California Provider News

December 2022 Anthem Blue Cross Provider News - California

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An overview of our medical necessity review process

Published: Dec 1, 2022 - **Administrative**

A medical necessity review may be called many things - including utilization review (UR), utilization management (UM) or medical management - within the evidence of coverage or benefit booklet. Requirements for medical necessity review vary based on the member's benefit plan. Reviews of a medical service may occur:

- When it is requested or planned (prospective or pre-service review).
- During the course of care (inpatient or outpatient ongoing care review).
- After services have been delivered (retrospective or post-service review).

With so many variables, it may help to get a clear picture of what to expect and how the process works.

Timing is important

We are committed to deciding cases quickly and professionally. Here are several time frames
you can expect:

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

Urgent pre-service review requests

An urgent pre-service review request is a request for pre-service review that in the view of the treating provider or any physician with knowledge of the member's medical or behavioral condition could without such care and treatment subject the member to adverse health consequences, pose an imminent and serious threat to the member's life or health or their ability to regain maximum function, or seriously jeopardize the life, health or safety of the member or others due to the member's psychological state.

Notification of delay in review determination
If we do not have the information we need to make our decision, we will try to get it from the physician or other healthcare provider who is requesting the service, medical procedure or equipment. If a delay is anticipated because the information is not readily available, we will notify the member as well as the requesting physician or other healthcare provider in writing. Delay letters include a description of the information we need to make a decision and also specify when the decision can be expected once the information is received. If we do not receive the necessary information, we will send a final letter explaining that we are unable to approve access to benefits due to lack of the information requested.

We use professional, qualified reviewers
Experienced clinicians review requests for services using medical criteria, established guidelines and applicable medical policies. Requests for covered benefits meeting those standards are certified as medically necessary.

Only a peer clinical reviewer may determine that a service is not medically necessary
Peer clinical reviewers (PCRs) are California licensed healthcare professionals qualified and clinically competent to evaluate the specific clinical aspects of the request and/or treatment under review. PCRs are licensed in California in the same license category as the requesting physician or other healthcare provider. If you are the treating practitioner directly involved in the member's care/treatment plan and need to discuss a medical necessity review decision, an Anthem Blue Cross (Anthem) medical director or peer clinical reviewer is available at **800-794-0838**. If the PCR is unable to approve a service, the requesting physician, another healthcare provider or the member has the right to request an appeal.

Decisions not to approve are in writing
Written notice is sent to the member and the requesting physician or other healthcare provider within two business days of the decision. This written notice includes:

- A clear and concise explanation of the reason for the decision.
- The name of the criteria and/or guidelines used to make the decision.

peer-to-peer discussion.

- Instructions for how to appeal a decision.
- Specific provisions of the contract that excludes coverage if the denial is based upon benefit coverage.

Access to criteria

Anthem *Medical Policy* and *Clinical Utilization Management Guidelines* for specific services are available to members, member representatives, healthcare providers and the public. Members may call the number on the back of their ID card for a copy of the guidelines used to determine their case. Anthem *Medical Policy* and *Clinical Utilization Management Guidelines* are also available at **www.anthem.com/ca**. Providers can access utilization management criteria by selecting the **For Providers** drop down at the top of the screen. Under *Provider Resources***,** select **Policies, Guidelines & Manuals**. Scroll down and select **View Medical Policies & Clinical UM Guidelines**; or call **800-794-0838** to request that a paper copy be sent to you. The requested criteria is provided free of charge.

A determination of medical necessity does not guarantee payment or coverage

The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of a member's coverage at the time of service. These terms include certain exclusions, limitations and other conditions, as outlined in the member's evidence of coverage or benefit booklet. Payment of benefits could be limited for a number of reasons, for example:

- The information submitted with the claim differs from that given at time of review.
- The service performed is excluded from coverage.
- The member is not eligible for coverage when the service is actually provided.

Decisions about coverage of service

Our utilization management decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for utilization management decision makers to encourage decisions resulting in under-utilization.

We are available for questions

If you need to request precertification, need information about our utilization management process, or have questions or issues, call our toll-free number at **800-274-7767**. Our associates are available Monday through Friday (except holidays), 8 a.m. to p.m. Pacific time. If you call after hours or do not reach someone during business hours, you may leave a confidential voice mail message. Please leave your name and phone number; we will return your call no later than the next business day during the hours listed above, unless other arrangements are made. Calls received after midnight will be returned the same business day. Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls.

Language assistance

For those who request language services, Anthem provides service in the requested language through bilingual staff or an interpreter, to help members with their utilization management issues. Language assistance is provided to members free of charge. Oral interpretation is available at all points of member contact regarding utilization management issues.

TDD/TTY services

TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. If you have a hearing or speech loss, call 711 to use the National Relay Service or the number below for the California Relay Service. A special operator will contact Anthem to help with member needs.

For English TTY/English voice, call **800-855-7100**.

For Federal Employee Program, call the number on the member ID card. Utilization management is administered by Blue Shield of California.

CABC-CM-012172-22

URL: https://providernews.anthem.com/california/article/an-overview-of-our-medical-necessity-review-process-3

Senate Bill 245 addressing abortion, abortion related services, cost sharing and utilization management, including prior authorizations

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As a reminder, Senate Bill 245, codified as Section 1367.251 of the Health and Safety Code, effective January 1, 2023, requires that health plans, and their delegates, not impose, except for high deductible plan cost sharing limits described below, a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services, including pre-abortion and follow-up services. It provides that except as otherwise authorized by this law, a health plan shall not impose any utilization management or utilization review, including prior authorization and annual or lifetime limits consistent with Sections 1367.001 and 1367.005 of the Health and Safety Code, on the coverage for outpatient abortion services.

The law does not require a health plan to cover an experimental or investigational treatment. Abortion is defined as any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

The law provides that for a high deductible health plan, the cost-sharing limits described in the law shall apply once an enrollee's deductible has been satisfied for the benefit year.

CABC-CM-012434-22

URL: https://providernews.anthem.com/california/article/senate-bill-245-addressing-abortion-abortion-related-services-cost-sharing-and-utilization-management-including-prior-authorizations

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CAA: Timely updates help keep our provider directories current

Published: Dec 1, 2022 - **Administrative**

Submitting your updates in a timely manner helps ensure we have the most current online provider directory information available to members. We ask that you review your information regularly and let us know as soon as possible if any of your information we show in our online directory has changed.

If updates are needed, you can use our online *Provider Maintenance Form*. Once you submit the form, you will receive an email acknowledging receipt of your request. Visit the ***Provider Maintenance Form*** webpage for complete instructions.

Online update options include:

- Add/change an address location.
- Name change.
- Tax ID changes.
- Provider leaving a group or a single location.
- Phone/fax number changes.
- Closing a practice location.

Note that some updates may require additional documentation.

The *Consolidated Appropriations Act (CAA)*, effective since January 1, 2022, contains a provision that requires online provider directory information be reviewed and updated (if needed) at least every 90 days. Help us keep our online provider directories current.

CABC-CM-012525-22-CPN12437

URL: https://providernews.anthem.com/california/article/caa-timely-updates-help-keep-our-provider-directories-current-6

Clinical practice and preventive health guidelines available on anthem.com/ca

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As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research.

All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website at **anthem.com/ca** > For Providers > Select Policies, Guidelines & Manuals under Provider Resources > scroll down and select Clinical Practice Guidelines or Preventive Health Guidelines.

CABC-CM-012590-22

URL: https://providernews.anthem.com/california/article/clinical-practice-and-preventive-health-guidelines-available-on-anthemcomca-3

Members' rights and responsibilities

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The delivery of quality healthcare requires cooperation between patients, their providers, and their healthcare benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem Blue Cross has adopted a *Members' Rights and Responsibilities* statement.

It can be found on our website under the FAQ question about *Laws and Rights that Protect You*. To access, go to **https://www.anthem.com/ca** and select **For Providers**. From there, select **Policies, Guidelines & Manuals** under *Provider Resources*. Select your state, and scroll down to *Member Rights and Responsibilities* under More Resources. Choose the **Read about member rights** link. Practitioners may access the FEP member website at **www.fepblue.org/memberrights** to view the FEPDO *Members' Rights and Responsibilities* statement.

CABC-CM-012673-22

Member’s assessment of behavioral healthcare after-hours messaging in 2022

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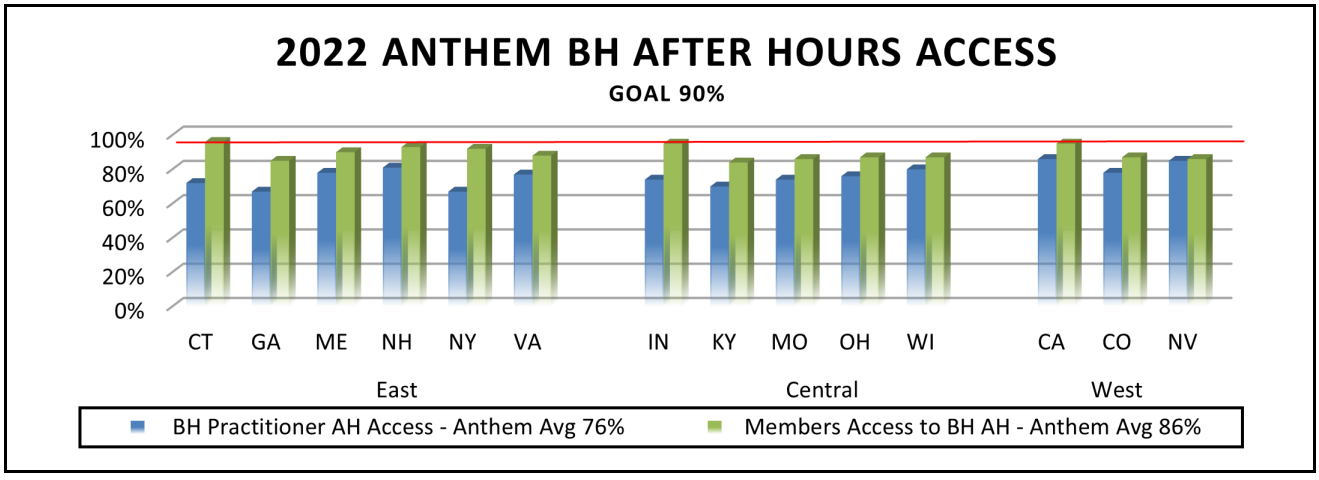
We have provided many articles advising of the compliant messaging when our members call your office during an urgent situation after regular business hours.

The annual after-hours access studies performed by our vendor, North American Testing Organization* based in California, assesses adequate phone messaging for our members with perceived emergency or urgent situations after office hours. Unfortunately, Anthem Blue Cross (Anthem) still falls short of the expectation of having a live person or a directive in place for after-hours calls.

Well, the members are experiencing this lack of ability to reach instructions and have voiced their opinions in the member experience survey fielded annually for commercial and marketplace exchange via a behavioral health specific survey. An average of 29% of members have a need to contact their behavioral health practitioner after regular hours for urgent care. They are recalling, in the last 12 months, if they were able to reach the office for instructions, get a consultation they needed or get a timely call back?

This chart represents the office level accessibility when contacted by the survey vendor compared to the member satisfaction survey results of the member's success getting their urgent needs meet after hours. As shown, the office level results are significantly below the expected 90% access to members with urgent symptoms.

Ironically, members express *getting advice as soon as needed* more often than the office assessment captures. Although a number of members sometimes, or never, reached the practitioner's office for urgent instructions.



To help both your patients' and Anthem's ability to reach your practice, we ask that you verify or update your office information using the online *Provider Maintenance Form* and that you also review your after-hours messaging and connectivity for patients' urgent accessibility.

1. Have accessibility *24/7/365*. Arrange to have your phone calls forwarded to a service or hospital, or have the appropriate messaging for the caller.
2. Be sure to turn on a messaging mechanism when you leave the office.
3. Be sure you are using the acceptable messaging for compliance with your contract.

Per the Provider Manual, have your messaging or answering service include appropriate instructions, specifically:

Emergency situations
Compliant response for an emergency instructs the caller/patient to hang up and call 911 or go to the Emergency Room (ER) or live person connects the caller directly to the practitioner.

Emergent/Urgent situations
Compliant responses for urgent needs after hours:

- Live person or via a service, advises their practitioner or on call practitioner is available and connects.
- Live person or recording directs or directly connects caller/patient to Urgent Care, 24-hour crisis services, 911 or ER.
    - May also, but not instead of directing, suggest caller/patient may contact their BH care practitioner (via cell phone, pager, text, email, voicemail, etc.) or request a call back for further urgent instructions.
- If a caller chooses to use a method to request a call back, a live person or recording must give the length of time for a return call.
- Mechanism connects the caller to their practitioner or the practitioner on call. (Must directly connect.)
- A live person or recording must express if there are prior arrangements with patients for after hour needs, to be compliant.

Non-compliant responses for urgent needs after hours:

Article Attachments

- No provision for after hour accessibility.
- Live person or recording **only** directs the caller/patient to a mechanism for contacting their practitioner (via cell phone, pager, text, email, voicemail, etc.) or to get a call back for urgent questions or instructions.

These scenarios are non-compliant because there is no direct connection to their practitioner, thus not ensuring a timely callback. This prompt can be used in addition to, but not in place of instructions.

Is your practice compliant?

CABC-CM-012676-22-CPN12417

URL: https://providernews.anthem.com/california/article/members-assessment-of-behavioral-healthcare-after-hours-messaging-in-2022

Coordination of care

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Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment, and referral. Anthem Blue Cross (Anthem) would like to take this opportunity to stress the importance of communicating with your patient's other healthcare practitioners. This includes PCPs, medical specialists, and behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services, and those referred to a behavioral health specialist by another healthcare practitioner. Anthem urges all its practitioners to obtain the appropriate permission from these patients to coordinate care between behavioral health and other healthcare practitioners at the time treatment begins.

We expect all healthcare practitioners to:

- Discuss with the patient the importance of communicating with other treating practitioners.
- Obtain a signed release from the patient and file a copy in the medical record.
- Document in the medical record if the patient refuses to sign a release.
- Document in the medical record if you request a consultation.
- If you make a referral, transmit necessary information, and if you are furnishing a referral, report appropriate information back to the referring practitioner.
- Document evidence of clinical feedback (for example, consultation report) that includes, but is not limited to:
    - Diagnosis.
    - Treatment plan.
    - Referrals.
    - Psychopharmacological medication (as applicable).

In an effort to facilitate coordination of care, Anthem has several tools available on our **provider website** for behavioral health and other medical practitioners including:

- *Coordination of Care Form.*
- *Coordination of Care Letter Template - Behavioral Health.*
- *Coordination of Care Letter Template - Medical.*

The following behavioral health forms, brochures, and screening tools for substance use and attention-deficit/hyperactivity disorder (ADHD) are also available on our **provider website**:

- *Alcohol Use Assessment*
- Antidepressant medication management.
- *Edinburgh Postnatal Depression Scale.*
- *Opioid Use Assessment* brochure.
- Substance Brief Intervention/Referral Tool (SBIRT).
- *Vanderbilt ADHD Diagnostic Parent Rating Scale*.

CABC-CM-012687-22-CPN12135

URL: https://providernews.anthem.com/california/article/coordination-of-care-31

Case management program

Published: Dec 1, 2022 - **Administrative**

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross is available to offer assistance in these difficult moments with our *Case Management Program*. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

	CM Email Address	CM Telephone Number	CM Business Hours
Local	Care.management@anthem.com	888-613-1130	Monday - Friday 8 a.m. - 7 p.m. PT
National	Care.management@anthem.com	877-783-2756 **Transplant** 888-574-7215	Monday - Friday 8 a.m. - 9 p.m. PT Saturday 9 a.m. - 5:30 p.m. PT **Transplant** Monday - Friday 8:30 a.m. - 5 p.m. ET
FEP	FEP_PPO_Case_Mgmt@blueshieldca.com	800-995-2800	Monday - Friday 8 a.m. - 7 p.m. PT Saturday 8 a.m. - 4:30 p.m. PT

CABC-CM-012701-22-CPN12136

URL: https://providernews.anthem.com/california/article/case-management-program-38

Contract compliance with accessibility standards for Appointment Availability and Emergency Care instructions after hours care

Published: Dec 1, 2022 - **Administrative**

As you know, Anthem Blue Cross (Anthem) monitors member access to a provider's care through several mechanisms, including provider and member surveys. These surveys are conducted by Anthem and external entities, such as Sutherland Healthcare Solutions, North American Testing Organization, and the CAHPS® program.

Surveys give insight:

- In surveying compliance with After Hours standards, participating providers' offices are called outside of normal business hours to determine if callers are given appropriate emergency instructions and have a mechanism to reach a provider after regular hours for urgent situations.
- In surveying compliance with Appointment Availability standards, participating providers' offices are called within normal business hours and are asked when the next available appointment for urgent and non-urgent care would be.
- Members are also surveyed via mail. The surveys, in addition to monitoring member complaints, help us to identify whether access to care is available to our members after or before normal business hours.

The key to our 2022 success is…you!

If you have already taken steps to comply with the standards - thank you. This year's surveys are now under way, and with your continued support and commitment, we can achieve the best results possible for 2022.

Take a minute to review the 2021 survey results in the table below. We hope sharing them with you provides a better understanding of how you can help improve 2022 results.

Provider After Hours results - 2021 survey

Question Threshold >85% of providers comply with the standard	Result (% compliant with standard)
What would you tell a caller who states he/she is dealing with a life-threatening emergency? Compliant answers: Hang up and dial 911 or go to the nearest emergency room, go to nearest emergency room, or hang up and dial 911.	Medical: 98.9% Behavioral Health: 97.1%
Urgent request after hours: In what time frame can the patient expect to hear from the provider or on-call provider? Note: Providers are expected to provide a specific timeframe in that a member can expect a return call. If a specific timeframe is not provided, the answer is considered noncompliant.	Medical: 92.5% Behavioral Health: 77.5%

Provider Appointment Availability Survey (PAAS) results - 2021 Survey

Question Threshold >85% of providers comply with the standard	Result (% compliant with standard)
When is the next available appointment time for an urgent appointment? Compliant answer: Appointment is available within 48 hours (PCP) or within 96 hours (Specialist).	Primary Care Physician: 48% Specialist Physician: 46% Behavioral Health: 56% Ancillary: N/A
When is the next available appointment time for a non-urgent appointment? Compliant answer: Appointment is available within 10 business days (PCP) or within 15 business days (Specialist)	Primary Care Physician: 68% Specialist Physician: 63% Behavioral Health: 75% Ancillary: 90%

You make a difference:

- Review the Commercial Access Standards under the Legal and Administrative Requirements section in your *Anthem Blue Cross California Facility and Professional Provider Manual*. Make sure your practice policy and procedures comply with the standards.
- Ensure your after-hours office staff, answering service, or answering machine message specifically informs callers when their urgent (nonemergent) calls will be returned.
- Ensure your after-hours office staff, answering service, or answering machine message directs callers to dial 911 or go to the nearest emergency room if they are experiencing an emergency.
- Ensure that your office staff are aware of and able to comply with the appointment availability standards when setting appointments for our members.

If your office was surveyed in 2021 and was found noncompliant with these standards, a letter with recommended compliance measures was sent to an active mailing address on file for you.

If you have questions, email your Provider Experience representative for assistance from the ***Contact Us*** page. Select **Provider Experience team** to open the email form and make sure to enter the words, *2021 Survey After Hours and PAAS Results* in the subject field. **Visit us online** to view other contact options.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CABC-CM-012149-22

URL: https://providernews.anthem.com/california/article/contract-compliance-with-accessibility-standards-for-appointment-availability-and-emergency-care-instructions-after-hours-care-2

IngenioRx will become CarelonRx on January 1, 2023

Published: Dec 1, 2022 - **Administrative**

This communication applies to the Commercial and Medicare Advantage programs from Anthem Blue Cross (Anthem) in California.

For our Commercial and Medicare Advantage plans
Our pharmacy benefit management partner IngenioRx will join the Carelon family of companies and change its name to CarelonRx on January 1, 2023.

This change will not affect the ways in which CarelonRx will do business with care providers and there will be no impact or changes to the prior authorization process, how claims are processed, or level of support.

If your patients are having their medications filled through IngenioRx's home delivery and specialty pharmacies, please take note of the following information:

- IngenioRx Home Delivery Pharmacy will become CarelonRx Mail.
- IngenioRx Specialty Pharmacy will become CarelonRx Specialty Pharmacy.

These are name changes only and will not impact patients' benefits, coverage, or how their medications are filled. Your patients will not need new prescriptions for medicine they currently take.

When e-prescribing orders to the mail and specialty pharmacies:

- Prescribers will need to **choose CarelonRx Mail or CarelonRx Specialty Pharmacy, not IngenioRx,** if searching by name.
- if searching by NPI (National Provider Identifier), **the NPI will not change**.

In addition to the mail and specialty pharmacies, your patients can continue to have their prescriptions filled at any in-network retail pharmacy.

Keeping you well informed is essential and remains our top priority. We will continue to provide updates prior to January and throughout 2023.

* IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross.

CABC-CRMMP-013089-22

URL: https://providernews.anthem.com/california/article/ingeniorx-will-become-carelonrx-on-january-1-2023-15

Signature requirements for laboratory orders or requisitions

Published: Dec 1, 2022 - **Administrative**

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

Anthem strives to ensure our providers understand documentation compliance, and we are committed to educating our providers in hopes of eliminating errors in documentation practices. It is a best practice and industry standard that physicians sign and date laboratory orders or requisitions.

Although the provider signature is not required on laboratory requisitions, if signed and dated, the requisition will serve as acceptable documentation of a physician order for the testing and so is it strongly encouraged. In the absence of a signed requisition, documentation of your intent to order each laboratory test must be included in the patient's medical record and available to Anthem upon request. Documentation must accurately describe the individual tests ordered; it is not sufficient to state "labs ordered."

Anthem will consider laboratory order or requisition requirements met with one of the following:

- A signed order or requisition listing the specific test(s)
- An unsigned order or requisition listing the specific test(s), and an authenticated medical record supporting the physician's intent to order the test(s)
- An authenticated medical record (for example, office notes or progress notes) supporting the physician's intent to order the specific test(s)

Attestation statements are not acceptable for unsigned physician order or requisitions. Signature stamps are not acceptable.

References:

- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf**
- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf**
- **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/medicare-provider-compliance-tips/medicare-provider-compliance-tips.html#BloodCount**

Title 42 CFR §410.32

- *Documentation Standards for Episodes of Care – Professional Administrative*

CABC-CDCRMMPCM-005974-22-CPN5368

URL: https://providernews.anthem.com/california/article/signature-requirements-for-laboratory-orders-or-requisitions-1

Reminder - updated AIM Musculoskeletal program effective January 1, 2023 - site of care reviews

Published: Dec 1, 2022 - **Policy Updates**

We previously communicated that AIM Specialty Health® (AIM),* a separate company, would expand the AIM Musculoskeletal program to perform medical necessity review of the requested site of service for certain joint and interventional pain procedures beginning September 1, 2022. The expansion was delayed and will now be effective January 1, 2023, for Anthem Blue Cross's (Anthem) self-funded (administrative services only) group members, as further outlined below.

AIM will continue to manage the AIM Musculoskeletal program and level of care review. **The AIM level of care guideline for musculoskeletal surgery and procedures** is used for the level of care review. Prior authorization will now also be required for the clinical appropriateness of the site in which the procedure is performed (site of care). AIM will use the following Anthem *Clinical Utilization Management Guideline: CG-SURG-52: Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services*. The *Clinical Criteria* to be used for these reviews can be found at **https://www.anthem.com/ca/provider/policies/**. *Please note, this does not apply to procedures performed on an emergent basis.*

A subset of the AIM Musculoskeletal program codes will be reviewed for site of care. A complete list of CPT® codes requiring prior authorization for the AIM Musculoskeletal site of care program is available on the **AIM Musculoskeletal microsite**. To determine if prior authorization is needed for an Anthem member on or after January 1, 2023, providers can contact the Provider Services phone number on the back of the member's ID card for benefit information. Providers will be informed whether the AIM Musculoskeletal program applies. AIM will also have a file upload from the health plan of the in-scope membership and will not provide prior authorization for members who are out of scope. If providers use the Interactive Care Reviewer (ICR) tool on Availity* to pre-certify an outpatient musculoskeletal, ICR will produce a message referring the provider to AIM. (Note: ICR cannot accept prior authorization requests for services administered by AIM.)

Members included in the new program

This program will be available to a small volume of self-funded (administrative services only) groups that currently participate in the AIM Musculoskeletal program and have added the AIM Musculoskeletal site of care program to their members' benefit package as of January 1, 2023. Program readiness was evaluated, and it was determined that we are not ready to launch for the fully insured membership. It will also expand to fully insured members currently participating in the AIM Musculoskeletal program at a future date.

Pre-service review requirements

® (FEP®).

For services provided on or after January 1, 2023, ordering and servicing providers may begin contacting AIM on January 1 for review. Providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*SM directly at **https://aimspecialtyhealth.com/providerportal**. Online access is available 24/7 to process orders in real-time, and this is the fastest and most convenient way to request authorization.
- Access AIM via Availity at **www.availity.com**.
- Call the AIM Contact Center toll-free number at **877-430-2288**, Monday through Friday, 8 a.m. to 6 p.m. ET.

Initiating a request on AIM's ***Provider****Portal*SM and entering all the requested clinical questions will allow you to receive an immediate determination. If the request is approved, you will receive the order ID, the number of visits, and valid time frame. **The AIM Musculoskeletal program microsite** on the AIM provider website helps you learn more, and you can access helpful information and tools such as order entry checklists.

AIM Musculoskeletal training webinars

Anthem invites you to take advantage of a free informational webinar that will introduce you to the program and the robust capabilities of the AIM ***Provider****Portal*SM. Go to the **AIM Musculoskeletal microsite** to register for an upcoming webinar. If you have previously registered for other services managed by AIM, there is no need to register again.

We value your participation in our network and look forward to working with you to help improve the health of our members.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross. Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross.

CABC-CM-014192-22

URL: https://providernews.anthem.com/california/article/reminder-updated-aim-musculoskeletal-program-effective-january-1-2023-site-of-care-reviews

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Reimbursement policy retraction: updates to professional and facility reimbursement policies

Published: Dec 1, 2022 - **Policy Updates** / Reimbursement Policies

Anthem Blue Cross (Anthem) mailed letters to its participating facilities on September 16, 2022, notifying providers that the following policies would receive updates effective January 1, 2023. However, Anthem has now decided to implement these policies at a later date. There will be no change in billing practices to these policies. We will provide notice when we expect to move forward:

- Bundled Services and Supplies - Professional:
  - Remove codes 99000, 99001, and H0048 from Option 1: Services and Supplies Not Eligible for Separate reimbursement:
    - Note: Moved to Laboratory and Venipuncture Services - Professional and Facility.

- Distinct Procedural Service, Modifiers 59, XE, XP, XS, and XU - Professional:
  - Deny 96365, 96369, 96372, 96373, 96374, and 96379 when reported with 78265, 78830, or 78835.

- Laboratory and Venipuncture - Professional and Facility:
  - Professional policy expanded to include facility providers.
  - Added codes 99000, 99001, and H0048:Note:
    - Moved from Bundled Services and Supplies - Professional.

- Modifier Rules - Professional:
  - Modifier FT is only allowed on critical care codes 99291, 99292, 99468, 99469, 99471, 99472, 99475, and 99476.
  - Added Modifiers 93, FQ to the Modifiers Impacting Adjudication list aligning with the Virtual Visits policy.
  - Added Modifier FS to Informational Modifier list.

- Multiple and Bilateral Surgery Processing - Professional:
  - Added 43497 to base code 43235 Esophagogastroduodenoscopy (EGD) section with the reduction of 100% primary and 25% subsequent.

Treatment Rooms with Evaluation and Management - Facility:

- Deny revenue codes 760 and 769 when billed with office Evaluation and Management codes.

- Virtual Visits - Professional and Facility:
  - Added modifiers 93 and FQ.

For specific policy details, visit the **reimbursement policy page** on the Anthem provider website.

CABC-CM-012322-22

URL: https://providernews.anthem.com/california/article/reimbursement-policy-retraction-updates-to-professional-and-facility-reimbursement-policies

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Reimbursement policy update: Multiple Surgery - Facility

Published: Dec 1, 2022 - **Policy Updates** / Reimbursement Policies

Anthem Blue Cross mailed letters to its participating facilities on September 24, 2021, to notify providers of a new commercial policy titled *Multiple Bilateral Surgery Processing - Facility* effective for dates of service on or after January 1, 2022. The policy indicated that Modifier 50 must be appended to facility claims when a bilateral procedure is performed. At this time, we have decided to remove this requirement for dates of service on or after January 1, 2022. Bilateral services should be billed as they were billed prior to January 1, 2022. The policy will be updated to remove the following:

- Modifier 50 must be appended to facility claims when a bilateral procedure is performed.
- When a surgical procedure code description contains the terminology “bilateral” or “unilateral or bilateral” or the code is considered inherently bilateral, modifiers LT, RT, or 50 should not be appended.

In addition, the policy title will be renamed to Multiple Surgery - Facility.

For additional information, please review the **reimbursement policy** at **anthem.com/ca**.

CABC-CM-012531-22

URL: https://providernews.anthem.com/california/article/reimbursement-policy-update-multiple-surgery-facility-1

Reimbursement policy retirement: Acupuncture Billed with Evaluation and Management - Professional

Published: Dec 1, 2022 - **Policy Updates** / Reimbursement Policies

Effective January 1, 2023, Anthem Blue Cross' (Anthem) Acupuncture Billed with Evaluation and Management - Professional policy will be retired. The policy aligns with standard correct coding requirements, as outlined in applicable CPT guidelines, which provide that Evaluation and Management services may be reported separately from acupuncture services by using modifier 25 when appropriate. Since the policy does not deviate from this guidance, the policy will be retired.

Anthem will enforce the requirements set forth in applicable CPT® guidelines. As always, Anthem reserves the right to request medical records when needed to validate appropriate billing.

For specific policy details, visit the **reimbursement policy page** at **anthem.com/ca** provider website.

CABC-CM-012645-22

URL: https://providernews.anthem.com/california/article/reimbursement-policy-retirement-acupuncture-billed-with-evaluation-and-management-professional-1

Overlapping Blue Plan service areas

Published: Dec 1, 2022 - **Products & Programs** / Behavioral Health

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

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

- If you contract with both plans in California, you may file an out-of-area Blue Plan member's claim with either plan.
- If you contract with one plan but not the other, file all out-of-area claims with your contracted plan.

Use the Anthem Blue Cross payer ID number that was assigned to you, not the Blue Shield of California payer ID number. If you submit an Anthem Blue Cross member claim with the Blue Shield of California payer ID number instead of the Anthem Blue Cross payer ID number, the claim will process as out-of-network.

CABC-CM-012398-22

URL: https://providernews.anthem.com/california/article/overlapping-blue-plan-service-areas-1

BlueCard program quick tips

Published: Dec 1, 2022 - **Products & Programs** / Behavioral Health

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

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

For claims inquiries, contact Anthem.

CABC-CM-012400-22

URL: https://providernews.anthem.com/california/article/bluecard-program-quick-tips-6

Find answers to BlueCard questions

Published: Dec 1, 2022 - **Products & Programs** / Behavioral Health

Get help navigating the BlueCard® program and information about claim filing, eligibility, preauthorization, and contact information from the *BlueCard Program Provider Manual*. Learn more on our website (**https://www.anthem.com/ca** > For Providers > Provider Resources > Policies, Guidelines & Manuals > select **Download the Manual** and then **Access previous versions and other manuals** > Blue Card Provider Manual). Or follow this **link** to directly access the *Provider Manual Library*.

Also, you have access to online supplemental education materials (SEM), with *SEM#10 - BlueCard (Out-of-Area)* available via the Anthem Blue Cross ***Provider Education and Training* webpage**, which provides helpful tips to improve your claim experience, facts about ID cards, and much more.

CABC-CM-012402-22

URL: https://providernews.anthem.com/california/article/find-answers-to-bluecard-questions-1

Practice status: open or closed

Published: Dec 1, 2022 - **Products & Programs** / Behavioral Health

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

Refer to the ***Anthem Blue Cross — California Facility and Professional Provider Manual*** for timeframes and information about reporting your practice status and other related information about your practice.

CABC-CM-012404-22

URL: https://providernews.anthem.com/california/article/practice-status-open-or-closed-6

Does your practice offer telehealth services? Let us know!

Published: Dec 1, 2022 - **Products & Programs** / Behavioral Health

Our online directories identify professional providers who offer telehealth services in their practice.

We encourage you to use the online *Provider Maintenance Form* to notify us about your telehealth services 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***.

CABC-CM-012405-22

URL: https://providernews.anthem.com/california/article/does-your-practice-offer-telehealth-services-let-us-know-25

Pharmacy information available on the provider website

Published: Dec 1, 2022 - **Products & Programs** / Pharmacy

Visit the ***Drug Lists*** **page** on **www.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 Exchange *Drug Lists* are posted to the website quarterly on the first day of the month in January, April, July, and October.

To locate the *Exchange Select Formulary* and pharmacy information, scroll down to **Select Drug Lists**. This drug list is also reviewed and updated regularly as needed.

Federal Employee Program (FEP) pharmacy updates and other pharmacy related information may be accessed at **www.fepblue.org** > Pharmacy Benefits.

CABC-CM-012587-CPN12133

URL: https://providernews.anthem.com/california/article/pharmacy-information-available-on-the-provider-website-3

Update to the Pregnancy Notification Form

Published: Dec 1, 2022 - **State & Federal** / Medi-Cal Managed Care

Anthem Blue Cross (Anthem) is excited to share that we have recently made an update to our *Pregnancy Notification Form*, which will allow us to gather additional information. This information will provide Anthem with important details about a member's conditions that are not easily garnered from claims alone. The information you provide on the *Pregnancy Notification Form*, as well as the health information that we are able to leverage via claims and authorizations, will allow Anthem to better identify pregnant members with high risk factors so that we can provide timely and comprehensive care management.

The *Pregnancy Notification Form* is available on the Anthem Blue Cross provider website at **https://providers.anthem.com/ca** > Resources > Forms under the **Pregnancy and Maternal Child Services** section for easy access and will replace any existing pregnancy notification form you are currently using.

You may also download the form here:
https://providers.anthem.com/docs/gpp/california-provider/CA_PregnancyNotificationFormCLUpdate.pdf?v=202010130128

If you have questions, please contact Provider Services at **800-407-4627** (outside L.A. County), **888-285-7801** (inside L.A. County), or your OB Practice Consultant.

CABC-CD-008834-22

URL: https://providernews.anthem.com/california/article/update-to-the-pregnancy-notification-form

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New Digital Provider Enrollment tool added to Availity

Published: Dec 1, 2022 - **State & Federal** / Medi-Cal Managed Care

In December, Anthem Blue Cross (Anthem) will add new functionality to the provider enrollment tool hosted on Availity* to further automate and improve your online enrollment experience.

Who can use this new tool?
Digital provider enrollment is currently only available for professional practitioners.

Note: Facilities and providers who submit rosters or have delegated agreements will continue to use the existing enrollment process in place.

What features does the tool provide?

- Apply to add new practitioners to an already existing group
- Apply and request a contract to enroll a new group of practitioners
- Monitor submitted applications statuses real-time with a digital dashboard

How the online enrollment application works
The system pulls in all your professional and practice details from Council for Affordable Quality Healthcare (CAQH) ProView to populate the information Anthem needs to complete the enrollment process - including credentialing, claims, and directory administration. Please ensure your provider information on CAQH is updated and in *complete* or *re-attested* status.

The online enrollment application will guide you through the process, and a dashboard will display real-time application statuses. You'll know where each provider is in the process without having to call or email for a status.

Accessing the provider enrollment application
Log onto **https://availity.com** and select **Payer Spaces > Anthem > Applications > Provider Enrollment** to begin the enrollment process.

Before you begin
If your organization is not currently registered for Availity, the person in your organization designated as the Availity administrator should go to **https://availity.com** and select **Register.**

For organizations already using Availity, your administrator(s) will automatically be granted access to the provider enrollment tool.

Staff using the provider enrollment tool need to be granted the user role **Provider Enrollment** by an administrator. To find yours, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

Need assistance with registering for Availity?

Log onto **https://www.availity.com/Contact-Us**.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross.

CABC-CD-009982-22

URL: https://providernews.anthem.com/california/article/new-digital-provider-enrollment-tool-added-to-availity-10

Keep up with Medi-Cal news - December 2022

Published: Dec 1, 2022 - **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:

- *Medical Policies* and *Clinical Utilization Management Guidelines update*

- Prior authorization updates for medications billed under the medical benefit (Releuko, Vabysmo)

URL: https://providernews.anthem.com/california/article/keep-up-with-medi-cal-news-december-2022

2023 Medicare Advantage service area and benefit updates

Published: Dec 1, 2022 - **State & Federal** / Medicare

An overview of notable 2023 benefit changes and service area updates are now available **here**. Please continue to check **https://www.anthem.com/ca/provider/medicare-advantage** for the latest Medicare Advantage information.

CABC-CR-010757-22-CPN10053

URL: https://providernews.anthem.com/california/article/2023-medicare-advantage-service-area-and-benefit-updates-1

Personal home helper benefit ending

Published: Dec 1, 2022 - **State & Federal** / Medicare

Navigating the complexities and nuances associated with the COVID-19 pandemic requires frequent review of benefits and their impacts to our member's social drivers of health. In recent evaluations, significant challenges have been identified by many agencies supporting our personal home helper benefit.

These nationwide impacts have led to many members unable to use the benefit to its fullest capacity. Therefore, effective January 1, 2023, the personal home helper benefit will no longer be offered within any of Anthem Blue Cross's (Anthem's) Medicare individual plans. Members have been notified via their *Annual Notice of Change*. Improving the life of our members is Anthem's focus and, while this change is difficult, Anthem will make best efforts to identify other resources for members or benefits to enhance their quality of life.

Please direct any member concerns or questions to the member services number on the back of their card.

CABC-CR-011948-22-CPN11945

URL: https://providernews.anthem.com/california/article/personal-home-helper-benefit-ending-1

Keep up with Medicare news - December 2022

Published: Dec 1, 2022 - **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:

- AIM Specialty Health Cardiology Clinical Appropriateness Guidelines CPT Code List update

- *Medical Policies* and *Clinical Utilization Management Guidelines* update

URL: https://providernews.anthem.com/california/article/keep-up-with-medicare-news-december-2022-1

Cal MediConnect Plans change effective January 1, 2023

Published: Dec 1, 2022 - **State & Federal** / Cal MediConnect

On January 1, 2023, the state is transitioning all Cal MediConnect Plans (CMC) to Medicare and Medi-Cal Managed Care plans operated by the same company. Therefore, the Anthem Blue Cross Cal MediConnect Plan
(Medicare-Medicaid Plan) will change to a Dual-Eligible Special Needs Plan (D-SNP) named Anthem MediBlue Full Dual Advantage (HMO D-SNP). The new plan coordinates care for those with both Medicare and Medicaid.

No action is needed by care providers or members already enrolled in Anthem Blue Cross Cal MediConnect. Members will receive a new ID card in the mail.

For more information:

- Members can visit **https://mss.anthem.com/california-mmp/home.html** for specific details on the transition.
- Medicare providers can read more on this transition on the **California Department of Health Care Services website**.

CABC-MMP-013421-22

URL: https://providernews.anthem.com/california/article/cal-mediconnect-plans-change-effective-january-1-2023

Keep up with Cal MediConnect news - December 2022

Published: Dec 1, 2022 - **State & Federal** / Cal MediConnect

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

- *Medical Policies* and *Clinical Utilization Management Guidelines* update

- Medical drug benefit *Clinical Criteria* updates

URL: https://providernews.anthem.com/california/article/keep-up-with-cal-mediconnect-news-december-2022