blue california

Promise Health Plan

June 23, 2021

Subject: **Notification of September 2021 Updates to the *Blue Shield Promise Health Plan Medi-Cal Provider Manual***

Dear Provider:

We have revised our *Blue Shield Promise Health Plan Medi-Cal Provider Manual.* The changes listed in the following provider manual sections are effective September 1, 2021.

On that date, you can search and download the revised manual on the Blue Shield Promise Provider website at www.blueshieldca.com/promise/providers. Click on *Provider manuals* under the *policies & guidelines* heading in the middle of the page.

You may also request a CD version of the revised *Blue Shield Promise Health Plan Medi-Cal Provider Manual* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Blue Shield Promise Health Plan Medi-Cal Provider Manual* is referenced 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 about the revisions that will be published in the September 2021 version of this manual, please contact Blue Shield Promise Provider Services at (800) 468-9935.

Sincerely,

Hugo Florez
Vice President, Provider Network Management
Promise Health Plan and PPO Specialty Networks

TBSP11964 (6/21)

Section 6: Grievances, Appeals and Disputes

6.2: Member Appeals Requests

*The following language **has been added** to indicate that providers and authorized member representatives can submit appeals on the member's behalf.*

The Member Appeals Process is designed to allow members, authorized member representatives or providers to file on their behalf, a complete and timely review within 30 calendar days of Blue Shield's receipt of the request.

6.2.1: Expedited Appeal

*This section has been **deleted and replaced** with the following:*

A provider on behalf of a Member or a Member may file an expedited appeal to an adverse benefit determination and ask to have it processed expeditiously. Expedited appeals are resolved within 72 hours. This type of appeal is generally used in a continued stay or continued treatment situation, and when indicated based on the critical clinical condition of the Member. The following circumstances may constitute, but are not limited to, an expedited appeal:

- The Member has been issued a denial for service
- The Member is scheduled for ongoing services or admission to a hospital within 72 hours
- The Member suffers from a terminal illness
- The Attending Physician indicates in writing the Member's health will suffer adverse consequence from the denial decision

All requests for expedited appeals will be triaged by licensed personnel to determine whether the appeal meets expedited criteria.

Documentation will be collected and presented to a Medical Director so that the case can be resolved and closed to the Member within 72 hours.