California Provider News

December 2019 Anthem Blue Cross Provider News - California

Administrative:

Reimbursement Policies:

Medical Policy & Clinical Guidelines:

Federal Employee Plan (FEP):

Medicare:

Medi-Cal Managed Care:

Cal MediConnect:

Pharmacy information available on anthem.com/ca

Published: Dec 1, 2019 - **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 anthem.com/pharmacyinformation. The commercial 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, select ***“California”***, scroll down to “Select Drug Lists.” 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.

URL: https://providernews.anthem.com/california/article/pharmacy-information-available-on-anthemcomca-10

Coding tip for Psychological and Neuropsychological testing

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

On January 1, 2019, a change to CPT codes for Psychological and Neuropsychological test administration and evaluation services was released. The new codes did not crosswalk on a one-to-one basis with the deleted codes. The coding changes separated test administration from test evaluation, psychological testing from neuropsychological testing, and defined the testing performed by a professional or technician. The new codes were as follows:

Neurobehavioral status exams are clinical interview examinations performed by a psychologist or neuropsychologist to assess thinking, reasoning and judgment. Providers should continue to use CPT code 96116 when billing for the first hour and new code 96121 when billing for each additional hour.

Testing evaluation services include the selection of the appropriate tests to be administered; integration of patient data; interpretation of standardized test results and clinical data; clinical decision-making; treatment planning; and reporting and interactive

feedback to the patient, family members, or caregivers, when performed. Providers should now use CPT code 96130 to bill for the first hour of psychological testing evaluation services and 96131 for each additional hour. Neuropsychological evaluation services should now be billed using CPT code 96132 for the first hour and 96133 for each additional hour.

Test administration and scoring by a psychologist or neuropsychologist (two or more tests using any method) should now be billed using CPT code 96136 for the first 30 minutes and 96137 for each additional 30 minutes.

Test administration and scoring by a technician (two or more tests using any method) should now be billed using CPT code 96138 for the first 30 minutes and 96139 for each additional 30 minutes. Single automated test administration should be reported with newly created code 96146 for a single automated psychological or neuropsychological instrument that is administered via electronic platform and formulates an automated result. Psychologists should not use this code if two or more electronic tests are administered and/or if administration is performed by the professional or technician. Instead, the psychologist should use the appropriate codes listed above for test administration and scoring.

Screening and risk assessment (repetitive assessment after screening) include brief emotional/behavioral assessment with scoring and documentation, per standardized instrument, should now be billed using CPT code 96127 separately from testing. Effective January 01, 2019, a change to CPT codes for Psychological and Neuropsychological test administration and evaluation services was released. The new codes do not crosswalk on a one-to-one basis with the deleted codes. The coding changes separate test administration from test evaluation, psychological testing from neuropsychological testing, and defines the testing performed by a professional or technician.

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Screening and risk assessment (repetitive assessment after screening) include brief emotional/behavioral assessment with scoring and documentation, per standardized instrument, should now be billed using CPT code 96127 separately from testing.

References: **www.apa.org**

URL: https://providernews.anthem.com/california/article/coding-tip-for-psychological-and-neuropsychological-testing-2

Anthem Blue Cross' Language Assistance Program: No interpreter? No problem!

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Anthem Blue Cross (Anthem) wants you to be able to communicate with your behavioral health patients clearly and accurately.

- It's easy, it's at no cost

- No advance notice required
- All languages

For patients whose primary language isn't English, Anthem offers at no charge, language assistance services through interpreters. Patients can call the Anthem Member Services number on their ID card (TTY/TDD: 711) during regular business hours. After regular business hours, telephonic interpreter services are available through the 24/7 NurseLine. If you would like to access an interpreter on behalf of a patient, call toll-free **1-800-677-6669**.

Please remember, in accordance with the California Language Assistance Program, you must notify Anthem members of the availability of the health plan interpreter services. You must also document a patient's refusal of any needed interpreter services in the patient's chart. Make sure to let your patients know that Anthem's Member Services representatives are available to help coordinate appointment scheduling through the interpreter services. Anthem does not delegate the provision of any Language Assistance services, below is what you can expect when accessing language services:

Telephone interpreters
Give the Member Services representative the patient's ID number.
Explain the need for an interpreter and state the language.
Wait on the line while the connection is made.
Once connected to the interpreter, the associate introduces the Anthem Blue Cross patient, explains the reason for the call, and begins the dialogue.

Face-to-Face interpreters including sign language
Patients can request to have an interpreter assist at your office. This request may be made in advance, or when the patient is in the office. Providers may make these requests on behalf of patient. Seventy-two business hours are required to schedule services, and 24 business hours are required to cancel.

Written materials are translated upon request

- Materials that are member-specific, for example, denial, delay, or claims letters are sent in English with the offer of translation when requested.
- Requested translated materials are sent to the member no later than 21 days from the request date.
- Physicians and other health care professionals should advise their patients to call Anthem toll-free at **1-888-254-2721** to request translated materials.

- Physicians and other health care professionals can call Anthem toll-free at **1-800-677-6669** to request translation on the member's behalf. Urgent requests are handled within one business day and non-urgent requests are handled within two business days. A copy of the document is required in order to complete the translation request.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-language-assistance-program-no-interpreter-no-problem-2

Behavioral Health providers serve Individual plans on and off exchange for 2020

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

EPO plans and network

For the 2020 benefit year, Anthem Blue Cross (Anthem) will continue to offer EPO individual on exchange and off exchange plans in Covered California.

We are also very pleased to announce the expansion of our individual EPO on and off exchange plans to areas of Northern California. Below is a list of counties located in regions where Anthem will be offering 2020 EPO on and off exchange individual plans.

Counties

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Monterey, Nevada, Plumas, San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yuba

As an Anthem Behavioral Health Network provider, your agreement includes plans on and off the exchange. You will continue to provide services to Anthem members who have purchased coverage of a plan on or off the exchange as you currently do under your Anthem provider agreement.

The 2020 EPO plans do not have out-of-network benefits except for emergent/urgent or authorized services only.

HMO plans and network

Starting with 2020 benefit year, Anthem is excited to re-enter the counties listed below rating with our HMO individual on exchange and off exchange plans. Below is a list of counties located in the regions where Anthem will be offering 2020 individual on and off exchange HMO plans.

Counties
Fresno, Kings, Madera, Los Angeles, Riverside, San Bernardino

These changes do not impact Anthem California individual “grandfathered” business.

Anthem appreciates your continued network participation in our individual on and off exchange plans. If you have any questions regarding this information, email our commercial Behavioral Health Network Relations team at cabhnetworkrelations@anthem.com.

URL: https://providernews.anthem.com/california/article/behavioral-health-providers-serve-individual-plans-on-and-off-exchange-for-2020

Contracted provider dispute resolution

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

If you have an issue or question about a claim, your first step is to call Claims Customer Service or send an online secure message via Availity. If after contacting a Customer Service representative, supervisor, or sending an Availity secure messaging and your claim issue remains unresolved, submit a provider dispute including any reference number(s) supporting any previous calls about your issue.

Use the *Provider Dispute Resolution Request* (PDR) form to initiate the formal dispute process for a claim already adjudicated or when you, the provider disagrees with an Anthem billing determination.

Uses for the Provider Dispute Resolution Request (PDR) form:

- Dispute the resolution of an adjudicated claim
- Appeal a medical necessity or Utilization Management decision
- Respond to a notice of overpayment or to appeal an overpayment withhold of an adjudicated claim

- Submit documentation for a contract dispute
- When there's a denial of medical group responsibility
    - For submissions of similar multiple claims, billing, or contractual disputes, which may be batched as a single dispute, utilizing the second page of the PDR form to detail the attachments
    - For other submissions that occur after adjudication of the claim

URL: https://providernews.anthem.com/california/article/contracted-provider-dispute-resolution

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Network Relations teams aren't the same – where to go with questions

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Behavioral Health providers can participate (contract) under three different types of agreements:

- Commercial Behavioral Health
- Medi-Cal Behavioral Health
- Employee Assistance Program (EAP).

It's important to understand that you might contract under one, two or all three agreements as a participating network provider, and that each agreement is different, has a specific fee schedule and a dedicated operational area to answer your unique network questions.

Network Relations answers questions about the fee schedule, agreement (contract) language or requirements as specified in the provider manual. Each network has a devoted Network Relations team to service specific needs.

Contact information for each team follows below.

- Commercial Behavioral Health - CABHNetworkRelations@anthem.com

- Medi-Cal Behavioral Health - BHMedi-CalNetworkRelations@anthem.com

- EAP - EAPProviderNetworks@anthem.com

URL: https://providernews.anthem.com/california/article/network-relations-teams-arent-the-same-where-to-go-with-questions

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Commercial Behavioral Health provider data updates

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Accurate and up-to-date information about your practice in our directories is important. As a result, Anthem conducts semi-annual outreaches 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. For any questions about updating your practice, send an email to CABHNetworkRelations@anthem.com

Follow steps listed below to submit practice changes:

Use the Practice Update Form to report your changes. Note: Tax ID changes require a W-9 form.
Send practice changes, additions or deletions to our Provider Database Management team.
Email the form to ProviderDatabaseAnthem@anthem.com with the words, BH CHANGE in the subject line.

Detailed information about submitting practice changes is available in our Behavioral Health Guides. Go online to anthem.com/ca/behavioralhealth > **Behavioral Health Guides**.

URL: https://providernews.anthem.com/california/article/commercial-behavioral-health-provider-data-updates

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Practice status - open or closed

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Prompt written notice of a closed practice prevents member servicing delays. Are you accepting new patients? Your practice status - open or closed must be reflected accurately in our provider directories. California law requires that participating health care providers notify health plans within five days when their “Accepting New Patients” status changes.

URL: https://providernews.anthem.com/california/article/practice-status-open-or-closed

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Forms make practice changes easy

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Practice information helps us direct referrals and members who access care directly. It’s key in delivering timely access to care. You play a big role in keeping our provider directories up-to-date.

Is your practice information (e.g. practice address, areas of exper tise, etc.) accurate? Prevent member servicing delays and notify us of any practice changes promptly. The *Practice Update Form* and the *Practice Profile* are convenient online options for updating your practice information.

Use the Practice Update Form to change the following information:

- Email address
- Phone and fax number
- Check/EOB/billing/ reimbursement address
- Open /closed practice status
- Mailing/correspondence address
- TaxID (include a W-9 form with your change)
- Practice/service address

Use the Practice Profile when updating:

- Self-reported areas of expertise
- Open/closed practice status
- Psychiatrists update ECT, TMS, Suboxone,

- and anti-psychotic injectable management if applicable.
- Age ranges treated
    - Additional languages spoken
    - Provider ethnicity (optional)

URL: https://providernews.anthem.com/california/article/forms-make-practice-changes-easy

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Network leasing arrangements are online

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call “other payors.” Other payors and affiliates use the Anthem Blue Cross (Anthem) network. Under the terms of your Agreement, members of these other payors and affiliates may access the Anthem provider network. As such, they are entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. An online list of these other payors is available via Availity. Login to availity.com > Payer Spaces > Anthem Blue Cross > Education and Reference Center> Administrative Support > Network Leasing Arrangements

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

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Stay “in the know” at no charge!

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

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

Registration is fast and easy. There is no limit to the number of subscribers who can register for *Provider News*, so you can submit as many email addresses as you like.

URL: https://providernews.anthem.com/california/article/stay-in-the-know-at-no-charge

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Misrouted protected health information

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Providers and facilities are required to review all member information received from Anthem Blue Cross (Anthem) and other providers to help ensure that misrouted protected health insurance (PHI) isn't included. Misrouted PHI includes information about members that a provider or facilit y is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or email. Providers and facilities are required to immediately inform the sender and to destroy any misrouted PHI and 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.

URL: https://providernews.anthem.com/california/article/misrouted-protected-health-information-2

BlueCard® Program quick tips

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Plans with Anthem Blue Cross. Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at **1-800-676-BLUE (2583**) to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to Anthem Blue

Cross.

- Submit the claim to Anthem Blue Cross. Always include the patient's complete identification number, which includes the three-character prefix.
- For claims inquiries, contact Anthem Blue Cross.

URL: https://providernews.anthem.com/california/article/bluecard-program-quick-tips

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Where and how to submit BlueCard® claims

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

You should always submit claims to Anthem Blue Cross. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character alpha/numeric prefix. Do not make up alpha prefixes. Claims with incorrect or missing alpha prefixes and/or member identification numbers cannot be processed.

URL: https://providernews.anthem.com/california/article/where-and-how-to-submit-bluecard-claims

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Overlapping service areas

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Submission of claims in overlapping Blue Plan service areas is dependent on what plan(s) the provider contracts with in that state, the type of contract the provider has for example, PPO, Traditional, etc., and the type of contract the member has with their Home Plan.

In other states, a company may carry the Blue Cross and Blue Shield name together, as a single entity. In California, there are two separate and independent Blue Cross Blue Shield companies. One is Anthem Blue Cross, and the other is Blue Shield of California.

- If you contract with both Plans in California, you may file an out-of-area Blue Plan member's claim with either Plan.

- If you contract with one Plan but not the other, file all out-of-area claims with your contracted Plan.
- Use the Anthem Blue Cross Payer ID number that was assigned to you, not the Blue Shield of California Payer ID number. If you submit an Anthem Blue Cross member claim with the Blue Shield of California Payer ID number instead of the Anthem Blue Cross Payer ID number, the claim will process as out-of-network.

URL: https://providernews.anthem.com/california/article/overlapping-service-areas

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Behavioral Health timely access regulations and language assistance program

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

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 (collectively, the "Timely Access Regulations").

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 time frames (also referred to as the "time elapsed standards" or "appointment wait time standards"). Anthem can only achieve this compliance with the help of our provider network par tners, 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 y Sur vey

- Provider Satisfaction Sur vey

- Provider After – Hours Sur vey

These surveys will begin soon. Review this information with your staff so they are prepared and understand the importance of each provider's 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.

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 table of standards open 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 toll-free telephone number listed on the back of the member ID card. A representative may be reached within 10 minutes during normal business hours.

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 Depar tment 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 Depar tment 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/behavioral-health-timely-access-regulations-and-language-assistance-program

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Clinical practice and preventive health guidelines available on the web

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

As par t 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 Qualit y 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 online at anthem.com/ca > Providers > **Policies and Guidelines**. Scroll down the page to **Clinical Practice Guidelines** or **Preventive Health Guidelines.**

URL: https://providernews.anthem.com/california/article/clinical-practice-and-preventive-health-guidelines-available-on-the-web-21

Anthem's member rights and responsibilities

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

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 providers and members (your patients) in our system, Anthem has adopted a Members' Rights and Responsibilities statement. You can find the statement on at anthem.com/ca > Providers > **Policies and Guidelines**. Scroll to Member Rights and Responsibilities > **Read about member rights**

URL: https://providernews.anthem.com/california/article/anthems-member-rights-and-responsibilities

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Release of medical records

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Under federal law, members have the right to their records or to have them forwarded to an authorized person(s) on their behalf. A written request must be received before any information can be shared. Member privacy is very important to us and we must make every reasonable effort to keep it safe. Please adhere to terms of your Agreement and processes outlined in the Manual to maintain confidentiality of protected health information and records,

comply with Anthem's *Privacy Notice*, and associated Health Insurance Portability and Accountability (HIPAA) standards.

URL: https://providernews.anthem.com/california/article/release-of-medical-records

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Pharmacy information available online

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

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 our website at anthem.com/pharmacyinformation.

Drug lists are updated as needed and available online by the first day of the month in January, April, July and October.
Website links for the Federal Employee Program® (FEP®) formulary and pharmacy related information are available online at fepblue.org > **Pharmacy Benefits**

URL: https://providernews.anthem.com/california/article/pharmacy-information-available-online-1

Reminder: Changes to timely filing requirements

Published: Dec 1, 2019 - **Administrative**

Timely receipt of medical claims for your patients, our members, helps our chronic condition care management programs work most effectively, and also plays a crucial role in our ability to share information to help you coordinate patient care. In an effort to simplify processes, improve efficiencies, and better support coordination of care, we changed all professional agreements to adopt a common time frame for the submission of claims to us. **Notification was sent on June 21, 2019, to providers of applicable networks and contracts.**

Effective **for all claims received by Anthem Blue Cross (Anthem) on or after October 1, 2019**, all impacted contracts will require the submission of all professional claims within ninety (90) days of the date of service. This means claims **submitted on or after October**

1, 2019, will be subject to a ninety (90) day timely filing requirement, and Anthem will refuse payment if submitted more than ninety (90) days after the date of service1.
If you have any questions, email our Network Relations staff at CAContractSupport@anthem.com.

1If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.

URL: https://providernews.anthem.com/california/article/reminder-changes-to-timely-filing-requirements

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Physical therapists and radiology providers – welcome to the future of Workers' Compensation

Published: Dec 1, 2019 - **Administrative**

Anthem Blue Cross (Anthem) is pleased to announce one of the most exciting changes in workers' compensation in decades. Anthem Workers' Compensation Digital Marketplace, powered by Transparent Health Marketplace, is a transformative new solution to help you grow your business and take control of your practice from costly intermediaries. Anthem will send contracted physical therapists and radiology providers an exclusive invitation to enroll in Anthem Workers' Compensation Marketplace within the next 60 days.

If you are an Anthem contracted physical therapist or radiology provider and you do not receive this information by email by the end of January 2020, please contact Anthem Workers' Compensation customer relations at **1-866-700-2168**.

URL: https://providernews.anthem.com/california/article/physical-therapists-and-radiology-providers-welcome-to-the-future-of-workers-compensation

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Retrieve your Anthem Blue Cross Patient's HEDIS care gaps through Patient360 located on the Availity Portal

Published: Dec 1, 2019 - **Administrative**

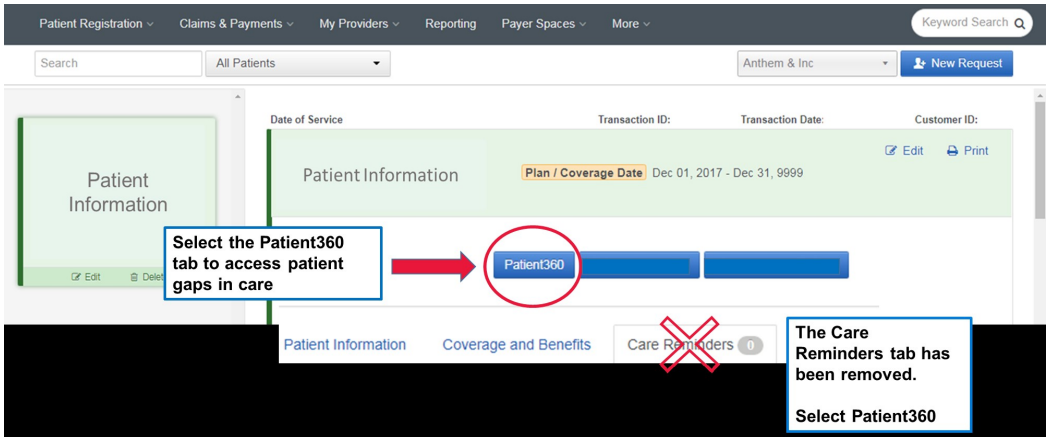
Pateint360 is a Longitudinal Patient Record (LPR) where you can access the complete view of Anthem Blue Cross (Anthem) information associated with an Anthem member.

You may have noticed that the Care Reminders tab on your Anthem patient's Eligibility and Benefits return on Availity was recently removed. You can still retrieve these important patient gaps in care through Patient360.

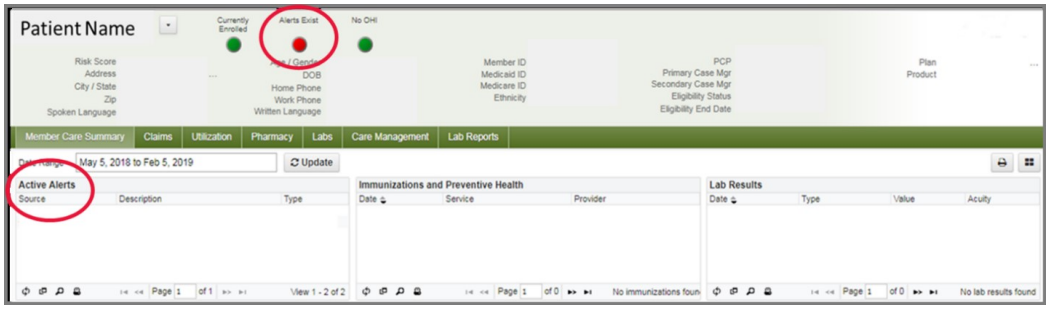
You are required to have the Patient360 role assigned to you by your Availity administrator to see the Patient360 tab located at the top of the patient's Eligibility and Benefits return. To access Patient360 select the tab and follow the steps to open the application.

If your patient does have a gap in care, you will see the red alert button on the top of Patient360 Member Care Summary. Details of the care gap can be found in the Active Alerts section.

Availity Eligibility and Benefits: Patient360 access



Patient360 Active Alerts located on the Member Care Summary



URL: https://providernews.anthem.com/california/article/retrieve-your-anthem-blue-cross-patients-hedis-care-gaps-through-patient360-located-on-the-availity-portal

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Individual on and off exchange plans: 2020 benefit year update

Published: Dec 1, 2019 - **Administrative**

For the 2020 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, with expansion into regions 9 and 12, and are re-entering our HMO plans in regions 11, 15, 16, and 17.

Below is a list of counties located in rating regions where Anthem will be offering individual on and off exchange EPO plans.

Region	County
1	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
7	Santa Clara
9	Monterey, San Benito, Santa Cruz
10	Mariposa, Merced, San Joaquin, Stanislaus, Tulare
12	San Luis Obispo, Santa Barbara, Ventura

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 patients who have purchased coverage on and off exchange as you currently do under your Anthem provider agreement

- The 2020 EPO plans do not have out-of-network benefits except for emergent/urgent or authorized services only.

Providers in Region 9 and 12

If you participated in the on- and off- exchange network in 2017, we have reinstated your participation in the Individual EPO exchange network under your Anthem provider agreement. We have further extended participation to several providers who previously did not participate in the Anthem Individual EPO exchange. A communication has been sent to both previously participating providers and new providers in the EPO Individual exchange.

- The 2020 EPO plans do not have out-of-network benefits except for emergent/urgent or authorized services only.

HMO Plans and Network

Starting with 2020 benefit year, Anthem is excited to re-enter rating regions 11, 15, 16 and 17 with our HMO Individual on exchange and off exchange plans. The Anthem HMO network in these regions is considered a "narrow" network and providers have been selected and agreements executed. Below is a list of counties located in the regions where Anthem will be offering 2020 Individual on and off exchange HMO plans.

Region	County
11	Fresno, Kings, Madera
15 & 16	Los Angeles
17	Riverside, San Bernardino

These changes do not impact Anthem California Individual "grandfathered" business. Anthem appreciates your partnership and continued participation in our Individual on and off exchange networks. If you have any questions regarding this information please contact Anthem's Network Relations department via email at CAContractSupport@Anthem.com.

URL: https://providernews.anthem.com/california/article/individual-on-and-off-exchange-plans-2020-benefit-year-update-1

Member grievance process and forms must be made available upon request at provider office

Published: Dec 1, 2019 - **Administrative**

The Department of Managed Health Care's (DMHC) routine medical survey includes evaluation of a Health Plan's compliance with California Health and Safety Code section 1368(a)(2); 28 CCR 1300.68(b)(6) and (7). These regulations require Health Plans to

ensure that grievance forms, a description of grievance procedures, and assistance in filing grievances are readily available at each contracting provider's office, contracting facility, or Plan facility and grievance forms are provided promptly upon request.

Please review and distribute the Anthem Blue Cross (Anthem) grievance form to all your participating offices. It is important to implement processes to provide grievance forms and assistance to Anthem members promptly upon request.

Your agreement with Anthem requires you to comply with all applicable laws and regulations and to cooperate with Anthem's administration of its grievance program.

Information can be accessed on the process of submitting member grievances and appeals, grievance forms, definitions and appeal rights, on Anthem's website at www.anthem.com/ca/forms. Go to **View by Topic** and click on the drop down menu and select Grievance & Appeals, then select the desired resource link.

Also, grievanceforms, grievanceproceduresand additionalinformationabout Anthem'sexpeditedgrievanceandappealsreviewprocess,canbefoundinyourProviderOperationsManual.

Anthem has posted a required learning course via Availity Portal (login required) to ensure all contracted provider offices have implemented processes to provide grievance forms and assistance to enrollees. Please make sure to complete this course and the required attestation by December 13, 2019. We appreciate your cooperation and support.

To Register for the Course:

Log in to Availity Portal at availity.com.
At the top of Availity Portal, click **Payer Spaces** > **Anthem Blue Cross**.
On the payer spaces landing page, click **Access Your Custom Learning Center** from the **Applications** tab.
Search for the **[Required Grievance Process/Form Course for Anthem Blue Cross Contracted Providers]** using keyword **grievance**.
Enroll and complete the course, including the required attestation module.

Refer to this guide for more information.

Not registered for the Availity Portal?
Have your organization's designated administrator **r**egister your organization for the Availity Portal.

Visit availity.com to register.
Click **Register**.
Select your organization type.
In the Registration wizard, follow the prompts to complete the registration for your organization. Refer to these PDF documents for complete registration instructions.

Getting Started
When you log in to Availity Portal for the first time, Availity prompts you to:

- Accept privacy and security statements
- Accept a confidentiality agreement
- Choose three security questions and answers
- Create a new password
- Verify your email address

For questions regarding the Availity Portal, please contact Availity Client Services at **1-800-282-4548**.

URL: https://providernews.anthem.com/california/article/member-grievance-process-and-forms-must-be-made-available-upon-request-at-provider-office

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Members Rights and Responsibilities

Published: Dec 1, 2019 - **Administrative**

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, *Anthem Blue Cross* has adopted a Members' Rights and Responsibilities statement.

It can be found on our web site. To access, go to the "Provider" home page at anthem.com/ca, **by selecting *Providers***, then choose *Providers Overview*. Scroll down to *Find Resources for California* choose Health & Wellness > **and select** Quality Improvement Standards **from the dropdown menu** > Member Rights & Responsibilities. 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-14

Anthem Blue Cross works to simplify Payment Recovery Process for National Accounts membership

Published: Dec 1, 2019 - **Administrative**

In our company's ongoing efforts to streamline and simplify our payment recovery process, we will be consolidating our National Accounts membership to a central system. With this change we will be aligning the payment recovery processes to be the same as the majority of our other lines of business.

Our recovery process for National Accounts membership is reflected on the Electronic Remittance Advice (835) in the PLB segment. The requested recovered amount on the Electronic Remittance Advice (835) is displayed at the time of the recovery.

As National Accounts membership transitions and claims are adjusted for recovery on the central system, the requested recovered amount will be held for 49 days. This will 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" section.

After 49 days, the requested recovered amount is reflected on the Electronic Remittance Advice (835) in the PLB segment.

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-1

Contracted provider claim escalation process

Published: Dec 1, 2019 - **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-14

Provider Education seminars, webinars, workshops and more!

Published: Dec 1, 2019 - **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. Scroll down the page to ***Partners in Health*** > Tools for Providers. In the middle of the page 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-14

Anthem Blue Cross provider directory and provider data updates

Published: Dec 1, 2019 - **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), 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-14

Easily update provider demographics with the online Provider Maintenance form

Published: Dec 1, 2019 - **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 Provider Maintenance Form landing page to review more.

The new online form can be found *the redesigned provider site* www.anthem.com/ca, select the Providers tab then select Provider Maintenance Form in the sub bullets. In addition, the Provider Maintenance Form can be accessed through 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 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, select the Providers tab, then select the Find A Doctor in the sub bullets) and review how you and your practice are being displayed.

URL: https://providernews.anthem.com/california/article/easily-update-provider-demographics-with-the-online-provider-maintenance-form-14

Anthem Blue Cross' Language Assistance Program: No interpreter? No problem!

Published: Dec 1, 2019 - **Administrative**

Anthem Blue Cross (Anthem) wants you to be able to communicate with your patients clearly and accurately.

- It's easy, it's free!
- No advance notice required
- All languages

For members whose primary language isn't English, Anthem offers free language assistance services through interpreters. Members can call the Anthem Member Services number on their member's ID card (TTY/TDD: 711) during regular business hours. After regular business hours, telephonic interpreter services are available through the 24/7 NurseLine. If you would like to access an interpreter on behalf of your member, please contact **1-800-677-6669**.

Please remember, in accordance with the California Language Assistance Program, you must notify Anthem members of the availability of the health plan interpreter services. You must also document a member's refusal of any needed interpreter services in his or her patient chart. Make sure to let your patients know that Anthem's Customer Service Representatives are available to help coordinate appointment scheduling through the interpreter services. Anthem does not delegate the provision of any Language Assistance services, below is what you can expect when accessing language services:

Telephone Interpreters
Give the customer care associate the member's ID number.
Explain the need for an interpreter and state the language.
Wait on the line while the connection is made.

Once connected to the interpreter, the associate introduces the Anthem Blue Cross member, explains the reason for the call, and begins the dialogue.

Face-to-Face Interpreters Including Sign Language
Members can request to have an interpreter assist at a doctor's office. This request may be made in advance, or when the member is in the office. Doctors may make these requests on behalf of members. Seventy-two business hours are required to schedule services, and 24 business hours are required to cancel

Written materials are translated upon request

- Materials who are Covered Individual-specific, for example, denial, delay, or claims letters are sent in English with the offer of translation when requested.
- Requested translated materials are sent to the Covered Individual no later than 21 days from the request date.
- Physicians and other health care professionals should advise their patients to contact Anthem Blue Cross by calling **1-888-254-2721** to request translated materials.
- Physicians and other health care professionals can call Anthem Blue Cross at **1-800-677-6669** to request translation on the Covered Individual's behalf. Urgent requests are handled within one business day and non-urgent requests are handled within two business days. A copy of the document is required in order to complete the translation request.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-language-assistance-program-no-interpreter-no-problem-3

Sign-up now for our Provider News today at no charge!

Published: Dec 1, 2019 - **Administrative**

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our *Provider News*.
Provider News 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 Provider News, so you can submit as many e-mail addresses as you like.

URL: https://providernews.anthem.com/california/article/sign-up-now-for-our-provider-news-today-at-no-charge-4

Network leasing arrangements

Published: Dec 1, 2019 - **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-14

New Professional Reimbursement Policies - Durable Medical Equipment: Rent to purchase and Durable Medical Equipment Modifiers

Published: Dec 1, 2019 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after December 1, 2019, Anthem Blue Cross' current Durable Medical Equipment policy will be retired and will be replaced by the new Durable

Medical Equipment – Rent to Purchase policy and the new Durable Medical Equipment – Modifiers policy. The new Durable Medical Equipment – Rent to Purchase policy has the same reimbursement guidelines and requirements as the current Durable Medical Equipment policy. The new Durable Medical Equipment – Modifiers policy has the same reimbursement guidelines for DME Modifiers as the current Durable Medical Equipment policy.

URL: https://providernews.anthem.com/california/article/new-professional-reimbursement-policies-durable-medical-equipment-rent-to-purchase-and-durable-medical-equipment-modifiers

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System updates for 2020 - Professional

Published: Dec 1, 2019 - **Policy Updates** / Reimbursement Policies

As a reminder, we will update our claim editing software monthly throughout 2020 with the most common updates occurring in quarterly in February, May, August and November of 2020. 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, medically unlikely edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)
- apply to any provider or provider group (tax identification number) and may apply to both institutional and professional claim types

URL: https://providernews.anthem.com/california/article/system-updates-for-2020-professional-6

An overview of our medical necessity review process

Published: Dec 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

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 can expect:

Type of review	**The maximum amount of time from receipt of the information in which a health plan must decide medical necessity**
Non-urgent pre-service	5 business days for fully-insured and HMO/POS plans 72 hours for non-urgent prescription drug requests for fully-insured and HMO/POS plans 15 calendar days for self-funded plans (unless otherwise stated in the member's Evidence of Coverage or benefit booklet)
Urgent pre-service	72 hours 24 hours for urgent prescription drug requests for fully-insured and HMO/POS plans
Urgent inpatient or outpatient ongoing care	24 hours (in specific instances, no later than within 72 hours of receiving a request)
Retrospective/post-service	30 calendar days

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 or behavioral condition could without such care and treatment subject the member to adverse health consequences, pose an imminent and serious threat to the member's life or health or their ability to regain maximum function, or seriously jeopardize the life, health or safety of the member or others due to the member's psychological state.

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 applicable medical policies. 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 are the treating practitioner directly involved in the member's care/treatment plan and need to discuss 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
- 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 Policy and Clinical UM Guidelines 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 and Clinical UM Guidelines are also available at www.anthem.com/ca. Providers can access UM criteria by selecting "Providers" at the top of the screen to access the "Providers Overview" page. Under **Provider Resources,** select "Policies, Guidelines & Manuals". Scroll down and select **View Medical Policies & UM Guidelines**; or call **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: **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 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 manage administered by Blue Shield of California.

URL: https://providernews.anthem.com/california/article/an-overview-of-our-medical-necessity-review-process-1

Case Management Program

Published: Dec 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

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 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?

CM Email Address	CM Telephone Number	CM Business Hours
Case.management@anthem.com National: NationalWest-CM@anthem.com FEP: FEP_PPO_Case_Mgmt@blueshieldca.com	Phone: 1-888-613-1130 National: 1-877-783-2756 888-574-7215 (Transplant) FEP: 1-800-995-2800 1-800-711-2225 (HMO)	Monday - Thursday 8:00 am - 8:00 pm PT Friday 8:00 am - 8:00 pm PT, Saturday 8:00 am – 4:30pm PT National: Monday - Friday 8am-9pm PST, Saturday 9am-4:30pm PST Monday-Friday 8:30am-5pm EST (Transplant) FEP: Monday – Friday 8am-8pm PT

Saturday 8am-4:30pm PT

URL: https://providernews.anthem.com/california/article/case-management-program-17

Clinical Practice and Preventive Health Guidelines available on anthem.com/ca

Published: Dec 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

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 at anthem.com/ca > Provider/Provider Overviews > scroll down and select “Find Resources for California > Health and Wellness > Practice Guidelines.

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

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Coordination of Care

Published: Dec 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross 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 Blue Cross 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 Blue Cross has several tools available on the Provider website including a Coordination of Care Form and Coordination of Care Letter Templates for both Behavioral Health and other Medical Practitioners.* Behavioral Health tools are available, which includes forms, brochures, and screening tools for Substance Abuse, ADHD, and Autism. Please refer to the website for a complete list.**

**Access to the forms and template letters are available at www.anthem.com/provider/forms/*
***Access to the Behavioral Health tools are www.anthem.com/provider/forms/*

URL: https://providernews.anthem.com/california/article/coordination-of-care-14

Appropriate 911/Emergency care procedures

Published: Dec 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

Emergency services are services provided in or out of the service area in connection with the initial treatment of a medical or psychiatric emergency and are available 24 hours a day

and seven (7) days a week.

A member who considers a medical or psychiatric condition to be an emergency should be instructed to call 911 or go to the nearest hospital emergency room immediately. Anthem Blue Cross (Anthem) covers emergency services that are necessary to screen and stabilize a condition. No authorization or pre-certification is needed if the member reasonably believes that an emergency medical or psychiatric condition exists. A member should be directed to call the telephone number on the back of their Anthem ID card with any questions.

A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately. Examples of medical/psychiatric emergencies include:

- Severe pain
- Chest pains
- Heavy bleeding
- Sudden weakness or numbness of the face, arm or leg on one side of the body
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Active labor
- Attempted suicide
- Suicidal/homicidal ideation
- Acute psychosis
- Hazardous drug reactions/interactions

California law prohibits health plans from denying payment for emergency services, even if the situation was discovered not to be emergent, unless the member did not require emergency services and care and the member reasonably should have known that an emergency did not exist. Answering machine instructions and after-hours answering service staff of all HMO and PPO practitioners must direct members to call 911 or go directly to the nearest emergency room if they reasonably believe they are experiencing an emergency.

URL: https://providernews.anthem.com/california/article/appropriate-911emergency-care-procedures

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Coordination of Benefits for a Federal Employee Program® member

Published: Dec 1, 2019 - **State & Federal** / Federal Employee Plan (FEP)

Anthem Blue Cross values the relationship we have with our providers, and we always look for opportunities to help expedite the claim processing. When a Federal Employee visits the provider office, the provider should obtain the most current medical insurance information, which 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-a-federal-employee-program-member

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Service area benefit changes

Published: Dec 1, 2019 - **State & Federal** / Medicare

Click here for additional information about the service area benefit changes.

URL: https://providernews.anthem.com/california/article/service-area-benefit-changes

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CMS reminder: expedited/urgent requests

Published: Dec 1, 2019 - **State & Federal** / Medicare

Click here for additional information about the CMS reminder: expedited/urgent requests.

URL: https://providernews.anthem.com/california/article/cms-reminder-expeditedurgent-requests-8

Group Retiree PPO program announcement

Published: Dec 1, 2019 - **State & Federal** / Medicare

Learn more here about the Group Retiree PPO program.

URL: https://providernews.anthem.com/california/article/group-retiree-ppo-program-announcement

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Aspire Health for Medicare members in need of palliative care

Published: Dec 1, 2019 - **State & Federal** / Medicare

Click here for additional information about Aspire Health for Medicare members in need of palliative care.

URL: https://providernews.anthem.com/california/article/aspire-health-for-medicare-members-in-need-of-palliative-care

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Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates

Published: Dec 1, 2019 - **State & Federal** / Medicare

Click here for additional information about the Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates.

URL: https://providernews.anthem.com/california/article/global-3819-medical-policy-and-technology-assessment-committee-prior-authorization-requirement-updates

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Prior authorization requirements for E0784, K0553 and K0554

Published: Dec 1, 2019 - **State & Federal** / Medicare

Click here for additional information about the prior authorization requirements for E0784, K0553 and K0554 .

URL: https://providernews.anthem.com/california/article/prior-authorization-requirements-for-e0784-k0553-and-k0554-1

Medical drug Clinical Criteria updates

Published: Dec 1, 2019 - **State & Federal** / Medi-Cal Managed Care

This communication applies to the Medicaid, Medicare Advantage and MMP programs for Anthem Blue Cross (Anthem).

On June 20, 2019, the Pharmacy and Therapeutic (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* are publicly available on the provider website, and the effective dates will be reflected in the **link to web posting**. Visit ***Clinical Criteria*** to search for specific policies.

For questions or additional information, use this **email**.

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URL: https://providernews.anthem.com/california/article/medical-drug-clinical-criteria-updates-23

Coding spotlight: provider's guide to coding behavioral and emotional disorders

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Codes within categories F90 through F98 represent behavioral and emotional disorders with onset usually occurring in childhood and adolescence and may be used regardless of the age of the patient.

Attention deficit hyperactivity disorder (ADHD) is among these common childhood disorders. While ADHD is not a learning disability, it can impact the ability to learn. This disorder is characterized by classic symptoms of inattention, hyperactivity and impulsivity. Three subtypes of ADHD have been identified:

- Hyperactive/impulsive type — The patient does not show significant inattention.
- Inattentive type – The patient does not show significant hyperactive-impulsive behavior.
- Combined type – Patient displays both inattentive and hyperactive-impulsive symptoms.