California Provider News

December 2018 Anthem Blue Cross Provider Newsletter - California

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Timely access regulations and language assistance program

Published: Dec 1, 2018 - **Products & Programs**

Blue Cross of California dba Anthem Blue Cross and Anthem Blue Cross Life & Health Insurance Company (collectively, "Anthem") are committed to keeping you, our network partners, updated on our activities related to our compliance with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) Timely Access to Non-Emergency Health Care Services Regulations (the "Timely Access Regulations"), respectively. Anthem maintains policies, procedures, and systems necessary to ensure compliance with the Timely Access Regulations, including access to non-emergency health care services within prescribed timeframes (also referred to as the "time elapsed standards" or "appointment wait times"). In addition, your agreement with Anthem requires your office to comply with the state law standards relative to appointment wait times. Anthem can only achieve this compliance with the help our provider network partners, you!

There are many activities that are conducted to support compliance with the regulations and we need you, as well as covered individuals, to help us attain the information that is needed. These studies allow our Plan to determine compliance with the regulations.

The activities include, but are not limited to the following:

- Provider Appointment Availability Survey
- Provider Satisfaction Survey
- Provider After – Hours Survey

These surveys are currently in process, please reviews this information with your office staff so they are prepared and understand the importance of each providers' participation in each of the surveys.

We appreciate that in certain circumstances time-elapsed requirements may not be met. The Timely Access Regulations have provided exceptions to the time-elapsed standards to address these situations:

Extending Appointment Wait Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of

practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

Preventive Care Services and Periodic Follow-up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Advanced Access: The primary care appointment availability standard may be met if the primary care physician office provides "advanced access." "Advanced access" means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

We hope this clarifies Anthem's expectations and your obligations regarding compliance with the *Timely Access Regulations*. Our goal is to work with our providers to successfully meet the expectations for the requirements with the least amount of difficulty and member abrasion.

To view the ***Standards for Medical Professionals*** click on the attachment.

Members also have access to Anthem's 24/7 NurseLine. The NurseLine wait time is not to exceed 30 minutes. The phone number is located on the back of the member ID card. In addition, Members and Providers have access to Anthem's Customer Service team at the telephone number listed on the back of the member ID card. A representative may be reached within 10 minutes during normal business hours.

Please contact the Anthem Member Services team at the telephone number listed on the back of the member ID card to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

If you have further questions, please contact Network Relations at CAContractSupport@anthem.com.

For Patients (Members) with Department of Managed Health Care Regulated Health plans:
If you or your patients are unable to obtain a timely referral to an appropriate provider or for additional information about the regulations, visit the Department of Managed Health Care's website at **www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx** or call toll-free **1-888-466-2219** for assistance.

For Patients (Members) with California Department of Insurance Regulated Health plans:
If you or your patients are unable to obtain a timely referral to an appropriate provider or for additional information about the regulations, visit the Department of Insurance's website at **www.insurance.ca.gov** or call toll-free **1-800-927-4357** for assistance.

Language Assistance Program
For members whose primary language isn't English, Anthem offers free language assistance services through interpreters and other written languages. If you or the member is interested in these services, please call the Anthem Member Services number on the member's ID card for help (TTY/TDD: 711).

URL: https://providernews.anthem.com/california/article/timely-access-regulations-and-language-assistance-program

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Case management program

Published: Dec 1, 2018 - **Products & Programs**

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross (Anthem) is available to offer assistance in these difficult moments with our Case Management Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience

and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us? Click on the attachment to view telephone numbers, days and hours of operations.

URL: https://providernews.anthem.com/california/article/case-management-program-5

Coordination of care

Published: Dec 1, 2018 - **Products & Programs**

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross (Anthem) would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

- Discuss with the patient the importance of communicating with other treating practitioners.

Obtain a signed release from the patient and file a copy in the medical record.
Document in the medical record if the patient refuses to sign a release.
Document in the medical record if you request a consultation.
If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:

- Diagnosis
- Treatment plan
- Referrals
- Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available on the Provider website including a Coordination of Care templates (includes cover letters for both Behavioral Health and other Healthcare Practitioners).* In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.**

*Access to the forms and cover letters are available at anthem.com/ca > Providers, scroll down to middle of page and select ***Find Resources for California*** > Answers@Anthem
**Access to the different Toolkits (program resources) are available using the same path and select the tab > Health and Wellness.

URL: https://providernews.anthem.com/california/article/coordination-of-care-1

ConditionCare program benefits patients and physicians

Published: Dec 1, 2018 - **Products & Programs**

Anthem Blue Cross (Anthem) members have additional resources available to help them better manage chronic conditions. The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of registered nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor’s orders and how to become a better self-manager of their condition.

Engagement methods vary by the individual's risk level but can include:

- Education about their condition through mailings, email newsletters, telephonic outreach, and/or online tools and resources.
- Round-the-clock phone access to registered nurses.
- Guidance and support from Nurse Care Managers and other health professionals.

Physician benefits:

- Save time by answering patients' general health questions and responding to concerns, freeing up valuable time for the physician and their staff.
- Support the doctor-patient relationship by encouraging participants to follow their doctor's treatment plan and recommendations.
- Inform the physician with updates and reports on the patient's progress in the program.

Please visit the www.anthem.com/ca website to find more information about the program such as program guidelines, educational materials and other resources. Also on our website is the Patient Referral Form, which you can use to refer other patients you feel may benefit from our Care Management program.

If you have any questions or comments about the program, call **1-877-681-6694**. Our nurses are available Monday-Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 5:30 p.m.

URL: https://providernews.anthem.com/california/article/conditioncare-program-benefits-patients-and-physicians-5

Introducing the new Clinical Criteria page for injectable, infused or implanted drugs

Published: Dec 1, 2018 - **Products & Programs** / Pharmacy

Beginning January 2019, providers will be able to visit the Clinical Criteria tab of the Pharmacy Information page to review clinical criteria for all injectable, infused or implanted prescription drugs.

Injectable oncology medical specialty drug clinical criteria will be located on the new site at a later date in 2019.

URL: https://providernews.anthem.com/california/article/introducing-the-new-clinical-criteria-page-for-injectable-infused-or-implanted-drugs-1

Pharmacy information available on anthem.com/ca

Published: Dec 1, 2018 - **Products & Programs** / Pharmacy

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit https://www11.anthem.com/ca/pharmacyinformation/. The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate “Marketplace Select Formulary” and pharmacy information, go to Customer Support, select your state, Download Forms and choose “Select Drug List. This drug list is also reviewed and updated regularly as needed.
FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org. > Pharmacy Benefits.

AllianceRX Walgreens Prime is the specialty pharmacy program for the Federal Employee Program. You can view the Specialty Drug List or call us at **1-888-346-3731** for more information.

URL: https://providernews.anthem.com/california/article/pharmacy-information-available-on-anthemcomca-2

Hospital recognition: NTSV C-Section Rates

Published: Dec 1, 2018 - **Administrative**

Anthem Blue Cross congratulates the 122 California hospitals that met or surpassed the Healthy People 2020 Nulliparious Term Singleton Vertex (NTSV) C-Section target rate,

aimed at reducing C-Sections for first-time mothers with low risk pregnancies as announced by the California Health and Human Services Agency on behalf of Smart Care California. The full honor roll list can be viewed here. You can learn more about reducing low-risk, first birth C-Sections here.

URL: https://providernews.anthem.com/california/article/hospital-recognition-ntsv-c-section-rates

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Availity to serve as EDI entry point for electronic submissions

Published: Dec 1, 2018 - **Administrative**

Anthem Blue Cross (Anthem) has designated Availity to operate and serve as your electronic data interchange (EDI) entry point or also called the EDI Gateway. The EDI Gateway is a **no-cost option** to our direct trading partners. With this change, Anthem continues our efforts to ensure consistency between your provider portal and the EDI Gateway.

As a mandatory requirement, all trading partners who currently submit directly to the Anthem EDI Gateway must transition to the Availity EDI Gateway. Availity is well known as a Web portal and claims clearinghouse. In addition, Availity functions as an EDI Gateway for multiple payers and is the single EDI connection for our company.

Your organization can submit and receive the following electronic transactions through Availity's EDI Gateway**:**

- 837- Institutional Claims
- 837- Professional Claims
- 837- Dental Claims
- 835 - Electronic Remittance Advice
- 276/277- Claim Status
- 270/271- Eligibility Request

If you wish to become a direct a trading partner with Availity, the setup is easy.

Use the Availity Welcome Application to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions. **If you prefer to use your clearinghouse or**

billing company, please work with them to ensure connectivity.

Need Assistance?
The Availity Quick Start Guide will assist you with any EDI connection questions you may have.

835 Electronic Remittance Advice (ERA)
Effective June 1, 2018, please use Availity to register and manage account changes for ERA. If you were previously registered to receive ERA, you must register using Availity to manage account changes.

Electronic Funds Transfer (EFT)
To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™ enrollment tool, a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes. No other action is needed.

Contacting Availity
If you have any questions, contact Availity Client Services at 1-800-Availity (**1-800-282-4548**), Monday through Friday 5 a.m. to 4:30 p.m. Pacific Time.

URL: https://providernews.anthem.com/california/article/availity-to-serve-as-edi-entry-point-for-electronic-submissions-1

Integrated Care Model for plans purchased on the health insurance marketplace benefits patients and physicians

Published: Dec 1, 2018 - **Administrative**

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the exchange) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being.

The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

How do you contact Case Management?
Members or caregivers can refer themselves or family members by calling the number below.

Email: case.management@anthem.com
Phone: 1-888-613-1130
Fax: 1-800-947-4074
Monday - Friday, 8:00 a.m. to 8:00 p.m. PT
Saturday, 9:00 a.m. to 4:30 p.m. PT

URL: https://providernews.anthem.com/california/article/integrated-care-model-for-plans-purchased-on-the-health-insurance-marketplace-benefits-patients-and-physicians-5

Anthem Blue Cross accepts electronic prior authorization requests for prescription medications online

Published: Dec 1, 2018 - **Products & Programs** / Pharmacy

Anthem Blue Cross (Anthem) accepts electronic medication prior authorization (ePA) requests for commercial health plans through covermymeds.com. This feature reduces processing time and helps determine coverage quicker. Some prescriptions are even approved in real time so that your patients can fill a prescription without delay. For example, medications such as celecoxib (Celebrex®), ezetimibe (Zetia®), fluocinolone acetonide

(Synalar®), Victoza®, and long acting opioids are automatically approved when a member meets step therapy and/or clinical criteria (as applicable).

Electronic ePA offers many benefits:

- More efficient review process
- Ability to identify if a prior authorization is required
- Able to see consolidated view of ePA submissions in real time
- Faster turnaround times
- A renewal program that allows for improved continuity of care for members with maintenance medications
- Prior authorizations are preloaded for the provider before the expiration date.

Providers can submit ePA requests by logging in at covermymeds.com. Creating an account is FREE.

For questions, please contact the provider service number on the member ID card.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-accepts-electronic-prior-authorization-requests-for-prescription-medications-online

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Anthem Blue Cross works to simplify payment recovery process for National Accounts membership

Published: Dec 1, 2018 - **Administrative**

In Anthem Blue Cross' (Anthem) ongoing efforts to streamline and simplify our payment recovery process, we continue to consolidate our internal systems and will begin transitioning our National Accounts membership to a central system in 2019. While this is not a new process, we are transitioning the National Accounts membership to align with the payment recovery process across our other lines of business.

Currently, our recovery process for National Accounts membership is reflected in the EDI PLB segment on the electronic remittance advice (835). This segment will show the negative balance associated with the member account number. Monetary amounts are displayed at the time of the recovery adjustment.

As National Accounts membership transitions to the new system and claims are adjusted for recovery, the negative balances due to recovery are held for 49 days to allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remits ***only*** within the “Deferred Negative Balance” sections.

After 49 days, the negative balances due are reflected within the 835 as a corrected and reversed claim in PLB segments.

If you have any questions or concerns, please contact the E- Solutions Service Desk toll free at **1-800-470-9630**.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-works-to-simplify-payment-recovery-process-for-national-accounts-membership

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Interactive Care Reviewer

Published: Dec 1, 2018 - **Administrative**

Interactive Care Reviewer (ICR), Anthem’s online authorization tool is adding a new feature to further increase the efficiency of your authorization process. In mid-December, you can begin using ICR to request a clinical appeal for denied authorizations and check the status of a clinical appeal. This feature is available for authorization requests submitted through ICR, phone or fax.

Requesting a clinical appeal is easy:
Logon to ICR from the Availity Portal and locate the case using one of the search options, or from your ICR dashboard.

- Select the **Request Tracking ID** link to open the case. If the case is eligible for an appeal you will see the **Request Appeal** menu option on the **Case Overview** screen.
- Select **Request Appeal** to open the **Appeal Details** screen and complete the required fields on the appeal template. (You also have the option of uploading attachments and images to support your request.)
- Select Submit

Take the steps below to check the status of a clinical appeal:
Logon to ICR from the Availity Portal

- Select **Check Appeal Status** from the ICR top menu bar
- Type the **Appeal Case ID** and **Member ID** in the allocated fields
- Select **Submit**

The appeal status and detail of the decision will open on the bottom of the screen.

Need more information on how to navigate the new ICR Appeals feature?

Download the *ICR Clinical Appeals Reference Guide* located on the Availity Portal. Select: **Payer Spaces | Applications | Education and Reference Center | Communication and Education**. Find the link to the reference guide below the ICR menu.

Additional Training:

If you are new to ICR or want to get a refresher please attend our monthly ICR webinar. The next event is taking place on December 6 at 1 PM ET. **Register Here**

URL: https://providernews.anthem.com/california/article/interactive-care-reviewer

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Individual on and off exchange plans: 2019 benefit year update

Published: Dec 1, 2018 - **Administrative**

For the 2019 benefit year, Anthem Blue Cross (Anthem) will continue to offer EPO Individual on-exchange and off-exchange plans in Covered California's rating regions 1, 7, and 10. As in 2018, for all other regions, Anthem will not be offering Individual health plans in 2019.* Below is a list of counties located in the regions where Anthem will be offering 2019 "non-grandfathered" EPO Individual plans.

Region 1 Counties:
Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba

Region 7 County:
Santa Clara

Region 10 Counties:
Mariposa, Merced, San Joaquin, Stanislaus, Tulare

**There is no change for members covered under an Anthem Individual "grandfathered" plan.*

Providers in Regions 1, 7 and 10
If you are participating in the on- and off-exchange network located in one of these regions, you will continue to provide services to Anthem members who have purchased coverage on- and off-exchange as you currently do under your provider agreement Please ensure that if your Anthem patient from regions 1, 7 or 10 **requires** an authorization or referral, that it is to an Anthem on- and off-exchange participating provider **within regions** 1, 7 or 10. The 2019 EPO plans do not have out-of-network benefits except for emergent/urgent or authorized services only.

URL: https://providernews.anthem.com/california/article/individual-on-and-off-exchange-plans-2019-benefit-year-update-2

Workers' Compensation Physicians Acknowledgments required by California Code of Regulations §9767.5.1 Medical Provider Networks

Published: Dec 1, 2018 - **Administrative**

As a reminder, the "Medical Provider Network (MPN) applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN."

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem's Provider Affirmation Portal, go to Availity and login. Once in, click on the Payer Spaces drop down menu in the top right hand corner, and select Anthem Blue Cross (Anthem) from the options available to you. On the next page click on "Resources" in the middle of the page and look for "MPN Provider Affirmation Portal."

If you cannot go online, call Anthem Workers' Compensation at **1-866-700-2168** and we can take action on your behalf in the Provider Affirmation Portal. Please also keep an eye out for email notifications from "Anthem MPN Admin."

Please also be advised the Provider Affirmation Portal will also notify participating medical providers when an MPN is terminating its relationship with Anthem and/or the Division of Workers Compensation.

URL: https://providernews.anthem.com/california/article/workers-compensation-physicians-acknowledgments-required-by-california-code-of-regulations-976751-medical-provider-networks-1

Contracted provider claim escalation process

Published: Dec 1, 2018 - **Administrative**

In an effort to better service our contracted providers right the first time, Anthem Blue Cross has improved our provider claim escalation process. Just click, Provider Claim Escalation Process to read, print, download and share the improved process with your office staff.

Our Network Relations Team is available by email at CAContractSupport@anthem.com to answer questions you have about the process.

URL: https://providernews.anthem.com/california/article/contracted-provider-claim-escalation-process-2

Provider Education seminars, webinars, workshops and more!

Published: Dec 1, 2018 - **Administrative**

Our Provider Network Education team offers quality complimentary educational programs and materials specially designed for our providers. For a complete listing of our workshops, seminars, webinars and job aids, log on to the Anthem Blue Cross website: www.anthem..com/ca. Select Provider, then scroll to the middle of the page to select the box ***Find Resources for California***. From the **Answers@Anthem** page, select the link titled Provider Education Seminars and Webinars link.

URL: https://providernews.anthem.com/california/article/provider-education-seminars-webinars-workshops-and-more-2

Anthem Blue Cross provider directory and provider data updates

Published: Dec 1, 2018 - **Administrative**

It is extremely important that we have accurate and up-to-date information about your practice in our directories. Senate Bill 137 (SB 137), which went into effect on July 1, 2016, requires that Anthem Blue Cross (Anthem) provide our members accurate and up-to-date provider directory data. As a result, Anthem will be conducting ongoing outreaches to all practices to confirm the information we have on file is accurate. Without verification from you that our Provider Directory information is accurate, we will be required to remove your practice from the directories we make available to our members. We appreciate your attention to this matter.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-provider-directory-and-provider-data-updates-2

Easily update provider demographics with the online Provider Maintenance Form

Published: Dec 1, 2018 - **Administrative**

Anthem Blue Cross (Anthem) providers should now submit changes to their practice profile using our online Provider Maintenance Form.

Online update options include: add an address location, name change, tax ID changes, provider leaving a group or a single location, phone/fax numbers, closing a practice location, etc. Visit the Anthem.com/ca form page to review more.

The new online form can be found on **www.anthem.com/ca/provider/ > *Find Resources for California >*** *Answers@Anthem tab>Provider Forms bullet>Provider Change Forms> Provider Maintenance Form*. In addition, the **Provider Maintenance Form** can be found on the **Availity Web Portal** by selecting *California> Payer Spaces-Anthem Blue Cross> Resources tab >Provider Maintenance Form.*

Important information about updating your practice profile:

- **Change request should be submitted using the online Provider Maintenance Form**

- Submit the change request online. No need to print, complete and mail, fax or email demographic updates
- You will receive an auto-reply e-mail acknowledging receipt of your request and another email when your submission has been processed
- For change(s) that require submission of an updated IRS Form w-9 or other documentation, attach them to the form online prior to submitting
- Change request should be submitted with advance notice
- Contractual agreement guidelines may supersede effective date of request

You can check your directory listing on the *Anthem Blue Cross: "Find a Doctor tool".* The Find a Doctor tool at Anthem is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To ensure Anthem has the most current and accurate information, please take a moment to access the Find A Doctor tool (www.anthem.com/ca) and review how you and your practice are being displayed.

To report discrepancies please make correction by completing this *Provider Maintenance Form* online.

URL: https://providernews.anthem.com/california/article/easily-update-provider-demographics-with-the-online-provider-maintenance-form-2

Sign-up now for our Network eUPDATE today – it's free!

Published: Dec 1, 2018 - **Administrative**

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our *Network eUPDATEs*.

Network eUPDATE is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates
- System changes
- Fee Schedules

- Medical policy updates
- Claims and billing updates

……and much more

Registration is fast and easy. There is no limit to the number of subscribers who can register for *Network eUPDATEs*, so you can submit as many e-mail addresses as you like.

URL: https://providernews.anthem.com/california/article/sign-up-now-for-our-network-eupdate-today-its-free-2

Network leasing arrangements

Published: Dec 1, 2018 - **Administrative**

Anthem Blue Cross (Anthem) has network leasing arrangements with a variety of organizations, which we call *Other Payors*. Other payors and affiliates use the Anthem network.

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem members. As such, they're entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payors* list on the Availity web portal, at www.Availity.com. From the Availity site, select Home > Anthem California > Education and Reference Center, or email us at CAContractSupport@Anthem.com.

URL: https://providernews.anthem.com/california/article/network-leasing-arrangements-2

Clinical practice and preventive health guidelines available online

Published: Dec 1, 2018 - **Policy Updates**

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances

and recent medical research.

All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to https://www.anthem.com/ca/provider/, scroll down and click on ***Review Polices***. This will take you to ***Medical Policy, Clinical UM Guidelines and Pre-Certification Requirements***. Then click on Medical Policies and Clinical UM Guidelines (for local Plan members).

URL: https://providernews.anthem.com/california/article/clinical-practice-and-preventive-health-guidelines-available-online-2

Members' rights and responsibilities

Published: Dec 1, 2018 - **Policy Updates**

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, *A*nthem Blue Cross (Anthem) has adopted a Members' Rights and Responsibilities statement.

The statement can be found on Anthem's web site, at www.anthem.com/ca. From there, select **Provider**, then scroll down to ***Find Resources for California***. Click on the ***Health & Wellness*** tab, and from the drop down menu, select ***Quality Improvement and Standards***. Then click on ***Member Rights & Responsibilities*** link. Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

URL: https://providernews.anthem.com/california/article/members-rights-and-responsibilities-1

Vaginal birth after cesarean certified shared decision making aid available on the web

Published: Dec 1, 2018 - **Policy Updates**

As part of our commitment to provide you with the latest clinical information, we have posted a Vaginal Birth After Cesarean (VBAC) shared decision making aid to our provider portal.

This is a tool for you to discuss with your patients to aid in making a decision regarding their treatment options. This has been reviewed and certified by the Washington Health Care Authority (HCA) and is available on our website. To access the aid, go to anthem.com/ca and select **Provider** from the top menu. From there, click on ***Providers Overview***, select your state and scroll down and choose ***Find Resources in California***. From the ***Health & Wellness*** page, choose **Practice Guidelines**, then **Shared Decision Making Aid**.

URL: https://providernews.anthem.com/california/article/vaginal-birth-after-cesarean-vbac-certified-shared-decision-making-aid-available-on-the-web-7

An overview of our medical necessity review process

Published: Dec 1, 2018 - **Policy Updates**

A medical necessity review may be called many things - including utilization review (UR), utilization management (UM) or medical management - within the Evidence of Coverage or benefit booklet. Requirements for medical necessity review vary based on the member's benefit plan. Reviews of a medical service may occur:

- when it is requested or planned (prospective or pre-service review)
- during the course of care (inpatient or outpatient ongoing care review)
- after services have been delivered (retrospective or post-service review)

With so many variables, it may help to get a clear picture of what to expect and how the process works.

Timing is Important

We are committed to deciding cases quickly and professionally. Here are several time frames you can expect: **Click on the attachment** to view the requirements.

Urgent Review Requests

An urgent review request is a request for pre-service review that in the view of the treating provider or any physician with knowledge of the member's medical condition, could without such care and treatment, seriously threaten the member's life or health or their ability to regain maximum function or subject them to severe pain that cannot be adequately managed without such care or treatment.

Notification of Delay in Review Determination
If we do not have the information we need to make our decision, we will try to get it from the physician or other health care provider who is requesting the service, medical procedure or equipment. If a delay is anticipated because the information is not readily available, we will notify the member as well as the requesting physician or other health care provider in writing. Delay letters include a description of the information we need to make a decision and also specify when the decision can be expected once the information is received. If we do not receive the necessary information, we will send a final letter explaining that we are unable to approve access to benefits due to lack of the information requested.

We Use Professional, Qualified Reviewers
Experienced clinicians review requests for services using medical criteria, established guidelines and Anthem Blue Cross Medical Policy. Requests for covered benefits meeting those standards are certified as medically necessary.

Only a Peer Clinical Reviewer May Determine That a Service is Not Medically Necessary
Peer Clinical Reviewers (PCRs) are California licensed health care professionals qualified and clinically competent to evaluate the specific clinical aspects of the request and/or treatment under review. PCRs are licensed in California in the same license category as the requesting physician or other health care provider. If you need to discuss a Medical Policy or a medical necessity review decision, an Anthem Blue Cross Medical Director or Peer Clinical Reviewer is available at 800-794-0838. If the PCR is unable to approve a service, the requesting physician, another health care provider or the member has the right to request an appeal.

Decisions Not to Approve Are in Writing
Written notice is sent to the member and the requesting physician or other health care provider within two business days of the decision. This written notice includes:

- a clear and concise explanation of the reason for the decision
- the name of the criteria and/or guidelines used to make the decision
- the name and phone number of the Peer Clinical Reviewer who made the decision, for peer-to-peer discussion
- instructions for how to appeal a decision o specific provisions of the contract that excludes coverage if the denial is based upon benefit coverage

Access to Criteria is Open
Anthem Blue Cross medical necessity guidelines and criteria for specific services are available to members, member representatives, health care providers and the public. Members may call the number on the back of their ID card for a copy of the guidelines used to determine their case. Anthem Blue Cross Medical Policy is also available at www.anthem.com/ca. Providers can access UM criteria by selecting “Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider Home page; or call 1-800-794-0838 to request that a paper copy be sent to you. The requested criteria is provided free of charge.

A Determination of Medical Necessity Does Not Guarantee Payment or Coverage
The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of a member’s coverage at the time of service. These terms include certain exclusions, limitations and other conditions, as outlined in the member’s Evidence of Coverage or benefit booklet. Payment of benefits could be limited for a number of reasons, for example:

- the information submitted with the claim differs from that given at time of review
- the service performed is excluded from coverage
- the member is not eligible for coverage when the service is actually provided

Decisions About Coverage of Service
Our utilization management decisions are based on the appropriateness of care and service needed, as well as the member’s coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization.

We Are Available for Questions
If you need to request precertification, need information about our UM process, or have questions or issues, call our toll-free number: 1-800-274-7767. Our associates are available Monday through Friday (except holidays), 8:00 a.m. to 5:00 p.m., Pacific Time. If you call after hours or do not reach someone during business hours, you may leave a confidential voice mail message. Please leave your name and phone number; we will return your call no later than the next business day during the hours listed above, unless other arrangements

are made. Calls received after midnight will be returned the same business day. Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. Language Assistance For those who request language services, Anthem Blue Cross provides service in the requested language through bilingual staff or an interpreter, to help members with their UM issues.

Language Assistance
For those who request language services, Anthem Blue Cross provides service in the requested language through bilingual staff or an interpreter, to help members with their UM issues. Language assistance is provided to members free of charge. Oral interpretation is available at all points of member contact regarding UM issues.

TDD/TTY Services
TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. If you have a hearing or speech loss, call 711 to use the National Relay Service or the number below for the California Relay Service. A special operator will contact Anthem to help with member needs.

1-800-855-7100 (English TTY/ English Voice)

For Federal Employee Program, call the number on the member ID card. Utilization management is administered by Blue Shield of California.

URL: https://providernews.anthem.com/california/article/an-overview-of-our-medical-necessity-review-process

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HEDIS 2018: Commercial results are in

Published: Dec 1, 2018 - **Policy Updates**

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) commercial data collection project for 2018. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report

validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate the HEDIS process improvement by:

- Responding to our requests for medical records within five days, if possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient's medical record

Further information regarding documentation guidelines and administrative codes can be found on the HEDIS page of our Provider Portal. In addition more information on HEDIS can be found by visiting the provider portal at: www.anthem.com > Provider > Choose State > Find Resources > Health & Wellness (top blue bar) > Quality Improvement and Standards > HEDIS Information. You will find reference documents entitled "HEDIS 101 for Providers" and "HEDIS Physician Documentation Guidelines and Administrative Codes".

The **attached table** shows some of our key measure rates across California.

- Yellow boxes indicate rates that are above the national average.
- **Bold** indicates improvement in rate over the previous year.
- B/R = Biased Rate, NR = Not Reported, NA = Not Applicable - denominator too small
- Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good

URL: https://providernews.anthem.com/california/article/hedis-2018-commercial-results-are-in-2

Restructure of AIM advanced imaging clinical appropriateness guidelines

Published: Dec 1, 2018 - **Policy Updates** / Medical Policy & Clinical Guidelines

AIM advanced imaging clinical appropriateness guidelines have been restructured to improve usability and to further link clinical criteria with supporting evidence. These structural enhancements resulted in no changes to existing clinical criteria or content.

- Access AIM's ***Provider****Portall*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: **1-877-291-0360**, Monday – Friday, 7:00 a.m. – 5:00 p.m., PT.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

URL: https://providernews.anthem.com/california/article/restructure-of-aim-advanced-imaging-clinical-appropriateness-guidelines-2

Update to AIM clinical appropriateness guidelines

Published: Dec 1, 2018 - **Policy Updates** / Medical Policy & Clinical Guidelines

Effective for dates of service on and after March 9, 2019, the following updates will apply to all of AIM's Clinical Appropriateness Guidelines, including Advanced Imaging, Cardiac, Sleep, Radiation Oncology and Musculoskeletal guidelines.

Clinical Appropriateness Framework

Replacing pretest requirements, this section will more accurately describe the guideline's purpose, which is to provide a summary of the fundamental components of a decision to pursue diagnostic testing. In order to support the full spectrum of AIM solutions, the terms "imaging request" or "diagnostic imaging" are replaced with "diagnostic or therapeutic

intervention”.

Ordering of Multiple Diagnostic or Therapeutic Interventions
Replacing ordering of multiple studies, this section expands its applicability to AIM solutions outside of diagnostic imaging. Terminology specific to imaging studies is replaced with the term “diagnostic or therapeutic intervention” to reflect a broader application of the principles included here.

Repeat Diagnostic Testing and **Repeat Therapeutic Intervention**
Replacing repeated imaging, these sections establish conditions in which duplication of the initial test or intervention may be warranted, and where such requests will require peer-to-peer discussion.

- Access AIM’s ***Provider****Portall*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: **1-877-291-0360**, Monday – Friday, 7:00 a.m. – 5:00 p.m., PT.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

URL: https://providernews.anthem.com/california/article/update-to-aim-clinical-appropriateness-guidelines-3

Important reminder: Professional reimbursement policy update Scope of License

Published: Dec 1, 2018 - **Policy Updates** / Reimbursement Policies

On November 30, 2017, Anthem Blue Cross (Anthem) mailed letters notifying its participating provider networks that effective March 1, 2018, Anthem would not reimburse services to a provider that is outside of their state requirements through Anthem's Scope of

License policy. Anthem has updated its editing systems to deny services deemed to be outside of a specific specialty's scope of license.

URL: https://providernews.anthem.com/california/article/important-reminder-professional-reimbursement-policy-update-scope-of-license

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Misrouted protected health information

Published: Dec 1, 2018 - **Administrative**

Providers and facilities are required to review all member information received from Anthem Blue Cross (Anthem) to help ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Anthem's provider services area to report receipt of misrouted PHI.

URL: https://providernews.anthem.com/california/article/evaluation-and-management-with-modifier-25-same-day-as-procedure-3

Anthem works to help ensure appropriate billing of E&M services

Published: Dec 1, 2018 - **Policy Updates** / Reimbursement Policies

As part of Anthem Blue Cross (Anthem) quality and utilization programs, we routinely analyze the billing patterns of practices in our provider networks using nationally recognized guidelines from the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA). For high-level evaluation and management (E&M) services, the

process involves identifying the number of patients receiving high-level E&M services while comparing practices within related specialties.

Beginning October 10, 2018, Anthem launched a program to help ensure high-level E&M codes are billed appropriately according to CMS and AMA requirements on the claims we receive. During our claims review, Anthem will identify physicians who order high-level E&M services at a significantly greater frequency than that of their peers. Should we find claims with a disproportionate number of high-level E&M services billed as compared to that of other physicians within similar specialties, we will reach out to physicians to provide education about appropriate billing guidelines. Educational outreach will allow for discussion between Anthem and the physician about nationally recognized guidelines and correct coding outcomes.

Those physicians who continue to bill high-level E&M service codes inappropriately may be subject to a decrease in the physician's fee schedule that is consistent with the terms of the physician's contract. Such rate adjustments will only be implemented after Anthem has completed provider education and confirmed the accuracy and reliability of billing inaccuracies for high-level E&M service codes.

Physicians can learn more about the details of this program by reviewing the policy, Evaluation for High Utilization of High Level Service Codes by Participating Providers.

URL: https://providernews.anthem.com/california/article/anthem-works-to-help-ensure-appropriate-billing-of-em-services

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Claims system updates for 2019: Professional

Published: Dec 1, 2018 - **Administrative**

As a reminder, our claim editing software will be updated monthly throughout 2019 with the most common updates occurring in quarterly in February, May, August and November of 2019. These updates will:

- reflect the addition of new, and revised codes (e.g. CPT, HCPCS, ICD-10, modifiers) and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits

- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, frequency edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

URL: https://providernews.anthem.com/california/article/claims-system-updates-for-2019-professional

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Coding tip: Claims processed with Modifier 79 should be reported by the same health care professional

Published: Dec 1, 2018 - **Administrative**

Current Procedural Terminology (CPT®) specifically states modifier 79 should be reported by the same individual when reporting unrelated procedures or services during the postoperative period. **For example**, this modifier is used when a patient presents with a problem that is unrelated to a previous surgery (yet within the postoperative period) and requires additional services by the same provider/individual. **When modifier 79 is appended for a different provider (e.g. Nurse Practitioner or Physician Assistant) during the postoperative period the claim line will deny.**

- In addition to modifier 79, modifiers 58 and 78 are also based on Same Physician or Other Qualified Health Care Professional as documented below:
- 58 – Staged/Related Procedure/Service by the Same Physician/Other Qualified Health Care Professional during the Postoperative Period.
- 78 – Unplanned Procedure/Service by Same Physician/Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure during the Postoperative Period.

URL: https://providernews.anthem.com/california/article/coding-tip-claims-processed-with-modifier-79-should-be-reported-by-the-same-health-care-professional-1

Coordination of benefits for an Federal Employee Plan member

Published: Dec 1, 2018 - **State & Federal** / Federal Employee Plan (FEP)

Anthem Blue Cross values the relationship we have with our providers, and always look for opportunities to help expedite the claim processing. When a Federal Employee visits the provider office, obtaining the most current medical insurance information will help to establish the primary carrier, and will alleviate claim denials and support accurate billing. For questions please contact the Federal Employee Customer Service at: **1-800-824-8839.**

URL: https://providernews.anthem.com/california/article/coordination-of-benefits-for-an-federal-employee-plan-fep-member

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Benefit change for Infliximab for Federal Employee Program

Published: Dec 1, 2018 - **State & Federal** / Federal Employee Plan (FEP)

Beginning January 1, 2019, Anthem Blue Cross (Anthem) Federal Employee Program® (FEP) benefit procedures will change for the autoimmune infusion drug infliximab (brand names Remicade, Inflectra, and Renflexis). Members currently receiving the drug may be covered under either pharmacy or medical benefits. Howeber, members who receive a first infusion or or after January 1, 2019, can only receive the drug under medical benefits. Members who receive it under pharmacy benefits prior to January 1, 2019, will continue receiving it under pharmacy benefits.

If you have anu questions please contact FEP Customer Serivce at: **1-800-284-9093.**

URL: https://providernews.anthem.com/california/article/benefit-change-for-infliximab-for-federal-employee-program-2

2019 FEP Benefit information available online

Published: Dec 1, 2018 - **State & Federal** / Federal Employee Plan (FEP)

To view the 2019 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2019, including information on the new PPO product *Blue Focus*, being offered to federal employees effective January 1, 2019. For questions please contact FEP Customer Service at: **1-800-284-9093.**

URL: https://providernews.anthem.com/california/article/2019-fep-benefit-information-available-online-2

New Medicare Advantage provider service phone number beginning January 1, 2019

Published: Dec 1, 2018 - **State & Federal** / Medicare

Effective January 1, 2019, Medicare providers will have toll free phone numbers specifically designated for their service inquiries. These new provider numbers will be listed separately on the back of the member ID cards and should be used beginning January 1, 2019. The associates answering your provider service calls are trained to answer your questions and resolve your issues as quickly as possible. To ensure you receive the most efficient service, please refrain from using the member services line and use only **1-844-421-5654** or the provider services phone number listed on the back of the member ID card for provider service for individual Medicare Advantage calls beginning January 1, 2019.

URL: https://providernews.anthem.com/california/article/new-medicare-advantage-provider-service-phone-number-beginning-january-1-2019-2

2019 Medicare Advantage individual benefits and formularies

Published: Dec 1, 2018 - **State & Federal** / Medicare

Summary of benefits, evidence of coverage and formularies for 2019 individual Medicare Advantage plans will be available at anthem.com/ca/medicareprovider. An overview of notable 2019 benefit changes also is available at Important Medicare Advantage Updates at anthem.com/ca/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/ca/medicareprovider for the latest Medicare Advantage information.

URL: https://providernews.anthem.com/california/article/2019-medicare-advantage-individual-benefits-and-formularies-2

CMS Medicare Preclusion list effective April 1, 2019

Published: Dec 1, 2018 - **State & Federal** / Medicare

The U.S. Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage and Part D organizations, including Anthem, will implement a new initiative, the Preclusion List, to protect the integrity of the Medicare Trust Funds. Beginning April 1, 2019, Medicare Advantage and Part D organizations will deny payment for items and services furnished by providers that CMS has placed on the Preclusion List. For more information, visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

URL: https://providernews.anthem.com/california/article/cms-medicare-preclusion-list-effective-april-1-2019-2

When and how to initiate Medicare Advantage reopenings

Published: Dec 1, 2018 - **State & Federal** / Medicare

When a claim must be corrected beyond the initial claim timely filing limit of one year from the **date of service**, a normal adjustment bill is not allowed. Providers must use the reopening process to correct the error. To learn when and how to initiate reopenings and adjustments, check Important Medicare Advantage Updates at anthem.com/ca/medicareprovider.

URL: https://providernews.anthem.com/california/article/when-and-how-to-initiate-medicare-advantage-reopenings-2

Individual Medicare plans move compound drugs off formulary beginning January 1, 2019

Published: Dec 1, 2018 - **State & Federal** / Medicare

Beginning January 1, 2019, Individual Medicare Advantage plans will move compounded drugs to non-formulary with the exception of home infusion drugs. Group-sponsored Medicare Advantage members will continue to have compounded drug coverage; these drugs will require prior authorization. Compounded home infusion drugs will continue to be covered for both Individual Medicare and group-sponsored members without prior authorizations. Members and/or providers can request a non-formulary exception for compounded drugs.

URL: https://providernews.anthem.com/california/article/individual-medicare-plans-move-compound-drugs-off-formulary-beginning-january-1-2019-2

Medicare Part B drugs may include Step Therapy beginning January 1, 2019

Published: Dec 1, 2018 - **State & Federal** / Medicare

CMS updated its guidance to allow Medicare Advantage plans the option of implementing step therapy for Part B drugs as part of a patient-centered care coordination program beginning January 1, 2019. The goal is to lower drug prices while maintaining access to covered services and drugs for beneficiaries. Anthem will implement step therapy edits to promote clinically appropriate and cost effective drug options for our members. A patient-centered care coordination program will be created to ensure member access to necessary drugs, provide medication reviews and reconciliations, educate members regarding their medications, encourage medication adherence, and provide incentives to members who complete care coordination programs.

URL: https://providernews.anthem.com/california/article/medicare-part-b-drugs-may-include-step-therapy-beginning-january-1-2019-2

Los Angeles Unified School District offers Medicare Advantage option

Published: Dec 1, 2018 - **State & Federal** / Medicare

Effective January 1, 2019, Los Angeles Unified School District (LAUSD) will offer an Anthem Medicare Preferred (PPO) plan. Retirees with Medicare Parts A and B are eligible to enroll in the Anthem Medicare Preferred (PPO) plan. The plan includes the National Access Plus benefit, which allows retirees to receive services from any provider, as long as the provider is eligible to receive payments from Medicare. In addition, LAUSD retirees pay no cost share for both in-network and out-of-network services. The MA plan offers the same hospital and medical benefits that Medicare covers and also covers additional benefits that Medicare does not, such as an annual routine physical exam, hearing, vision, chiropractic care, acupuncture, LiveHealth Online and SilverSneakers®.

The prefix on LAUSD cards will be MBL. The cards will also show the LAUSD logo and National Access Plus icon. Providers may submit claims electronically using the electronic payer ID for the Blue Cross and Blue Shield plan in their state or submit a UB-04 or CMS-1500 form to the Blue Cross and Blue Shield plan in their state. Claims should not be filed with Original Medicare. Contracted and non-contracted providers may call the provider services number on the back of the member ID card for benefit eligibility, prior authorization requirements and any questions about LAUSD member benefits or coverage.

Detailed prior authorization requirements also are available to contracted providers by accessing the Provider Self-Service Tool at Availity.com.

URL: https://providernews.anthem.com/california/article/los-angeles-unified-school-district-lausd-offers-medicare-advantage-option

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Keep up with Medicare news

Published: Dec 1, 2018 - **State & Federal** / Medicare

Please continue to check Important Medicare Advantage Updates at anthem.com/ca/medicareproviderfor the latest Medicare Advantage information, including:

2019 provider annual notice of change
Prior authorization requirements for Colonoscopy and Upper Gastrointestinal Endoscopy
Medicare Advantage Reimbursement Policy October Provider Bulletin
Prior authorization requirements for Part B drugs: Moxetumomab Pasudotox, Cemiplimab and Fulphila
Prior authorization requirements for Part B drugs: Nivestym
Prior authorization requirements for high level definitive drug testing(s)
July Medicare Advantage reimbursement policy
Submit PA medication requests electronically; new phone number for MA prescription PAs
CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective Jan. 1, 2019
Inpatient Readmissions
Group sponsored Medicare Advantage plan members to receive new ID cards

74837MUPENMUB 10/25/2018

URL: https://providernews.anthem.com/california/article/keep-up-with-medicare-news-19

Quarterly pharmacy formulary change

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

The formulary changes listed in the **attached table** were reviewed and approved at our first quarter 2018 Pharmacy and Therapeutics Committee meeting.

Effective August 1, 2018, these changes were applied to Anthem Blue Cross (Anthem) patients.

What action do I need to take?
Please review these changes and work with your Anthem patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

What if I need assistance?
We recognize the unique aspects of patients' cases. If for medical reasons your Anthem patient cannot be converted to a formulary alternative, please call our Pharmacy department at **1-866-310-3666** and follow the voice prompts for pharmacy prior authorization. You can find the *Preferred Drug List* on our provider website at **https://mediproviders.anthem.com/ca**.

If you need assistance with any other item, contact the Customer Care Center at **1-800-407-4627** (outside L.A. County) or **1-888-285-7801** (inside L.A. County).

URL: https://providernews.anthem.com/california/article/quarterly-pharmacy-formulary-change

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Claims requiring additional documentation

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

Professional providers and facilities are required to submit additional documentation for adjudication of applicable types of claims. If the required documentation is not submitted, the claim may be denied. Anthem Blue Cross may request additional documentation or notify the provider or facility of additional documentation required for claims, subject to contractual obligations.

Effective March 1, 2019, if an itemized bill is requested and/or required, then it must include the appropriate revenue code for each individual charge.

For additional information, please review the Claims Requiring Additional Documentation reimbursement (*policy 06-031*) at **https://mediproviders.anthem.com/ca**.

URL: https://providernews.anthem.com/california/article/claims-requiring-additional-documentation

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Coding spotlight: Substance use disorders and smoking

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

Substance use disorders can affect a person's brain and in turn their behavior. Substance use can start with the experimental use of a drug in a social situation or exposure to prescribed medications. Eventually it can lead to an inability to control the use of the legal or illegal drug or medication. When a patient is diagnosed with an alcohol- or drug- use disorder, the diagnosis is often more complex, as such conditions are susceptible to both psychological and physiological signs, symptoms, manifestations and comorbidities. This article will provide you with the information you need to provide high-quality care to patients struggling with substance use as well as how to code for the services provided to them.

Drug and substance addiction in the U.S.

The U.S. Department of Health and Human Services declared a public health emergency in 2017 due to an unprecedented opioid epidemic. Drug overdose deaths and opioid-involved deaths continue to increase in the U.S.[1]

Smoking is the leading preventable cause of death in the United States. According to the Centers for Disease Control (CDC), 15.5 % of all adults (37.8 million people) were current cigarette smokers in 2016.[2]

Health risks of drug use and smoking

Drugs can have significant and damaging short-term and long-term effects, including psychotic behavior, seizures or death due to overdose. Dependence on drugs can create a number of dangerous and damaging complications, such as accidents, suicide, family/work/school problems and legal issues.

Smoking diminishes overall health and is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease (COPD) and many other diseases. There are also health dangers of involuntary exposure to (second-hand) tobacco smoke. Smoking increases risks for preterm delivery.[3]

Diagnosis and treatment

Diagnosing substance use disorders requires a thorough evaluation and includes an assessment by a psychiatrist or a psychologist or an independently licensed behavioral health practitioner that has met the state requirements to render a diagnosis. Blood, urine or other lab tests are used to assess drug use.

People with behavioral disorders are more likely to experience a substance use disorder and people with a substance use disorder are more likely to have behavioral health issues when compared to the general population. According to the National Survey of Substance Abuse Treatment Services, about 45% of Americans seeking treatment of substance use/abuse have also been diagnosed with behavioral health problems.[4]

When diagnosing a substance use disorder, most mental health professionals use criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association.

Treatment depends on the type of substance used and any related medical or behavioral health disorders that the patient may have. Some treatment options include:

- Chemical dependence treatment programs
- Detoxification
- Behavioral therapy
- Self-help groups

There are a lot of treatments to support tobacco cessation, including behavioral therapies and FDA-approved medications. Some treatment options to help ensure tobacco cessation include:

- Nicotine replacement therapy (NRT), as well as bupropion and varenicline

- Combination of behavioral treatment and cessation medications
- Mobile devices and social media help to boost tobacco cessation
- Tobacco cessations are not recommended for adolescents due to lacking high-quality studies
- Behavioral counseling can be provided either in person or by telephone and a variety of approaches are available such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), telephone support lines, text messaging, web-based services and social media.[5]

HEDIS® quality measures

Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment (IET) is a measure that assesses the percentage of plan members' ages 13 years and older with the new episode of alcohol or other drug (AOD) abuse or dependence who received the following: initiation of AOD and engagement of AOD.

Initiation of treatment is the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Engagement of treatment is the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days after the initiation visit.[6] This measure now includes medication-assisted treatment (MAT) as an appropriate treatment for people with alcohol and opioid dependence. This measure also adds telehealth to treatment options.

Use of Opioids at High Dosage (UOD) is a first year quality measure that assesses the number of members 18 years and older per 1,000 beneficiaries receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average morphine equivalent dose > 120 mg).[7]

Use of Opioids from Multiple Providers (UOP) is a first year quality measure that assesses the number of members 18 years and older per 1,000 receiving a prescription for opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

- *Multiple prescribers* – the rate per 1,000 members receiving prescriptions for opioids from four or more different prescribers during the measurement year

- *Multiple pharmacies* – the rate per 1,000 members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
- *Multiple prescribers and multiple pharmacies* – the rate per 1,000 members receiving prescriptions for opioids from four or more different prescribers *and* four or more different pharmacies during the measurement year.[7]

Unhealthy Alcohol Use Screening and Follow-Up (ASF) is a measure that assess the percentage of health plan members 18 years and older who were screened for unhealthy alcohol use using a standardized tool and, if screened positive, received appropriate follow-up care.

- *Unhealthy alcohol use screening* – the percentage of members who had a systematic screening for unhealthy alcohol use
- *Counseling or other follow-up* – the percentage of members who screened positive for unhealthy alcohol use and received brief counseling or other follow-up care within 2 months of a positive screening.

The intent of the measure: alcohol misuse is a leading cause of illness, lost productivity and preventable death in the U.S.[7]

Medical Assistance with Smoking and Tobacco Use Cessation (MSC) is a survey measure that assesses different facets of providing medical assistance with smoking and tobacco use cessation. There are three components of the survey:

- *Advising Smokers and Tobacco Users to Quit:* Adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year
- *Discussing Cessation Medications:* Adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year
- *Discussing Cessation Strategies:* Adults 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.

ICD-10-CM: general coding information

When a patient is diagnosed with an alcohol- or drug-related disorder, the diagnosis is often more complex, as such conditions are susceptible to both psychological and physiological signs, symptoms, manifestations, and comorbidities.

Details are required from the documentation to identify *use, abuse* or *dependence* of the substance.

Based on ICD-10-CM Coding Guidelines, when *use, abuse* or *dependence* of the same substance are documented in the medical record, only one code should be assigned based on the following hierarchy:

- If both *use* and *abuse* are documented, the code for *abuse* should be assigned
- If both *abuse* and *dependence* are documented, the code for *dependence* should be assigned

- If *use, abuse* and *dependence* are documented, the code for *dependence* should be assigned
- If both *use* and *dependence* are documented, the code for *dependence* should be assigned.[8]

Alcohol dependence and abuse

- Alcohol related disorders are classified to category **F10**-. An additional code for blood alcohol level **(Y90.-)** may be assigned, if applicable

- Alcohol *abuse* is classified under subcategory **F10.**-, Alcohol abuse

- Alcohol *dependence* is classified under subcategory **F10.2-**, Alcohol dependence
- Both categories *alcohol abuse* and *alcohol dependence***,** are further subdivided to specify the presence of *intoxication* or *intoxication delirium*. Additional characters are also provided to specify *alcohol-induced mood disorder*, *psychotic disorder*, and *other alcohol-induced disorders*

- Codes in sub classification **F10.23**-, Alcohol dependence with withdrawal, provide additional detail regarding withdrawal symptoms such as *delirium* and *perceptual disturbance*

- Selection of codes “in remission” for categories **F10-F19** requires the provider’s clinical judgement. The appropriate codes for “in remission” are assigned only on the basis of provider documentation, unless otherwise instructed by the classification
- Toxic effect of alcohol is not classified to category F10 but to subcategory **T51.0**- instead.[9]

Drug dependence and abuse

ICD-10-CM classifies drug dependence and abuse in the following categories according to the class of the drug:

F12	Cannabis related disorders
F13	Sedative, hypnotic or anxiolytic related disorders
F14	Cocaine related disorders
F15	Other stimulant related disorders
F16	Hallucinogen related disorders
F17	Nicotine dependence
F18	Inhalant related disorders
F19	Other psychoactive substance related disorders

- In most cases, fourth characters indicate whether the disorder is *nondependent abuse* (1), *dependence* (2), or *unspecified use* (9).
- Additional characters also provided to specify *intoxication*, *intoxication delirium*, and *intoxication with perceptual disturbance*.
- Patients with substance abuse or dependence often have related physical complications or psychotic symptoms. These complications are classified to the specific drug abuse or dependence, with the fifth or sixth characters providing further specificity regarding any associated *drug-induced mood disorder*, *psychotic disorder*, *withdrawal*, and *other drug-induced disorders* (such as sleep disorder).

Tobacco use and dependence
Category F17. - (nicotine dependence) codes are located in chapter 5 of the ICD-10-CM book.

The Excludes 1 note reminds that this is not the same diagnosis as tobacco use **(Z72.0)** nor the history of tobacco dependence **(Z87.891).** Therefore, the documentation will need to specifically discern between tobacco use and nicotine dependence.

The Excludes 2 note reminds to code tobacco use (smoking) during pregnancy, childbirth and the puerperium **(O99.33-)** and toxic effect of nicotine **(T65.2-).**

If the patient has been in contact with, or in close proximity to, a source of tobacco smoke, then **Z77.22**, Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic), need to be reported.

Tobacco abuse counseling is reported using code **Z71.6** with the additional code for nicotine dependence **(F17.-).**

ICD-10-CM classifies nicotine dependence by substance:

- F17.20-, nicotine dependence, unspecified
- F17.21-, nicotine dependence, cigarettes
- F17.22-, nicotine dependence, chewing tobacco
- F17.29-, nicotine dependence, other tobacco product.9

Each category further breaks down the dependence using a sixth character to denote:

0	Uncomplicated
1	In remission
3	With withdrawal
8	With other nicotine-induced disorders

References:
Opioid overdose. Overview of an epidemic.
https://www.cdc.gov/drugoverdose/data/index.htm

Current cigarette smoking among adults – United States, 2016. **https://www.cdc.gov/mmwr/volumes/67/wr/mm6702a1.htm?s_cid=mm6702a1_w%20**
CDC. Health effects of cigarette smoking. Retrieved on 1/18/2018 from **https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm**
Treatment for co-occurring mental and substance use disorders. **https://www.samhsa.gov/treatment**
What are treatments for tobacco dependence? Retrieved on 1/18/2018 from **https://www.drugabuse.gov/publications/tobacco-nicotine-e-cigarettes/what-are-treatments-tobacco-dependence**
HEDIS Benchmarks and Coding Guidelines for Quality Care. Amerigroup RealSolutions in healthcare. Retrieved from **https://providers.amerigroup.com**
NCQA updates quality measures for HEDIS 2018. **http://www.ncqa.org/newsroom/details/ncqa-updates-quality-measures-for-hedisreg-2018?ArtMID=11280&ArticleID=85&tabid=2659**
ICD-10-CM Expert for Physicians. The complete official code set (2017). Optum 360
Leon-Chisen N. (2017). ICD-10-CM and ICD-10-PCS Coding Handbook 2018. American Hospital Association, Chicago, IL.

These links lead to third-party sites. These organizations are solely responsible for the content on their sites.

URL: https://providernews.anthem.com/california/article/coding-spotlight-substance-use-disorders-and-smoking-3

Prior authorization requirements for subcutaneous implantable defibrillator system

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

Effective February 1, 2019, prior authorization (PA) requirements will change for the Subcutaneous Implantable Defibrillator system to be covered by Anthem Blue Cross. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following:

- Subcutaneous Implantable Defibrillator system — Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation (33270)

To request PA, you may use one of the following methods:

- **Web: https://www.availity.com**
- **Fax: 1-800-754-4708**
- **Phone:**
    - o **1-888-831-2246** (Medi-Cal)
    - o **1-877-273-4193** (Medi-Cal Access Program and Major Risk Medical Insurance Program)

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal (**https://www.availity.com**). Providers who are unable to access Availity may call us for PA requirements at **1-888-831-2246** (Medi-Cal) or **1-877-273-4193** (Medi-Cal Access Program and Major Risk Medical Insurance Program).

URL: https://providernews.anthem.com/california/article/prior-authorization-requirements-for-subcutaneous-implantable-defibrillator-system-2

Need up to date pharmacy information?

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

Log in to our provider website (**https://mediproviders.anthem.com/ca**) to access our *Formulary*, *Prior Authorization* form, *Preferred Drug List* and process information.

Have questions about the *Formulary* or need a paper copy?
Call Provider Services at 1-**800-407-4627** (outside L.A. County) or **1-888-285-7801** (inside L.A. County).

Our Member Services representatives serve as advocates for our members. To reach our Customer care Center, please call**1-800-407-4627 (TTY 1-888-757-6034)**.

URL: https://providernews.anthem.com/california/article/need-up-to-date-pharmacy-information

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Practitioners' rights during credentialing process

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

The credentialing process must be completed before a practitioner begins seeing members and enters into a contractual relationship with a health care insurer. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application.
- Correct erroneous information regarding a credentialing application.
- Be notified of the status of credentialing or recredentialing applications.

The Council for Affordable Quality Healthcare (CAQH®) universal credentialing process is used for all providers who contract with Anthem Blue Cross (Anthem). To apply for credentialing with Anthem, go to the CAQH website at **https://www.caqh.org** and select **CAQH ProView™**. There is no application fee.

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members' claims.

URL: https://providernews.anthem.com/california/article/practitioners-rights-during-credentialing-process

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Updated prior authorization form for providers

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

As of October 1, 2018 you should be utilizing the new Anthem Blue Cross (Anthem) prior authorization form for Medi-Cal Managed Care and L.A. Care members.

You will be happy to know that we have added additional requirements to make it easier for you when submitting prior authorization requests. This will help in a faster turn-around-time and will help us in servicing you better.

Additional requirements added include:

- A checkbox for the provider to choose between an initial request and a continuation.
- Fields for both physicians and facilities: servicing physician/facility name, tax ID/Medicare number, NPI, address, phone number and fax number.

Acquire an Anthem prior authorization form via web, phone or fax:

- **Web:** Access the form directly at **https://mediproviders.anthem.com/ca** Provider Support > Forms > Prior Authorization Forms > Request for Preservice Review.
- **Phone:** Call **1-888-831-2246, option 3** and ask for a form to be faxed to you.
- **Fax:** Send your request to: **1-800-754-4708**.

URL: https://providernews.anthem.com/california/article/updated-prior-authorization-form-for-providers

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Electronic data interchange gateway update

Published: Dec 1, 2018 - **State & Federal** / Medi-Cal Managed Care

Anthem Blue Cross has designated Availity as a **no-cost option** to operate and service your electronic data interchange (EDI) entry point (or EDI gateway). This designation will ensure greater consistency and efficiency in EDI submission.

Who is Availity?
Availity is well known as a web portal and claims clearinghouse, but they are much more. Availity also functions as an EDI gateway for multiple payers and serves as the single EDI connection.

Your organization can submit and receive the following transactions through Availity's EDI gateway:

- 837 — institutional claims
- 837 — professional claims
- 837 — dental claims
- 835 — electronic remittance advice (ERA)
- 276/277 — claim status
- 270/271 — eligibility request

Get started with Availity:

- If you wish to submit directly to Availity, setup is easy. Go to the **Availity Welcome Application** and begin the process of connecting to the Availity EDI Gateway for your EDI transmissions.
- If you wish to use a clearinghouse or billing company, please work with them to ensure connectivity.

Need assistance?
The ***Availity Quick Start Guide*** will assist you with any EDI connection questions.

Availity payer IDs
You can access the *Availity Payer List* here.

Electronic funds transfer (EFT) registration
To register or manage account changes for EFT only, use the **EnrollHub™, a CAQH Solutions™ enrollment tool**, a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at a time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes.

ERA registration

Use Availity to register and manage account changes for ERA. If you were previously registered to receive ERA, you must register using Availity to manage account changes. Manage your paper remittance vouchers suppression (turn off) **here**.

Contacting Availity
If you have any questions, call Availity Client Services at **1-800-AVAILITY (1-800-282-4548)** Monday through Friday from 5 a.m. to 4:30 p.m. Pacific time.

URL: https://providernews.anthem.com/california/article/electronic-data-interchange-gateway-update

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Claims requiring additional documentation

Published: Dec 1, 2018 - **State & Federal** / Cal MediConnect

Professional providers and facilities are required to submit additional documentation for adjudication of applicable types of claims. If the required documentation is not submitted, the claim may be denied. Anthem Blue Cross may request additional documentation or notify the provider or facility of additional documentation required for claims, subject to contractual obligations.

Effective March 1, 2019, if an itemized bill is requested and/or required, then it must include the appropriate revenue code for each individual charge.

For additional information, please review the Claims Requiring Additional Documentation reimbursement policy (policy 06-031) at **https://mediproviders.anthem.com/ca**.

URL: https://providernews.anthem.com/california/article/claims-requiring-additional-documentation-1

Short and long acting narcotics regulatory changes and limits to days' supplies

Published: Dec 1, 2018 - **State & Federal** / Cal MediConnect

In the *Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* issued in April

2018, CMS included guidance related to opioid analgesics to help improve patient safety and reduce the misuse and abuse of opioid analgesics.

Beginning January 1, 2019, all short- and long-acting opioids will reject at the point of sale if they are prescribed for more than seven days. This edit applies to members who do not have a prescription in the previous 60 days. The edit excludes members with cancer and members in hospice.

The regulatory change and specific prescription drug edits are intended to:

- Lessen the risk of long-term use and addiction potential for those using the medication for acute pain.
- Promote regular review by prescribers to ensure therapy duration is appropriate for those using the medication for acute pain.
- Allow pain control for those with intractable pain in the case of cancer.
- Support and monitor access and remedy the unfortunate effects of overutilized opioids.

For more information, please read the CMS ***CY 2019 Final Call Letter***.

URL: https://providernews.anthem.com/california/article/short-and-long-acting-narcotics-regulatory-changes-and-limits-to-days-supplies-1

Prior authorization requirements for Part B drug Nivestym

Published: Dec 1, 2018 - **State & Federal** / Cal MediConnect

Effective January 1, 2019, prior authorization (PA) requirements will change for Part B injectable/infusible drug Nivestym (filgrastim-aafi) to be covered by Anthem Blue Cross for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid plan) members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage.
Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following:

- Nivestym (filgrastim-aafi) — for treatment of febrile neutropenia, hematopoietic syndrome of acute radiation syndrome, mobilization of autologous peripheral blood progenitor cells (PBPCs) into the peripheral blood, and severe chronic neutropenia (J3590)

Please note, the drug noted above is currently billed under the not otherwise classified (NOC) HCPCS J-code J3590. Since this code includes all drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS code.

To request PA, you may use one of the following methods:

- **Web: https://www.availity.com**
- **Fax: 1-866-959-1537**
- **Phone: 1-855-817-5786**

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal (**https://www.availity.com**). Providers who are unable to access Availity may call us at **1-855-917-5786** for PA requirements.

URL: https://providernews.anthem.com/california/article/prior-authorization-requirements-for-part-b-drug-nivestym-filgrastim-aafi

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Electronic data interchange gateway update

Published: Dec 1, 2018 - **State & Federal** / Cal MediConnect

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URL: https://providernews.anthem.com/california/article/electronic-data-interchange-gateway-update-1

MediConnect Plan network update

Published: Dec 1, 2018 - **State & Federal** / Cal MediConnect

On September 1, 2018, CareMore Health will take on the responsibility to coordinate care for our Anthem Blue Cross Cal MediConnect Plan population in Santa Clara County. As an Anthem Blue Cross affiliate, CareMore will work with you and the Anthem Blue Cross Cal MediConnect Plan membership.

This transition in care management will not have any impact on the member's benefits or your reimbursement rates. CareMore will reach out to you to coordinate your patient's care.

Your contractual relationship with Anthem Blue Cross Cal MediConnect Plan will not change at this time.

Provider resources are available on the website at **https://mediproviders.anthem.com/ca**. If you have questions about this update, please contact the Customer Care Center at **1-855-817-5786**.

To contact CareMore Health, please call **1-888-291-1358**.

To ensure streamlined coordination, it's important to remember, utilization management, case management, discharge planning, quality management and claims payment activities

are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

URL: https://providernews.anthem.com/california/article/mediconnect-plan-network-update

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