California Provider News

March 2021 Anthem Blue Cross Provider News - California

Behavioral Health:

Behavioral Health communication update 3

Pharmacy:

Pharmacy information available on anthem.com/ca 3

Administrative:

Medical attachment capability, itemized bill and more! 4

Anthem Blue Connection Exclusive Provider Organization Network Launch 7

Timely Access Regulations and Language Assistance Program 8

Anthem Blue Cross provider directory and provider data updates 15

Easily update provider demographics with the online Provider Maintenance Form 16

Provider Education 17

Stay “in the know” at no charge! 17

Network leasing arrangements 18

Medical Policy & Clinical Guidelines:

Update: Notice of changes to the AIM Small Joint Surgery Guideline 18

Reimbursement Policies:

Claims editing update for ICD-10-CM Excludes 1 notes 20

Medi-Cal Managed Care:

Access to more claim denial information is now self-service 21

MCG Care Guidelines 24th edition customization 23

March – Child life month 23

Coding spotlight: Overview of the 2021 evaluation and management changes . . . 23

Medicare:

New provider directory indicator for telehealth services . . . 28

DME checklist of information needed from providers . . . 29

MCG Care Guidelines 24th edition customization . . . 29

Access to more claim denial information is now self-service . . . 29

Cal MediConnect:

MCG Care Guidelines 24th edition customization . . . 31

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

Access to more claim denial information is now self-service . . . 35

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Behavioral Health communication update

Published: Mar 1, 2021 - **Products & Programs** / Behavioral Health

If you have the old address listed below on file, please update your records. The address is in older agreements and forms.

Old address:	**New address:**
Anthem Blue Cross	Anthem Blue Cross
Behavioral Health Network Management	Behavioral Health Network
Management	
9655 Granite Ridge Drive 6th Floor	P.O. Box 420790
San Diego, CA 92123	San Diego CA 92142

You can use this address to submit a termination or other notice, but our preferred method of communication is email. If you have further questions, email Behavioral Health Network Relations at **CABHNetworkRelations@anthem.com**.

994-0321-PN-CA

URL: https://providernews.anthem.com/california/article/behavioral-health-communication-update

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Pharmacy information available on anthem.com/ca

Published: Mar 1, 2021 - **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.

977-0221-PN-CA

URL: https://providernews.anthem.com/california/article/pharmacy-information-available-on-anthemcomca-18

Medical attachment capability, itemized bill and more!

Published: Mar 1, 2021 - **Administrative**

To help ensure accuracy and eliminate delays in the adjudication of your claims, the itemized bill must be included with qualifying claim submissions. Submitting an itemized bill for a high dollar claim just got easier for submitting ***unsolicited*** medical attachments.

Did you know there is an **"itemized bill"** submission option under **Attachments – New!**

- Log in to Availity Portal
- Select **Claims & Payments | Attachments – New**
- Select **Send Attachment**
- Under the **Request for Information**, select **No, if you are including the supplemental information/attachment for an 837 claim PWK.**
- Provide provider, patient and claim information
- Attach Supporting Documentation and Reason
- Send Attachment(s)

Request for Information

Select Yes, if you are responding to a request from the health plan or need to submit documentation for a specific claim number.

Select No, if you are including the supplemental information/attachment for an 837 claim PWK.

Yes No

Attach Supporting Documentation

ADDING ATTACHMENTS:
- This Health Plan supports file types including .jpeg, .jpg, .pdf, .tiff and .tif.
- File names cannot contain spaces or special characters with the exception of "_" and "-".

Reason

Choose one ...

Add File

11503-0 - Medical Records

48768-6 - Itemized Bills

Add Attachment

Clear Values

Send Attachment(s)

Also, available for you is the option to submit a claim attachment using Availity Portal for ***solicited*** medical attachments.

Submit supporting documentation in response to a formal (solicited) request from the payer.

- Log in to Availity Portal
- Select **Claims & Payments | Attachments – New**
- Select **Send Attachment**
- Under the **Request for Information**, select **Yes, if you are responding to a request from the health plan or need to submit documentation for a specific claim number**
- Add supporting documentation and Reason
- Submit

Request for Information

Select Yes, if you are responding to a request from the health plan or need to submit documentation for a specific claim number.

Select No, if you are including the supplemental information/attachment for an 837 claim PWK.

Yes No

Select...

Other Claim Documentation Request

Quality Claims Review (QCR)

Special Investigations Unit (SIU)

As an added bonus, if you attended a previous webinar there is updated information we want to share with you around submitting an EDI 837 batch, which includes a PWK segment in loops 2300/2400; this detail is the linkage between the electronic claim and your supplemental documentation that can be submitted through the Availity portal.

What does this mean for you?
You may now submit attachments electronically (EDI) using the PWK segment to specify that documents are being submitted in support of the claim and no additional face sheet or coversheet is needed.
Here are the steps:

- Log in to Availity Portal
- Select **Claims & Payments I Attachments - New**
- From the **Inbox** tab, select the appropriate claim or open the request in your work queue
- Add files with supporting documentation
- Submit

Get Trained
Attend an Availity hosted webinar to learn more about all capabilities. You can register for an upcoming live webinar hosted by Availity here

or
Log into www.Availity.com and select **Help & Training | Get Trained** to open the Availity Learning Center in a new tab (it is your dedicated ALC account).

- Search by keyword (**Medattach**) to find on-demand and live training options
- Click Enroll to enroll for a course and then go to your Dashboard to access it any time

Article Attachments

Screen shot 1.png
image/png - 43.18 KB

Screen shot 2.png
image/png - 24.62 KB

Screen shot 3.png
image/png - 82.59 KB

Get started today with these wide-ranging capability enhancements to transform your business operations to a quick, secure, paperless and simple process to fulfill medical records requests electronically through Availity.

1017-0321-PN-CA

URL: https://providernews.anthem.com/california/article/medical-attachment-capability-itemized-bill-and-more-1

Anthem Blue Connection Exclusive Provider Organization Network Launch

Published: Mar 1, 2021 - **Administrative**

Anthem Blue Cross (Anthem) is pleased to announce the launch of the **Anthem Blue Connection Exclusive Provider Organization (EPO) Network (Blue Connection)**. Blue Connection is a health plan option designed to specifically meet the evolving health care needs of our employer groups in the San Francisco Bay area. You can expect to see members later this year.

Northern California Service Area
Blue Connection currently serves the following northern California counties: Alameda, Contra Costa, El Dorado, Marin, Placer, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma and Yolo.

Blue Connection Providers

Members have direct access to more than 3,500 select Anthem physicians, hospitals and ambulatory surgery centers in the exclusive Blue Connection network. This commercial network also includes behavioral health professionals and facilities, outpatient diagnostic imaging centers, birthing centers, and ancillary providers.

Member ID Cards

Members enrolled in this plan are issued an ID card that displays Blue Connection EPO on the front, bottom right-hand corner. Virtual ID cards are accessible to members through the Sydney Health and Engage Wellbeing apps.

Questions

We are excited about collaborating with you to continue providing quality and affordable health care to our California members. If you have any questions about this network, please use the following contact information below:

1. Behavioral Health: CABHNetworkRelations@anthem.com
2. Physicians: CAContractSupport@anthem.com
3. Ancillary (Acupuncturists, Cardiac Event Monitoring (CEM), Ground and Air Ambulance, Skilled Nursing, Lab, Hospice, Home Health, Home Infusion, Dialysis, DME, PT/OT/SP Therapy, Registered Dietitians, Audiology/Hearing Aid Suppliers): EnterpriseAncillary@anthem.com

1016-0321-PN-CA

URL: https://providernews.anthem.com/california/article/anthem-blue-connection-exclusive-provider-organization-network-launch

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Timely Access Regulations and Language Assistance Program

Published: Mar 1, 2021 - **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. Each year we communicate Anthem’s Timely Access

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

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). **Note: This exception does not apply to commercial Behavioral Health.**

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

Please take a moment to review and share with your staff the Access Standards tables for Medical Professionals and Behavioral Health that follow.

Access Standards for Medical Professionals

Type of Care	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.

Note: The next available appointment date and time can be either In-Person or by Telehealth.

Email any questions to the commercial medical Network Relations at CAContractSupport@anthem.com .

Access Standards for Behavioral Health and EAP Providers

Type of Care	Standard
Emergency Care Instructions (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 the emergency room if the caller is experiencing an emergency) Members are directed to 911 or the nearest emergency room.	Members are directed to 911 or the nearest emergency room.
Non-Life-Threatening Emergency Care	Appointment within 6 hours Members are directed to 911 or the nearest emergency room.
Urgent Care (does not require prior authorization)	Appointment within 48 hours Members are directed to 911 or the nearest emergency room.
Urgent Care (requires prior authorization)	96 hours
Routine Office Visit/Non-urgent Appointment	10 Business days (Psychiatrists)* 10 Business days (Non-Physician Mental Health Care Providers) 5 Business days (EAP)

Access to After-hours Care	Available 24 hours/7 days. Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Behavioral Health/EAP provider and be informed when the call will be returned.
In Office Waiting Room Time	Usually members do not have to wait longer than 15 minutes after their scheduled appointment to see a Behavioral Health/EAP provider.

** The DMHC Timely Access standard is 15 Business days for Psychiatrists; however, to comply with the NCQA accreditation standard of 10 Business Days, Anthem uses the more stringent standard.*

Note: The next available appointment date and time can be either In-Person or by Telehealth services.

Email any questions to Behavioral Health Network Relations at CABHNetworkRelations@anthem.com.

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, at no cost, 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).

992-0321-PN-CA

URL: https://providernews.anthem.com/california/article/timely-access-regulations-and-language-assistance-program-7

Anthem Blue Cross provider directory and provider data updates

Published: Mar 1, 2021 - **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.

1014-0321-PN-CA

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-provider-directory-and-provider-data-updates-29

Easily update provider demographics with the online Provider Maintenance Form

Published: Mar 1, 2021 - **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.

1015-0321-PN-CA

URL: https://providernews.anthem.com/california/article/easily-update-provider-demographics-with-the-online-provider-maintenance-form-29

Provider Education

Published: Mar 1, 2021 - **Administrative**

Our Provider Network Education team offers quality complimentary educational programs and materials specially designed for our providers. Log on to the Anthem Blue Cross website: www.anthem.com/ca. Select ***Providers***, under ***Communications*** go to ***Education and Training***. Scroll down to view ***Training, Educational and Resource offerings***.

1011-0321-PN-CA

URL: https://providernews.anthem.com/california/article/provider-education

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Stay "in the know" at no charge!

Published: Mar 1, 2021 - **Administrative**

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our Provider News publication. Provider News is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates

- System changes
- Fee Schedules
- Medical policy updates
- Claims and billing updates
- …and much 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 email addresses as you like.

1013-0321-PN-CA

URL: https://providernews.anthem.com/california/article/stay-in-the-know-at-no-charge-10

Network leasing arrangements

Published: Mar 1, 2021 - **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.

1012-0321-PN-CA

URL: https://providernews.anthem.com/california/article/network-leasing-arrangements-29

Update: Notice of changes to the AIM Small Joint Surgery Guideline

Published: Mar 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

As indicated in our notice August 2020, effective November 1, 2020, AIM Specialty Health® (AIM) began administering the AIM Musculoskeletal program to perform medical necessity reviews for certain elective surgeries of the small joints using AIM clinical guidelines for Anthem Blue Cross (Anthem) fully insured members and some ASO groups.

Effective March 14, 2021, the AIM Small Joint Surgery Guideline has been updated with the following:

- Clarified requirements for imaging reports.
- Removed radiographic requirement for confirmation of lesser toe deformities.
- Ankle arthrodesis and total ankle arthroplasty added as new indications for revision of failed previous reconstructions.
- Removed total ankle arthroplasty requirements for adjacent joint or inflammatory arthritis.
- Clarified contraindications only apply to total ankle arthroplasty.

Providers should continue to submit prior authorization review requests to AIM using one of the following ways:

- Access AIM ***Provider****PortalSM* directly at providerportal.com. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at availity.com
- Call the AIM toll-free number at 1-877-291-0360Monday through Friday 7:00 am – 5:00 pm PT.

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

993-0321-PN-CA

URL: https://providernews.anthem.com/california/article/update-notice-of-changes-to-the-aim-small-joint-surgery-guideline-6

Claims editing update for ICD-10-CM Excludes 1 notes

Published: Mar 1, 2021 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after March 1, 2021, Anthem Blue Cross (Anthem) will be implementing revised claims editing logic tied to Excludes 1 notes from ICD-10-CM 2020 coding guidelines. To help ensure the accurate processing of claims, use ICD-10-CM Coding Guidelines when selecting the most appropriate diagnosis for member encounters. Please remember to code to the highest level of specificity. For example, if there is an indication at the Category level that a code can be billed with another range of codes, it is imperative to look for Excludes 1 notes that may prohibit billing a specific code combination.

For assistance in determining proper coding guidance, the following site should be helpful: https://www.cdc.gov/nchs/icd/icd10cm.htm

One of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes 1 notes. An Excludes 1 note indicates that the excluded code identified in the note should not be billed with the code or code range listed above the Excludes 1 note. These notes appear below the affected codes – if the note appears under the Category (first three characters of a code), it applies to the entire series of codes within that category. If the Excludes 1 note appears beneath a specific code (3, 4, 5, 6 or 7 characters in length) then it applies only to that specific code.

In ICD-10-CM, when a category includes an Excludes 1 note, it outlines what codes should NOT be billed together. Examples of this code scenario would include but are not limited to the following:

- Reporting Z01.419 with Z12.4
  - Z01.41X (encounter GYN exam w/out abnormal findings) has an Excludes 1 note below that includes Z12.4.
  - Z12.4 (encounter for screening malignant neoplasm cervix)
- Reporting Z79.891with F11.2X
  - Z79.891 (long-term use of Opiates) has an Excludes 1 note after it for F11.2X. F11.2X (Opioid dependence)
- Reporting M54.2 with M50.XX

- M54.2 (Cervicalgia) has an Excludes 1 note below it for M50.XX (cervicalgia due to intervertebral disc disorder)

- Reporting M54.5 with S39.012X and/or M54.4x

  - M54.5 (low back pain) has an Excludes 1 note below it which includes; S93.012X (strain of muscle, fascia and tendon of lower back), M54.4X (low back pain) M51.2X (lumbago due to intervertebral disc disorder)

- Reporting J03.XX with J02.XX, J35.1, J36, J02.9

  - J03.- (Acute tonsillitis) has an Excludes 1 note below it which includes; J02.- (acute sore throat), J35.1 (hypertrophy of tonsils), J36 (Peritonsillar abscess)

- Reporting N89 with R87.62X, D07.2, R87.623, N76.XX, N95.2, A59.00

  - N89 (Other inflammatory disorders of the vagina) has an Excludes 1 note below the category for R87.62X (abnormal results from vaginal cytological exam), D07.2 (vaginal intraepithelial neoplasia), R87.623 (HGSIL of vagina), N76.XX inflammation of the vagina), N95.2 (senile [atrophic] vaginitis), A59.00 (trichomonal leukorrhea)

Finally, if you believe an Excludes1 note denial is incorrect, please consult the ICD-10-CM codebook to verify appropriate use of the billed codes and provide supporting documentation through the normal dispute process as to why the billed diagnoses codes are appropriately used together.

985-0321-PN-CA

URL: https://providernews.anthem.com/california/article/claims-editing-update-for-icd-10-cm-excludes-1-notes-3

Access to more claim denial information is now self-service

Published: Mar 1, 2021 - **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).

Through predictive analytics, healthcare teams can now receive real-time solutions to claim denials.

Anthem is committed to providing digital first solutions. Healthcare teams can now use self-service tools to reduce the amount of time spent following up on claim denials. **Through the application of predictive analytics, Anthem has the answers before you ask the questions.** With an initial focus on claim-level insights, Anthem has streamlined claim denial inquiries by making the reasons for the claim denial digitally available. In addition to the reason for the denial, we supply you with the next steps needed to move the claim to payment. This eliminates the need to call for updates and experience any unnecessary delays waiting for the *EOP*.

Access the *Claims Status Listing* on Payer Spaces from https://mediproviders.anthem.com/ca by using the Log In button or through the secure provider portal via Availity.* We provide a complete list of claims, highlight those claims that have proactive insights, provide a reason for the denial, and the information needed to move the claim forward.

Claim resolution daily

Automated updates make it possible to refresh claims history daily. As you resolve claim denials, the claim status changes, other claims needing resolution are added, and claims are resolved faster.

Anthem made it easier to update and supply additional information, too. While logged into the secure provider portal, you have the ability to revise your claim, add attachments, or eliminate it if filed in error. Even if you did not file the claim digitally, you can access the proactive insights. Predictive analytics supplies the needed claim denial information online — all in one place.

Predictive proactive issue resolution and near real-time digital claim denial information is another example of how Anthem is using digital technology to improve the healthcare experience. If you have questions, please reach out to your Provider Relations representative.

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URL: https://providernews.anthem.com/california/article/access-to-more-claim-denial-information-is-now-self-service-7

MCG Care Guidelines 24th edition customization

Published: Mar 1, 2021 - **State & Federal** / Medi-Cal Managed Care

Click here for more information on MCG Care Guidelines 24th edition customization.

URL: https://providernews.anthem.com/california/article/mcg-care-guidelines-24th-edition-customization-10

March – Child life month

Published: Mar 1, 2021 - **State & Federal** / Medi-Cal Managed Care

Did you know that 9 of the 10 leading causes of death in the United States — including chronic lower respiratory disease, stroke, cancer, heart disease and diabetes, along with a range of mental illnesses — are related to toxic experiences that people experience in their first 18 years of life? These experiences are called adverse childhood events (ACEs), and they are made up of 10 categories that fit under the broad domains of abuse, neglect and household dysfunction. The more of these categories experienced, the higher lifetime risk of complications from these illnesses; the life expectancy of individuals with six or more ACEs is 19 years shorter than that of individuals with none. This is why the California Surgeon General has made it a priority to start screening for ACEs during regular doctor appointments for both adults and children and then connecting identified Californians with the proper resources to lower their level of risk.

The screenings and two-hour training, including two CME or MOC credits, are all provided online for free. Once this training is completed, Medi-Cal Managed Care providers can be reimbursed for each screening done and can help their patients live longer, healthier lives. For more information, check out **https://www.acesaware.org**.

URL: https://providernews.anthem.com/california/article/march-child-life-month

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Coding spotlight: Overview of the 2021 evaluation and management changes

Published: Mar 1, 2021 - **State & Federal** / Medi-Cal Managed Care

Why are these changes necessary?

Changes are meant to simplify code selection criteria, make coding more clinically relevant and to reduce documentation overload for office-based evaluation and management (E/M) services, while continuing to differentiate payment based on complexity of care.

Key elements of major revisions for 2021:

- Physicians may choose their documentation based on **medical decision making (MDM)** or **total time** (including non-face-to-face services).
- History and exam are still important parts of the notes and may contribute to both time and MDM, but they will no longer be scored for determining the level of the E/M
- MDM criteria has moved away from simply adding up tasks to instead focusing on tasks that affect the management of a patient's
- Code 99201 was
- Codes 99202 to 99215 were

Changes to time documentation

Time will now be defined as the **total** time spent by the provider (both face-to-face and time spent on non-face-to-face activities related to this patient's visit performed on the same day as the visit). This may include the services listed below but should not include time spent on separately billable services (such as X-ray interpretation). Effective January 1, 2021:

- The total time spent must be documented clearly by the provider for the E/M level to be determined by time and does not include ancillary staff
- Time will no longer need to be dominated by
- All time used for leveling the E/M must be on the same day as the face-to-face

Services included in total time:

- Preparing for the visit (for example, reviewing test results)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering tests, medications, prescriptions or procedures after the visit
- Referring and communicating with other health care professionals (when not reported separately)

- Documenting clinical information in the patient's medical record
- Independently interpreting results (not separately reportable) and communicating results to the patient/family/caregiver
- Care coordination (not separately reportable)

New patient E/M code	Typical time (2020)	Total time (2021)
99201	10 minutes	Code deleted
99202	20 minutes	15 to 29 minutes
99203	30 minutes	30 to 44 minutes
99204	45 minutes	45 to 59 minutes
99205	60 minutes	60 to 74 minutes

Established patient E/M code	Typical time (2020)	Total time (2021)
99211	5 minutes	Time component removed
99212	10 minutes	10 to 19 minutes
99213	15 minutes	20 to 29 minutes
99214	25 minutes	30 to 39 minutes
99215	40 minutes	40 to 54 minutes

Prolonged office services

2021 changes include addition of a new add-on code **(currently labeled 99417)** for prolonged office visits *when time is used for code level selection*, including face-to-face and non-face-to-face provider time of at least 15 additional minutes on the same date of service for level five office visits (99205, 99215).

Medical decision making (MDM)

Using the new MDM table, medical decision making for office/outpatient visits will be based on meeting (or exceeding) two out of three categories:

MDM must meet two out of three elements				
Code	**Level of MDM**	Number and complexity of problems addressed	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management
99211	**N/A**	N/A	N/A	N/A
99202 99212	**Straightforward**	Minimal	Minimal or none	Minimal
99203 99213	**Low**	Low	Limited	Low
99204 99214	**Moderate**	Moderate	Moderate	Moderate
99205 99215	**High**	High	Extensive	High

Number and complexity of problems addressed at the encounter:

- **Straightforward:** One self-limited or minor problem
- **Low:** Two or more self-limited or minor problems; one stable chronic illness, one acute, uncomplicated illness or injury
- **Moderate:** One or more chronic illnesses with exacerbation, progression or side effects of treatments; two or more stable chronic illnesses; one undiagnosed new problem with uncertain prognosis; one acute illness with systemic symptoms; one acute complicated injury
- **High**: One or more chronic illnesses with severe exacerbation, progression or side effects of treatment; one acute or chronic illness or injury that poses a threat to life or bodily

Amount and/or complexity of data to be reviewed and analyzed
The 2021 guidelines list three categories for data:

1. Tests, documents or independent
2. Independent interpretation of tests

3. Discussion of management or test

- **Straightforward:** Minimal or none
- **Low** (one category required):
  - Two tests/documents or independent historian
- **Moderate** (one category required):
  - Three tests, documents and/or independent historian
  - Independent interpretation of a test
  - Discussion of management or test interpretation
- **High** (two categories required):
  - Three items between documents and independent historian
  - Independent interpretation of a test
  - Discussion of management or test interpretation

Risk of complications and/or morbidity or mortality of patient management
For the purposes of MDM, level of risk is based upon the consequences of the problem(s) addressed at the encounter *when appropriately treated.* Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization:

- **Minimal:** Rest, gargle, elastic bandages, superficial dressings
- **Low:** OTC drugs, physical therapy, minor surgery with no identified risk factors, IV fluids without additives
- **Moderate:** Management of a prescription drug, minor surgery with identified risk factors, decision regarding major surgery without identified risk factors, diagnosis or treatment
- **High:** Need to discuss higher risk problems that could happen for which physician or other qualified health care professional will watch or

Tips to prepare your practice for E/M office visit changes:

- Identify project lead
- Schedule team preparation time
- Update practice protocols
- Consider coding support
- Review business liability coverage
- Guard against fraud/abuse
- Update compliance plan
- Check with your electronic health record (EHR) vendor
- Assess financial impact
- Understand medical liability coverage

Resources:

1. CPT® Professional Edition, 2021. AMA
2. AMA Elements of Medical Decision Making. **https://www.ama-assn.org/system/files/2019-06/cpt-revised- mdm-grid.pdf**
3. AMA Press Release 2021 CPT code **https://www.ama-assn.org/press-center/press-releases/ama-releases- 2021-cpt-code-set**
4. Major E/M Changes Coming Soon. Are you prepared? **https://www.aapc.com/evaluation-management/em- codes-changes-2021.aspx**

URL: https://providernews.anthem.com/california/article/coding-spotlight-overview-of-the-2021-evaluation-and-management-changes-2

New provider directory indicator for telehealth services

Published: Mar 1, 2021 - **State & Federal** / Medicare

Anthem Blue Cross will begin publishing a new indicator in our online provider directories to help members easily identify professional providers who offer telehealth services.

We encourage providers who offer telehealth services to use the online *Provider Maintenance Form* to notify us, and we will add a telehealth indicator to your online provider directory profile.

Visit **https://www.anthem.com/ca** to locate the ***Provider Maintenance Form***. Please contact Provider Services if you have any questions.

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URL: https://providernews.anthem.com/california/article/new-provider-directory-indicator-for-telehealth-services-22

DME checklist of information needed from providers

Published: Mar 1, 2021 - **State & Federal** / Medicare

Click here for more information about DME checklist of information needed from providers.

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URL: https://providernews.anthem.com/california/article/dme-checklist-of-information-needed-from-providers

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MCG Care Guidelines 24th edition customization

Published: Mar 1, 2021 - **State & Federal** / Medicare

Click here for more information about MCG Care Guidelines 24th edition customization.

516850MUPNMUB

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

Access to more claim denial information is now self-service

Published: Mar 1, 2021 - **State & Federal** / Medicare

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

Through predictive analytics, healthcare teams can now receive real-time solutions to claim denials.

Anthem is committed to providing digital first solutions. Healthcare teams can now use self-service tools to reduce the amount of time spent following up on claim denials. **Through the application of predictive analytics, Anthem has the answers before you ask the questions.** With an initial focus on claim-level insights, Anthem has streamlined claim denial inquiries by making the reasons for the claim denial digitally available. In addition to the reason for the denial, we supply you with the next steps needed to move the claim to payment. This eliminates the need to call for updates and experience any unnecessary delays waiting for the *EOP*.

Access the *Claims Status Listing* on Payer Spaces from https://mediproviders.anthem.com/ca by using the Log In button or through the secure provider portal via Availity.* We provide a complete list of claims, highlight those claims that have proactive insights, provide a reason for the denial, and the information needed to move the claim forward.

Claim resolution daily

Automated updates make it possible to refresh claims history daily. As you resolve claim denials, the claim status changes, other claims needing resolution are added, and claims are resolved faster.

Anthem made it easier to update and supply additional information, too. While logged into the secure provider portal, you have the ability to revise your claim, add attachments, or eliminate it if filed in error. Even if you did not file the claim digitally, you can access the proactive insights. Predictive analytics supplies the needed claim denial information online — all in one place.

Predictive proactive issue resolution and near real-time digital claim denial information is another example of how Anthem is using digital technology to improve the healthcare experience. If you have questions, please reach out to your Provider Relations representative.

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URL: https://providernews.anthem.com/california/article/access-to-more-claim-denial-information-is-now-self-service-8

MCG Care Guidelines 24th edition customization

Published: Mar 1, 2021 - **State & Federal** / Cal MediConnect

Click here for more information about MCG Care Guidelines 24th edition customization.

516850MUPENMUB

URL: https://providernews.anthem.com/california/article/mcg-care-guidelines-24th-edition-customization-12

Medical policies and clinical utilization management guidelines update

Published: Mar 1, 2021 - **State & Federal** / Cal MediConnect

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

The *Medical Policies*, *Clinical Utilization Management (UM) Guidelines* and *Third-Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed.

Please share this notice with other members of your practice and office staff.

To view a guideline, visit https://www11.anthem.com/ca_search.html.

Notes/updates:
Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

- ***GENE.00055** – Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity

- Gene expression profiling for risk stratification of inflammatory bowel disease (IBD) severity, including use of PredictSURE IBD, is considered investigational and not medically necessary for all indications

- ***LAB.00037** – Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)

  - Serological testing for biomarkers of irritable bowel syndrome (for example, CdtB and anti-vinculin), using tests such as, IBSDetex, ibs-smart or IBSchek, is considered investigational and not medically necessary for screening, diagnosis or management of irritable bowel syndrome, and for all other indications

- ***DME.00011** – Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices

  - Revised scope to only include non-implantable devices and moved content addressing implantable devices to SURG.00158
  - Added “non-implantable” to bullet point on percutaneous neuromodulation therapy
  - Added percutaneous electrical nerve field stimulation (PENFS) as investigational and not medically necessary for all indications

- ***SURG.00062** – Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele

  - Expanded scope to include percutaneous testicular vein embolization for varicocele and added embolization of the testicular (spermatic) veins as investigational and not medically necessary as a treatment of testicular varicocele

- ***CG-LAB-15** – Red Blood Cell Folic Acid Testing

  - RBC folic acid testing is considered not medically necessary in all cases

- ***CG-LAB-16** – Serum Amylase Testing

  - Serum amylase testing is considered not medically necessary for acute and chronic pancreatitis and all other conditions

- ***CG-GENE-04** – Molecular Marker Evaluation of Thyroid Nodules
- Added the Afirma Xpression Atlas as not medically necessary

- **00158** – Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain
  - A **new *Medical Policy*** was created from content contained in DME.00011.
  - There are no changes to the policy content.
  - Publish date is December 16, 2020.

- **CG-GENE-21** – Cell-Free Fetal DNA-Based Prenatal Testing
  - A **new *Clinical Guideline*** was created from content contained in GENE.00026.
  - There are no changes to the guideline content.
  - Publish date is December 16, 2020.

Medical Policies

On November 5, 2020, the medical policy and technology assessment committee (MPTAC) approved the following *Medical Policies* applicable to Anthem. These guidelines take effect March 8, 2021.

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
12/16/2020	***GENE.00055**	**Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity**	New
12/16/2020	***LAB.00037**	**Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)**	New
11/12/2020	**ANC.00009**	**Cosmetic and Reconstructive Services of the Trunk and Groin**	Revised
12/16/2020	***DME.00011**	**Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices**	Revised
11/12/2020	**GENE.00052**	**Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling**	Revised
11/12/2020	**MED.00129**	**Gene Therapy for Spinal Muscular Atrophy**	Revised
12/16/2020	**SURG.00011**	**Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting**	Revised
12/16/2020	***SURG.00062**	**Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele**	Revised

Clinical UM Guidelines

On November 5, 2020, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. These guidelines were adopted by the medical operations committee for Anthem members on November 19, 2020.

These guidelines take effect March 8, 2021.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
12/16/2020	***CG-LAB-15**	**Red Blood Cell Folic Acid Testing**	New
12/16/2020	***CG-LAB-16**	**Serum Amylase Testing**	New
11/12/2020	**CG-DME-42**	**Non-implantable Insulin Infusion and Blood Glucose Monitoring Devices**	Revised
12/16/2020	***CG-GENE-04**	**Molecular Marker Evaluation of Thyroid Nodules**	Revised
12/16/2020	**CG-GENE-18**	**Genetic Testing for TP53 Mutations**	Revised
12/16/2020	**CG-GENE-20**	**Epidermal Growth Factor Receptor (EGFR) Testing**	Revised
11/12/2020	**CG-MED-87**	**Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications**	Revised

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URL: https://providernews.anthem.com/california/article/medical-policies-and-clinical-utilization-management-guidelines-update-43

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URL: https://providernews.anthem.com/california/article/access-to-more-claim-denial-information-is-now-self-service-9