California Provider News

July 2020 Anthem Blue Cross Provider News - California

Medicare:

Cal MediConnect:

Claims status listing and remittance inquiry updates for Atypical providers

Published: Jul 1, 2020 - **Administrative**

Atypical providers may now utilize the **Claims Status Listing** and **Remittance Inquiry** tools on www.Availity.com, **Payer Spaces** using a State Medicaid ID.

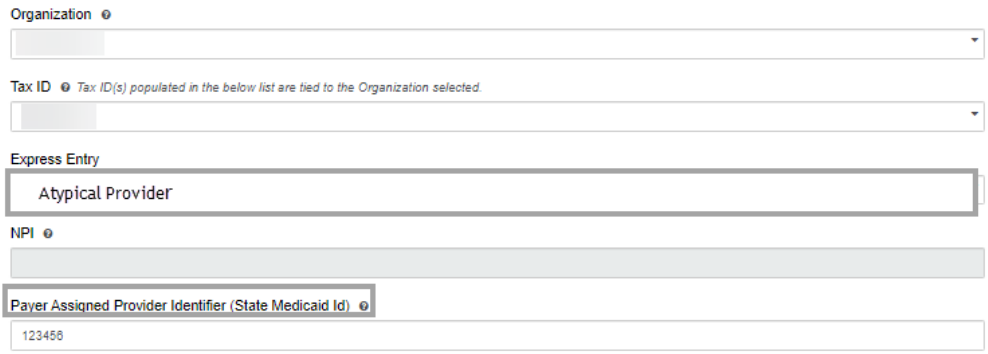
The Remittance Inquiry tool has been updated to allow atypical providers to search for remittances using the date range search option. Enhancements to the claims status-listing tool, allows atypical providers to view a list of claims. Both tools now have a State Medicaid ID search capability.

HOW TO ACCESS THE TOOL

From the Availity home page, select **Payer Spaces** Anthem Blue Cross (Anthem) payer tile | **Applications**. Choose the tool you want to proceed with, **Claims Status Listing** or **Remittance Inquiry**, followed by the organization name > **TIN**

CLAIM STATUS LISTING

Choose your provider from the Express Entry drop down box. *If the selected provider has been designated as atypical, the NPI field will gray out and the **Payer Assigned Provider Identifier (State Medicaid ID)** field will be populated.

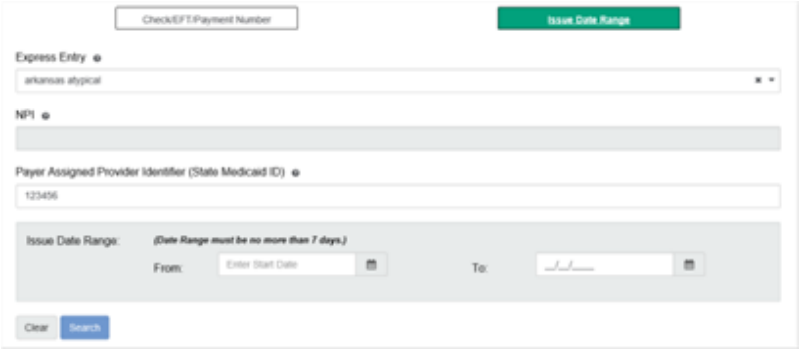


- Enter **Dates of Service (DOS)** to search (*a **30 day** date span can be searched at one time*) > select **Search**
- View a list of your claims that fall within the search criteria entered.

Article Attachments

REMITTANCE INQUIRY

Choose your provider from the Express Entry drop down box. *If the selected provider has been designated as atypical, the NPI field will gray out and the **Payer Assigned Provider Identifier (State Medicaid ID)** field will be populated.



- Enter **Dates of Service (DOS)** to search (*a **7 day** date span can be searched at one time)* > Select **Search**
- View a list of your remittances that fall within the search criteria entered

***Note: A provider must first be designated as atypical through the Express Entry process.**

URL: https://providernews.anthem.com/california/article/claims-status-listing-and-remittance-inquiry-updates-for-atypical-providers

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Updated Coverage for HIV PrEP medications

Published: Jul 1, 2020 - **Administrative**

Beginning July 1, 2020, most of Anthem Blue Cross' (Anthem) ACA-complaint non-grandfathered health plans will cover pre-exposure prophylaxis (PrEP) medication at 100% with no member cost share.

Since medications used for PrEP can also be used *to treat* HIV, and when used for prevention of HIV and dispensed at an in-network pharmacy with a prescription. Anthem will review medical and pharmacy claims data to determine if a member has been diagnosed and prescribed treatment for HIV or prescribed PrEP for preventive purposes. When prescribed for prevention of HIV, this drug is covered with no member cost share. When prescribed for treatment of HIV, member cost shares apply based on the member's benefit plan. Coverage includes Truvada (200- 300 mg), and its generic components, Emtriva 200mg and tenofovir 300mg. When medically necessary, a prior authorization process is available for Descovy to be covered with no member cost share when used for prevention of HIV.

Providers can contact the provider service number on the back of the member ID card to determine if a member's plan includes this benefit.

URL: https://providernews.anthem.com/california/article/updated-coverage-for-hiv-prep-medications-6

Welcome to the Customer Learning Center in Availity

Published: Jul 1, 2020 - **Administrative**

The Custom Learning Center in the Availity portal offers an array of learning opportunities where you can access required training, recommended/elective trainings and view additional learning resources. Access to the Custom Learning Center is via **Payer Spaces** in the Availity Portal.

Highlights of the Custom Learning Center

- All the learning is in one place
- You can filter topics of interest
- View all your completed training
- Course resources may include links to a job aid

Your required courses are easily accessible and the available content is specific to your region. You may track your accomplishments, and view or download your training history via the Custom Learning Center **Dashboard**.
Select **Access Your Custom Learning Center** from the **Applications** tab in **Payer Spaces**.

Examples of trainings offered in the Custom Learning Center:

- Authorizations
- Coding and Documentation
- Claims and Payments
- Recommended administrative support courses

In addition, illustrated reference guides are located on Custom Learning Center - **Resources**. Select **Resources** from the menu located on the upper left corner of the screen. Usually, you may download or print reference guide materials.

Current Reference Guide topics include:

- Interactive Care Reviewer – Request Appeals Reference Guide
- Interactive Care Reviewer – Inquiries Reference Guide
- Patient 360 Navigation
- Remittance Inquiry Tips

Be sure to visit the Custom Learning Center in the Availity Portal often. New content is regularly added to the site.

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

URL: https://providernews.anthem.com/california/article/welcome-to-the-customer-learning-center-in-availity

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Commercial Risk Adjustment reporting update: 2020 program year progression; what's in it for you and your patients?

Published: Jul 1, 2020 - **Administrative**

As a provider, we understand you are committed to providing the best care for our members, which now involves telehealth visits. Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. As we reported in the May and June newsletters, we are completing our prospective and retrospective reviews for

What's in it for you?

First, monthly you will receive a list of your patients who are Anthem members enrolled in Affordable Care Act (ACA) compliant coverage who may have gaps in care to help you reach out to them, so they can come in for office visits earlier.

Second, we've heard resoundingly from providers that participation in these programs helps them better evaluate their patients and, as a result, perform more strongly in population health management and gain sharing programs. Many cite that they ask different questions today that allow them to better manage their patients end to end.

Finally, when you see Anthem ACA members and submit health assessments, **we pay incentives of $50 for a paper submission and $100 for an electronic submission**. For additional details on how to earn these incentives and the options available, please contact the CRA Network Education Representative listed below.

What's in it for your patients?

Anthem is completing monthly postcard campaigns to members with ACA compliant coverage when we suspect a high-risk condition with messaging to encourage the member to call his or her Primary Care Provider (PCP) and schedule an annual checkup. The goal is to get the members to have a visit with their PCPs, so the PCPs have an overall picture of their patients' health and schedule any screenings that may be needed. Telehealth visits have become very flexible formats for patients and doctors to meet, so we encourage telehealth visits to be scheduled if that is what the patient is most comfortable with at this time.

We will continue these monthly postcard mailings throughout the remainder of 2020 to encourage the members to schedule an annual checkup, which supplements any patient outreach you may be doing.

If you have any questions regarding our reporting processes, please contact the CRA Network Education Representative by email at Socorro.Carrasco@anthem.com.

URL: https://providernews.anthem.com/california/article/commercial-risk-adjustment-reporting-update-2020-program-year-progression-whats-in-it-for-you-and-your-patients

Timely access regulations and language assistance program

Published: Jul 1, 2020 - **Administrative**

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"). Anthem can only achieve this compliance with the help of 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 will begin soon; please review this information with your office 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.

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.

Access Standards for Medical Professionals

Access to	Standard
Non-urgent appointments for Primary Care (PCP)	Must offer the appointment within 10 business days of the request
Urgent Care appointments not requiring prior authorization	Must offer the appointment within 48 hours of request
Non-urgent appointments with Specialist Physicians	Must offer the appointment within 15 business days of the request
Urgent Care (that requires prior authorization)	Must offer the appointment within 96 hours of request
Non-urgent appointment for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of the request
In-office waiting room time	Usually members do not wait longer than 15 minutes to see a physician or his/her designee
After Hours Care	Member to reach a recorded message or live voice response providing emergency instructions; and for non-emergent (urgent) matters, information when to expect to receive a call back
Emergency Care: Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller is experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller is experiencing an emergency.	Immediate Access to Emergency Care. Members are directed to dial 911 or go to the nearest emergency room

Member Services by Telephone: Access to Member Services to obtain information about how to access clinical care and how to resolve problems. (This is a Plan responsibility and not a physician responsibility; and this also applies to our Behavioral Health members.)	Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate <5%). The Member NurseLine is available 24/7 and the wait time is not to exceed 30 minutes.

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 is not 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-4

Anthem Blue Cross provider directory and provider data updates

Published: Jul 1, 2020 - **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-21

Easily update provider demographics with the online Provider Maintenance Form

Published: Jul 1, 2020 - **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-21

Network leasing arrangements

Published: Jul 1, 2020 - **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 are 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-21

New MCG 24th Edition Guidelines

Published: Jul 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

Effective July 1, 2020, we will begin using the new acute viral illness guidelines that have been added to the 24th edition of MCG. Based on the presenting symptoms or required interventions driving the need for treatment or hospitalization, these guidelines are not a substantive or material change to existing MCG guidelines we use now, such as systemic or infectious condition, pulmonary disease, or adult or pediatric pneumonia guidelines.

Inpatient & Surgical Care (ISC)

- Viral Illness, Acute – Inpatient Adult (M-280)
- Viral Illness, Acute – Inpatient Pediatric (P-280)
- Viral Illness, Acute – Observation Care (OC-064)

Recovery Facility Care (RFC)

- Viral Illness, Acute – Recovery Facility Care (M-5280)

For questions, please contact the provider service number on the back of the member's ID card.

URL: https://providernews.anthem.com/california/article/new-mcg-24th-edition-guidelines-6

Medical policies and clinical utilization management guidelines update

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

Click here for more information about the Medical Policies and Clinical Utilization Management Guidelines update.

URL: https://providernews.anthem.com/california/article/medical-policies-and-clinical-utilization-management-guidelines-update-27

2020 affirmative statement concerning utilization management decisions

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

To learn more about the 2020 affirmative statement concerning utilization management decisions.

URL: https://providernews.anthem.com/california/article/2020-affirmative-statement-concerning-utilization-management-decisions-5

Medical drug benefit Clinical Criteria updates

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

On November 15, 2019, and February 21, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem Blue Cross. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the ***Clinical Criteria Web Posting February 2020***. Visit ***Clinical Criteria*** to search for specific policies.

If you have questions or would like additional information, use this **email**.

URL: https://providernews.anthem.com/california/article/medical-drug-benefit-clinical-criteria-updates-33

Coding spotlight: Provider guide to coding for cardiovascular conditions

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

In this coding spotlight, we will focus on several cardiovascular conditions; codes from Chapter 9 of the
ICD-10-CM are listed in the table below.

Diseases of the circulatory system	Category codes
Acute rheumatic fever	I00-I02
Chronic rheumatic heart diseases	I05-I09
Hypertensive diseases	I10-I16
Ischemic heart diseases	I20-I25
Pulmonary heart disease and diseases of pulmonary circulation	I26-I28
Other forms of heart disease	I30-I52
Cerebrovascular diseases	I60-I69
Diseases of arteries, arterioles and capillaries	I70-I79
Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified	I80-I89
Other and unspecified disorders of the circulatory system	I95-I99

Hypertension

ICD-10-CM classifies hypertension by type as essential or primary (categories I10 to I13) and secondary (category I15). Categories I10 to I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), chronic kidney disease (I12), or heart and chronic kidney disease combined (I13).[1]

Elevated blood pressure versus hypertension

A diagnosis of elevated blood pressure reading, without a diagnosis of hypertension, is assigned code R03.0. This code is never assigned on the basis of a blood pressure reading documented in the medical record; the physician must have specifically documented a diagnosis of elevated blood pressure.

The postoperative hypertension is classified as a complication of surgery, and code **I97.3, post procedural hypertension**, is assigned. When the surgical patient has pre-existing hypertension, only codes from categories I10 to I13 are assigned.

Hypertensive heart disease

ICD-10-CM presumes a causal relationship between hypertension and heart involvement and classifies hypertension and heart conditions to category I11 — hypertensive heart disease — because the two conditions are linked by the term *with* in the alphabetic index of the ICD-10-CM. These conditions should be coded as related even in the absence of provider documentation linking them. First, code **I11.0, hypertensive heart disease with heart failure** as instructed by the note at category **I50, heart failure**. If the provider specifically documents different causes for the hypertension and the heart condition, then the heart condition (I50.-, II51.4-I51.9) and hypertension are coded separately.[1]

Other heart conditions that have an assumed causal connection to hypertensive heart disease

Code	Description
I51.4	Myocarditis, unspecified
I51.5	Myocardial degeneration
I51.7	Cardiomegaly
I51.81	Takotsubo syndrome
I51.89	Other ill-defined heart diseases
I51.9	Heart disease, unspecified

Hypertension, secondary

Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. For example:

- Hypertension due to systemic lupus erythematosus, M32.10 + I15.8.

Hypertensive crisis

A code from category I16, hypertensive crisis, is assigned for any documented hypertensive urgency (I16.0), hypertensive emergency (I16.1), or unspecified hypertensive crisis (I16.9). Report two codes, at a minimum, for hypertensive crisis. The crisis code is reported in addition to the underlying hypertension code (I10-I15).[1]

Pulmonary hypertension

Pulmonary hypertension is classified to category I27, other pulmonary heart diseases. For secondary pulmonary hypertension (I27.1, I27.2-), any associated conditions or adverse effect of drugs or toxins should be coded.[2]

Ischemic heart disease

Category I25, chronic ischemic heart disease, includes coronary atherosclerosis, old myocardial infarction, coronary artery dissection, chronic coronary insufficiency, myocardial ischemia, and aneurysm of the heart.

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are **I25.11, atherosclerotic heart disease with angina pectoris** and **I25.7, atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris**.

When using one of these combination codes, it is not necessary to use an additional code for angina pectoris. **A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates that angina is due to a condition other than atherosclerosis.[2]**

Heart failure

Systolic heart failure is coded as I50.2 and diastolic heart failure is coded as I50.3-; combined systolic and diastolic heart failure is assigned code I50.4. Fifth characters further specify whether the heart failure is unspecified, acute, chronic or acute on chronic.

Other classifications of heart failure include:

- Right heart failure, unspecified (I50.810)
- Acute right heart failure (I50.811)
- Chronic right heart failure (I50.812)
- Acute on chronic right heart failure (I50.813)
- Right heart failure due to left heart failure (I50.814)
- Biventricular heart failure (I50.82)
- High output heart failure (I50.83)
- End-stage heart failure (I50.84)
- Other heart failure (I50.89)
- Unspecified (I50.9)

For a diagnosis of left ventricular, biventricular and end-stage heart failure, two codes are required to completely describe the condition: one to report the left, biventricular or end-stage heart failure, and one to identify the type of heart failure.

Cardiomyopathy
Cardiomyopathy is coded as I42- with the third character describing:

- I42.0 Dilated cardiomyopathy, which includes congestive cardiomyopathy
- I42.1 Obstructive hypertrophic cardiomyopathy, including idiopathic hypertrophic subaortic stenosis
- I42.2 Other hypertrophic cardiomyopathy, including nonobstructive hypertrophic cardiomyopathy
- I42.3 Endomyocardial (eosinophilic) disease, including endomyocardial (tropical) fibrosis and Loffler's endocarditis
- I42.4 Endocardial fibroelastosis, including congenital cardiomyopathy and elastomyofibrosis
- I42.5 Other restrictive cardiomyopathy, including constrictive cardiomyopathy not otherwise specified
- I42.6 Alcoholic cardiomyopathy due to alcohol consumption: a code for alcoholism (F10.-) is also assigned if present
- I42.7 Cardiomyopathy due to drug and external agent: code first the poisoning due to drug or toxin; if applicable (T36-T65 with fifth or sixth character 1-4 or 6); if the condition is caused by an adverse effect, use an additional code, if applicable, to identify the drug (T35-T50 with fifth or sixth character)
- I42.8 Other cardiomyopathies
- I42.9 Unspecified

Two codes may be required for cardiomyopathy due to other underlying conditions; for example, cardiomyopathy due to amyloidosis is coded E85.4, organ-limited amyloidosis, and I43, cardiomyopathy in diseases classified elsewhere. The underlying disease, amyloidosis, is sequenced first.[2]

Status Z codes
ICD-10-CM provides several Z codes to indicate that the patient has a health status related to the circulatory system, such as the following:

- Z94.1 Heart transplant status
- Z95.0 Presence of cardiac pacemaker
- Z95.1 Presence of aortocoronary bypass graft
- Z95.810 Presence of automatic (implantable) cardiac defibrillator
- Z95.811 Presence of heart assist device
- Z95.828 Presence of other vascular implants and grafts

These codes are assigned only as additional codes and are reportable only when the status affects the patient's care for a given episode.

Resources

1 ICD-10-CM Expert for Physicians. The complete official code set. Optum360, LLC. 2020.
2 ICD-10-CM/PCS Coding. Theory and practice. 2019/2020 Edition. Elsevier

URL: https://providernews.anthem.com/california/article/coding-spotlight-provider-guide-to-coding-for-cardiovascular-conditions-2

Access to care standards

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

Participating providers are responsible for offering members access to covered services 24/7. Access includes regular office hours on weekdays and the availability of a provider or designated agent by telephone after regular office hours, on weekends and on holidays. When unavailable, providers must arrange for on-call coverage by another participating provider. Providers are also required to meet appointment access standards as described below.

After-hours calls:

- The answering service or after-hours personnel must ask the member if the call is an emergency. In the event of an emergency, the member must be immediately directed to dial **911** or to proceed directly to the nearest hospital emergency room.
- If staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct members with emergency health care needs to dial **911** or go directly to the nearest hospital emergency room. The

message must also give members an alternative contact number so they can reach the primary care physician (PCP) or on-call provider with medical concerns or questions.

- Non-English-speaking members who call their PCP after hours should expect to get language-appropriate messages. In the event of an emergency, these messages should direct the member to dial **911** or proceed directly to the nearest hospital emergency room.

In a nonemergency situation, members should receive instruction on how to contact the on-call provider. If an answering service is used, the service should know where to contact a telephone interpreter. All calls taken by an answering service must be returned.

Appointment access

Health care providers must make appointments for members from the time of request as follows:

General appointment scheduling	
Emergency examination	Immediate access, 24/7
Urgent (sick) examination	Within 48 hours of request if authorization is not required or within 96 hours of request if authorization is required, or as clinically indicated
Nonurgent (sick) examination	Within 48-72 hours of request or as clinically indicated
Routine primary care examination (nonurgent)	Within 10 business days of request
Nonurgent consults/specialty referrals	Within 15 business days of request
Nonurgent care with nonphysician mental health providers (where applicable)	Within 10 business days of request
Nonurgent ancillary	Within 15 business days of request
Mental health appointment, nonphysician	Within 10 business days of request

Services for members under the age of 21 years	
Initial health assessments:	
Children from birth to 20 years of age	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Services for members 21 years of age and older	
Initial health assessments	Within 120 days of enrollment
Preventive care visits	Within 14 days of request
Routine physicals	Within 30 days of request
Prenatal and postpartum visits	
1st and 2nd trimester	Within 7 days of request
3rd trimester	Within 3 days of request
High-risk pregnancy	Within 3 days of identification
Postpartum	Between 21 and 56 days after delivery
Long-term services and supports	
Skilled nursing facility	· Rural and small counties — within 14 business days of request · Medium counties — within 7 business days of request · Small counties — within 5 business days of request
Intermediate care facility/developmentally disabled (ICF-DD)	· Rural and small counties — within 14 business days of request · Medium counties — within 7 business days of request · Small counties — within 5 business days of request
Community-based adult services (CBAS)	Capacity cannot decrease in aggregate statewide below April 2012 level

Medical appointment standards (Los Angeles County only):

General appointment scheduling	
Emergency examination	Immediate access, 24/7
Urgent (sick) examination	Within 24 hours of request
Nonurgent (sick) examination	Within 48 hours of request
Nonurgent routine examination	Within 10 days of request
Standing referral	Within 3 business days of request
Mental health appointment, nonphysician	Within 10 business days of request
Members under the age of 18 months	
Initial health assessments	Within 120 days of enrollment
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services/child health and disability prevention (CHDP) or preventive care visits	Within 2 weeks of request
Services for members 18 months of age or older	
Initial health assessments	Within 120 days of enrollment
EPSDT/CHDP or preventive care visits	Within 2 weeks of request
Routine physicals	Within 30 days of request
Prenatal and postpartum visits	
First prenatal visit	Within 2 weeks of request
High-risk pregnancy	Within 3 days of identification
Postpartum	Between 21 and 56 days after delivery

Specialists

The following guidelines are in place for our specialists:

- For urgent care, the specialist should see the member within 24 hours of receiving the request.
- For routine care, the specialist should see the member within 15 business days of receiving the request.
- A copy of the medical records and/or results of the visit should be sent to the PCP's office to allow continuity of care.

Wait times

When a provider's office receives a call from an Anthem Blue Cross (Anthem) member during regular business hours for assistance and possible triage, the provider or another health care professional must either take the call or call the member back **within 30 minutes** of the initial call.

Noncompliance

Please ensure that you comply with the standards described; compliance with these standards is a contractual requirement. Anthem monitors compliance through a number of mechanisms, including annual telephonic surveys, to determine if participating provider offices meet the above standards. For additional details, please review the provider operations manual at **https://mediproviders.anthem.com/ca/pages/manuals-training-more.aspx**.

URL: https://providernews.anthem.com/california/article/access-to-care-standards-1

Modifier use reminders

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

For more information about the Modifier use reminders.

URL: https://providernews.anthem.com/california/article/modifier-use-reminders-21

Prior authorization requirements for angiographic evaluation of stenotic or thrombosed

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

To view more information about Prior authorization requirements for angiographic evaluation of stenotic or thrombosed dialysis circuits.

URL: https://providernews.anthem.com/california/article/prior-authorization-requirements-for-angiographic-evaluation-of-stenotic-or-thrombosed

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Now caring for Medi-Cal Managed Care members under Anthem Blue Cross for Adventist Health Tulare

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

Adventist Health Tulare is now part of Anthem's Medi-Cal hospital network:

Adventist Health Tulare
869 N. Cherry St.
Tulare, CA 93274

For more information, please contact Anthem:

- **1-888-252-6331**
- **https://mediproviders.anthem.com/ca/pages/communications-updates.aspx**

URL: https://providernews.anthem.com/california/article/now-caring-for-medi-cal-managed-care-members-under-anthem-blue-cross

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Now caring for Medi-Cal Managed Care members under Anthem Blue Cross for Palmdale Regional

Published: Jul 1, 2020 - **State & Federal** / Medi-Cal Managed Care

Palmdale Regional Medical Center is now part of Anthem's Medi-Cal network:

Palmdale Regional Medical Center
38600 Medical Center Drive
Palmdale, CA 93551

For more information, please contact Anthem:

- **1-888-252-6331**
- **https://mediproviders.anthem.com/ca/pages/communications-updates.aspx**

URL: https://providernews.anthem.com/california/article/now-caring-for-medi-cal-managed-care-members-under-anthem-blue-cross-for-palmdale-regional

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Medical policies and clinical utilization management guidelines update

Published: Jul 1, 2020 - **State & Federal** / Medicare

Easily access more information about the Medical Policies and Clinical Utilization Management Guidelines update.

URL: https://providernews.anthem.com/california/article/medical-policies-and-clinical-utilization-management-guidelines-update-28

Updates to AIM Specialty Health advanced imaging clinical appropriateness guidelines

Published: Jul 1, 2020 - **State & Federal** / Medicare

To view information about Updates to AIM Specialty Health advanced imaging Clinical Appropriateness Guidelines.

URL: https://providernews.anthem.com/california/article/updates-to-aim-specialty-health-advanced-imaging-clinical-appropriateness-guidelines

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Transition to AIM rehabilitative services clinical appropriateness guidelines

Published: Jul 1, 2020 - **State & Federal** / Medicare

Click here for more information about the Transition to AIM Rehabilitative Services Clinical Appropriateness Guidelines.

URL: https://providernews.anthem.com/california/article/transition-to-aim-rehabilitative-services-clinical-appropriateness-guidelines-6

2020 affirmative statement concerning utilization management decisions

Published: Jul 1, 2020 - **State & Federal** / Medicare

Learn more about the 2020 affirmative statement concerning utilization management decisions.

URL: https://providernews.anthem.com/california/article/2020-affirmative-statement-concerning-utilization-management-decisions-6

2020 special needs plans

Published: Jul 1, 2020 - **State & Federal** / Medicare

Introduction

Anthem Blue Cross (Anthem) is offering Special Needs Plans (SNPs) to people eligible for both Medicare and Medicaid benefits or who are qualified Medicare Advantage beneficiaries. SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These include supplemental benefits such as hearing, dental, vision and transportation to medical appointments. Some SNP plans include a card or catalog for purchasing over-the-counter items. SNPs do not charge premiums.

SNP members under Anthem benefit from a model of care that is used to assess needs and coordinate care. Within 90 days of enrollment and annually thereafter, each member receives a comprehensive health risk assessment (HRA) that covers physical, behavioral and functional needs, and a comprehensive medication review. The HRA is used to create a member Care Plan. Members with multiple or complex conditions are assigned a health plan case manager.

SNP HRAs, Care Plans and case managers support members and their providers by helping to identify and escalate potential problems for early intervention, ensuring appropriate and timely follow-up appointments, and providing navigation and coordination of services across Medicare and Medicaid programs.

Provider training required

Providers contracted for SNP plans are required to complete an annual training to stay up-to-date with plan benefits and requirements, including details on coordination of care and model of care elements. Every provider contracted for SNP is required to complete an attestation, which states they have completed their annual training. These attestations are located at the end of the self-paced training document.

To take the self-paced training, go to the *Model of Care Provider Training* link on the **Availity Portal**.*

How to access the *Custom Learning Center* on the Availity Portal

1. Log in to the **Availity Portal**.

1. At the top of Availity Portal, select **Payer Spaces** and select the appropriate payer.

2. On the *Payer Spaces* landing page, select **Access Your Custom Learning Center** from *Applications*.
3. In the *Custom Learning Center*, select **Required Training**.
4. Select **Special Needs Plan and Model of Care Overview**.
5. Select **Enroll**.
6. Select **Start**.
7. Once the course is completed, select **Attestation** and complete.

Not registered for Availity?
Have your organization's designated administrator register your organization for Availity.

1. Visit **https://www.availity.com** to register.
2. Select **Register**.
3. Select your organization type.
4. In the *Registration* wizard, follow the prompts to complete the registration for your organization.

Q&A

What does it mean to be dual-eligible? What is a D-SNP?
The term dual eligible refers to people with Medicare coverage who also qualify for some type of state Medicaid
benefit — meaning that these members are eligible for both Medicaid and Medicare. These individuals may have higher incidence of chronic conditions, cognitive impairments and functional limitations. D-SNPs are special Medicare Advantage plans that enroll only dual-eligible people, providing them with more intensive coordination of care and services than those offered by traditional Medicare and Medicare Advantage plans.

What is a SNP model of care?
CMS requires Special needs plans (SNPs) to have a model of care that describes how the SNP will administer key components of care management programs, including assessments and training. The model of care describes the unique needs of the population being served and how Anthem will meet these needs. Each SNP model of care is evaluated and scored by the NCQA and approved by CMS.

How does the model of care help physicians?
The three major components of the model of care, 1) the HRA, 2) *Care Plan* and 3) case manager, support providers in serving D-SNP members. Each member receives a comprehensive HRA that covers physical, behavioral and functional needs, and a comprehensive medication review. Health plan staff use the HRA information to create a *Care Plan*. Members with multiple or complex conditions may be assigned to a case manager.

These key model of care components identify and escalate potential problems for early intervention, ensure appropriate and timely follow-up, and help coordinate services across Medicare and Medicaid programs. Through the provider website, providers have access to review the *Care Plan*, the results of the HRA and other information to help manage care.

How are transitions of care managed?
Anthem case managers are involved in transitions of care (for example, discharge from hospital to home for those at high risk of readmission). Such transitions may trigger a reassessment and updates to the member's *Care Plan* as needed. Following a discharge, case managers help ensure that D-SNP members see their PCP within a week and work through barriers that members experience in adhering to post-discharge medication regimens.

Who makes up the Interdisciplinary Care Team (ICT)?
Members of the ICT include any of the following: nurses, physicians, social workers, pharmacists, the member and/or the member's caregiver, behavioral health specialists, or other participants as determined by the member, the member's caregiver, or a relative of the member.

Providers who care for Anthem members are considered participants in the ICT and may be contacted by a case manager to discuss the member's needs. The case manager may present recommendations concerning care coordination or other needs. The goal of the ICT is to assist providers in managing and coordinating patient care.

Do I have to become a Medicaid provider?
You are not required to become a Medicaid provider, but we recommend that you do. Even if you are only providing services covered by Medicare Part A or Part B to SNP members, we recommend that you attain a Medicaid ID because the state Medicaid agency may require this for the Medicare cost share.

Do I need a separate agreement or contract to see SNP members under Anthem?
No, if you see Medicare Advantage HMO members under Anthem, you are considered contractually eligible to see SNP members under Anthem.

How do I file claims for SNP members?
Claims for services to SNP members are filed the same way claims are filed for Medicare Advantage members under Anthem who are not part of SNP. Providers should ensure that the claim has the correct member ID (including the prefix).

How is the SNP member's cost sharing handled?
SNP benefits are administered similarly to Medicare fee-for-service benefits. Upon receiving an *EOP* from Anthem, you should bill the state Medicaid agency or the applicable Medicaid MCO contracted with the state for processing of any Medicare cost sharing applied.

Medicare cost sharing is paid according to each state's Medicaid reimbursement logic. Some states do not reimburse for Medicare cost sharing if the payment has already met or exceeded Medicaid reimbursement methodology.

Do I have to file claims twice for SNP members?
Yes, when you treat SNP members under Anthem, you will file the initial claim with Anthem and then bill the state Medicaid agency or the applicable Medicaid MCO contracted with the state for Medicare cost sharing processing. Please use the same electronic claim submission or address you currently use for Anthem claims filing.

Do SNP members have access to the same prescription drug formulary as other Medicare Advantage members under Anthem?
Yes, SNP members have coverage for the same prescription drugs listed on the Medicare Advantage prescription drug formulary for Anthem.

Please note that in California the tier placement may vary. Be sure to review the plan's specific formulary for details on California SNPs as the formulary depends on the market.

What are SNP benefits for Anthem members?
The SNP for Anthem members covers all Medicare Part A and Part B services and includes full Part D prescription coverage. Anthem also covers a range of preventive services with no cost sharing for the member. In addition, the SNP includes coverage for supplemental benefits that may include routine dental, vision and nonemergency medical transportation. A summary of the SNP benefits is posted on the provider website for Anthem members.

Any Medicaid benefits available to the member will be processed under their Medicaid coverage directly with the state or the Medicaid organization in which the member is enrolled.

Does the SNP use the same procedure codes and EDI payer codes?
Yes, the SNP uses the same procedure and payer codes and electronic filing procedures as other Medicare Advantage plans under Anthem.

Is the electronic data interchange (EDI) payer ID for this product the same as others?
Yes, all the claim submission information will be the same (this applies to EDI and paper). Providers must submit this information with the correct ID. Please check the EDI section of the provider website for the correct payer codes to use for your market.

URL: https://providernews.anthem.com/california/article/2020-special-needs-plans-7

Anthem Blue Cross expanded HMO network guidance

Published: Jul 1, 2020 - **State & Federal** / Medicare

Anthem Blue Cross (Anthem) expanded its Medicare Advantage network in 2018 by amending Prudent Buyer Agreements to include all Medicare Advantage products. We are providing this information as a reminder of how these plans operate.

Background
Anthem amended Prudent Buyer Agreements with the Medicare Advantage PPO to add all Medicare Advantage plans in order to expand our product offerings in California. There will be no change in reimbursement. This allows Anthem to expand our product offerings across the state and provide our members with access to quality providers.

Effective date

The contract effective date was February 1, 2018.

Out-of-scope areas
Amendments to the Prudent Buyer Agreements for Anthem were out-of-scope for the following geographical areas due to a robust network of contracted provider medical groups (PMGs): Los Angeles, Riverside, Orange, San Bernardino and San Diego.

Anthem product lines for Medicare Advantage

1. PPO and HMO Plans: Medicare Advantage (Part C) includes Part A hospital coverage and Part B medical coverage in a convenient, all-in-one plan that also includes prescription drug coverage (Part D). Plans vary by region.
2. Dual-Eligible Special Needs Plan (D-SNP): For individuals who have both Medicare Part A and Part B and receive state medical assistance.
3. End-stage renal disease (ESRD) Chronic Condition Special Needs Plan (C-SNP): Medicare SNPs are a Medicare Advantage Plan (like an HMO or PPO). ESRD C-SNP limits membership to people with
end-stage renal disease. Benefits, provider choices and drug formularies are tailored to best meet the specific needs of ESRD patients.

PCP assignment for HMO members
In some areas, members have the option to choose a primary care physician (PCP) through a PMG or a PCP directly contracted with Anthem through their amended Prudent Buyer Agreement:

- Members assigned to a PCP through an Independent Practice Association (IPA) or PMG will have an ID card indicating the PCP name and IPA/Group name. Reimbursement and referrals are coordinated through the PMG.
- **New:** Members may select a PCP directly contracted with Anthem. The member ID card will indicate the assigned PCP and will **not** indicate an IPA/PMG. Providers are reimbursed fee-for-service at the rate indicated in the Prudent Buyer Agreement for Anthem for Medicare products. See below for details regarding reimbursement, referrals and claims.

Eligibility verification:

- Review member’s ID card

- Online via Availity* at https://www.availity.com
- Call **1-888-230-7338**

Copays and deductibles
Copays and deductibles vary by plan. Please refer to the resources listed above in the **Eligibility verification** section to confirm for each member.

Reimbursement
Services rendered to Medicare Advantage PPO members and Medicare Advantage HMO members through the Prudent Buyer Agreement for Anthem are paid according to the Medicare Advantage fee-for-service fee schedule. Services rendered to Medicare Advantage HMO members through an IPA/PMG agreement are reimbursed according the terms of the agreement with the IPA/PMG.

Claims submission (except those related to IPA/PMG contracted services)
Submit claims directly to Anthem:
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Referral process
Anthem does not require referrals to in-network specialists. For providers contracted through an IPA/PMG arrangement, continue to follow your current referral process.

Authorizations
Anthem requires prior authorization for some procedures, and providers should obtain a list of procedures requiring prior authorization. The function of our authorization process is to confirm member eligibility, plan coverage, medical necessity and appropriateness of care to identify members who may need care management and disease prevention services. Our Innovative Care Management Model supports patients' healthiest outcomes by our medical appropriateness of services.
For providers contracted through an IPA/PMG arrangement, continue to follow your current authorization process.

What if I have questions or need more information?
Claims, membership, benefits and eligibility questions should be directed to the Provider Services phone number listed on the member's ID card.

If you have any questions about this update, please feel free to contact California Medicare Provider Solutions via email at CAContractSupport@anthem.com.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-expanded-hmo-network-guidance

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Medical drug benefit clinical criteria updates

Published: Jul 1, 2020 - **State & Federal** / Medicare

On November 15, 2019, and February 21, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem Blue Cross (Anthem). These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the Anthem provider website, and the effective dates will be reflected in the ***Clinical Criteria Web Posting February 2020***. 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-benefit-clinical-criteria-updates-34

Prior authorization codes moving from AIM Specialty Health to Anthem Blue Cross

Published: Jul 1, 2020 - **State & Federal** / Medicare

AIM Specialty Health® (AIM) currently performs utilization management review for bi-level positive airway pressure (BiPAP) equipment and all associated supplies. Beginning July 1, 2020, the following codes will require prior authorization with Anthem Blue Cross (Anthem) rather than with AIM.

AIM will continue to manage the supply codes for automatic positive airway pressure (APAP) and continuous positive airway pressure (CPAP) requests.

Anthem will continue to follow the COVID-19 Public Health Emergency orders from CMS until the waivers no longer apply. If the Public Health Emergency Orders are no longer in place beginning July 1, 2020, the following codes will require prior authorization with Anthem rather than with AIM when used in combination with the BiPAP codes above.

Line of business: Individual Medicare Advantage, Group Retiree Solutions, and Medicare-Medicaid Plans

E0470	Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with noninvasive interface, such as a nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, such as a nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

Precertification requests
Submit precertification requests via:

- Fax — **1-866-959-1537**
- Phone — please dial the customer service number on the back of the member's card, identify yourself as a provider and follow the prompts to reach the correct precertification team. There are multiple prompts. Select the prompt that fits the description for the authorization you plan to request
- Web — Use the Availity Web Tool by following this link: **https://apps.availity.com/availity/web/public.elegant.login**

A4604	Tubing with heating element
A7046	Water chamber for humidifier, replacement, each
A7027	Combination Oral/Nasal Mask used with positive airway pressure device, each
A7030	Full Face Mask used with positive airway pressure device, each
A7031	Face Mask Cushion, Replacement for Full Face Mask
A7034	Nasal Interface (mask or cannula type), used with positive airway pressure device, with/without head strap
A7035	Headgear
A7036	Chinstrap
A7037	Tubing
A7039	Filter, non-disposable
A7044	Oral Interface for Positive Airway Pressure Therapy
A7045	Replacement Exhalation Port for PAP Therapy
A7028	Oral Cushion, Replacement for Combination Oral/Nasal Mask, each
A7029	Nasal Pillows, Replacement for Combination Oral/Nasal Mask, pair
A7032	Replacement Cushion for Nasal Application Device
A7033	Replacement Pillows for Nasal Application Device, pair
A7038	Filter, disposable

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URL: https://providernews.anthem.com/california/article/prior-authorization-codes-moving-from-aim-specialty-health-to-anthem-blue-cross

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Modifier use reminders

Published: Jul 1, 2020 - **State & Federal** / Medicare

For more information about the **Modifier use reminders.**

URL: https://providernews.anthem.com/california/article/modifier-use-reminders-22

Medical policies and clinical utilization management guidelines update

Published: Jul 1, 2020 - **State & Federal** / Cal MediConnect

For more information about our Medical Policies and Clinical Utilization Management Guidelines update.

URL: https://providernews.anthem.com/california/article/medical-policies-and-clinical-utilization-management-guidelines-update-29

Medical drug benefit clinical criteria updates

Published: Jul 1, 2020 - **State & Federal** / Cal MediConnect

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If you have questions or would like additional information, use this **email**.

URL: https://providernews.anthem.com/california/article/medical-drug-benefit-clinical-criteria-updates-35

Modifier use reminders

Published: Jul 1, 2020 - **State & Federal** / Cal MediConnect

For more information about the Modifier use reminders.

URL: https://providernews.anthem.com/california/article/modifier-use-reminders-23
