August 2019 Anthem Blue Cross Provider News - California

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Clinical criteria and prior authorization updates for specialty pharmacy are available

Anthem Blue Cross (Anthem) prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Revised Clinical Criteria effective June 10, 2019

The following new clinical criteria were revised to expand medical necessity indications or criteria. The table attached will assist you in identifying the new document number for the clinical criteria that corresponds with the previous Clinical or Coverage Guideline.

Pharmacy information available 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, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

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

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

Help with claim issue resolution

If you have an issue or question about a claim, call Claims Customer Service or send an online secure message via Availity. When calling Customer Service have this information:

- Member ID number,
- Claim number (DCN) and
- Prior call reference number. The reference number, also known as a tracking number is a record of you contacting Anthem previously.

Note: If you have a need to call Anthem more than once, ask for the reference number each time. If the issue remains unresolved, ask for a supervisor.

If the issue isn’t resolved with a Customer Service representative or supervisor, submit a provider dispute including any reference number(s) supporting any previous calls about your issue.

Verify BlueCard member eligibility and coverage

You have several options to verify member eligibility and coverage for BlueCard.

- For Anthem Blue Cross members, visit our website at anthem.com/ca
- Other Blue Plans: contact Anthem Blue Cross electronically or through Availity at availity.com
- Call BlueCard Eligibility toll-free at 1-800-676-BLUE (2583) to verify member eligibility and coverage
- Electronic: submit a HIPAA 270 transaction (eligibility) to Anthem Blue Cross or through Availity

Workers’ Compensation acknowledgments required

As a reminder, the Workers’ Compensation Physicians Acknowledgments is required by California Code of Regulations §9767.5.1, “Medical Provider Networks” (MPN). The “MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN.”

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem’s Provider Affirmation Portal, go to Availity and login. Once in, click on the Payer Spaces drop down menu in the top right hand corner, and select Anthem Blue Cross from the options available to you. On the next page click on “Resources” in the middle of the page and look for “MPN Provider Affirmation Portal.”

Availity>Payer Spaces>Anthem Blue Cross>Resources>MPN Provider Affirmation Portal

If you cannot go online, call Anthem Workers’ Compensation at **1-866-700-2168** and we can take action on your behalf in the Provider Affirmation Portal. Please also keep an eye out for email notifications from “Anthem MPN Admin.”

Please also be advised the Provider Affirmation Portal will also notify participating medical providers when an MPN is terminating its relationship with Anthem and/or the Division of Workers Compensation.

Contracted provider claim escalation process

In an effort to better service our contracted providers right the first time, Anthem Blue Cross has improved our provider claim escalation process. Just click, Provider Claim Escalation Process to read, print, download and share the improved process with your office staff.

Our Network Relations Team is available by email at CAContractSupport@anthem.com to answer questions you have about the process.

Provider Education seminars, webinars, workshops and more!

Our Provider Network Education team offers quality complimentary educational programs and materials specially designed for our providers. For a complete listing of our workshops, seminars, webinars and job aids, log on to the Anthem Blue Cross website: www.anthem..com/ca. Scroll down the page to ***Partners in Health*** > Tools for Providers. In the middle of the page select the box ***Find Resources for California***. From the **Answers@Anthem** page, select the link titled Provider Education Seminars and Webinars link.

Anthem Blue Cross provider directory and provider data updates

It is extremely important that we have accurate and up-to-date information about your practice in our directories. Senate Bill 137 (SB 137), which went into effect on July 1, 2016, 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.

Easily update provider demographics with the online Provider Maintenance Form

Anthem Blue Cross (Anthem) providers should now submit changes to their practice profile using our online Provider Maintenance Form.

Online update options include: add an address location, name change, tax ID changes, provider leaving a group or a single location, phone/fax numbers, closing a practice

location, etc. Visit the Anthem.com/ca form page to review more.

The new online form can be found on **www.anthem.com/ca/provider/** ***> Find Resources for California >*** *Answers@Anthem tab>Provider Forms bullet>Provider Change Forms> Provider Maintenance Form*. In addition, the **Provider Maintenance Form** can be found on the **Availity Web Portal** by selecting *California> Payer Spaces-Anthem Blue Cross> Resources tab >Provider Maintenance Form.*

Important information about updating your practice profile:

- **Change request should be submitted using the online Provider Maintenance Form**
- Submit the change request online. No need to print, complete and mail, fax or email demographic updates
- You will receive an auto-reply e-mail acknowledging receipt of your request and another email when your submission has been processed
- For change(s) that require submission of an updated IRS Form w-9 or other documentation, attach them to the form online prior to submitting
- Change request should be submitted with advance notice
- Contractual agreement guidelines may supersede effective date of request

You can check your directory listing on the *Anthem Blue Cross: "Find a Doctor tool".* The Find a Doctor tool at Anthem is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To ensure Anthem has the most current and accurate information, please take a moment to access the Find A Doctor tool (www.anthem.com/ca) and review how you and your practice are being displayed.

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

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our *Provider News* (formerly *Network eUPDATEs)*.

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 (formerly *Network eUPDATE)*, so you can submit as many e-mail addresses as you like.

Network leasing arrangements

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, or email us at CAContractSupport@Anthem.com.

Misrouted protected health information

Providers and facilities are required to review all member information received from Anthem Blue Cross (Anthem) and other providers to help ensure no misrouted protected health insurance (PHI) is included. Misrouted PHI includes information about members that a provider or facilit y is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or email. Providers and facilities are required to immediately inform the sender and to destroy any misrouted PHI and safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI.

Drug screen testing (Policy 19-001, effective 10/01/19)

Anthem Blue Cross (Anthem) Medicare Advantage allows reimbursement for presumptive and definitive drug screening services. In certain circumstances, Anthem Medicare Advantage allows reimbursement for presumptive drug testing by instrumented chemistry analyzers and definitive drug screening services for the same member provided on the same day by a reference laboratory.

Definitive drug testing may be done to confirm the results of a negative presumptive test or to identify substances when there is no presumptive test available. Provider's documentation and member's medical records should reflect that the test was properly ordered and support that the order was based on the result of the presumptive test.

In the event a reference lab (POS = 81) performs both presumptive and definitive tests on the same date of service, records should reflect that the ordering/treating provider issued a subsequent order for definitive testing based on the results of the presumptive tests.

For additional information, refer to the Drug Screen Testing reimbursement policy at **www.anthem.com/ca/medicareprovider**

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New service types added to Availity

Enhancements have been made to the Availity Portal that will now allow you to access more service types when using the Eligibility and Benefits Inquiry tool and will also allow us to share even more valuable information with you electronically.

You may have already noticed new additions to service types, including:

- Medically related transportation.
- Long-term care.
- Acupuncture.
- Respite care.
- Dermatology.
- Sleep study therapy (found under diagnostic medical).
- Allergy testing.

Note, although there is an extensive list of available benefit types available when submitting an eligibility and benefits request, these types do vary by payer.

Here are some important points to remember when selecting service types:

- The benefit/service type field is populated with the last benefit type you selected. If you don't see a specific benefit in the results, submit a new request and select the specific benefit type/service code.
- You have the ability to inquire about 50 patients at one time using the Add Multiple Patients feature.

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AIM Specialty Health programs may require documentation

Currently, providers submit various pre-service requests to AIM Specialty Health® (AIM). As part of our ongoing quality improvement efforts for outpatient diagnostic imaging services, cardiac procedures and sleep studies, AIM may request documentation to support the clinical appropriateness of certain requests.

When requested, providers should verify information by submitting documentation from the medical record and/or participating in a pre-service consultation with an AIM physician reviewer. If medical necessity is not supported, the request may be denied as not medically necessary.

Should you have any questions, please call the Provider Services number on the back of the member ID card.

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Special needs plans, provider training required

Anthem Blue Cross offers special needs plans (SNPs) to people eligible for either Medicare and Medicaid benefits or who are qualified Medicare Advantage beneficiaries. SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These include supplemental benefits such as hearing, dental, vision and transportation to medical appointments. Some SNPs include a card or catalog for purchasing over-the-counter items. SNPs do not charge premiums. As you are aware, CMS regulations protect SNP members from balance billing.

Providers who are contracted for SNPs are required to take **annual training** to stay current on plan benefits and requirements, including coordination-of-care and model-of-care elements. Providers contracted for our SNPs received notices in the first quarter of 2019 containing information for online, self-paced training through our training site hosted by SkillSoft. Each provider contracted for our SNPs is required to complete this annual training and select the attestation stating they have completed the training. Attestations can be completed by individual providers or at the group level with one signature.

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Emergency department: Level of Evaluation and Management Services

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement by Anthem Blue Cross (Anthem) Medicare Advantage if the service is covered by a member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem Medicare Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem Medicare Advantage strives to minimize these variations.
Anthem Medicare Advantage reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy
Anthem Medicare Advantage allows reimbursement for facility emergency department (ED) evaluation and management (E&M) services unless provider, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement for facility ED services is based on the highest level E&M code for which a claim qualifies.

Anthem Medicare Advantage determines the appropriate level of ED E&M code by classification of intensity and/or complexity of resources or interventions a facility utilizes to furnish all services indicated on the claim. Providers must utilize appropriate CPT/HCPCS and revenue codes for all services rendered during the ED encounter.

Anthem Medicare Advantage classifies the intensity/complexity of facility interventions used for services with an E&M code level. E&M services will be reimbursed based on this classification at the highest E&M level supported on the claim.

Exclusions

- ED visits resulting in observation status or inpatient admission
- Critical access hospital services
- Trauma or critical care services
- Surgical intensive care services

Note: Anthem Medicare Advantage adheres to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) and federal managed care regulations.

Prepayment clinical validation review process

Click here for additional information about the prepayment clinical validation review process.

Update to emergency department: Level of E&M services reimbursement policy

Click here for additional information about the Level of E&M Services Reimbursement Policy.

Unspecified diagnosis code update

Click here for additional information about the unspecified diagnosis code update.

Keep up with Medicare news

Please continue to check Important Medicare Advantage Updates at anthem.com/ca/medicareprovider for the latest Medicare Advantage information, including:

- Hearing Care Solutions now serves individual Medicare Advantage members in CT, NY, VA and all Group Retiree Solutions members
- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus

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Pharmacy management information

Need up-to-date pharmacy information?
Log in to our provider website (**https://mediproviders.anthem.com/ca**) to access our *Formulary*, *Prior Authorization* form, *Preferred Drug List* and process information.

Have questions about the *Formulary* or need a paper copy?
Call our Pharmacy department at **1-800-407-4627** (outside L.A. County) or **1-888-285-7801** (inside L.A. County). Pharmacy technicians are available Monday through Friday from 7 a.m. to 7 p.m Pacific time.

Our Member Services representatives serve as advocates for our members. To reach our Customer care Center, please call **1-800-407-4627 (TTY 1-888-757-6034)**.

Use the Provider Maintenance Form to update your information

We continually update our provider directories to ensure thatyour current practice information is available to our members. At least 30 days prior to making any changes to your practice — including updating your address and/or phone number, adding or deleting a physician from your practice, closing your practice to new patients, etc. — please notify us by completing the *Provider Maintenance Form* at **https://mediproviders.anthem.com/ca/pages/forms.aspx**. Thank you for your help and continued efforts in keeping our records up to date.

Clinical criteria updates

On March 29, 2019, April 12, 2019, and May 1, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Anthem Blue Cross. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider website (**https://mediproviders.anthem.com/ca**), and the effective dates will be reflected in the

Clinical Criteria web posting Q2 2019. Visit ***Clinical Criteria*** to search for specific policies.

For questions or additional information, use this **email**.

New reimbursement policy: Drug screen testing

Click here for additional information about the New Reimbursement Policy: Drug Screen Testing.

Unspecified diagnosis code update

Click here for additional information about the unspecified diagnosis code update.

Prior authorization requirements for hyperbaric oxygen and supervision of hyperbaric oxygen therapy

Click here for additional information about the Prior authorization requirements.

January 2019 medical policies and clinical utilization management guidelines update

Click here for additional information about the January 2019 Medical Policies and Clinical Utilization Management Guidelines Update.

Prepayment clinical validation review process

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