California Provider News

October 2021 Anthem Blue Cross Provider News - California

Pharmacy:

Medi-Cal Managed Care:

Medicare:

Cal MediConnect:

Federal Price Transparency and Consolidated Appropriations Act phase in new mandates beginning January 1, 2022

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

In late 2020, the Price Transparency final rule and the Consolidated Appropriations Act (CAA) were enacted. By law, many of these provisions require that Anthem Blue Cross (Anthem) must disclose pricing and other information previously not available publicly. Below is a summary of provisions that may impact you. Some sections of these laws are pending further rulemaking/regulations.

Transparency in pricing regulation – Overview of changes and action Anthem is taking

Transparency requirements will be phased in over three years beginning July 2022 as follows:

Plan years that begin	Regulation requirements	Anthem's action
On or after January 1, 2022	Anthem must make three separate machine-readable files in a standardized format available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers. The three files must be placed on a publicly available website and updated monthly. 1. Negotiated in-network provider rates for all covered items and services 2. Historical payments to, and billed charges from, out-of-network providers 3. In-network negotiated rates and historical net prices for all covered prescription drugs administered by Anthem at the pharmacy location level. The rate information is required to include Provider NPI and TIN information.	We are developing the files that will be available through our website for the data we administer and maintain. Machine Readable Files will be published beginning July 1, 2022, except those for prescription drugs, which are pending further rulemaking.
January 1, 2023	Anthem must make personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services – including prescription drugs – available to participants, beneficiaries, and enrollees.	As required, we are on track with making information available through an internet-based, self-service tool and in paper form upon request.
January 1, 2024	Anthem must expand our transparency tools to encompass all covered items and services.	We continue to review and assess guidance regarding the regulation and are working to comply with requirements.

Consolidated Appropriations Act (CAA)

As a part of the Consolidated Appropriations Act or CAA, there are significant new health plan requirements, including protections for patients from surprise medical bills and other significant health coverage related provisions. Most of these provisions are effective January 1, 2022.
Regulatory detail needed for full implementation is still pending in most cases. However, the Centers for Medicare & Medicaid Services (CMS) has indicated good faith compliance should be pursued pending regulatory implementation detail.

Some key provisions of the CAA, effective January 1, 2022, are listed below that may impact your business interactions with us.

Surprise billing and independent dispute resolution process

The CAA requires that patients be held responsible for only in-network cost sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). The provision also prohibits out-of-network providers from balance billing except in limited circumstances where the out-of-network provider has obtained a notice and consent from the patient. An independent dispute resolution (IDR) process is available when an out-of-network provider and Anthem cannot reach an agreement on payment.

In July 2021, an interim final rule (IFR) provided some of the regulatory detail around cost sharing calculations for surprise billing. Further regulatory guidance is expected in the coming months – including guidance regarding the IDR process.

Anthem is moving forward with changes in calculations and payment based on the guidance received to date. We will continue to monitor for additional regulatory guidance.

Increasing transparency by removing contract provisions known as gag clauses that may prohibit health plans from disclosing price and quality information

The CAA requires Anthem to provide access to provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become Anthem enrollees.

Due to the gag clause provision, we will no longer be able to allow suppression of price and quality data upon provider request.

Member identification card changes

Member ID cards issued for plan years on and after January 1, 2022, must include information to ensure that members know how to access current information regarding their deductibles and out-of-pocket limits. Additionally, member ID cards must include a telephone number and internet address for members to use for assistance should they have questions such as whether a provider participates in our networks. We encourage in-network providers to continue to use Availity for member cost share information.

Continuity of care

As a part of the Consolidated Appropriations Act, there is a continuity of care protection requirement that allows patients with serious or complex care needs (continuing care patients) to have up to a 90-day period of continued coverage at the same terms and conditions when a provider changes network status or an insured group contract terminates. This provides continued coverage at in-network cost sharing rates to allow for a transition of care to an in-network provider or until the patient is no longer a continuing care patient under the CAA.

Anthem must notify individuals who qualify as continuing care patients at the time of the provider's termination as an in-network provider of the option to continue care for the transitional period of up to 90 days. Providers subject to this provision must accept the continued in-network payment as payment in full and otherwise comply with all policies, procedures and quality standards Anthem imposes. If an insured group terminates with Anthem, continuing care patients also have up to a 90-day period of continued care at in-network cost sharing rates. Applicable contract rates will apply for providers.

Protecting patients and improving the accuracy of provider directory information

Anthem must maintain a provider directory available to consumers online that includes a list of the in-network providers and facilities. Anthem must verify provider/facility name, address, specialty, phone number and digital contact information at least every 90 days.

1341-1021-PN-CA

URL: https://providernews.anthem.com/california/article/federal-price-transparency-and-consolidated-appropriations-act-phase-in-new-mandates-beginning-january-1-2022

Clarification: Anthem's enhanced claim edits for outpatient facility claims

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

In the June 2021 edition of *Provider News*, we announced additional enhancements to our claims editing systems to include an automated front end adjudication of claims edits.

To clarify, this enhancement *does not affect* any of our reimbursement policies. The enhanced edits update our claims editing process for outpatient facility claims.

These enhanced edits provide an opportunity to shift certain existing back-end reviews to front-end adjudication for outpatient facility claims including but not limited to scenarios with:

- Revenue code billing
- CPT/HCPCS code reporting
- Modifier usage

1347-1021-PN-CA

URL: https://providernews.anthem.com/california/article/clarification-anthems-enhanced-claim-edits-for-outpatient-facility-claims

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For 2022, Anthem Blue Cross continues to offer EPO and HMO Individual on and off exchange products, and is excited to announce the expansion of the EPO offerings to new regions

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

EPO Plans and Network

For the 2022 benefit year, Anthem Blue Cross (Anthem) will continue to offer EPO individual on and off exchange plans in Covered California's rating regions 1, 7, 9, 10, 12, 13 and 14.

We are also very pleased to announce the expansion of our individual EPO on and off exchange plans into rating regions 2, 3, 4, 5, 6 and 8. Below is a list of counties located in those regions where these

plans will be offered.

Rating Region	County
1	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
2	Marin, Napa, Solano, Sonoma
3	El Dorado, Placer, Sacramento, Yolo
4	San Francisco
5	Contra Costa
6	Alameda
7	Santa Clara
8	San Mateo
9	Monterey, San Benito, Santa Cruz
10	Mariposa, Merced, San Juaquin, Stanislaus, Tulare
12	San Luis Obispo, Santa Barbara, Ventura
13	Imperial, Inyo, Mono
14	Kern

Providers in Regions 1, 7, 9, 10, 12, 13 and 14

If you are already participating in the Pathway (on and off exchange) network located in one of these regions, you will continue to provide services to Anthem members who have purchased coverage on and off exchange as you currently do under your Anthem provider agreement.

Providers in Regions 2, 3, 4, 5, 6 and 8

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

HMO Plans and Network

Anthem will continue to offer individual on and off exchange HMO plans in the below regions in 2022.

Rating Region	County
11	Fresno, Kings, Madera
15	Los Angeles (Northern: High Desert/Antelope Valley and Eastern metropolitan half of county, including San Gabriel Valley)
16	Los Angeles (Western and Downtown Los Angeles County, covering the central and southern metropolitan portions of the county)
17	Riverside, San Bernardino
18	Orange

Note: These changes do not impact Anthem's California individual "grandfathered" business.
Anthem appreciates your partnership and continued participation in our Individual Pathway EPO and HMO networks. If you have questions or need additional information, contact your assigned Provider Experience associate or visit the Contact Us page on our provider website for up-to-date contact information. Log onto Anthem.com/ca > For Providers > Communications / Contact Us: https://www.anthem.com/ca/provider/contact-us/.

1330-1021-PN-CA

URL: https://providernews.anthem.com/california/article/for-2022-anthem-blue-cross-continues-to-offer-epo-and-hmo-individual-on-and-off-exchange-products-and-is-excited-to-announce-the-expansion-of-the-epo-offerings-to-new-regions

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Your recommendation is key to encouraging cancer screenings for your female patients

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

The American Cancer Society estimates there will be approximately 1,898,160 cancer cases diagnosed in 2021. That's the equivalent of 5,200 new cases each and every day. [1] The good news is, patients say they are more likely to get screened when you recommend it. What else can you do to influence cancer screenings?[2]

1. Understand the power of the physician recommendation.

   - Your recommendation is the most influential factor in whether a person decides to get screened.
   - Patients are 90% more likely to get a screening when they reported a physician recommendation.
   - “My doctor did not recommend it,” is the primary reason for screening avoidance.

2. Recognize cultural barriers that may impact your diverse patients

   - Culturally sensitive conversations with your patients can help with fear, embarrassment, anxiety, and misconceptions about screenings.
   - Go to com for information and resources.

3. Measure the screening rates in your practice; it may not be as high as you think.

   - Set goals to get screening rates up.
   - Follow the HEDIS guidelines included in this article to help accurately track your care gap closures.

4. More screening doesn’t have to mean more work for you.

   - Reach out to us about available member data – we may be able to help identify or supply access to data for those members who are due screenings.
   - Develop a reminder system, which has been demonstrated to be effective, to remind you and staff that patients have screenings due.

5. Help members access benefit information about screenings to eliminate the cost barrier.

   - Log onto com and use the Patient Information tab to run an Eligibility and Benefits inquiry.
   - Members can access their benefit information by logging onto com, through Live Chat, or by downloading the Sydney Health App.
   - Blue Cross Blue Shield Service Benefit Plan members, also known as Federal Employee Program® members, can access their benefit information by logging onto org, or by downloading the fepblue App from the Apple Store or on Google Play.

Measure up: HEDIS® measure specifications for cancer screenings for women
Cervical cancer screening

Organized and continuous screenings along with removal of precancerous lesions can lead to a 60% decrease in cervical cancer.[3]

Cervical cancer screening is measured by the percentage of women, 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.
- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Description	CPT/HCPCS Code
Cervical cytology lab test	**CPT:** 88141–88143, 88147, 88148, 88150, 88152–88153, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
hrHPV lab test	**CPT:** 87620–87622, 87624, 87625 **HCPCS:** G0476 **LOINC:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0
Absence of cervix diagnosis	**ICD-10-CM:** Q51.5, Z90.710, Z90.712
Hysterectomy with no residual cervix	**CPT:** 51925, 56308, 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552, 58553, 58554, 58570–58573, 58575, 58951, 58953, 58954, 58956, 59135 **ICD-10-PCS:** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

Breast cancer screening

More women in the United States are surviving and thriving after breast cancer than ever before. In fact, in the last 30 years, the breast cancer death rate has dropped an astounding 40%. The decreases are believed to be the result of finding breast cancer earlier through screening, increased awareness, and better treatments.[4]

Breast cancer screening is measured by the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Compliant members have one or more mammograms any time on or between October 1st two years prior to the measurement year and December 31st of the measurement year.

Description	CPT/HCPCS Code
Mammography	**CPT:** 77057, 77061–76063, 77065–77067 **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0
Online assessments	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012, G2061–G2063
Telephone visits	**CPT:** 98966–98968, 99441–99443

Chlamydia screening in women

Sexual health is an essential element of overall health and well-being. Many patients want to discuss their sexual health with you, but most of them want you to bring it up. The National Coalition for Sexual Health has published a guide to help physicians feel comfortable about the conversation. Get a copy of the Sexual Health and Your Patients: A Providers Guide by clicking on the title or through this website: ctcfp.org.

Chlamydia screening in women is measured by the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Description	CPT/HCPCS Code
Chlamydia tests	**CPT:** 87110, 87270, 87320, 87490–87492, 87810

1 CA: A Cancer Journal for Clinicians. Cancer Statistics, 2021 https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21654

2 http://thecanceryoucanprevent.org/wp-content/uploads/14893-80_2018-PROVIDER-PHYS-4-PAGER-11-10.pdf
3 National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/9253676/
4 Research to Help Women Prevent Breast Cancer or Live their best life with it. American Cancer Society. https://www.cancer.org/latest-news/research-to-help-women-prevent-breast-cancer-or-live-their-best-life-with-it.html

1352-1021-PN-CA

URL: https://providernews.anthem.com/california/article/your-recommendation-is-key-to-encouraging-cancer-screenings-for-your-female-patients

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Good news! Non-payment remittance advice enhancements coming soon

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

In the coming months, we will be enhancing your ability to search, review and download a copy of the remittance advice on Availity when there is no associated payment. For remittance advices with payments, you may continue to search with the check/EFT number.

What's changing?

1. Non-payment number display in the Check Number and Check/EFT Number fields:

- **Current** - Today, there are two sets of numbers for the same remittance advice. The paper remittance displays 10 bytes (9999999999 or 99#########) and the corresponding 835 (ERA) displays 27 bytes (9999999999 – [year] ###############).
- **Enhancement** - The updated numbering sequence for the paper remittance and corresponding 835 (ERA) will contain the same ten-digit number beginning with 9 (9XXXXXXXXX). Each non-payment remittance issued will be assigned a unique number.

1. Searching for non-payment remittance:

- **Current** - When using Remit Inquiry, the search field requires a date range and tax ID to locate a specific remittance due to same number scenario being used for every non-payment remittance.
- **Enhancement** - Once the unique ERA non-payment remittance number is available, it can be entered in the check number field in Remit Inquiry. This new way of assigning check numbers will provide a faster and simplified process to find the specific remittance.

The way your organization receives remittances and payments is not changing; we have simply enhanced the numbering for the non-pay remittances. These changes will not impact previously issued non-payment remittance advices. We'll provide further information before this change is implemented.

1355-1021-PN-CA

URL: https://providernews.anthem.com/california/article/good-news-non-payment-remittance-advice-enhancements-coming-soon

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Looking to earn continuing medical education credits? Register for these on-demand webinars

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

Overview

If you missed our live continuing medical education (CME) webinars, you can still register for the recorded webinars and earn CME credits. Join our CME webinar series and learn best practices to overcoming barriers in achieving clinical quality goals, attaining better patient outcomes and improving STARs performance.

Program objectives:

Article Attachments

- Learn strategies to help you and your care team improve your performance across a range of clinical areas.
- Apply the knowledge you gain from the webinars to improve your organization's quality and STARs ratings.

Attendees will receive one CME credit upon answering required questions at the conclusion of each webinar.

REGISTER HERE for our upcoming live and on-demand clinical quality webinars.

1359-1021-PN-CA

URL: https://providernews.anthem.com/california/article/looking-to-earn-continuing-medical-education-credits-register-for-these-on-demand-webinars

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Clinical appeals

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

The clinical appeal process is designed to provide appropriate and timely review when providers disagree with a decision made by Anthem Blue Cross (Anthem). The procedures also meet requirements of state laws and accreditation agencies. Appeals can be made verbally, in writing, or by using Interactive Care Reviewer through the Availity portal.

Clinical appeals refer to a situation in which an **authorization or claim** for a service was denied as not medically necessary or experimental/investigational. Medical necessity and prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the clinical appeal process.

To learn more about our appeals process in detail, we encourage you to go to Anthem's provider manual, available on our website at anthem.com/ca.

1368-1021-PN-CA

URL: https://providernews.anthem.com/california/article/clinical-appeals

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Are you talking to ALL of your patients about breast cancer screenings?

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

Race and ethnicity continue to be a factor influencing mammography use according to a National Library of Medicine.[2] While research and studies show that annual screenings greatly reduce breast cancer deaths, 35% of women still do not get an annual mammogram and the percentage is even higher in African American and Hispanic women.

While African American and White women get breast cancer at about the same rate, African American women have a higher rate of death from breast cancer, according to the Centers for Disease Control and Prevention. African American and Hispanic women are 20% more likely to be diagnosed with advanced stage breast cancer, and they have, respectively, up to 70% and 14% increased risk of death.[4]

A common theme stressed in all of the major breast screening guidelines has been for providers to talk with patients about mammography. But when? Knowing that younger African American and Hispanic women are already considered a “high-risk” group, the conversation can be confusing to your patient under 30.

Help your African American and Hispanic patients understand the importance of early screening by sharing information with them about their unique risks. We’ve included links to videos that address breast cancer screening in both African American and Hispanic women. We hope you will share it with your patients either in your waiting rooms, or by offering to play them during their visits.

Why mammograms matter for Black women.

Why mammograms matter for Hispanic women.

There are other resources available through the Center for Disease control and the American Cancer Society, to name a few. The American College of Radiology has a Talking to Patients about Breast Cancer Screening CME Toolkit that offers CME credits for completing the toolkit.

Talking to women about taking everyday steps to lower their risk for getting breast cancer is the first step in closing disparity gaps in care.

1 https://jamanetwork.com/journals/jamaoncology/article-abstract/2775169

2 https://pubmed.ncbi.nlm.nih.gov/8909641/
3 https://www.acr.org/Media-Center/ACR-News-Releases/2019/ACR-Offers-New-Talking-to-Patients-about-Breast-Cancer-Screening-CME-Toolkit
4 https://www.eurekalert.org/news-releases/475470

1362-1021-PN-CA

URL: https://providernews.anthem.com/california/article/are-you-talking-to-all-of-your-patients-about-breast-cancer-screenings

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Network leasing arrangements

Published: Oct 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're entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payors* list on the Availity web portal, at www.Availity.com. From the Availity site, select Home > Anthem California > Education and Reference Center.

1364-1021-PN-CA

URL: https://providernews.anthem.com/california/article/network-leasing-arrangements-33

Provider education

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

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

1365-1021-PN-CA

URL: https://providernews.anthem.com/california/article/provider-education-3

Provider directory and provider data updates

Published: Oct 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.

1366-1021-PN-CA

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

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Stay “in the know” at no charge!

Published: Oct 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.

1367-1021-PN-CA

URL: https://providernews.anthem.com/california/article/stay-in-the-know-at-no-charge-11

REMINDER: EnrollSafe, the new electronic funds transfer enrollment portal for Anthem Blue Cross providers – replacing CAQH Enrollhub effective November 1, 2021

Published: Oct 1, 2021 - **Administrative** / Digital Tools

As a reminder, effective **November 1, 2021**, EnrollSafe will replace CAQH Enrollhub as the electronic funds transfer (EFT) enrollment portal for Anthem Blue Cross (Anthem) providers. As of November 1, 2021, CAQH Enrollhub will no longer offer EFT enrollment to new users. **CAQH Enrollhub is the only CAQH tool being decommissioned. All other CAQH tools will not be impacted.**

Benefits of EFT

Not only is receiving your payment more convenient, so is signing up for EFT. When you sign up for EFT through EnrollSafe, the new enrollment portal, you'll receive your payments up to seven days sooner than through the paper check method. What's more, it's easier to reconcile your direct deposits.

Secure and available 24-hours a day – EnrollSafe

Beginning November 1, 2021, if you need to make changes to an existing EFT enrollment or create a new first-time account, log onto the EnrollSafe enrollment hub at https://enrollsafe.payeehub.org to enroll in EFT. Once you have completed registration, you'll be directed through the EnrollSafe secure portal to the enrollment page, where you'll provide the required information to receive direct payment deposits.

Already enrolled in EFT through CAQH Enrollhub?

Please note if you're already enrolled in EFT through CAQH Enrollhub, no action is needed unless making changes. Your EFT enrollment information will not change as a result of the new enrollment hub.

If you have changes to make, after October 31, 2021, use EnrollSafe to update your account.

Electronic remittance advice (ERA) makes reconciling your EFT payments easy and paper-free

Now that you are enrolled in EFT, using the digital ERA is the very best way to reconcile your deposits – securely and safely. You'll be issued a trace number with your EFT deposit that matches up with your ERA on Availity.

ERAs can be retrieved directly from Availity. Log onto Availity and select **Claims and Payments** > **Send and Receive EDI Files** > **Received Files** folder. When using a clearinghouse or billing service, they will supply the 835 ERA for you. You also have the option to view or download a copy of the **Remittance Advice** under **Payer Spaces** > **Remittance Inquiry tool.**

Contact information

Electronic Remittance Advice (ERA), Electronic Funds Transfer (EFT) registration and contact information			
Type of transaction:	**How to register, update, or cancel:**	**For registration related questions, contact:**	**To resolve issues after registration, contact:**
EFT only	Use EnrollSafe	EnrollSafe help desk at **1-877-882-0384**	EnrollSafe help desk at **1-877-882-0384**
ERA (835) only	Use Availity	Availity Support **1-800-282-4548**	Availity at **1-800-282-4548** *NOTE – Providers should allow up to 10 business days for ERA enrollment processing.*

1343-1021-PN-CA

URL: https://providernews.anthem.com/california/article/reminder-enrollsafe-the-new-electronic-funds-transfer-enrollment-portal-for-anthem-blue-cross-providers-replacing-caqh-enrollhub-effective-november-1-2021

Reimbursement policy clarification: Claims Requiring Additional Documentation - facility

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

In the May 2021 issue of *Provider News*, we communicated the thresholds for the itemized bill requirement for claims reimbursed at a percent of charge:

- The threshold for requiring an itemized bill for inpatient claims is $100,000.
- The threshold for requiring an itemized bill for outpatient claims is $50,000.

We subsequently communicated in the August 2021 *Provider News* that the wording of the policy was updated to remove the threshold language from the policy; however, the removal of the language from the policy DOES NOT change the thresholds in place. The communicated thresholds remain at $100,000 for inpatient and $50,000 for outpatient. We will communicate any future changes in thresholds via *Provider News.*

1353-1021-PN-CA

URL: https://providernews.anthem.com/california/article/reimbursement-policy-clarification-claims-requiring-additional-documentation-facility

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Pharmacy information available on anthem.com/ca

Published: Oct 1, 2021 - **Products & Programs** / Pharmacy

Visit Pharmacy Information for Providers on anthem.com/ca 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
- Any other requirements, restrictions, or limitations that apply to using certain drugs

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.

1333-1021-PN-CA

URL: https://providernews.anthem.com/california/article/pharmacy-information-available-on-anthemcomca-22

Diabetes testing and screening HEDIS measures

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

Comprehensive Diabetes Care HEDIS® measure

The Comprehensive Diabetes Care HEDIS measure evaluates the percent of adult members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following during the measurement year:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Retinal eye exam performed
- Blood pressure control (<140/90 mm Hg)

Kidney Health Evaluation for Patients with Diabetes
Additionally, the Kidney Health Evaluation for Patients with Diabetes measure was added as a first year HEDIS measure in 2020. This measure evaluates the percent of members 18 to 85 years of age with diabetes who received a kidney health evaluation, including an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

Record your efforts
Document results in the in the member's medical record: HbA1c tests and results, retinal eye exam, blood pressure, urine creatinine test, GFR test.

Helpful tips:

- Have reminders set in your electronic medical record (EMR) to alert staff when a patient's screenings are due.
- Provide reminders to patients for upcoming appointments and screenings.
- Draw labs in your office if available or refer patients to a local lab for screenings.
- Refer patients to participating eye professionals for annual retinal eye exams.
- Follow up on lab test, eye exams and specialist referrals and document in your chart.
- Telephone visits, e-visits and virtual check-ins are acceptable settings for blood pressure readings and should be recorded in the chart.
- Include Category II reporting codes on claims to reduce the burden of HEDIS medical record review.
- Educate patients on topics (for example, home monitoring of blood sugar and blood pressure, taking medications as prescribed, and other healthy lifestyle education like diet, exercise, and smoking cessation).

Other available resources:

- Clinical Practice Guidelines are available on our provider self-service website.
- Contact the Health Plan for a copy of *Quality Measures Desktop Reference for Medicaid Providers* and the *HEDIS Benchmarks and Coding Guidelines for Quality*.
- Diabetes programs may be available to our members, contact your Provider Solutions representative for more information.

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

ACA-NU-0360-21

URL: https://providernews.anthem.com/california/article/diabetes-testing-and-screening-hedis-measures

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New policy: Sexually transmitted infections testing, effective January 1, 2022 - professional

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

Anthem Blue Cross (Anthem) allows reimbursement of sexually transmitted infection (STI) tests unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. We consider certain STI testing CPT® codes to be part of a laboratory panel grouping. When Anthem receives a claim with two or more single tests laboratory procedure codes reported, we will bundle those two or more single tests into the comprehensive laboratory procedure code listed below.

Applicable single STI CPT codes:

- 87491: Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique
- 87591: Infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, amplified probe technique
- 87661: Infectious agent detection by nucleic acid (DNA or RNA); trichomonas vaginalis, amplified probe technique

Applicable comprehensive code:

- 87801: Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

Anthem will reimburse the more comprehensive, multiple organism code for infectious agent detection by nucleic acid, amplified probe technique (CPT code 87801), when two or more single test CPT codes are billed separately by the same provider on the same date of service. Reimbursement will be made based on a single unit of CPT code 87801 regardless of the units billed for a single code. No modifiers will override the edit.

For additional information, please review the Sexually Transmitted Infections Testing — Professional reimbursement policy at **https://providers.anthem.com/ca**.

ACA-NU-0366-21

URL: https://providernews.anthem.com/california/article/new-policy-sexually-transmitted-infections-testing-effective-january-1-2022-professional

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Get your payments faster when you sign up for electronic funds transfer

Published: Oct 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).

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When you sign up for EFT through **https://enrollsafe.payeehub.org**, the new enrollment website, you'll receive your payments up to seven days sooner than through the paper check method. Not only is receiving your payment more convenient, so is signing up for EFT. What's more, it's easier to reconcile your direct deposits.

EnrollSafe is safe, secure and available 24-hours a day
Beginning November 1, 2021, log onto the EnrollSafe enrollment hub at **https://enrollsafe.payeehub.org** to enroll in EFT. You'll be directed through the EnrollSafe secure portal to the enrollment page, where you'll provide the required information to receive direct payment deposits.

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ACA-NU-0367-21
519338MUPENMUB

URL: https://providernews.anthem.com/california/article/get-your-payments-faster-when-you-sign-up-for-electronic-funds-transfer-8

Keep up with Medi-Cal news – October 2021

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

Please continue to check for important Medi-Cal Managed Care updates at https://providers.anthem.com/california-provider/communications/news-and-announcements for the latest Medi-Cal Managed Care information, including:

- 2021 affirmative statement concerning utilization management decisions

- May 2021 Medical Policies and Utilization Management Guidelines update

URL: https://providernews.anthem.com/california/article/keep-up-with-medi-cal-news-october-2021

Information about 2021 special needs plans

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

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

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

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

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

To take the self-paced training, please go to the MOC Provider Training link at **https://www.availity.com**.

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

1. Log in to the Availity Portal at **https://www.availity.com**.

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

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

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

1. Visit **https://www.availity.com** to register.
2. Select **Register**.
3. Select your organization type.

In the *Registration* wizard, follow the prompts to complete the registration for your organization.

Q&A

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

What is a SNP Model of Care?

The Centers for Medicare & Medicaid Services (CMS) requires Special Needs Plans (SNPs) to have a model of care (MOC) that describes how the SNP will administer key components of care management programs, including assessments and training. The MOC describes the unique needs of the population being served and how Anthem Blue Cross (Anthem) will meet those needs. Each SNP MOC is evaluated and scored by the NCQA and approved by CMS.

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

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

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

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

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

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

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

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

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

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

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

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

What are SNP benefits for Anthem members?

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

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

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

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

ABCCRNU-0188-21
519271MUPENMUB

URL: https://providernews.anthem.com/california/article/information-about-2021-special-needs-plans

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New policy: Sexually transmitted infections testing, effective January 2022 - professional

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

Anthem Blue Cross (Anthem) allows reimbursement of sexually transmitted infection (STI) tests unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. We consider certain STI testing CPT® codes to be part of a laboratory panel grouping. When Anthem receives a claim with two or more single tests laboratory procedure codes reported, we will bundle those two or more single tests into the comprehensive laboratory procedure code listed below.

Applicable single STI CPT codes:

- 87491: Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique
- 87591: Infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, amplified probe technique
- 87661: Infectious agent detection by nucleic acid (DNA or RNA); trichomonas vaginalis, amplified probe technique

Applicable comprehensive code:

- 87801: Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

Anthem will reimburse the more comprehensive, multiple organism code for infectious agent detection by nucleic acid, amplified probe technique (CPT code 87801), when two or more single test CPT codes are billed separately by the same provider on the same date of service. Reimbursement will be made based on a single unit of CPT code 87801 regardless of the units billed for a single code. No modifiers will override the edit.

For additional information, please review the Sexually Transmitted Infections Testing — Professional reimbursement policy at **https://www.anthem.com/ca/medicareprovider**.

ABCCRNU-0190-21
519310MUPENMUB

URL: https://providernews.anthem.com/california/article/new-policy-sexually-transmitted-infections-testing-effective-january-2022-professional

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HEDIS® medical record submission made easier with our remote EMR access service

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

Instead of faxing multiple pages of medical records for HEDIS® studies, use Anthem Blue

We have a centralized EMR team experienced with multiple EMR systems and extensively trained annually on HIPAA, EMR systems, and HEDIS measure updates. We complete medical record retrieval based on minimum necessary guidelines:

- We only access medical records of members pulled into the HEDIS sample using specific demographic data.
- We only retrieve the medical records that have evidence related to the HEDIS® measures.
- We only view face sheets when there are demographic discrepancies.
- We exclude data related to hospice, long-term care, inpatient, and palliative care.

Let us help you! Getting started with Remote EMR Access is just one click away. Download and complete this registration form and email it to us at Centralized_EMR_Team@anthem.com.

To learn more about our Remote EMR Access Service, view the Frequently Asked Questions below.

Q. How do you retrieve our medical records?
A. We access your EMR using a secure portal and retrieve only the necessary documentation by printing to an electronic file we store internally, on our secure network drives.

Q. Is printing necessary?
A. Yes. The NCQA audit requires print-to-file access.

Q. Is this process secure?
A. Yes. We only use secure internal resources to access your EMR systems. All retrieved records are stored on Anthem secure network drives.
Q. Why does Anthem need full access to the entire medical record?
A. There are several reasons we need to look at the entire medical record of a member:

- HEDIS measures can include up to a 10-year look back at a member’s information.
- Medical record data for HEDIS compliance may come from several different areas of the EMR system, including labs, radiology, surgeries, inpatient stays, outpatient visits, and case management.

- Compliant data may be documented or housed in a non-standard format, such as an in-office lab slip scanned into miscellaneous documents

Q. What information do I need to submit to use your Remote EMR Access Service?
A. Complete the registration form that requests the following information:

- Practice/facility demographic information (e.g., address, National Provider ID, taxpayer identification numbers, etc.)
- EMR system information (e.g., type of EMR system, required access forms, access type – web based or VPN-to-VPN connection, special requirements needed for access, etc.)
- List of current providers/locations or a website for accessing this list. Also, if applicable, a list of providers affiliated with the group that are not in the EMR System.

ABCCRNU-0193-21

URL: https://providernews.anthem.com/california/article/hedis-medical-record-submission-made-easier-with-our-remote-emr-access-service-7

New medical step therapy requirements

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

Effective November 1, 2021, the *Clinical Criteria* ING-CC-0005 will include a trial and inadequate response or intolerance to two preferred hyaluronan agents in the Part B medical step therapy precertification review. Step therapy review will apply upon precertification initiation, in addition to the current medical necessity review (as-is current procedure). Step therapy will not apply for members who are actively receiving non-preferred medications listed below.

Clinical Criteria are publicly available on the provider website. Visit the ***Clinical Criteria page*** to search for specific criteria.

Clinical Criteria	Preferred drug(s)	Nonpreferred drug(s)
ING-CC-0005	Euflexxa (J7323) Supartz FX (J7321) Durolane (J7318) Gelsyn-3 (J7328)	Including but not limited to: • Gel-One (J7326) • GenVisc 850 (J7320) • Hymovis (J7322) • Monovisc (J7327) • Orthovisc (J7324) • Synvisc/Synvisc One (J7325) • TriVisc (J7329) • Hyalgan/Visco-3 (J7321) • Triluron (J7332)

ABCCRNU-0195-21/ABCCARE-0624-21
519447MUPENMUB

URL: https://providernews.anthem.com/california/article/new-medical-step-therapy-requirements

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519338MUPENMUB

URL: https://providernews.anthem.com/california/article/get-your-payments-faster-when-you-sign-up-for-electronic-funds-transfer-9

Keep up with Medicare news – October 2021
Published: Oct 1, 2021 - **State & Federal** / Medicare

Please continue to check for important Medicare Advantage updates at https://www.anthem.com/ca/provider/medicare-advantage/ for the latest Medicare Advantage information, including:

- May 2021 Medical Policies and Utilization Management Guidelines update

- 2021 affirmative statement concerning utilization management decisions

URL: https://providernews.anthem.com/california/article/keep-up-with-medicare-news-october-2021

New policy: Sexually transmitted infections testing, effective January 2022 - professional

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

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- 87661: Trichomonas vaginalis

Applicable comprehensive code:

- 87801: Comprehensive multiple organism code

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ACAD-NU-0166-21
519310MUPENMUB

URL: https://providernews.anthem.com/california/article/new-policy-sexually-transmitted-infections-testing-effective-january-2022-professional-1

New specialty pharmacy medical step therapy requirements

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

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ACADPEC-0024-21/ACAD-NU-0170-21
519447-MUPENMUB

URL: https://providernews.anthem.com/california/article/new-specialty-pharmacy-medical-step-therapy-requirements-16

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519338MUPENMUB

URL: https://providernews.anthem.com/california/article/get-your-payments-faster-when-you-sign-up-for-electronic-funds-transfer-10

Keep up with Cal MediConnect news October 2021

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

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URL: https://providernews.anthem.com/california/article/keep-up-with-cal-mediconnect-news-october-2021
