California Provider News

June 2020 Anthem Blue Cross Provider News - California

Administrative:

A special thank you to Care Providers 4

Anthem Blue Cross introduces lower cost Anthem Health Access Plans on June 1 in response to COVID-19 crisis 4

Availity portal notification center 5

Commercial Risk Adjustment program update: Retrospective program begins; prospective program continues 6

Quality Corner: CPT® Category II Codes: Collaborating for enhanced patient care 7

Contracted provider claim escalation process 8

Anthem Blue Cross provider directory and provider data updates 9

Easily update provider demographics with the online Provider Maintenance Form 9

Provider Education seminars, webinars, workshops and more! 10

Sign-up now for our Provider News today at no charge! 11

Network leasing arrangements 11

Behavioral Health:

Follow-up after hospitalization for Mental Illness 12

Anthem Blue Cross enhances process for submitting behavioral health authorizations now available 13

Contracted provider dispute resolution 15

Network relations teams aren’t the same, where to go with questions 15

Commercial behavioral health provider data updates 16

Practice status: Open or closed 17

Forms make practice changes easy 17

Network leasing arrangements are online 18

Stay “in the know” at no charge! 19

Misrouted protected health information . . . 19

Behavioral health timely access regulations and language assistance program . . . 19

Clinical practice and preventive health guidelines available on the web . . . 22

Anthem Blue Cross' member rights and responsibilities . . . 22

Release of medical records . . . 22

Pharmacy information available online . . . 23

Anthem Blue Cross' Language Assistance Program: No interpreter? No problem! . . . 23

Member grievance process and forms must be made available upon request at behavioral health provider offices . . . 25

New digital provider enrollment application for behavioral health . . . 27

Overlapping service areas . . . 28

Where and how to submit BlueCard® claims . . . 28

BlueCard® Program quick tips . . . 29

Pharmacy:

CVS Specialty, Anthem's designated specialty pharmacy . . . 29

Pharmacy information available on anthem.com/ca . . . 30

Medical Policy & Clinical Guidelines:

Transition to AIM Rehabilitative Services Clinical Appropriateness Guidelines . . . 31

Medi-Cal Managed Care:

Medical policies and clinical utilization management guidelines update . . . 31

Modifier use reminders . . . 31

Acquisition of Beacon Health Options . . . 33

MCG care guidelines: 24 Edition . . . 33

Coding spotlight: Provider's guide to code social determinants of health . . . 33

Follow-up after hospitalization for mental illness . . . 36

Complex case management program . . . 38

Important information about utilization management . . . 38

Members’ Rights and Responsibilities Statement 39
CVS Specialty: Our designated specialty pharmacy 40
Resources supporting our providers during COVID-19 41

Medicare:

Anthem Blue Cross (Anthem) working with Optum to collect medical records for risk adjustment 42
2020 Medicare risk adjustment provider trainings 43
Diabetes HbA1c < 8 HEDIS guidance 45
Modifier use reminders 48

Cal MediConnect:

MCG care guidelines: 24th Edition 49
Anthem Blue Cross (Anthem) working with Optum to collect medical records for risk adjustment 49
Modifier use reminders 50
Updates to AIM Sleep Disorder Management clinical appropriateness guideline 51

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association. Use of the Anthem Web sites constitutes your agreement with our Terms of Use.

A special thank you to Care Providers

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

We want to express our most sincere thanks for your dedication to serving the patients in your care. Please take a moment to watch this brief thank you message from Anthem Blue Cross.

URL: https://providernews.anthem.com/california/article/a-special-thank-you-to-care-providers-6

Anthem Blue Cross introduces lower cost Anthem Health Access Plans on June 1 in response to COVID-19 crisis

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

Like many, Anthem Blue Cross (Anthem) is closely monitoring COVID-19 developments and what it means for our customers and our health care provider partners. Anthem is working to help employers who are facing tough decisions on furloughing or reducing hours of their workforce. Anthem is doing this by creating health insurance options that provide continued access to care. We continue to seek ways to support our customers by offering affordable alternate products with more flexibility while ensuring members can continue to see their established physicians.

Beginning June 1, 2020, Anthem is introducing our Anthem Health Access Plans for certain large group employers currently enrolled in our commercial lines of business only.

Anthem Health Access Plans cover the diagnosis and treatment for COVID-19 at 100% in accordance with Anthem guidelines.

These benefit plans cover preventive care, unlimited telemedicine, office visits, prescriptions, and more. In addition, members enrolled in these plans have digital ID cards and access to Sydney Health and Sydney Care Anthem's mobile app that runs on intelligence – as part of our digital strategy).

These plans include some coverage exclusions or limitations. For information about eligibility, available benefits, and a list of exclusions, please visit Availity – our Web-based provider tool at www.availity.com.

We are committed to working with our provider partners to help our members focus on their health and well-being. The new Health Access plans give your patients the needed coverage to manage their everyday health needs.

NOTE: *As with all eligibility and benefits inquiries on Availity, providers must have the member ID number (including the three-character prefix) and one or more search options of date of birth, first name and last name.*

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-introduces-lower-cost-anthem-health-access-plans-on-june-1-in-response-to-covid-19-crisis

---

Availity portal notification center

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

Anthem Blue Cross (Anthem) is now using the **Notification Center** on the Availity Portal home page to communicate vital, time sensitive information. A **Take Action** call out and a red flag in front of the message will make it easy to see that there is something new requiring your attention.

The notification Center is currently being used to notify you if there are payment integrity requests for medical records or recommended training in the Custom Learning Center. Select the **Take Action** icon to instantly access the custom learning recommended course.

For membership where the disputes tool is available, Availity will also post a message in the notification center when a dispute request you have submitted is finalized. Selecting the **Take Action** icon will allow easy access to your appeals worklist for details.

Viewing the Notification Center updates should be included as part of your regular workflow so you are always aware of any outstanding action items and can respond timely.

URL: https://providernews.anthem.com/california/article/availity-portal-notification-center-6

Commercial Risk Adjustment program update: Retrospective program begins; prospective program continues

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

Anthem is committed to collaborating with the provider community and offering flexible options to meet the needs of both the retrospective program and the prospective program. The retrospective program focuses on medical chart collection. The prospective program focuses on member health assessments for patients with undocumented Hierarchical Condition Categories (HCC's), in order to help close patients' gaps in care.

Retrospective Chart Requests

We appreciate that care providers across the country on the front line are committed to providing care during these challenging times, and as such, that care results in a visit where we may need the medical chart. Medical chart collection must be done to obtain undocumented HCC's on your patients in order to be compliant with the provisions of the Affordable Care Act, (ACA), that require our company to collect and report diagnosis code data for ACA membership. This process will begin in June. In order, to make these chart requests the most efficient for your office, we have electronic options available:

- EMR Interoperability
- Allscripts (Opt in -- signature required)
- NextGen
- Athenahealth
- MEDENT
- Remote/Direct Anthem access
- Vendor virtual or onsite visit (if the offices are opened back up from COVID-19 closures)
- Secure FTP

The goal of these electronic options is to both improve the medical record data extraction and the experience for Anthem's providers. If you are interested in this type of set up or any other remote access options, please contact the Commercial Risk Adjustment Network Education Representative listed below.

Prospective Patient Outreach (Incentive opportunity for properly completed health assessments: Physicians are eligible to receive $100 for electronic submissions or $50 for paper in addition to the office visit reimbursement.)

We encourage members to form a relationship with their Primary Care Physician to complete a clinical assessment to ensure you have a clearer picture of your patients' health. Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. Previous Anthem news updates have given telehealth reimbursement guidance to follow when submitting the claim.

As a reminder, the May *Provider News* mentioned incentives for prospective program participation **($100 or $50)**. We would be happy to meet and review incentive opportunities along with other flexible options for program participation and chart collection. Please contact the Commercial Risk Adjustment network education representative listed below to set up a meeting.

Please contact our Commercial Risk Adjustment Network Education Representative if you have any questions via email at Socorro.Carrasco@anthem.com.

Thank you for your continued efforts with our CRA Program.

URL: https://providernews.anthem.com/california/article/commercial-risk-adjustment-program-update-retrospective-program-begins-prospective-program-continues

---

Quality Corner: CPT® Category II Codes: Collaborating for enhanced patient care

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

The American Medical Association has an alphabetical listing of clinical conditions with which measures and CPT Category II codes are associated. The use of CPT Category II Codes and ICD-10-CM codes can reduce the number of medical records that we request during the HEDIS® medical record review season (January – May each year), thus reducing the administrative burden on physician offices.

Please open the attachment to view some commonly used codes for your convenience.

Article Attachments

Quality Corner_CPT Category II Codes.pdf
application/pdf - 73.66 KB

URL: https://providernews.anthem.com/california/article/quality-corner-cpt-category-ii-codes-collaborating-for-enhanced-patient-care-6

Contracted provider claim escalation process

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

In an effort to better service our contracted providers' right the first time, Anthem Blue Cross (Anthem) has improved our provider claim escalation process. Following the steps below.

- All inquiries related to eligibility and claims payment should be obtained by utilizing Anthem's self-service tools or by contacting Provider Care.
- Please use the Provider Care phone number on the back of the member's ID card for any information that you are unable to obtain via our self-service or web-based tools.
- In the event our self-service tools and Provider Care representatives are unable to assist you, you may ask for your inquiry to be escalated to a Provider Care Supervisor.
- If a Supervisor is unable to assist you immediately, you will receive a call back within 2 business days.
- Provider Care will provide an inquiry number for your phone call. Be sure to retain this number for any future inquiries. Please ask the representative to provide you with your inquiry tracking number at the beginning of your call, to avoid inconveniences to you, in the event your call is disconnected.
- Going forward, all claim inquiries must be handled via the escalation process within Provider Care. Network Relations will only assist with issues that have been addressed via this process. Escalations to Network Relations must include both a phone inquiry tracking reference number and a two business day period without response from a Supervisor.

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-17

Anthem Blue Cross provider directory and provider data updates

Published: Jun 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-20

Easily update provider demographics with the online Provider Maintenance Form

Published: Jun 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-20

Provider Education seminars, webinars, workshops and more!

Published: Jun 1, 2020 - **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 ***Providers > Education and Training***.

URL: https://providernews.anthem.com/california/article/provider-education-seminars-webinars-workshops-and-more-17

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

Published: Jun 1, 2020 - **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-5

Network leasing arrangements

Published: Jun 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-20

Follow-up after hospitalization for Mental Illness

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

As a provider, we understand you are committed to providing the best care for our members, including follow up appointments with members after a behavioral health (BH) inpatient stay. Since regular monitoring, follow up appointments and making necessary treatment recommendations or changes are all part of excellent care, we would like to provide an overview of the related HEDIS measure.

The Follow-Up after Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members (6 years and older) who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of behavioral health inpatient discharges for which the member received follow-up within 7 days after discharge.
- The percentage of behavioral health inpatient discharges for which the member received follow-up within 30 days after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are being recommended and scheduled during the inpatient stay as part of discharge planning by the eligible behavioral health facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as practicing behavioral health providers.

Please consider the following for improving member outcomes for this measure:

1. Earliest follow up with a BH provider can help with continuing treatment after leaving the hospital.
2. With greater emphasis on care coordination, primary care providers can help facilitate the BH follow up appointments.
3. Weekend member discharges have shown to have very inconsistent follow up after discharge. Start discharge planning as soon as possible while members are inpatient so those who are discharged on weekends have scheduled follow up appointments.

4. In addition, other social determinants of health pertinent to the member such as housing, food, living in a rural area, transportation, job schedule, family and social support, childcare, etc., can affect follow-up opportunities. Please address these needs and issues; refer to resources that can help support the member.
5. Social workers at the facilities can contact [brand] member services to learn if additional sources of assistance are available through [brand] such as case management and other referrals.
6. Telehealth services have been identified as part of follow up for this HEDIS measure available in certain parts of the country. Telehealth follow up may not be the best choice for everyone; however, not having a BH follow up for several weeks can be detrimental to the member can be a reason for relapse.

URL: https://providernews.anthem.com/california/article/follow-up-after-hospitalization-for-mental-illness-7

Anthem Blue Cross enhances process for submitting behavioral health authorizations now available

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Anthem Blue Cross (Anthem) is excited to announce an enhanced process for submitting behavioral health authorizations. We have enhanced the Interactive Care Reviewer (ICR) tool on the Availity Portal to provide the opportunity for quicker resolutions.

The ICR tool on the Availity Portal will now utilize sophisticated clinical analytics in order to provide an immediate decision on an authorization for higher levels of care such as inpatient, intensive outpatient (IOP) and partial hospitalization (PHP). Here are a few of the many reasons behavioral health providers will benefit from using ICR with the newly enhanced functionality:

1. Reduction of administrative burden
2. Quicker access to care for some services deemed eligible for our immediate decisions
3. Increased member focus
4. Prioritizes more complex cases
5. Reduced possibility of errors such as illegible faxes

6. Maximize the amount time spent with members

Follow these instructions to access ICR through the Availity Portal (www.Availity.com)
First, ask your Availity administrator to grant you the appropriate role assignment.
Do you create and submit prior authorization requests?
Required role assignment: *Authorization and Referral Request*
Do you check the status of the case or results of the authorization request?
Required role assignment: *Authorization and Referral Inquiry*

Once you have the authorization role assignment, log onto Availity with your unique user ID and password follow these steps.

1. Select **Patient Registration** from Availity's home page
2. Select **Authorizations & Referrals**
3. Select **Authorizations** *(for requests)* **|** Select **Auth/Referral Inquiry** *(for inquiries)*

Training:
Follow these instructions to access ICR on demand training through the Availity Custom Learning Center:

- From Availity's home page, select **Payer Spaces Anthem tile | Applications | Custom Learning Center tile.**
- From the **Courses** screen use the filter catalog, and select **Interactive Care Reviewer – Online Authorizations** from the menu and click **Apply**.

You will find two pages of online courses consisting of on demand videos and reference documents illustrating navigation and features of ICR. Enroll for the course(s) you want to take immediately or save for later.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-enhances-process-for-submitting-behavioral-health-authorizations-now-available

---

Contracted provider dispute resolution

Published: Jun 1, 2020 - **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-1

Network relations teams aren't the same, where to go with questions

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

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

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

It is 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-1

Commercial behavioral health provider data updates

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Accurate and up-to-date information about your practice in our directories is important. As a result, Anthem Blue Cross 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:

1. Use the Practice Update Form to report your changes. Note: Tax ID changes require a W-9 form.
2. Send practice changes, additions or deletions to our Provider Database Management team.
3. 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-1

Practice status: Open or closed

Published: Jun 1, 2020 - **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-1

Forms make practice changes easy

Published: Jun 1, 2020 - **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-

Is your practice information (e.g. practice address, areas of expertise, 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
- Tax ID (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-1

Network leasing arrangements are online

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

To learn more about Anthem Blue Cross' network leasing arrangements online.

URL: https://providernews.anthem.com/california/article/network-leasing-arrangements-are-online-1

Stay “in the know” at no charge!

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Learn how to stay connected with Anthem Blue Cross **easier, faster and more convenient with our *Provider News***.

URL: https://providernews.anthem.com/california/article/stay-in-the-know-at-no-charge-4

Misrouted protected health information

Published: Jun 1, 2020 - **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) is not included. Misrouted PHI includes information about members that a provider or facility 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 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-3

Behavioral health timely access regulations and language assistance program

Published: Jun 1, 2020 - **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

There are many activities conducted to support compliance with the regulations and we need you, as well as Members, 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

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 successfully with our providers to meet the expectations for the requirements with the least amount of difficulty and member abrasion.

Open the attachment to view the Access Standards for Behavioral Health and EAP providers table.

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.

Article Attachments

Access Standards for Behavioral Health and EAP Providers Table.pdf
application/pdf - 29.83 KB

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/behavioral-health-timely-access-regulations-and-language-assistance-program-1

Clinical practice and preventive health guidelines available on the web

Published: Jun 1, 2020 - **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 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 online at anthem.com/ca > Providers > Policies, Guidelines & Manuals. 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-22

Anthem Blue Cross' member rights and responsibilities

Published: Jun 1, 2020 - **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 Blue Cross (Anthem) has adopted a Members' Rights and Responsibilities statement. You can find the statement on at anthem.com/ca > Providers > **Policies**, **Guidelines & Manuals**. Scroll to Member Rights and Responsibilities > Read about member rights.

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

---

Release of medical records

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Under federal law, members have the right to their records or to have them forwarded to an

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-1

Pharmacy information available online

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Learn more about Pharmacy Information online.

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

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

Published: Jun 1, 2020 - **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

1. Give the Member Services representative the patient’s ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made.
4. 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.

Member grievance process and forms must be made available upon request at behavioral health provider offices

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

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.

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, and then select the desired resource link.

In addition, grievance forms, grievance procedures, Anthem's expedited grievance and appeals review process, can be found in the Anthem Blue Cross Facility and Professional Provider Manual

Anthem has posted a required learning course via Availity Portal (login required) to ensure 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 June 1, 2020:

1. Log in to Availity Portal at com.
2. At the top of Availity Portal, click **Payer Spaces** > **Anthem Blue Cross**.

3. On the payer spaces landing page, click **Access Your Custom Learning Center** from the **Applications**
4. Search for the **Member Grievance Form and Attestation - Online Course** using keyword **grievance**.
5. 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 register your organization for the Availity Portal.

1. Visit com to register.
2. Click **Register**.
3. Select your organization type.
4. 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, call Availity Client Services toll-free at **1-800-282-4548**.

We appreciate your cooperation and support.

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

---

New digital provider enrollment application for behavioral health

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

Anthem Blue Cross (Anthem) continues to make it easier and more convenient to become a participating Behavioral Health (BH) or ABA provider. The Digital Provider Enrollment application has been designed to speed up the enrollment process, allow new providers or currently contracted BH groups to submit data at one time, and obtain real-time updates on the status of an application or the add to a contracted group. BH or ABA providers can begin the path to participation by using the Digital Provider Enrollment application.

Access to the new application is available through Availity, our secure provider website. New and current Availity users should ensure their user ID has the correct access. Please ensure that you have been assigned the role for **Provider Enrollment**.

Digital provider enrollment offers many benefits**:**

- Existing BH and ABA contracted groups can add providers to their existing contract.
- New BH and ABA individual providers or groups can request a contract.
- Providers can check the status of an application in real-time using the enrollment dashboard (*MyDashboard*) located within Availity.

To use the new Digital Enrollment application, please ensure your provider data on CAQH is current and in a complete or re-attested status, then log into Availity and use the following navigation: Choose your state > Payer Spaces > Provider Enrollment.

If you experience issues with Availity organization registration, call Availity support toll-free at **1-800-282-4548** (1-800-AVAILITY) or visit the **Contact Us** page on the Availity Portal.

URL: https://providernews.anthem.com/california/article/new-digital-provider-enrollment-application-for-behavioral-health

---

Overlapping service areas

Published: Jun 1, 2020 - **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-1

Where and how to submit BlueCard® claims

Published: Jun 1, 2020 - **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-1

BlueCard® Program quick tips

Published: Jun 1, 2020 - **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-1

CVS Specialty, Anthem's designated specialty pharmacy

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

Anthem Blue Cross (Anthem) is pleased to offer CVS Specialty* as our designated specialty pharmacy for specialty medications administered in the office or outpatient hospital setting.

To comply with Anthem's programs related to the management of pharmacy expenses, providers will be required to obtain specialty pharmacy medications administered in the office or outpatient hospital setting through CVS Specialty effective July 1, 2020. This applies to all specialty drugs covered through the Medicaid health maintenance organization (HMO) member's medical benefits where *Anthem has financial risk* for the cost of specialty medications.
For dates of services on or after July 1, 2020, providers will be required to contact CVS Specialty's dedicated Anthem line listed below to order specialty medications for Medicaid HMO members.

Providers should continue to submit for administration of the medication, but not bill for the medication itself. CVS Specialty will bill us, and we will pay them directly. **If specialty medications are obtained through other pharmacies, the claim will be denied.**

CVS Specialty dedicated Anthem Provider Services:

- Phone number: **1-877-254-0015**
- Fax: **1-866-336-8479**
- Hours of operation:
  - Monday through Friday from 5 a.m. to 7:30 p.m. Pacific Time
  - Saturday from 6 a.m. to 10 a.m. Pacific Time

* CVS Specialty is an independent company providing specialty pharmacy services on behalf of Anthem.

URL: https://providernews.anthem.com/california/article/cvs-specialty-anthems-designated-specialty-pharmacy

---

Pharmacy information available on anthem.com/ca

Published: Jun 1, 2020 - **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 and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate “Marketplace Select Formulary” and pharmacy information, 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-13

Transition to AIM Rehabilitative Services Clinical Appropriateness Guidelines

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

Effective October 1, 2020, Anthem Blue Cross (Anthem) will transition the clinical criteria for medical necessity review of certain rehabilitative services to AIM Rehabilitative Service Clinical Appropriateness Guidelines. Clinical criteria will include certain physical therapy, occupational therapy and speech therapy services.

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

URL: https://providernews.anthem.com/california/article/transition-to-aim-rehabilitative-services-clinical-appropriateness-guidelines-5

Medical policies and clinical utilization management guidelines update

Published: Jun 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-26

Modifier use reminders

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

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

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Anthem reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is "above and beyond" or "separate and significant" from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Anthem will publish additional articles on correct coding in provider communications.

509409MUPENMUB

URL: https://providernews.anthem.com/california/article/modifier-use-reminders-17

Acquisition of Beacon Health Options

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

For more information about Acquisition of Beacon Health Options.

URL: https://providernews.anthem.com/california/article/acquisition-of-beacon-health-options-4

MCG care guidelines: 24 Edition

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

Click here for more information about the MCG care guidelines -24th edition.

URL: https://providernews.anthem.com/california/article/mcg-care-guidelines-24-edition

---

Coding spotlight: Provider’s guide to code social determinants of health

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

What are social determinants of health (SDOH)?

The World Health Organization (WHO) defines SDOH as "conditions in which people are born grow, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequalities." Capturing SDOH is becoming a necessary element of documentation.

Official coding guidelines for SDOH - new update

For 2019, the ICD-10-CM Official Guidelines for Coding and Reporting has been updated to allow reporting SDOH using the documentation of clinicians other than the patient's provider. Most of the patient-specific SDOH information is captured by ancillary staff supporting the physcians.

Do SDOH affect everyone?

The SDOH codes are very powerful tools in capturing the complexity of patient populations and allowing application of more accurate care. These conditions affect patient care. This

publicly reported data will also improve capture of conditions that impact readmission reduction and mortality metrics.

SDOH diagnosis codes are one of the few tools that are shared collectively to measure and evaluate SDOH on a national scale. **How can providers address SDOH issues for the members?**

- Using the CMS Screening Tool, which can be found at:
  - https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf
- Submitting ICD-10-CM codes from Chapter 21 (Z00 to Z99) to idenitify issues that may impact member health via claims

Coding SDOH
SDOH codes are represented in ICD-10-CM code categories Z55 to Z65 — persons with potential health hazards related to socioeconomic and psychosocial circumstances. Codes in the Z55 to Z65 groupings include the following:

Code grouping	Examples
Z55 — Problems related to education and literacy	Illiteracy/low level of literacy, schooling unavailable
Z56 — Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, military deployment status, sexual harassment on the job
Z57 — Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, tobacco, toxic agents in agriculture, extreme temperature
Z59 — Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, extreme poverty, low income
Z60 — Problems related to social environment	Adjustment to lifestyle transition, problems living alone, acculturation difficulty, social exclusion and rejection
Z62 — Problems related to upbringing	Inadequate parental supervisions and control, parental overprotection, institutional upbringing
Z63 — Other problems related to primary support group, including family circumstances	Problems with spousal or other relationship, absence of a family member, alcoholism or drug addiction in family
Z64 — Problems related to certain psychosocial circumstances	Problems with unwanted pregnancy, problems related to multiparity, discord with counselors
Z65 — Problems related to other psychosocial circumstances	Conviction, imprisonment, victim of crime or terrorism

Open the attachment to view the SDOH diagnosis code reference.

Resources

World Health Organization, About social determinants of health, found online at: **https://www.who.int/social_determinants/sdh_definition/en**.

ICD-10-CM Expert for Physicians, the complete official code set, Optum360, LLC. 2020.

Article Attachments

SDOH diagnosis code reference.pdf
application/pdf - 58.57 KB

Coding 2020-06-01.png
image/png - 20.56 KB

URL: https://providernews.anthem.com/california/article/coding-spotlight-providers-guide-to-code-social-determinants-of-health-2

Follow-up after hospitalization for mental illness

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

We understand providers are committed to providing our members with quality care, including follow-up appointments after a behavioral health (BH) inpatient stay. Since regular monitoring, follow-up appointments and making necessary treatment recommendations or changes are all part of quality care, we would like to provide an overview of the related HEDIS® measure.

The Follow-Up After Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members 6 years and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of BH inpatient discharges for which the member received follow-up within seven days after discharge.
- The percentage of BH inpatient discharges for which the member received follow-up within 30 day after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are recommended and scheduled during the inpatient stay as part of discharge planning by the eligible BH facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as by practicing BH providers.

Please consider the following for improving member outcomes for this measure:

- Earliest follow-up with a BH provider can help with continuing treatment after leaving the hospital.
- With greater emphasis on care coordination, PCPs can help facilitate the BH follow-up appointments.
- Weekend discharges have shown to have very inconsistent follow-up appointments after discharge. Start discharge planning as soon as possible during inpatient stay so those who are discharged on weekends have already scheduled follow-up appointments.
- In addition, facilitate discussion of other social determinants of health (such as housing, food, living in a rural area, transportation, job schedules, family and social support, child care, etc.) which can influence follow-up opportunities. Please address these needs and issues during the behavior health inpatient stay.
- Social workers at the facilities can contact Member Services for Anthem Blue Cross to learn if additional sources of assistance are available through case management or other referrals.
- Telehealth services may be considered as part of follow-up for this HEDIS measure if permitted in your state for BH follow-up and must be based on your clinical evaluation since this may not be the best choice of follow up for everyone.
    - However, it is also extremely important to note that telehealth services are subject to state and federal policies, coding and other requirements.
    - Please follow required guidelines and policies related to telehealth services specific to this measure.
- Our goal is continuity of care and treatment within seven days of inpatient BH discharge, followed by another visit within 30 days.

Please note this bulletin is for informational purposes only, as a resource for BH HEDIS follow up guidelines.

URL: https://providernews.anthem.com/california/article/follow-up-after-hospitalization-for-mental-illness-8

Complex case management program

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

Managing illness can be a daunting task for our members. It is not always easy to understand test results, know how to obtain essential resources for treatment, or know whom to contact with questions and concerns.

Anthem Blue Cross (Anthem) is available to offer assistance in these difficult moments with our **Complex Case Management program**. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals working to support members, families, primary care physicians and caregivers. The complex case management process uses the experience and expertise of the Case Coordination team to educate and empower our members by increasing self-management skills. The complex case management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Member Services number located on the back of their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can contact us by phone at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County). Case Management business hours are Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

URL: https://providernews.anthem.com/california/article/complex-case-management-program-12

Important information about utilization management

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

Our utilization management (UM) 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

https://www.anthem.com/ca/provider/policies.

You can request a free copy of our UM criteria from our Medical Management department. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the numbers listed below. To access UM criteria online, go to https://www.anthem.com/ca/provider/policies.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests by:

- Calling **1-888-831-2246, options 3** (includes both inside and outside L.A. County).
- Faxing **1-800-754-4708** (includes both inside and outside L.A. County).

Have questions about utilization decisions or the UM process?
Call our clinical team at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County) Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

URL: https://providernews.anthem.com/california/article/important-information-about-utilization-management-32

Members' Rights and Responsibilities Statement

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

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*. You may locate it in the provider manual.

If you need a physical copy of the statement, call us at **1-800-407-4627** (outside L.A. County) or

1-888-285-7801 (inside L.A. County).

URL: https://providernews.anthem.com/california/article/members-rights-and-responsibilities-statement-9

CVS Specialty: Our designated specialty pharmacy

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

Anthem Blue Cross (Anthem) is pleased to offer CVS Specialty* as our designated specialty pharmacy for specialty medications administered in the office or outpatient hospital setting.

To comply with Anthem's programs related to the management of pharmacy expenses, providers will be required to obtain specialty pharmacy medications administered in the office or outpatient hospital setting through CVS Specialty effective July 1, 2020. This applies to all specialty drugs covered through the Medicaid health maintenance organization (HMO) member's medical benefits where *Anthem has financial risk* for the cost of specialty medications.

For dates of services on or after July 1, 2020, providers will be required to contact CVS Specialty's dedicated Anthem line listed below to order specialty medications for Medicaid HMO members.

Providers should continue to submit for administration of the medication, but *not* bill for the medication itself. CVS Specialty will bill us, and we will pay them directly. **If specialty medications are obtained through other pharmacies, the claim will be denied.**

CVS Specialty's dedicated Anthem Provider Services contact information:

- Phone number: **1-877-254-0015**
- Fax: **1-866-336-8479**
- Hours of operation:

- Monday through Friday from 5 a.m. to 7:30 p.m. Pacific time
- Saturday from 6 a.m. to 10 a.m. Pacific time

Resources supporting our providers during COVID-19

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

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

Supporting providers and those who deliver care to our members is our top concern during the COVID-19 health emergency. Navigating the rapidly changing information is especially important to us so you can focus on what's important – patient care.

Our provider website will host the most accurate information from Anthem.

Visit the COVID-19 section of the Medicaid provider site: **https://mediproviders.anthem.com/ca/pages/covid.aspx**. Information here includes:

1. Frequently asked questions about changes to Anthem policies or benefit coverage during COVID-19. **These FAQ are updated regularly; please continue to check back each week.** Topics include:

    1. Testing and treatment coverage updates.
    2. Telehealth/telephonic care guidance for medical and behavioral health.
    3. Coding, billing and claims.

2. Federal resources available for health care providers and employers in the federal *CARES Act*.
3. Other resources as provided by the California Department of Health Care Services.

Commercial plan information

Visit the Commercial *Provider News* site: **https://providernews.anthem.com/california**. Information here includes:

1. The *Provider Spotlight* and *Articles* sections with the most recent notifications for Anthem's commercial health plans related to COVID-19 including FAQ about changes to Anthem policies or benefit coverage during COVID-19. T**hese FAQ are updated regularly; please continue to check back each week.**
2. The latest edition of the monthly Provider News publication, published on the first of the month.

Medicare Advantage plan information
Visit the Medicare Advantage Provider site:
https://www.anthem.com/provider/news/archives/?category=medicareadvantage > and select your state by going to *Change State* in the top right hand corner. Information here is specific to Anthem Medicare Advantage plans, including information about benefit changes and coverage, telehealth options through **LiveHealth Online**,* and testing and treatment.

Additional member support information
Anthem's coronavirus website at **https://www.anthem.com/coronavirus** offers additional solutions that can connect members exhibiting symptoms with a doctor, help members understand risk for COVID-19 and find COVID-19 services in their community.

* LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Anthem Blue Cross.
509605MUPENMUB

URL: https://providernews.anthem.com/california/article/resources-supporting-our-providers-during-covid-19-2

Anthem Blue Cross (Anthem) working with Optum to collect medical records for risk adjustment

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

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Anthem will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or
1-843-666-1970.

Additional information, including an FAQ, will be available on the **provider website** under **Important Medicare Advantage Updates**.

509218MUPENMUB

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-anthem-working-with-optum-to-collect-medical-records-for-risk-adjustment

---

2020 Medicare risk adjustment provider trainings

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

The Medicare Risk Adjustment Regulatory Compliance team at Anthem Blue Cross offers two provider training programs regarding Medicare risk adjustment and documentation guidelines. Information for each training is outlined below.

Medicare Risk Adjustment and Documentation Guidance (General)

When: Offered the first Wednesday of each month from 1 to 2 pm ET

Learning objective: This onboarding training will provide an overview of Medicare Risk Adjustment, including the Risk Adjustment Factor and the Hierarchical Condition Category (HCC) Model, with guidance on medical record documentation and coding.

Credits: This live activity, Medicare Risk Adjustment and Documentation Guidance, from January 8, 2020, to December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at **https://bit.ly/2z4A81e**.
**Note: Dates may be modified due to holiday scheduling.*

Medicare Risk Adjustment, Documentation and Coding Guidance (Condition specific)

Series: Offered on the third Wednesday of every other month at 12 to 1 pm ET

Learning objective: This is a collaborative learning event with Enhanced Personal Health Care (EPHC) to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.

Credits: This live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from January 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:

- Red Flag HCCs, part one: Training will cover HCCs most commonly reported in error as identified by CMS (chronic kidney disease stage 5, ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, end-stage liver disease) *{Recording will play upon registration.}*

- **https://bit.ly/3ae9znc**

- Red Flag HCCs, part two: Training will cover HCCs most commonly reported in error as identified by CMS (atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation) *{Recording will play upon registration.}*

- **https://bit.ly/3abKg52**

- Neoplasms (*recording link will be available later 2020.)*

- Acute, Chronic and Status Conditions (July 15, 2020)
- **https://bit.ly/2ygZfNR**
- Diabetes Mellitus and Other Metabolic Disorders (September 16, 2020)
- **https://bit.ly/2XQ9hjZ**
- TBD - This Medicare Risk Adjustment webinar will cover the critical topics and updates that surface during the year (November 18, 2020)
- **https://bit.ly/2xxjhUj**

509514MUPENMUB

URL: https://providernews.anthem.com/california/article/2020-medicare-risk-adjustment-provider-trainings-15

Diabetes HbA1c < 8 HEDIS guidance

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

Diabetes is a complex chronic illness requiring ongoing patient monitoring. The National Committee for Quality Assurance (NCQA) includes diabetes in its HEDIS® measures on which providers are rating annually.

Since diabetes HbA1c testing is a key measure to assess for future medical conditions related to complications of undiagnosed diabetes, NCQA requires that health plans review claims for diabetes in patient health records. The findings contribute to health plan Star Ratings for commercial and Medicare plans and the Quality Rating System measurement for marketplace plans. A systematic sample of patient records is pulled annually as part of the HEDIS medical record review to assess for documentation.

Which HEDIS measures are diabetes measures?
The diabetes measures focus on members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following assessments:

- Hemoglobin A1c (HbA1c) testing

- HbA1c poor control (> 9%)
- HbA1c control (< 8%)
- Dilated retinal exam
- Medical attention for nephropathy

The American College of Physicians' guidelines for people with type 2 diabetes recommend the desired A1c blood sugar control levels remain between 7% to 8%.[1]

In order to meet the HEDIS measure *HbA1c control < 8*, providers must document the date the test was performed and the corresponding result. For this reason, report one of the four Category II codes and use the date of service as the date of the test, not the date of the reporting of the Category II code.

To report most recent hemoglobin A1c level greater than or equal to 8% and less than 9%, use 3052F. To report most recent A1c level less than or equal to 9%, use codes 3044F, 3051F and 3052F:[2]

1. If the most recent hemoglobin A1c (HbA1c) level is less than 7%, use 3044F.
2. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 7% and less than 8%, use 3051F.
3. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 8% and less than or equal to 9%, use 3052F.

Continued management and diverse pathways to care are essential in controlling blood glucose and reducing the risk of complications. While it is extremely beneficial for the patient to have continuous management, it also benefits our providers. As HEDIS rates increase, there is potential for the provider to earn maximum or additional revenue through Pay for Quality, Value-Based Services and other pay-for-performance models.[3]

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Racial and ethnic disparities with diabetes

It is also important for providers to be aware of critical diabetes disparities that exist for diverse populations.

Compared to non-Hispanic whites:[4]

- African Americans, Hispanics, and American Indian/Alaska Natives have higher mortality rates from diabetes.
- African Americans and Hispanics have higher rates of complications from uncontrolled diabetes, including lower limb amputation and end-stage renal disease.
- More than half of Asian Americans and nearly half of Hispanic Americans with diabetes are undiagnosed.[5]
- Asian Americans are at risk for type 2 diabetes at a lower body mass index (BMI); therefore, diabetes screening at a BMI of 23 is recommended.[6]

Sources include:

- **Diabetes prevalence:**

- 2015 State Diagnosed Diabetes Prevalence, **https://www.cdc.gov/diabetes/data**.
- 2012 State Undiagnosed Diabetes Prevalence, Dall et al., "The Economic Burden of Elevated Blood Glucose Levels in 2012", *Diabetes Care*, December 2014, vol. 37.

- **Diabetes incidence:**

- 2015 State Diabetes Incidence Rates, **https://www.cdc.gov/diabetes/data**.

- **Cost:**

- American Diabetes Association, "Economic Costs of Diabetes in the U.S. in 2017", Diabetes Care, May 2018.

- **Research expenditures:**

- 2017 National Institute of Diabetes and Digestive and Kidney Diseases funding, **https://projectreporter.nih.gov**.
- 2017 CDC diabetes funding, **https://www.cdc.gov/fundingprofiles**.

1 **https://www.medicalnewstoday.com/articles/321123#An-A1C-of-7-to-8-percent-is-recommended**
2 **https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf**

3 **https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html**
4 Office of Minority Health. Minority Population Profiles:
https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlID=26
5 U.S. Department of Health and Human Services, National Institutes of Health. (2015, September 8), *More than half of Asian Americans with diabetes are undiagnosed*. Retrieved from **https://www.nih.gov/news-events/news-releases/more-half-asian-americans-diabetes-are-undiagnosed**.
6 ADA; NCAPIP; AANHPI DC; Joslin Diabetes Center Asian American Diabetes Initiative. (2015, September). Screen at 23. Retrieved from **http://screenat23.org/wp-content/uploads/2015/10/Screenat23package-1.pdf**
509427MUPENMUB

URL: https://providernews.anthem.com/california/article/diabetes-hba1c-8-hedis-guidance-6

Modifier use reminders

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

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

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Anthem reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where

the E&M service is “above and beyond” or “separate and significant” from any procedures performed the same day.

- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Anthem will publish additional articles on correct coding in provider communications.
509409MUPENMUB

URL: https://providernews.anthem.com/california/article/modifier-use-reminders-18

MCG care guidelines: 24th Edition

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

Click here for more information about the MCG care guidelines -24th edition.

URL: https://providernews.anthem.com/california/article/mcg-care-guidelines-24th-edition-11

Anthem Blue Cross (Anthem) working with Optum to collect medical records for risk adjustment

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

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services

(CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Anthem will work with Optum,* who is working with Ciox Health,* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Additional information, including an FAQ, will be available on the **provider website** under **News and Announcements**.
509218MUPENMUB

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-anthem-working-with-optum-to-collect-medical-records-for-risk-adjustment-1

Modifier use reminders

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

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

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Anthem reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.

- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is “above and beyond” or “separate and significant” from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Anthem will publish additional articles on correct coding in provider communications.

509409MUPENMUB

URL: https://providernews.anthem.com/california/article/modifier-use-reminders-19

Updates to AIM Sleep Disorder Management clinical appropriateness guideline

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

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

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health®* (AIM) *Sleep Disorder Management Clinical Appropriateness Guideline*.

***Sleep Disorder Management Clinical Appropriateness Guideline* updates by section:**

- Bi-Level Positive Airway Pressure (BPAP) Devices:
  - Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and alignment with Medicare requirements for use of BPAP
- Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing:
  - Style change for clarity
  - Code changes: none

As a reminder, ordering and servicing providers may submit prior authorization (PA) requests to AIM by:

- Accessing AIM's ***Provider**Portal*SM directly at **com**. Online access is available 24/7 to process orders in real time, and is the fastest and most convenient way to request PA.
- Accessing AIM via the **Availity Portal**.*
- Calling the AIM Contact Center at **1-800-714-0040** from 5 a.m. to 5 p.m. PT.

What if I need assistance?
If you have questions related to AIM guidelines, email AIM at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

509517MUPENMUB

URL: https://providernews.anthem.com/california/article/updates-to-aim-sleep-disorder-management-clinical-appropriateness-guideline-22