**Accommodation Code**
Hospital DP/NF-B – Ventilator dependent	180	79
Hospital DP/NF-B – Non-ventilator dependent	180	80
Free-standing NF-B – Ventilator dependent	180	81
Free-standing NF-B – Non-ventilator dependent	180	82

Effective for dates of service prior to 2/1/2024

Leave of Absence (Pediatric) – Maximum 18 Days per Calendar Year		
Description	**Revenue Code**	**Accommodation Code**
Hospital DP/NF-B – Ventilator dependent	180	89
Hospital DP/NF-B – Non-ventilator dependent	180	90
Free-standing NF-B – Ventilator dependent	180	95
Free-standing NF-B – Non-ventilator dependent	180	96

Effective for dates of service on or after 2/1/2024

Leave of Absence (Pediatric) – Maximum 18 days per Calendar Year		
Description	**Revenue Code**	**Accommodation Code**
NF-B Pediatric Subacute, Hospital DP/NF-B – Ventilator Dependent, Leave of Absence	180	89
NF-B Pediatric Subacute, Hospital DP/NF-B – Non-Ventilator Dependent, Leave of Absence	180	90
NF-B Pediatric Subacute, Free-standing NF-B – Ventilator Dependent Services, Leave of Absence	180	95
NF-B Pediatric Subacute, Free-standing NF-B – Non-Ventilator Dependent Services, Leave of Absence	180	96

Effective for dates of service prior to 2/1/2024

Leave of Absence Long-Term Non-Skilled Care (Custodial) – Maximum 18 days per Calendar Year		
Description	**Revenue Code**	**Accommodation Code**
NF-B Regular	180	03
NF-B Rural swing bed program	180	05
NF-B Special treatment program – mentally disordered	180	12
NF-A Regular	180	23
Rehabilitation Program – mentally disordered	180	32
ICF Developmental Disability Program	180	43
ICF/DD-H 4-6 Beds	180	63
ICF/DD-H 7-15 Beds	180	68
ICF/DD-N 4-6 Beds	180	64
ICF/DD-N 7-15 Beds	180	69

Effective for dates of service on or after 2/1/2024

Leave of Absence Long-term Non-Skilled Care (Custodial) – Maximum 18 days per Calendar Year		
Description	**Revenue Code**	**Accommodation Code**
NF-B In A Free-Standing Facility, Non-DD Patient, Leave Of Absence	180	08
NF-B Rural Swing Bed Program, Leave Days, Non-DD Patient	180	05
NF-B Special Treatment Program – Mentally Disordered, Leave Days, Non-DD Patient	180	12
NF-A Regular, Leave Days, DD Patient	180	23
NF-A Rehabilitation Program – Mentally Disordered, Leave Days, Non-DD Patient	180	32
ICF/DD, Leave Days, DD Patient [1 To 59 Bed Capacity]	180	43
ICF/DD-H, 4–6 Beds, Leave Days, DD Patient	180	63
ICF/DD-H, 7–15 Beds, Leave Days, DD Patient	180	68
ICF/DD-N, 4–6 Beds, Leave Days, DD Patient	180	64
ICF/DD-N, 7–15 Beds, Leave Days, DD Patient	180	69
ICF/DD, Leave Days, DD Patient [60 Or More Bed Capacity]	180	44
NF-B Regular, Leave Days, DD Patient [Free-standing]	180	03
NF-B Regular, Leave Days, DD Patient [Free-standing]	180	09

Blue Shield Promise accepts the following member IDs for claim submission:

- Care 1st Health Plan ID number (from former Care 1st Health Plan, before it was renamed to Blue Shield of California Promise Health Plan)
- Blue Shield of California Promise Health Plan ID number
- Medi-Cal 8 position Client Identification Number (CIN)
- Medicare ID Health insurance claim number/Medicare beneficiary Identifier HIC/MBI

The provider explanation of benefits (EOB) and remittance advice (RA) will have the Blue Shield Promise plan ID number.

Electronic Claims Submission

Blue Shield Promise strongly encourages electronic submission of claims through the following approved clearinghouses:

Office Ally
Payer ID: CISCA
(360) 975-7000
www.officeally.com

Change Health Plan
Payer ID: 57115
(866) 371-9066
www.changehealthcare.com

Date of Receipt

If the claims are sent to Blue Shield Promise electronically, the date the claim is received from the claim's clearinghouse will serve as the date of receipt for the claim. The date of receipt for paper claims is the date Blue Shield Promise receives the claim, as indicated by its data stamp on the claim.

Claim Reimbursement Timelines

Blue Shield Promise will make every effort to pay claims as required by regulations.

Medicare Claims

- A **"clean" claim** that is submitted by a non-contracted provider, (i.e., it includes all the necessary information, as well as documentation, if needed) will be paid within 30 calendar days from the date it is received by Blue Shield Promise.
- A claim submitted by a non-contracted provider that is not "clean," i.e., does not initially include all the necessary information, as well as documentation, if needed) will be paid within 60 days of the date it is received by Blue Shield Promise.

  CMS requires that 95% of "clean" claims are paid within 30 calendar days and 95% of all other claims are paid or denied within 60 calendar days.

Medi-Cal Claims

- A claim will be processed (paid, denied, or contested) within 30 calendar days from the date the claim was received by Blue Shield Promise.
- 90% of claims must be paid, denied, or contested within 30 calendar days from the date the claim is received by Blue Shield Promise.

Reimbursement Rates

1. Blue Shield Promise will reimburse contracted providers at contractual rates or letter of agreement.
2. Out-of-network or non-contracted providers will be reimbursed at rates not less than the current Medicare fee schedule for services covered under Medicare Part A (skilled services for days 1-100).
3. Out-of-network or non-contracted providers will be reimbursed at rates not less than the current Medi-Cal fee schedule for Medi-Cal members.
4. Sub-acute nursing facility and long-term services leave of absence and bed hold will be paid at 100% of the current facility specific Medi-Cal sub-acute facility and skilled nursing facility rates schedule as published by DHCS.
5. Out-of-network or non-contracted providers will be reimbursed at rates not less than the current Medicare for Part B covered services such as physical, occupational therapies and Medi-Cal rates for those services that are covered under Medi-Cal.
6. Medi-Cal fee schedule rate for nursing facility and long-term care facility covered services includes all supplies, drugs, equipment, and personal hygiene items necessary to provide a designated level of care. These items are included in the Medi-Cal rate unless listed as separately reimbursable in California Code of Regulations (CCR), Title 22. All incontinence supplies are included in the facility rates and are not separately reimbursable for dual-eligible members.
7. Blue Shield Promise will not reimburse the provider for the inclusive items listed below.
    - Routine Supplies
    - Non-legend Drugs
    - Incontinence Supplies (except for ICF/DD-N and ICF/DD-H)
    - Personal hygiene items
    - Nursing services
8. The following items are excluded from the Medi-Cal fee schedule for nursing facility and long-term care facility covered services per California Code of Regulations (CCR), Title 22 and such items are separately reimbursable (except for sub-acute facilities, see CCR Title 22 for details). Prior authorization from Blue Shield Promise or its delegated IPA/medical group is required prior to delivery to dual-eligible members and prior to payment. The provider will use best efforts to ensure Blue Shield Promise that designated participating providers for such items are used and Blue Shield Promise reserves the right to redirect, accordingly.

Excluded, separately reimbursable items for non-sub-acute facilities are as follows:

- Allied health services ordered by the attending physician
- Alternating pressure mattresses/pads with motor
- Atmospheric oxygen concentrators, enrichers, and accessories
- Blood, plasma, and substitutes
- Dental services
- Durable medical equipment (DME) as specified in CCR, Title 22, Section 51321(g)
- Insulin
- Intermittent positive pressure breathing equipment
- Intravenous trays, tubing, and blood infusion sets
- Laboratory services
- Legend drugs (payable only through pharmacy benefit management system)
- Liquid oxygen system
- MacLaren or Pogon brand buggies
- Medical Supplies as specified in the Welfare and Institutions Code (W&I Code), Section 14105.47
- Nasal Cannula
- Osteogenesis stimulator device
- Oxygen (except for emergencies)
- Parts and labor for repairs of DME if originally separately reimbursable or owned by recipient
- Physician services
- Portable aspirator
- Portable gas oxygen system and accessories
- Pre-contoured structures (VASCO-PASS, cut out foam)
- Prescribed prosthetic and orthotic devices for exclusive use of patient
- Reagent testing sets
- Therapeutic air/fluid support systems/beds
- Therapy services that are provided by a licensed therapist, identified in the Minimum Data Set, included in the recipient's plan of care, and prescribed by the recipient's physician
- Traction equipment and accessories
- Variable height beds
- X-rays

Electronic Payment

To enroll in electronic fund transfer (EFT), log on to the Blue Shield Promise Provider website for the Electronic Payments Enrollment Form Guide and Form. Complete the form and then fax it, along with supporting documentation, to (866) 276-8456.

Contact the EDI Platform Services team by phone at (800) 480-1221.

Share of Cost

1. Blue Shield Promise will process claims submitted by nursing facilities consistent with Medi-Cal Share of Cost (SOC) provisions.
2. Blue Shield Promise will process claims submitted by nursing facilities consistent with Medi-Cal guidelines for SOC.
3. SOC for Non-Covered Services

   As a result of the *Johnson v. Rank* settlement agreement, Medi-Cal beneficiaries, not their providers, can elect to use SOC funds to pay for necessary, non-covered, medical/ remedial services, supplies, equipment, and drugs prescribed by a physician and part of the care plan authorized by the beneficiary's attending physician. A medical service is considered a non-covered benefit if:

   - The medical service is rendered by a non-Medi-Cal provider; or
   - The medical service falls into the category of services for which an authorization request must be submitted and approved before Medi-Cal will pay and an authorization request is not submitted or is denied because the service is not considered medically necessary; or
   - The physician's prescriptions for SOC expenditures must be maintained in the beneficiary's medical record.

   As required by the *Johnson v. Rank* settlement agreement, if a beneficiary spends part of the SOC on "non-covered" medical services or remedial services or items, the nursing facility will subtract those amounts from the beneficiary's SOC. The nursing facility will adjust the amount on the claim and Blue Shield Promise shall pay the balance (i.e., Medi-Cal or contracted rates minus covered service SOC).

   Over the counter (OTC) drugs cannot be billed on a beneficiary's SOC since these drugs are included in facility's per diem rate.

How to Determine Which Costs to Bill to Blue Shield Promise

When a Medi-Cal beneficiary has a **long-term care aid code and a SOC**, the nursing facility shall separate the covered services SOC from the non-covered services SOC. Blue Shield Promise will pay the difference of allowed amount minus the SOC amount for covered services. This also applies to SOC met in the beginning of the month. Blue Shield Promise may validate SOC billed by nursing facility with the state eligibility tape and/or the Medi-Cal eligibility transaction website.

- Services covered under Medicare must be billed to Medicare FFS or other Medicare Advantage Plan prior to collecting SOC. The patient's liability is limited to the amount of the Medicare deductible and coinsurance.
- Do not submit a claim to Blue Shield Promise if the beneficiary has not met their SOC.

Crossover Claims

1. Beneficiary has Medicare and Medi-Cal coverage under Blue Shield Promise
   - Blue Shield Promise D-SNP benefit plans do not have copay, coinsurance or deductible.
   - Claims will be processed under the beneficiary's Medicare account first for the Medicare covered services.
   - Medicare payment will be compared against Medi-Cal allowed amount.
     - Medi-Cal allowed amount is less than Medicare allowed amount.
       - No additional payment will be made, Medicare payment will be the payment in full.
     - Medi-Cal allowed amount is greater than Medicare allowed amount.
       - Difference of Medi-Cal allowed, SOC and Medicare amounts will be paid no more than the coinsurance/deductible amount.

         Example: Medicare allowed amount is $2500; SOC is $100, Medi-Cal is $3500, additional reimbursement will be $900.
   - Providers will receive two Remittance Advices from Blue Shield Promise, one under the Medicare account and the other under the Medi-Cal account.
2. Beneficiary's Medicare coverage under Medicare FFS or under other Medicare Advantage Plans, Medi-Cal coverage under Blue Shield Promise
   - Claim must be billed to Medicare FFS or other Medicare Advantage Plans first.
   - Medicare EOB must be submitted with the claim.
   - Blue Shield Promise will pay the Medicare deductible, coinsurance and/or copay.
     - If Member has SOC, the coinsurance plus Medicare deductible minus SOC will be paid.
     - If Medicare deductible, coinsurance and/or copay is more than difference between Medicare payment and Medi-Cal allowance, Blue Shield Promise will pay the difference minus the applicable SOC.
   - Providers will receive two Remittance Advices from Blue Shield Promise, one under the Medicare account and the other under the Medi-Cal account.
3. A claim must be billed with Blue Shield Promise's Medicare member number. The number must be entered on Field 60 of UB-04 form (Insured's Unique ID).

4. A paper claim must be billed to Blue Shield Promise with a copy of the Medicare Evidence of Payment or Remittance Advice, and sent to the following address:

   Blue Shield of California Promise Health Plan
   P.O. Box 272660
   Chico, CA 95926

5. Under no circumstances should a provider of Medi-Cal services submit claims to, or demand or otherwise collect reimbursement from a Medi-Cal beneficiary or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal Managed Care Program's scope of benefits as well as any applicable Medicare deductibles or coinsurance.

Determining the Correct Payer

In order to determine the appropriate payer and where to submit the bill, please refer to the authorization.

- Medicare beneficiary:
  - Shared Risk IPA/Medical Group – IPA provides authorization for all services; Provider to bill Plan for facility charges.
  - Full Risk IPA/Medical Group – IPA provides authorization for all services; Provider to bill Full Risk Hospital partner for facility charges.
- Medi-Cal Long-Term Care:
  - All beneficiaries receive authorization and payment from the Plan.
- Medi-Cal Long-Term Care with Medicare Part B:
  - All beneficiaries receive authorization and payment from Plan.

Subacute Level of Care Criteria

Blue Shield Promise will determine which subacute levels of care are applicable to the subacute services provided based on the following criteria:

(i) **Level I** refers to the following care or care for the following conditions:

- (A) Meals, including special dietary services
- (B) Nursing care, including skilled observation per Medi-Cal guidelines
- (C) Medication, including prescriptions, OTC, and pharmacy supplies (see exclusions)
- (D) Pharmacy services
- (E) Administration of medications including PO, IM, SQ
- (F) Diabetic education and diabetic care for insulin dependent diabetics
- (G) Routine laboratory and radiology services
- (H) Oxygen services and supplies
- (I) Enteral nutrition services and supplies
- (J) Wound care for Stage I and II dermal ulcers and post-surgical wound care requiring once per day simple dressing changes
- (K) Case management, social services, and discharge planning
- (L) Standard DME (wheelchair, trapeze, walker, commodes, feeding pumps, etc.
- (M) Care of colostomy/ileostomy
- (N) Nasogastric (NG) or G tube (including supplies)

(ii) **Level II** refers to the care/conditions set forth in Level I, plus the following, but not limited to, additional care or conditions:

- (A) PT, OT, ST up to 60 minutes per day, including evaluations, 5 times per week
- (B) IV hydration
- (C) Care of a single Stage III or IV dermal ulcer
- (D) Care of any single wound that requires sterile dressing changes twice per day

(iii) **Level III** refers to the care/conditions set forth in Levels I and II, plus the following, but not limited to, additional care or conditions:

- (A) Isolation patients, not including universal precautions
- (B) PT, OT, ST up to 120 minutes per day, including evaluations 5 times per week
- (C) IV medication administration via peripheral lines up to twice per day
- (D) Care of two or more Stage III and/or IV dermal ulcers
- (E) Respiratory Therapy by a Respiratory Therapist a minimum of twice per day for pulmonary toilet

(iv) **Level IV** refers to the care/conditions set forth in Levels I, II and III, plus the following, but not limited to, additional care or conditions:

(A) IV therapy administration via central lines

(B) Continuous IV medication administration

(C) IV therapy administration three times or more per day

(D) TPN

(E) Chemotherapy administration

(F) PT, OT, ST provided in excess of 120 minutes per day, including evaluations

(G) Care of patients with tracheostomies requiring suctioning at least once per shift and with continuous oxygen or mist via the tracheostomy

(v) **Level V** includes the following, but not limited to:

(A) Care of patients requiring mechanical ventilation at least fifty percent (50%) of the day

(B) Care of patients requiring weaning from the ventilator

Care Managers

Blue Shield Promise has Care Managers and employs both social workers and licensed nurses to perform care management functions.

For members residing in nursing facilities, the care managers work collaboratively with the nursing facilities to ensure members are at the appropriate level of care, needed covered benefits are accessed in a timely manner, and carved out services, as well as community resources, are effectively utilized.

The state requires that Blue Shield Promise perform an assessment to determine a patient's willingness and capacity to return to community living, and to facilitate that transition, if needed.

When to Contact Blue Shield Promise

Please contact Blue Shield Promise under the following circumstances, for coordination:

- New admission
- New enrollment to Blue Shield Promise
- Member transfer
- Member expiration
- Bed-holds
- Member departure from facility, against medical advice (AMA)
- Admission to hospital
- Member's change in Level of Care
- To request for ancillary services and equipment
- For general questions regarding authorizations, claims, billing, and contracting

Note: Direct care related issues and medical changes of condition should be referred to the attending physician, as is customary.

Health Risk Assessment

The health risk assessment (HRA) is a biological/medical/psychological/social/functional assessment. An HRA is conducted upon initial enrollment into the health plan and annually thereafter for Medi-Cal SPD (Seniors & Persons with Disabilities) and Dual Special Needs Program members. An HRA is conducted either by phone, mail, or in-person with a Blue Shield Promise healthcare professional. An individualized care plan (ICP) is then developed for the member based on the responses to their HRA responses and/or with historical healthcare data. The HRA and ICP are shared with the skilled nursing facility when applicable.

Transportation

Financial responsibility for transportation to the emergency room is outlined below.

- **Medi-Cal Long-Term Care Member**
  Payment for transportation for Medi-Cal long-term care transportation to an emergency room is the financial responsibility of Blue Shield Promise.
- **Skilled Member**
  Payment for transportation for a skilled member to an emergency room is the financial responsibility of Blue Shield Promise, except for Med-Cal members of full-risk IPA/medical groups. A Medi-Cal full-risk IPA/medical group is financially responsible for the cost transporting their Medi-Cal patient to the emergency room.

Leave of Absence and Bed Holds

Blue Shield Promise will include any leave of absence or bed hold as a covered benefit if provided in accordance with Title 22 California Code of Regulations or California's Medicaid State Plan.

Transitional Care Services (TCS)

The goal of Transitional Care Services (TCS) is to ensure that Blue Shield Promise members receive the highest-level of care from the time of admission to post discharge until they have been successfully connected to all needed services and supports. The following requirements are referenced from the DHCS CalAIM: Population Health Management (PHM) Policy Guide and build upon existing facility requirements. These requirements are meant to ensure coordination of care, continuity of care, and optimum outcomes for Plan members in their care transitions. Care transitions are defined as a member transferring from one setting or level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and skilled nursing facilities (SNFs) to home- or community-based settings, Community Supports placements (including Sobering Centers, Recuperative Care and Short-Term Post Hospitalization), post-acute care facilities, or long-term care (LTC) settings.

Admission, Discharge, and Transfer (ADT) Data

In accordance with CMS Interoperability and Patient Access Final Rule (CMS-9115-F) and the CalHHS Data Exchange Framework (DxF), general acute care hospitals and emergency departments, as defined by California's Health & Safety Code §1250, (together "Participating Facilities"), must send admission, discharge, or transfer (ADT) notifications to other organizations that have signed the DxF Data Sharing Agreement if requested in advance of the admission, discharge, or transfer event (ADT Event).

Participating Facilities are required to send notification of ADT Events unless prohibited by applicable law. They must also accept notification of ADT Events from any other participant and send notification of ADT Events as requested using a HIPAA-compliant method and in a format acceptable and supported by the requesting participant. These DxF requirements will support Blue Shield Promise capabilities to receive ADT notifications from a variety of Participating Facilities.

Requirements for High- vs. Lower-Risk Transitioning Members

Minimum TCS requirements vary for high-risk and lower-risk transitioning members as described below. "High-risk" transitioning members means all members listed in the DHCS PHM Policy Guide as:

- Those with Long-Term Services and Supports (LTSS) needs;
- Those in or entering Complex Care Management (CCM) or Enhanced Care Management (ECM);
- Children with special health care needs (CSHCN);
- Pregnant individuals: for the purposes of TCS, "pregnant individuals" includes individuals hospitalized during pregnancy, admitted during the 12-month period postpartum, and discharges related to the delivery; and
- Seniors and persons with disabilities who meet the definitions of "high-risk" established in existing DHCS All Plan Letter (APL) requirements (APL 17-012 and APL 17-013).
- Other members assessed as high-risk by Risk Stratification Segmentation and Tiering (RSST).

In addition to these groups, discharging facilities must also consider the following members "high-risk" for the purposes of TCS:

- Any member who has been served by county Specialty Mental Health Services (SMHS) and/or Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS) (if known) within the last 12 months, or any member who has been identified as having a specialty mental health need or substance use disorder by Blue Shield Promise or discharging facility;
- Any member transitioning to or from a SNF; and
- Any member that is identified as high-risk by the discharging facility and thus is referred to or recommended by the facility for high-risk TCS.

Notifying a Care Manager

I. High-Risk Members

Once a member has been identified as being admitted as high-risk, Blue Shield Promise will assign a Care Manager responsible for TCS, who is the single point of contact responsible for ensuring completion of TCS requirements across all settings and delivery systems.

Members may choose to have limited or no contact with the care manager. In these cases, the discharging facilities must, at minimum, comply with federal and state discharge planning requirements listed below and assist in care coordination with the Care Manager, the Primary Care Provider (PCP), and any other identified follow-up providers.

For high-risk members in transition, their assigned Care Managers (including ECM and CCM) must be notified within 24 hours of admission, transfer, or discharge when an ADT feed is

available, or within 24 hours of Blue Shield Promise being aware of any planned admissions, or of any admissions, discharges, or transfers for instances where no ADT feed exists (such as for SNF admissions). However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

II. Lower-Risk Members

Blue Shield Promise will provide a dedicated TCS team available to lower-risk members in transition that is available via phone at (877) 702-5566 from 8 a.m. to 5 p.m. Monday through Friday.

The discharging facility must incorporate the Blue Shield Promise TCS phone number (877) 702-5566 into the discharge documents for lower-risk members. Lower-risk members will have access to the dedicated TCS team for at least 30 days from discharge.

Discharge Risk Assessment and Discharge Planning

Discharge planning is required for all members experiencing a care transition. Hospitals must provide patient-centered discharge planning under their Conditions of Participation (CoPs) for Medicare and Medicaid programs set forth in federal regulation; national Joint Commission accreditation standards; and state statutory requirements; and certain similar requirements apply to SNFs.

At the time of the member's discharge, all necessary services that require a prior authorization are processed within the time frames outlined below. For elective inpatient stays, special requirements may be identified prior to hospitalization and coordinated through the prior authorization process. All prior authorizations required for the member's post-discharge services are processed within time frames consistent with the urgency of the member's condition, not to exceed five (5) working days for routine authorizations, or 72 hours for expedited authorizations. The discharge planning requirements below should be considered when transfers occur between discharging facilities (general acute care hospital, long-term acute care, and skilled nursing facilities).

All discharging facilities must complete a discharge planning process that includes the elements outlined below.

- Engages members, and/or members' parents, legal guardians, or Authorized Representative, as appropriate, when being discharged from a hospital, institution, or facility.
- Focuses on the member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
- Ensures each member is evaluated for all care settings appropriate to the member's condition, needs, preferences, and circumstances.
- Members are not to be discharged to a setting that does not meet their medical and/or mental health needs.
- A consistent discharge risk assessment process and/or assessment tools to identify members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with discharging facilities' current processes.
    - For high-risk members, discharging facility must share this information with Blue Shield Promise assigned care manager and have processes in place to screen and refer

members to longer-term Care Management programs (ECM or CCM) and/or Community Supports, as needed.
    - For members not already classified as high-risk by Blue Shield Promise per above definitions, the discharging facility must have processes in place to leverage the assessment to identify members who may benefit from high-risk TCS services. This process must include referrals to Blue Shield Promise for:
        - Any member who has a specialty mental health need or substance use disorder.
        - Any member who is eligible for an ECM Population of Focus.
        - Any member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.
- Ensures that discharging facilities share discharge instructions/summaries with a Blue Shield Promise assigned Care Manager and Member's PCP in a timely manner.
- The Care Manager will work with discharging facilities to ensure the Care Manager's name and contact number is included in key discharge documents. The state mandates that Blue Shield Promise follow-up with:
    - High-risk members within **7 days** post discharge
    - Lower-risk members within **30 days** post discharge
- Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with discharging facilities' current requirements.
- Notifies post-discharge providers and share clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
- Sends a discharge notification letter to the Primary Care Physician of record within 24 hours of discharge.
- Ensures members and their caregivers are informed of the continuing health care requirements through discharge instructions and that this information must be provided in a culturally and linguistically appropriate manner.
- Discharge summaries and medication lists must be shared with the Blue Shield Promise Care Manager, the member, the member's caregivers, PCP, and treating providers.
    - This must include a pre-discharge medication reconciliation completed upon discharge that includes education and counseling about the member's medications.
    - A second medication reconciliation must be completed after discharge once the member is in their new setting (post-discharge) and this can be completed by a follow-up provider, such as the PCP, care manager, or another provider with the appropriate license.

Oversight and Monitoring

Blue Shield Promise is accountable for providing all TCS in collaboration and partnership with discharging facilities, including ensuring hospitals provide discharge planning as required by federal and state requirements. For managing care transitions, Discharging facilities (general acute care hospitals, long-term acute care hospitals, and skilled nursing facilities) must follow all applicable Code of Federal Regulations, California state laws, Joint Commission requirements, and relevant Blue Shield Promise policies and procedures (e.g., Discharge Planning Policy and Managing Care Transitions Policy).

The hospital/discharging facility's responsibility to perform discharge planning does not supplant the need for TCS. Discharging facilities are required to have their own published policies and procedures that account for the above requirements and those noted in the DHCS PHM Policy Guide to support effective care transitions. Blue Shield Promise will conduct routine oversight and monitoring activities to ensure compliance with DHCS requirements and that key protocols are being followed to provide the highest level of care and services to our members.

Continuity of Care

Blue Shield Promise will follow DPL 13-005 as it pertains to how we will administer Nursing Facility Services. Refer to the claims section for payment for out-of-network (OON) providers.

Change in Coverage, Condition, or Discharge

The nursing facility can modify its care of a beneficiary or discharge the beneficiary if:

- The nursing facility is no longer capable of meeting the beneficiary's health care needs;
- The beneficiary's health has improved so that he or she no longer needs nursing facility services; or
- The beneficiary poses a risk to the health or safety of individuals in the nursing facility.

Blue Shield Promise will request documentation from the nursing facility to verify that the modification was made for an allowable reason.

Appealing a Discharge

A beneficiary may appeal a discharge. Please see Filing a Grievance or Appeal on the Blue Shield Promise website.

Nursing Facility Delegation for Short-Term Skilled Care

The nursing facility's responsibilities when the beneficiary belongs to an IPA/medical group are:

- The IPA/medical group inpatient case manager shall coordinate approval to the nursing facility.
- The nursing facility shall obtain the authorization from the IPA/medical group.
- The IPA/medical group shall obtain daily clinical information from the nursing facility and perform concurrent review.
- IPA/medical group decisions shall be submitted to Blue Shield Promise via a secure file transfer protocol (SFTP) site on a weekly basis.

Blue Shield Promise's role when the beneficiary belongs to an IPA/medical group:

- The nursing facility shall notify Blue Shield Promise of the admission.
- Blue Shield Promise shall note on the Face Sheet if an IPA/medical group is delegated for nursing facility concurrent review and needs to contact the IPA/medical group.
- Blue Shield Promise will contact the IPA/medical group designee to obtain updates on all prolonged stays at the nursing facility on a weekly basis until the member is discharged and assist IPA/medical group with discharge planning needs, if necessary.

Nursing Facility Behavioral Health

Blue Shield Promise has a team dedicated to behavioral health services. The behavioral health component is shared between Blue Shield Promise and the nursing facility to ensure behavioral health needs are met for Blue Shield Promise members who are receiving care in nursing facilities.

Services that Require Prior Authorization

Authorization is required for the services listed below.
Prior authorizations are required for elective services.
Only covered services are eligible for reimbursement.

- Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services: Inpatient, partial hospitalization, day treatment, intensive outpatient programs (IOP), electro-convulsive therapy (ECT).
  - Non-MD/APRN BH outpatient visits and community-based outpatient programming, after initial evaluation for outpatient and home settings.
  - Medicare does not require authorization for outpatient behavioral health services.
- Chiropractic Services
- Dental General Anesthesia:>7 years old or per state benefit (not a Medicare covered benefit)
- Dialysis: Notification only
- Durable Medical Equipment: Refer to Blue Shield Promise's website for specific codes that require authorization
  - Medicare hearing supplemental benefit: Contact Avesis at (800) 327-4462
- Home Health Care
- Home Infusion
- Hospice and Palliative Care
- Imaging: CT, MRI, MRA, PET, SPECT, Cardiac nuclear studies, CT angiograms, intimal media thickness testing, three-dimensional (3D) imaging.
- Inpatient Admissions: Non-emergent acute hospital, nursing facilities (NF), rehabilitation, long-term acute care (LTAC) facility, hospice (hospice requires notification only)
- Long-Term Services and Supports: Community-based adult services (CBAS), long-term care (LTC)
- Neuropsychological and Psychological Testing and Therapy
- Office visits, procedures, labs, diagnostic studies, inpatient stays
- Nutritional Supplements and Enteral Formulas (under special circumstances)
- Occupational Therapy after initial evaluation for outpatient and home settings
- Specialist Referrals
- Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedures: Refer to Blue Shield Promise's website for specific codes that are EXCLUDED from authorization requirements.
- Pain Management Procedures, including sympathectomies, neurotomies, injections, infusions, blocks, pumps or implants, and acupuncture (acupuncture is not a Medicare covered benefit)
- Physical Therapy: After initial evaluation for outpatient and home settings
- Prosthetics/Orthotics
- Rehabilitation Services, including cardiac, pulmonary, and comprehensive outpatient rehab facility (CORF). CORF services for Medicare only
- Sleep studies
- Specialty Pharmacy Drugs (oral and injectable) used to treat the following disease states, but not limited to anemia, Chron's disease/ulcerative colitis, cystic fibrosis, growth hormone deficiency, hemophilia, hepatitis C, immune deficiencies, multiple sclerosis, oncology, psoriasis, pulmonary hypertension, rheumatoid arthritis, and RSV prophylaxis. Refer to Blue Shield Promise's website for specific codes that require authorization
- Speech Therapy, after initial evaluation for outpatient and home settings
- Transportation evaluation and services
- Transportation: non-emergent ambulance (ground and air)
- Wound therapy, including wound vacs and hyperbaric

Health Information and Data Record Sharing with Blue Shield Promise

Providers shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, and the compliance milestones established for Calendar Year 2022-2024 and other program policy and procedure requirements, and additional state and federal regulations as applicable, and as updated and amended from time to time. Such program requirements and State law, implementing regulations and regulatory guidance shall govern the sharing of electronic health record data beginning January 31, 2024. Blue Shield Promise is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Providers shall participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield Promise within the timelines set forth in the State requirements as they may be amended from time to time. For informational purposes, as of January 1, the required timelines include:

On or before January 31, 2024, unless otherwise stated:

- General acute care hospitals, as defined by Section 1250. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Provider and physician organizations and medical groups. as defined by Section 127500.2. (Fewer than 25 physicians, and nonprofit clinics with fewer than 10 providers, the compliance date is 1/31/26.)
- Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
- Acute psychiatric hospitals, as defined by Section 1250. (Fewer than 100 beds and state-run acute psychiatric hospitals, the compliance date is 1/31/26.)
- Emergency medical services, as defined by Section 1797.72.

Important Information for Working with Blue Shield Promise

Information required to support authorization decision making includes:

- Current (up to 6 months), adequate patient history related to the requested services
- Relevant physical examination that addresses the problem
- Relevant lab or radiology results to support the request (including previous MRI, CT Lab, or X-ray report/results)
- Relevant specialty consultation notes
- Any other information or data specific to the request

The urgent/expedited service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the enrollee's ability to regain maximum function. Requests outside of this definition will be handled as routine/non-urgent.

If a request for services is denied, the requesting provider and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the provider by telephone/fax or electronic notification.

Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member's condition. Providers can request a copy of the criteria used to review requests for medical services by contacting the Blue Shield Promise Utilization Management Department at (800) 468-9935 for both Los Angeles and San Diego counties.

Providers may register for a username and password in order to log in and verify eligibility using Blue Shield Promise's provider website at www.blueshieldca.com/en/bsp/providers.

Blue Shield Promise Department Contact List

Department Name	Phone Number	Fax number
Medi-Cal Long-term Services and Supports	(855) 622-2755	(844) 200-0121
Social Services	(877) 221-0208	(323) 889-2109 Los Angeles (619) 219-3320 San Diego
Utilization management for Home Health Services	(800) 468-9935, Option 6, then 0, then 1	(323) 889-6574
Utilization Management (inpatient)	(800) 468-9935, Option 6, then 0, then 2	(619) 219-3301
Utilization Management (outpatient)	(800) 468-9935	(323) 889-6506
Utilization Management (long-term care)	(800) 468-9935	(844)-200-0121
Utilization Management (skilled nursing)	(800) 468-9935	(323) 889-6573
Request a skilled nursing Facility prior authorization form	(800) 468-9935, Option 6, then 2, then 2	

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