Provider Manual
Medi-Cal Managed Care
Major Risk Medical Insurance Program
Medi-Cal Access Program
Anthem Blue Cross
Version 2.1  Updated December 2014
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CHAPTER 1: INTRODUCTION

Welcome

Welcome. Thank you for being part of the Anthem Blue Cross (Anthem) family of health care services.

Anthem has been selected by the California Department of Health Care Services (DHCS) and the California Department of Public Health (DPH) to provide health care services for Medi-Cal Managed Care (Medi-Cal) Members in the following counties:

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- El Dorado
- Fresno
- Glenn
- Inyo
- Kings
- Los Angeles (in partnership with L.A. Care Health Plan)
- Madera
- Mariposa
- Mono
- Nevada
- Placer
- Plumas
- Sacramento
- San Benito
- San Francisco
- Santa Clara
- Sierra
- Sutter
- Tehama
- Tulare
- Tuolumne
- Yuba

Medi-Cal, which includes the Medi-Cal Access Program (MAP) (formerly the Access for Infants and Mothers (AIM)) and the Major Risk Medical Insurance Program (MRMIP), provides health care coverage for California's most vulnerable low income citizens who lack health insurance. Medi-Cal is the second largest source of health care coverage in California and is surpassed only by employer-based coverage.

We have a long-standing history of providing Medi-Cal services to Californians. In fact, Anthem was the original Medi-Cal Managed Care Organization and continues to be Medi-Cal’s largest health plan provider.

As such, we represent a growing network of health care Providers who make it easier for our Members to receive quality care. We provide first-class customer service by improving access to all necessary health care services, by encouraging coordination of medical care and by emphasizing prevention and education. Our approach is results-oriented, community-based and centered on the customer.

At Anthem, we are committed in providing comprehensive services in which our members and providers can attain the highest level of care. Our Health Plan model is structured to service our partners by method of communication and outreach with our Independent Physicians Associations (IPAs), Hospitals, Providers, and other business sources as needed. The Network Relations department is proud to serve our community and ensure advocacy for our members and providers. This improves the overall health of our Members’ by informing, educating and encouraging self-care in the prevention, early detection and treatment of existing conditions and chronic disease.

About this Manual

This Provider Manual is designed for Anthem contracted physicians, hospitals and Ancillary Providers; our goal is to create a useful reference guide for you and your office staff. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our Members. Providers contracted with an Independent Physician Association (IPA)
or other provider organization, may have separate policies and procedures. Please contact the organization’s administrator for details.

We recognize that managing our Members’ health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of health care services and responsibilities. This includes everything from initial health assessments to case management and from proper storage of medical records to billing for emergencies. With that in mind, we’ve divided this manual into broad sections that reflect your questions, concerns and responsibilities before and after an Anthem Member walks through your doors. The manual is divided into the following sections:

- Legal Requirements
- Contact Information
- Before Rendering Services
- After Rendering Services
- Operational Standards, Requirements & Guidelines
- Additional Resources

**Legal Requirements**

The information contained in this manual is proprietary, will be updated regularly and is subject to change. This section provides specific information on the legal obligations of being part of the Anthem network.

**Contact Numbers**

The Contact Numbers section is your easy reference for important contact numbers, websites and mailing addresses.

**Before Rendering Services**

This section provides the information and tools you'll need before providing services, including how to verify Member Eligibility as well as a helpful list of Covered and Non-Covered Services. It also includes a chapter on the prior authorization process and coordination of complex care through Utilization Management.

We take pride in our proactive approach to our members’ health care. The Health Services Programs chapter details how targeted programs can supplement Providers' treatment plans to make the services you provide more effective. For example, ConditionCare, a special grouping of health services programs, takes direct aim at combating the most common and serious conditions and illnesses facing our Members, including asthma, heart disease and diabetes. Telehealth, which was developed exclusively by Anthem, takes full advantage of modern communications technology by linking Providers and Members with non-local in-network specialists. The ER Initiative is designed to educate and promote proper use of emergency room services. And our program on Cultural Diversity & Linguistic Services is designed to help Providers improve Provider/Member communications by providing tools and resources to reduce language and other cultural barriers.

**After Rendering Services**

At Anthem, our goal is to make the billing process as streamlined as possible. This section provides guidelines and detailed coding charts for fast, secure and efficient Billing, including specific information on filing claims for professional and institutional services. In addition, the Member Transfers chapter outlines
the steps for Members who want to change their assignment of **Primary Care Provider** (PCP) or transfer to another health plan. When there are questions or concerns about claims or access to care, our chapter on **Grievances and Appeals** will take you step-by-step through the process.

**Operational Standards, Requirements & Guidelines**

This section summarizes the requirements involved in the operation of Provider offices, including **Access Standards**, which ensures across-the-board consistency when our Members need to consult with Providers for initial health assessments, referrals, coordination of care and follow-up care.

Separate chapters detail **Provider Credentialing**, **Provider Roles & Responsibilities** and **Enrollment & Marketing** guidelines. Chapters on **Clinical Practice & Preventive Health Guidelines** and **Case Management** outline the steps Providers should take to coordinate care and help Members take a proactive stance in the fight against disease. And finally, there is a chapter on our commitment to participate in **Quality Assessments** which help **Anthem** measure, compare and continually improve our standards of care.

**Additional Resources**

We've included a chapter on **Member Rights & Responsibilities**, taken directly from our **Member Handbook**.

At **Anthem**, we've expanded our coverage to include services from two important state programs: **Seniors and Persons with Disabilities** (SPD) and **Community-Based Adult Services** (CBAS). A dedicated chapter outlines the intent of each program and its covered services. For example, CBAS stresses partnership with the Member, the family, the Provider and the community in working toward maintaining personal independence.

We also work with nationally recognized health care organizations to stay current on the latest health care discoveries. This manual provides easy links to access that information and a variety of other subjects, including:

- **Health Education Materials**: Information about preventive health and disease management programs, including **ConditionCare**
- **Prior Authorization**: A comprehensive listing of services requiring prior authorization, custom forms and **Medical Management** clinical guidelines
- **Provider Directory**
- **Telehealth**: A link to the website for complete information on the **Telehealth** communications system

**County Medical Services Program**

The Manual contains information, resources, policies and procedures relating to **Anthem’s** administration of benefits and services for **Medi-Cal Managed Care**, **Medi-Cal Access Program (formerly Access for Infants and Mothers Program)** and the **Major Risk Medical Insurance Program**. For information on **Anthem’s** administration of the **County Medical Services Program** (CMSP) benefits and services, please see the **CMSP Provider Manual**. This Manual is located under the **Provider Communications** heading on the **Provider Resources** page of our website at **www.anthem.com/ca**. For directions on how to access the **Provider Resources** page, please see **How to Access Information, Forms and Tools on Our Website** below.
Using This Manual

This manual is provided to you on our website at: www.anthem.com/ca.

Click on any topic in the Table of Contents and you will be automatically redirected to that topic’s location within the Manual. Click on any web address, and you will be redirected to that site. Each chapter may also contain cross-links to other chapters, important phone numbers, or our website or outside websites containing additional information.

If you have any questions about the content of this manual, please contact our Customer Care Center or your Provider network representative.

Websites

The Anthem website and this manual may contain links and references to Internet sites owned and maintained by third-party sites. Neither Anthem nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites. Such information, products, services and related materials are provided “as is” without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. Anthem disclaims all warranties, express or implied, including, but not limited to, implied warranties of merchantability and fitness. Anthem does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.

How to Access Information, Forms and Tools on Our Website

A wide array of valuable tools, information and forms are accessible via the State Sponsored Plans - Provider Resources page of our website, www.anthem.com/ca. Throughout this manual, we will refer you to items located on the Provider Resources page. To access this page, please follow these websteps:

1. Go to www.anthem.com/ca
2. Select OTHER ANTHEM WEBSITES: Providers
3. Select Learn More: State Sponsored Plans
CHAPTER 2: LEGAL AND ADMINISTRATIVE REQUIREMENTS

Legal and Administrative Requirements

Proprietary Information

The information contained in this Provider Manual is proprietary. By accepting this manual, Anthem Providers agree:

- Not to disclose the information contained in this manual
- To protect and hold the manual’s information as confidential
- To use this manual solely for the purposes of referencing information regarding the provision of medical services to Medi-Cal, Medi-Cal Access Program and Major Risk Medical Insurance Program (MRMIP) Members who have chosen Anthem as their health plan

This manual provides standards for services to Members of the Medi-Cal, Medi-Cal Access Program and MRMIP programs. It does not establish standards for services to any other Members of Anthem or its affiliates. If a section of the manual applies only to a specific program, that program will be indicated. If there is no such indication, the information is applicable to all programs.

This manual does not obligate Providers to provide services to Members enrolled in any of these programs unless the Provider is under contract with Anthem to provide services in one or more of these programs. Providers are only required to follow the standards in this manual that are applicable to the program in which the Member is currently enrolled.

Legal and Administrative Requirements

Privacy and Security

The Anthem Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant privacy and security statement can be found under Standards and Policies: HIPAA Readiness Disclosure Statement on the Provider Resources page of our website at: www.anthem.com/ca. For information on how to access this page, please refer to Chapter 1: How to Access Information, Forms and Tools on our Website.

Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate only and is not intended to be used or relied upon in any circumstance or instance.

Please be aware that when you travel from the Anthem website to another website, whether through links provided by Anthem or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such sites before providing any personal information.

Anthem uses the Secure eMail encryption tool to ensure that your Member’s Protected Health Information (PHI) is kept private and secure. We do this because we recognize that many people are concerned about identity theft. Secure eMail encrypts emails and attachments that it identifies as potentially having PHI. Providers can also use Secure eMail to send encrypted email to Anthem.
Legal and Administrative Requirements

Misrouted Protected Health Information

Providers and facilities are required to review all Member information received from Anthem to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about Members that a Provider or facility is not treating. PHI can be misrouted to Providers and facilities by mail, fax, email or electronic Remittance Advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or facilities permitted to misuse or redisclose misrouted PHI. If Providers or facilities cannot destroy or safeguard misrouted PHI, please contact the appropriate Customer Care Center at the following numbers:

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
Medi-Cal Access Program: 1-877-687-0549
MRMIP Customer Care Center: 1-877-687-0549

Legal and Administrative Requirements

Updates and Changes

The Provider Manual, as part of your Provider Agreement and related Addendums, may be updated at any time and is subject to change. In the event of an inconsistency between information contained in the manual and the Agreement between you or your facility and Anthem, the Agreement shall govern.

In the event of a material change to the Provider Manual, we will make all reasonable efforts to notify you in advance of such change through web-posted newsletters, fax communications and other mailings. In such cases, the most recently published information should supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all Anthem policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially targeted communications, including but not limited to letters, bulletins and newsletters.

This manual does not contain legal, tax or medical advice. Please consult with your own advisors for such advice.
### Contact List

#### Overview

The following resource grid is a consolidation of the most-used phone and fax numbers, websites and addresses found within the manual itself. We've also included other valuable contact information for you and your staff. The first chart below gives you contact information for **Medi-Cal Programs**, while the second chart is contact information for the health services programs handled by the state.

#### Medi-Cal Programs

<table>
<thead>
<tr>
<th>Contact</th>
<th>Outside Los Angeles County</th>
<th>Inside Los Angeles County</th>
<th>Hours of Operation</th>
<th>Address, E-mail, Fax and/or Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>1-800-282-4548</td>
<td>1-800-282-4548</td>
<td></td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
</tr>
<tr>
<td>Utilization Management: Medi-Cal</td>
<td>1-888-831-2246</td>
<td>1-888-831-2246</td>
<td>8am-5pm, Monday to Friday</td>
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<td>Fax: 1-800-754-4708</td>
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<td>Behavioral Health:</td>
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<td><a href="mailto:Medi-calBHUM@wellpoint.com">Medi-calBHUM@wellpoint.com</a></td>
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<td>Fax: 1-855-473-7902</td>
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<tr>
<td>Utilization Management: MAP and MRMIP</td>
<td>1-877-273-4193</td>
<td>1-877-273-4193</td>
<td>8am-5pm, Monday to Friday</td>
<td>Fax: 1-800-754-4708</td>
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<tr>
<td></td>
<td>or 1-877-273-4193</td>
<td>or 1-877-273-4193</td>
<td></td>
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<tr>
<td>Utilization Management: Medical Groups</td>
<td>1-888-831-2246</td>
<td>1-888-831-2246</td>
<td>8am-5pm, Monday to Friday</td>
<td>Fax: 1-888-232-0708</td>
</tr>
<tr>
<td>Delegated to Perform UM</td>
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<tr>
<td>Case Management</td>
<td>1-866-595-0145</td>
<td>1-866-595-0145</td>
<td>8am-5pm, Monday to Friday</td>
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<tr>
<td>Claims: Follow-Up</td>
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<td>Claim Follow-Up:</td>
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<td>Anthem Blue Cross</td>
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<td></td>
<td>P.O. Box 60007</td>
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<td>Los Angeles, CA 90060-0007</td>
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## Chapter 3: Contacts

<table>
<thead>
<tr>
<th>Contact</th>
<th>Outside Los Angeles County</th>
<th>Inside Los Angeles County</th>
<th>Hours of Operation</th>
<th>Address, E-mail, Fax and/or Website</th>
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<tbody>
<tr>
<td>Claims: Overpayment Recovery</td>
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<td>Overpayment Recovery&lt;br&gt;Anthem Blue Cross&lt;br&gt;P. O. Box 92420&lt;br&gt;Cleveland, Ohio 44135&lt;br&gt;The above address does not accept overnight packages. Those must be sent to:&lt;br&gt;Overpayment Recovery&lt;br&gt;Anthem Blue Cross&lt;br&gt;Lockbox 92420&lt;br&gt;4100 West 150th Street&lt;br&gt;Cleveland, OH 44135</td>
</tr>
<tr>
<td>Claims Submissions: Electronic</td>
<td>Electronic Data Interchange (EDI) 1-800-227-3983</td>
<td>Electronic Data Interchange (EDI) 1-800-227-3983</td>
<td>8-4:30pm, Monday to Friday</td>
<td>E-mail:&lt;br&gt;<a href="mailto:ent.edi.support@anthem.com">ent.edi.support@anthem.com</a></td>
</tr>
<tr>
<td>Claims Submissions: Paper</td>
<td></td>
<td></td>
<td></td>
<td>Anthem BlueCross&lt;br&gt;P.O. Box 60007&lt;br&gt;Los Angeles, CA 90060-0007</td>
</tr>
<tr>
<td>Community-Based Adult Services (CBAS)</td>
<td>California Department of Aging: 1-800-510-2020</td>
<td>California Department of Aging: 1-800-510-2020 1-800-776-5746</td>
<td>8am-5pm, Monday to Friday</td>
<td><a href="http://www.aging.ca.gov">www.aging.ca.gov</a> <a href="http://www.disabilityrightsca.org">www.disabilityrightsca.org</a></td>
</tr>
<tr>
<td>Network Relations Department</td>
<td>Central CA Region 1-559-488-1380&lt;br&gt;Northern CA Region 1-916-325-4200&lt;br&gt;Tulare/Kings: 1-559-623-0480</td>
<td>Los Angeles: 1-800-465-2272</td>
<td>8am-5pm, Monday to Friday</td>
<td></td>
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<tr>
<td>County Medical Services Program (CMSP)</td>
<td>1-805-557-6462 1-805-557-6106</td>
<td>1-805-557-6462 1-805-557-6106</td>
<td>8am-5pm, Monday to Friday</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
</tr>
<tr>
<td>Customer Care Center: Medi-Cal</td>
<td>1-800-407-4627 1-888-757-6034 (TTY)</td>
<td>1-800-407-4627 L.A. Care: 1-888-452-2273 1-888-757-6034 (TTY)</td>
<td>7am-7pm, Monday to Friday</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a> For after-hours services, please call 24/7 NurseLine (see below).</td>
</tr>
<tr>
<td>Contact</td>
<td>Outside Los Angeles County</td>
<td>Inside Los Angeles County</td>
<td>Hours of Operation</td>
<td>Address, E-mail, Fax and/or Website</td>
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<tr>
<td>Customer Care Center: Medi-Cal – Health Care Options</td>
<td>1-800-430-4263</td>
<td>1-800-430-4263</td>
<td>8am-5pm, Monday to Friday</td>
<td></td>
</tr>
<tr>
<td>Customer Care Center: Medi-Cal Access Program</td>
<td>1-800-433-2611 or 1-877-687-0549 1-888-757-6034 (TTY)</td>
<td>1-877-687-0549 1-888-757-6034 (TTY)</td>
<td>8am-8pm, Monday to Friday 8am-5pm Saturday 7am-7pm, Monday to Friday</td>
<td>For after-hours services, please call 24/7 NurseLine (see below).</td>
</tr>
<tr>
<td>Customer Care Center: MRMIP</td>
<td>1-877-687-0549 1-888-757-6034 (TTY)</td>
<td>1-877-687-0549 1-888-757-6034 (TTY)</td>
<td>8:30am-7pm, Monday to Friday</td>
<td><a href="http://www.dhcs.ca.gov">www.dhcs.ca.gov</a> For after-hours services, please call 24/7 NurseLine (see below).</td>
</tr>
<tr>
<td>Express Scripts: Customer Care Center</td>
<td>1-800-227-3032</td>
<td>1-800-227-3032</td>
<td>5am-10pm, Monday to Friday 6am-3pm Saturday/Sunday</td>
<td>Request for Formulary Changes: Formulary Addition Requests: Anthem Prescription Mgt., LLC Attn: Formulary Department PO Box 746000 Cincinnati, OH 45274-6000</td>
</tr>
<tr>
<td>Electronic Data Interchange</td>
<td>1-800-227-3983</td>
<td>1-800-227-3983</td>
<td>8-4: 30pm, Monday to Friday</td>
<td><a href="mailto:ent.edi.support@anthem.com">ent.edi.support@anthem.com</a></td>
</tr>
<tr>
<td>Express Scripts: Prior Authorization Center</td>
<td>1-866-302-7166</td>
<td>1-866-302-7166</td>
<td>7am-7pm, Monday to Friday</td>
<td>Fax: 1-866-302-7167</td>
</tr>
<tr>
<td>Fraud and Abuse: Medi-Cal</td>
<td>1-800-407-4627 or 1-888-231-5044 (Blue Cross of California Fraud Hotline)</td>
<td>1-888-285-7801</td>
<td>7am-7pm, Monday to Friday</td>
<td>Fax: 1-866-454-3990</td>
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<tr>
<td>Fraud and Abuse: Medi-Cal Access Program &amp; MRMIP</td>
<td>1-877-687-0549</td>
<td>1-877-687-0549</td>
<td>7am-7pm, Monday to Friday</td>
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<th>Contact</th>
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<th>Hours of Operation</th>
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<td>Grievances &amp; Appeals</td>
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<td>Mailing Address:</td>
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<td>Attn: Grievance &amp; Appeals Department</td>
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<td>Anthem Blue Cross</td>
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<td>Fax: 1-866-387-2968</td>
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</table>
| Medi-Cal for Families Information Line       | 1-800-880-5305             |                           | 8am-8pm, Monday to Friday 8am-5pm, Saturday   | For additional information, visit the California Relay Service webpage at: http://ddtp.cpuc.ca.gov/defaul
t1.aspx?id=1482                                                                                 |
<p>| Hearing Impaired Services: California Relay Service | 711 or Voice to TTY, English: 1-800-735-2922 | 711 or Voice to TTY, English: 1-800-735-2922 | 24 Hours a Day, 7 Days a Week |                                                                                                       |
|                                              | Spanish: 1-800-855-3000    | Spanish: 1-800-855-3000   |                                              |                                                                                                       |
|                                              | TTY to Voice, English: 1-800-735-2929 | TTY to Voice, English: 1-800-735-2929 |                                              |                                                                                                       |
|                                              | Spanish: 1-800-855-3000    | Spanish: 1-800-855-3000   |                                              |                                                                                                       |
| Interpreter Services                         | During regular business hours: For Medi-Cal members: 1-800-407-4627 For Medi-Cal Access Program and MRMIP members: 1-800-845-3604 | During regular business hours: For Medi-Cal members: 1-888-285-7801 For Medi-Cal Access Program and MRMIP members: 1-800-845-3604 | 24 Hours a Day, 7 Days a Week | Face-to-Face interpreters can be requested via email at: <a href="mailto:ssp.interpret@wellpoint.com">ssp.interpret@wellpoint.com</a> For more information, including how to access our Interpreter Services webpage, please see Chapter 14: Access Standards and Access to Care – Interpreter Services. |
|                                              | Requests made after hours, use 24/7 NurseLine: 1-800-224-0336 1-800-368-4424 (TTY) | Requests made after hours, use 24/7 NurseLine: 1-800-224-0336 1-800-368-4424 (TTY) |                                              |                                                                                                       |
| L.A. Care                                    | 1-888-839-9909             | 1-888-839-9909             | 7am-7pm, Monday to Friday                    |                                                                                                       |
| Member Eligibility: Anthem                   | Interactive Voice Response (IVR) 1-800-407-4627 | Interactive Voice Response (IVR) 1-888-285-7801 | 24 Hours a Day, 7 Days a Week |                                                                                                       |</p>
<table>
<thead>
<tr>
<th>Contact</th>
<th>Outside Los Angeles County</th>
<th>Inside Los Angeles County</th>
<th>Hours of Operation</th>
<th>Address, E-mail, Fax and/or Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Eligibility: State of California</td>
<td>Automated Eligibility Voice System (AEVS) 1-800-456-2387</td>
<td>Automated Eligibility Voice System (AEVS) 1-800-456-2387</td>
<td>24 Hours a Day, 7 Days a Week</td>
<td><a href="http://www.medi-cal.ca.gov/eligibility/login.asp">www.medi-cal.ca.gov/eligibility/login.asp</a></td>
</tr>
<tr>
<td>24/7 Nurseline</td>
<td>1-800-224-0336</td>
<td>1-800-224-0336</td>
<td>24 Hours a Day, 7 Days a Week</td>
<td>Can be used for after-hours Member eligibility verification and after-hours requests for interpreter services</td>
</tr>
<tr>
<td>Pharmacy: Express Scripts Prior Authorization</td>
<td>1-866-302-7166</td>
<td>1-866-302-7166</td>
<td>7am-7pm, Monday to Friday</td>
<td>Fax: 1-866-302-7167</td>
</tr>
<tr>
<td>Pharmacy: Customer Service</td>
<td>1-800-227-3032</td>
<td>1-800-227-3032</td>
<td>5am-10pm, Monday to Friday; 6am-3pm Saturday and Sunday</td>
<td></td>
</tr>
<tr>
<td>Provider Relations (Behavioral Health Providers)</td>
<td></td>
<td></td>
<td>9am-4pm, Monday to Friday</td>
<td><a href="mailto:BHNetworks@wellpoint.com">BHNetworks@wellpoint.com</a></td>
</tr>
<tr>
<td>Secure eMail: eBusiness Help Desk</td>
<td>1-866-755-2680</td>
<td>1-866-755-2680</td>
<td>5am-5pm, Monday to Friday</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a> &gt;Providers &gt;Enter &gt;Behavioral Health Resources</td>
</tr>
<tr>
<td>TTY</td>
<td>1-888-757-6034</td>
<td>1-888-757-6034</td>
<td>8: 30am-7pm, Monday to Friday</td>
<td></td>
</tr>
<tr>
<td>Telehealth</td>
<td>1-866-855-2271</td>
<td>1-866-855-2271</td>
<td>8am-5pm, Monday to Friday</td>
<td><a href="http://www.anthem.com/ca/telemedicine">www.anthem.com/ca/telemedicine</a></td>
</tr>
<tr>
<td>Vision Services: Vision Service Plan (VSP)</td>
<td>1-800-615-1883</td>
<td>1-800-615-1883</td>
<td>5am-8pm, Monday to Friday; 6am-5pm Saturday</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Web Portal</td>
<td></td>
<td></td>
<td>12: 30am-Midnight, Monday 1: 30am-Midnight, Tuesday to Friday 1: 30am-7pm Saturdays</td>
<td><a href="https://provideraccess.com">https://provideraccess.com</a></td>
</tr>
</tbody>
</table>

Log in or follow instructions to create an account
### Contact List

#### State of California

<table>
<thead>
<tr>
<th>STATE SERVICES CONTACTS</th>
<th>PHONE/FAX NUMBERS</th>
<th>OTHER CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Eligibility Verification System (AEVS)</td>
<td>1-800-456-2387</td>
<td></td>
</tr>
<tr>
<td>California Children's Services (CCS)</td>
<td>Phone numbers are county specific. For example: Los Angeles County Phone: 1-800-288-4584 Fax: 1-800-924-1154 (Refer to website for additional phone numbers)</td>
<td>Referrals: <a href="http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx">www.dhcs.ca.gov/services/ccs/Pages/default.aspx</a></td>
</tr>
<tr>
<td>Community-Based Adult Services (CBAS)</td>
<td>Disability Rights California: 1-800-776-5746 L.A. Care: 1-888-839-9909</td>
<td><a href="http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx">www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx</a> <a href="http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/">www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/</a></td>
</tr>
<tr>
<td>Denti-Cal</td>
<td>1-800-423-0507</td>
<td><a href="http://www.denti-cal.ca.gov">www.denti-cal.ca.gov</a></td>
</tr>
<tr>
<td>8am-5pm, Monday to Friday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health Care Services Medi-Cal Managed Care Ombudsman</td>
<td>1-800-452-8609</td>
<td><a href="http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCOFFICEoftheOmbudsman.aspx">www.dhcs.ca.gov/services/medi-cal/Pages/MMCOFFICEoftheOmbudsman.aspx</a></td>
</tr>
<tr>
<td>Department of Health Care Services Office of Family Planning</td>
<td>1-800-942-1054</td>
<td><a href="http://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx">www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.aspx</a></td>
</tr>
<tr>
<td>Department of Social Services Public Inquiry and Response Unit</td>
<td>1-800-952-5253</td>
<td></td>
</tr>
<tr>
<td>Department of Managed Health Care</td>
<td>1-877-525-1295</td>
<td><a href="http://www.dmhc.ca.gov">www.dmhc.ca.gov</a></td>
</tr>
<tr>
<td>Indian Health Services</td>
<td>1-916-930-3927</td>
<td><a href="http://www.ihs.gov/California">www.ihs.gov/California</a></td>
</tr>
<tr>
<td>Medi-Cal Telephone Service Center</td>
<td>1-800-541-5555</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 4: COVERED AND NON-COVERED SERVICES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
Medi-Cal Access Program and MRMIP Customer Care Center:
1-877-687-0549

Hours of Operation: Monday to Friday, 7am-7pm

Covered and Non-Covered Services

Overview

This chapter outlines covered and noncovered services for the Medi-Cal, Medi-Cal Access Program, and Major Risk Medical Insurance (MRMIP) programs. Program benefits administered by the State of California, including California Children’s Services (CCS) and Community-Based Adult Services (CBAS), are also defined in this chapter.

Covered and Non-Covered Services

Program Definitions

Medi-Cal

Medi-Cal, the second largest provider of California health care, is a complex network of public and private health care Providers who serve California’s most vulnerable citizens: low-income California residents who lack health insurance. Medi-Cal pinpoints 165 categories of eligibility, but generally covers the following populations:

- Aged, Blind or Disabled Persons
- Individuals in Special Treatment Programs (including tuberculosis and dialysis)
- Individuals with Refugee Status
- Low-Income Children and Their Parents
- Low-Income Pregnant Women
- Qualified Low-Income Medicare Recipients
- Seniors and Persons with Disabilities

Anthem provides Medi-Cal services (Medicaid) for the California Department of Health Care Services and the Department of Public Health in the following counties:

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- El Dorado
- Fresno
- Glenn
- Inyo
- Kings
- Los Angeles (in partnership with L.A. Care Health Plan)
- Madera
- Maiposa
- Mona
- Nevada
- Placer
- Plumas
- Sacramento
- San Benito
- San Francisco
- Santa Clara
- Sierra
- Sutter
- Tehama
- Tulare
- Tuolumne
- Yuba
Medi-Cal Access Program (MAP) was created for middle-income families who don’t have health insurance or whose income is too high to qualify for no-cost Medi-Cal. The program encompasses the following:

- Program coverage includes comprehensive health care services, hospital delivery and 60 days postpartum care

To qualify for MAP, a woman must meet the following criteria:

- Pregnant, but not more than 30 weeks pregnant as of the application date
- California resident
- Not in Medi-Cal or Medicare Parts A and B as of the application date
- Not covered by private insurance costing less than $500 for maternity coverage deductions and copayments
- Within AIM income guidelines

**Major Risk Medical Insurance Program (MRMIP)**

The Major Risk Medical Insurance Program (MRMIP) was designed to help insure the very high-risk and those unable to secure private health coverage. The program is defined by the following:

- The program is a high-risk insurance pool
- The program is designed for those unable to secure private health coverage
- The program provides 36 months of access to health insurance
- The program requires an annual deductible
- The program requires copays for covered services

To qualify for MRMIP, applicants must meet the following criteria:

- California resident
- Effective January 1, 2014 any applicants who have been denied individual coverage will now be the only eligibility criteria to be considered under Title 10 2698.200 (b)(1)](D

**Covered and Non-Covered Services**

**State and County-Sponsored Programs**

To ensure continuity and coordination of care for our Members, Anthem enters into agreements with locally-based state and county public health services and programs. Providers are responsible for notifying Utilization Management when a referral is made to any of the agencies or programs listed below.

This notification ensures that case manager nurses and social workers can follow up with Members to coordinate care. It also ensures that Members receive all necessary services while keeping the Provider informed.

- Behavioral Health
- California Children's Services (CCS)
- California Early Start
- Child Health and Disability Prevention Program
- Directly Observed Therapy for Tuberculosis (DOT)
- Family Planning Services
• HIV Counseling and Testing
• Immunization Services
• Women, Infants and Children (WIC)
• Waiver Programs
CHAPTER 4A: MEDI-CAL COVERED AND NON-COVERED SERVICES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (L.A. County Only)
Hours of Operation: Monday to Friday, 7am-7pm
Denti-Cal: 1-800-322-6384

Medi-Cal: Covered and Non-Covered Services

Overview

Medi-Cal, California’s Medicaid program, provides quality health care services to low-income California residents who lack health insurance. Medi-Cal pinpoints 165 categories of eligibility, but generally covers the following populations:

- change to “Senior andPersons with Disabilities”
- Individuals in Special Treatment Programs
- Individuals with Refugee Status
- Low-Income Children and Their Parents
- Qualified Low-Income Medicare Recipients

Medi-Cal Covered and Non-Covered Services
Emergent Transportation - Ambulance Services

Ambulance services must come from a licensed ambulance or air ambulance company and be used only for emergencies. Coverage includes:

- Base Charge and Mileage
- Cardiac Defibrillation
- CPR
- EKGS
- IV Solutions
- Monitoring
- Oxygen
- Supplies

Medi-Cal Covered and Non-Covered Services
Behavioral Health Services

For information concerning Behavioral Health Services, please refer to CHAPTER 5A: Behavioral Health Services, Medi-Cal Covered and Non-Covered Services.

Community-Based Adult Services (CBAS)

The primary objectives of the Community-Based Adult Services program are the following:

- Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities
- Delay or prevent inappropriate or personally undesirable institutionalization
CBAS stresses partnership with the Member, the family and/or caregiver, the Primary Care Provider (PCP), and the community in working toward maintaining personal independence. Each center has a multidisciplinary team of health professionals who conduct a comprehensive assessment of each potential participant to determine and plan services needed to meet the individual's specific health and social needs. Services provided at regional centers include the following:

- Behavioral Health Services
- Hot Meals and Nutritional Counseling
- Physical, Occupational and Speech Therapies
- Professional Nursing Services
- Therapeutic Activities
- Transportation To and From the Member's Residence

For more information on CBAS, call the California Department of Aging: 1-800- 510-2020

For a complete list of CBAS centers and contact numbers, please go to the California Department of Aging website at www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/.

**Medi-Cal Covered and Non-Covered Services**

**Dental Services**

In general, basic dental services are not covered. Medi-Cal Members must be from 1 of the following groups to receive dental services:

- Pregnant women who receive dental services as part of their pregnancy care or for treatment of a condition that may cause problems in the pregnancy
- Members 20 years of age and younger who receive full scope Medi-Cal
- Members who live in a licensed nursing home or sub-acute facility
- Members needing dental treatment that could have been provided by a doctor

For the Members mentioned above, we provide the following coverage:

- Treatment when the natural teeth are injured or broken by an accident, and within 6 months of the injury
- General anesthesia for dental work given in a hospital or surgical center to the following Members:
  - Under 7 years of age
  - Under 21 years of age with a developmental issue
  - Any Member when it is medically necessary

For more information on dental services, please call Denti-Cal at: 1-800-322-6384. Or go to the Denti-Cal website at: www.denti-cal.ca.gov.

**Medi-Cal Covered and Non-Covered Services**

**Diagnostic X-Ray and Laboratory Services**

Some diagnostic services require Prior Authorization and must be performed in an in-network lab. They include the following:

- CT Scans
- MRAs
- MRIs
• PET Scans
• SPECT Scans

Covered diagnostic services that also must be performed in an in-network lab include the following:

• Blood Tests
• Cervical Cancer Screenings
• Human Papilloma Virus (HPV) Tests
• Lab Tests Used to Manage Diabetes (Including Cholesterol and HDL/LDL)
• Radiation Therapy
• X-Rays

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services**

Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided. EPSDT services include all services covered by Medi-Cal. In addition to the regular Medi-Cal benefits, a beneficiary under the age of 21 may receive additionally medically necessary services.

**Family planning services**

These services help members know how to:

- Be as healthy as they can be before getting pregnant
- Not get pregnant
- Guard themselves from getting sexually transmitted infections (STIs)

Family planning services include the following:

• Medical visits for birth control (including all forms of FDA-approved birth control)
• Teaching about family planning and counseling
• Pregnancy tests
• Tests for STIs
• Sterilization

**Medi-Cal Covered and Non-Covered Services**

**Home Health Care**

**Home Health Care** services require **Prior Authorization** and include the following:

• Care from a health aide who works under a registered nurse or therapist
• Physical, occupational or speech therapy evaluations
• Visits or supplies from a licensed home health agency or nursing group
Medi-Cal Covered and Non-Covered Services

Hospice

Members who have a terminal illness and 12 months or less to live (if the disease runs its normal course) may choose Hospice Care instead of routine health care, including - the following:

- Medical Care
- Physical Needs
- Social Needs
- Spiritual Comfort

Medi-Cal Covered and Non-Covered Services

Hospital Services

Hospital Services, with the exception of emergencies and childbirth, require Prior Authorization and include the following:

- Blood Transfusions
- Breast Cancer Surgery (Lumpectomy, Mastectomy or Lymph Node Dissection)
- Care In Special Units
- Chemotherapy
- Drugs, including oxygen, given during the hospital stay
- Emergency Room Use (and services to keep the Member stable after emergency)
- Hemodialysis Treatment
- Hospital Room (with two or more beds)
- Operating, Delivery and Special Treatment Rooms
- Physical and Occupational Therapy
- Radiation Therapy
- Supplies
- Tests on Blood, Heart and Urine
- X-Rays

Medi-Cal Covered and Non-Covered Services

Hysterectomies

A completed Hysterectomy–Informed Consent Form must be attached to all claims submitted for hysterectomy services. For more information on this form, including a printable sample form, please go to the Medi-Cal website at www.medi-cal.ca.gov. To locate hysterectomy information, select Featured: Provider Manuals and then scroll down to Inpatient/Outpatient Services and select Inpatient Services (IPS). From there, scroll down to Hysterectomy and open the MS Word file.
Medi-Cal Covered and Non-Covered Services

Maternity

Pregnancy and Maternity Care covered services include the following:

- Abortions
- Alpha-fetoprotein (AFP) Screening
- C-Sections Delivery / Vaginal Delivery
- Classes Taken Before Birth
- Doctor Visits Before and After Birth
- Hospital Care
- Newborn Baby Exam
- Nurse-Midwife
- Pregnancy Tests (while pregnant)
- Follow-up home health visit after early post partum discharge

Please Note: The length of time applicable for covered hospital maternity services depends on the mode of delivery:

- Vaginal Delivery: 48 Hours
- Cesarean section: 96 Hours

Medi-Cal Covered and Non-Covered Services

Medical Supplies & Equipment

Medical supplies and equipment, including custom-made durable medical equipment, may require Prior Authorization. Covered services include the following:

- Breast Replacement Supplies
- Colostomy Supplies
- Diabetes Equipment and Supplies, including blood sugar monitors and insulin needles
- Durable Medical Equipment
- Manmade Body Parts

Medi-Cal Covered and Non-Covered Services

Non-Emergency Transportation

Non-Emergency Transportation, which may require Prior Authorization, allows Members to be transferred from a hospital to another hospital, facility or home. It is a covered service when the following criteria have been met:

- Medical Necessity
- Provider Requests the Service
Medi-Cal Covered and Non-Covered Services

Pharmacy

Prescription drugs, without a copay or deductible, are a covered Medi-Cal benefit if the following conditions are met:

- The drug must be prescribed by a physician.
- The drug must be used for the care and treatment of an injury or illness.
- The drug must be preapproved by Anthem when it is not included on the Preferred Drug List (PDL).

Prescriptions will be written for a maximum 30-day supply. Providers may approve refills on the initial prescription. A Pharmacist or hospital emergency room may dispense a 72-hour emergency supply, as warranted.

Please Note: Members must have their prescriptions filled by drugstores within the Anthem network.

The following medications are not covered by the pharmacy benefit:

- Cosmetic and Hair Medications
- Dietary Supplements, except for treatment of phenylketonuria (PKU)
- Fertility Drugs
- Weight Loss Drugs, unless medically necessary

The following medications are administered by the state and reimbursed by Fee-for-Service (FFS) Medi-Cal:

- Antipsychotic Drugs
- Erectile Dysfunction Drugs
- Heroin Detoxification Drugs
- HIV Drugs

Medi-Cal Covered and Non-Covered Services

Professional Services

Covered Professional Services may require Prior Authorization and include the following:

- Routine office visits (including first-time visits)
- Allergy tests and treatment
- Anesthesia (during surgery)
- Blood transfusions
- Breast exams and mammograms
- Cancer screening tests
- Chemotherapy
- Child Health and Disability Prevention (CHDP) program services
- Diabetes management
- Fluoride treatment (for children under the age of 6)
- Foot care (for children and young adults under the age of 21)
- Hearing aids (hearing exams are covered for children and young adults under the age of 21)
- Human Papilloma virus (HPV)
• Outpatient X-rays
• Pap smears
• Phenylketonuria (PKU) services
• Physical, occupational and speech therapy
• Radiation therapy
• Specialists
• Surgery and reconstructive surgery
• Transgender services
• Well-Baby care and Well-Child care
  o Newborns should be seen within 30 days of birth
  o Children should be seen within 60 days of joining Anthem

### Medi-Cal Covered and Non-Covered Services

#### Sensitive Services

**Adolescent Sensitive Services**

Members between 12 and 18 years of age can go to any doctor or clinic, in or out of the Anthem network, without consent from their parents or legal guardian for the following Sensitive Services:

- Outpatient behavioral health for
  - Sexual or physical abuse
  - When they may hurt themselves or others
- Pregnancy
- Family planning
- Sexual assault
- HIV/AIDS Testing
- Sexually Transmitted Infections (STIs)
- Drug and alcohol abuse

**Adult Sensitive Services**

An adult may choose any doctor or clinic for these:

- Family planning
- Sexually transmitted infections (STIs)
- HIV/AIDS testing

**Sensitive abortion services**

Members 12 years of age and older may obtain abortion services from any provider without a prior authorization. The doctor or clinic does not have to be part of the Anthem network.
Medi-Cal Covered and Non-Covered Services

Skilled Nursing Facilities

Skilled Nursing Facilities covered services apply for the month the Member enters the facility plus 1 additional month. Covered services include the following:

- Blood Transfusions
- Drugs
- Hospice Service (more than 60 days per year)
- Lab Tests
- Physical, Occupational and Speech therapy
- Room (with two or more beds)
- Special Treatment Rooms

Please Note: Members needing long-term care must disenroll from this health care plan and will be covered by Fee-For-Service Medi-Cal.

Medi-Cal Covered and Non-Covered Services

Telehealth

Telehealth is a health care delivery method that applies high-speed telecommunications systems, computer technology and specialized medical cameras to examine, diagnose, treat and educate patients at a distance. For example, through a telehealth encounter, a patient at a telehealth clinic in a rural area may seek medical treatment from a provider or specialist in Los Angeles or San Francisco without incurring the expense of traveling to such distant locations.

The advantages of communicating via Telehealth are the following:

- Providers can choose from the Anthem network of specialists, no matter where the Member lives
- The Member does not have to wait long periods of time to schedule an appointment with a specialist
- Providers can electronically send the Member's medical data to a specialist for review
- Specialists can use the computers and other equipment to send a recommendation for care back to the Providers and Members from a distance

Please Note: Utilizing Telehealth does not require prior authorization.

Telehealth does not include services rendered by audio-only telephone, fax or email communication.

Medi-Cal Covered and Non-Covered Services

Vision Services

Vision benefits are offered to all Anthem Medi-Cal Members through the Vision Service Plan (VSP). Search for a VSP Provider at www.vsp.com > Find a VSP Doctor.

Vision coverage for adults includes:

- A single eye exam every two years
- A second eye exam within two years if the Member shows signs of needing the exam
- Contact lenses and vision aids that are medically necessary
- Diabetic Retinal Exam (DRE) every year or as appropriate
Vision coverage for children and young adults under 21 years of age includes:
- A single eye exam and a single pair of glasses every two years

The following are not covered vision services:
- Eyeglasses or contact lenses uses for reasons other than to correct vision
- Eye surgery to correct vision

For questions about vision benefits, please call the Vision Service Plan at: 1-800-877-7195 or 1-800-428-4833 (TTY).

### Medi-Cal Covered and Non-Covered Services

#### Benefits Grid

The following table lists benefits provided by the Medi-Cal Managed Care Program.

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion</td>
<td>Covered</td>
</tr>
<tr>
<td>Acupuncture Outside L.A. County: Not covered for Members 21 years and older</td>
<td></td>
</tr>
<tr>
<td>Mainstream and L.A. County: Fee-For-Service</td>
<td></td>
</tr>
<tr>
<td>Sacramento County: Not Covered</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>Covered, Antigen Covered</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Covered, Air Ambulance Covered, Dry Runs Covered, Ground Ambulance Covered, Nonemergent transport, from home to doctor's office, dialysis or physical therapy Covered, Prior Authorization required</td>
</tr>
<tr>
<td>Amniocentesis</td>
<td>Covered</td>
</tr>
<tr>
<td>Anesthetics (Administration)</td>
<td>Covered</td>
</tr>
<tr>
<td>Artificial Insemination</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Audiology Services</td>
<td>Outside L.A. County: Not Covered for Members 21 and older, except in cases of emergency and where the benefit is required to treat the emergency Inside L.A. County: Not covered</td>
</tr>
<tr>
<td>Benefits/Services</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Behavioral Health</td>
<td>Administered by the state</td>
</tr>
<tr>
<td>• Outpatient Behavioral Health (including alcohol and</td>
<td>Administered by the state</td>
</tr>
<tr>
<td>substance use services, crisis intervention and</td>
<td></td>
</tr>
<tr>
<td>treatment)</td>
<td></td>
</tr>
<tr>
<td>• Professional Behavioral Health Services for mild</td>
<td>Covered: May require preauthorization. Note: Marriage and Family</td>
</tr>
<tr>
<td>to moderate level of impairment</td>
<td>Therapy for relationship problems are not a covered service.</td>
</tr>
<tr>
<td>• ABA – Applied Behavioral Analysis for children</td>
<td>Covered</td>
</tr>
<tr>
<td>diagnosed with Autism</td>
<td></td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>Covered</td>
</tr>
<tr>
<td>Cancer Screening (Refer to Member Handbook)</td>
<td>Covered</td>
</tr>
<tr>
<td>Cataract Spectacles and Lenses</td>
<td>Covered when medically necessary</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required</td>
</tr>
<tr>
<td>CHDP Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Chemical Dependency Rehabilitation</td>
<td>Administered by the state</td>
</tr>
<tr>
<td>Chemotherapy Drugs</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>If under 21 years of age, CCS</td>
</tr>
<tr>
<td>Circumcision</td>
<td>Not covered, unless medically necessary</td>
</tr>
<tr>
<td>Colostomy Supplies</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility</td>
<td>Covered</td>
</tr>
<tr>
<td>• Outpatient Dispensing</td>
<td>Covered</td>
</tr>
<tr>
<td>• In Conjunction with Home Health</td>
<td>Covered</td>
</tr>
<tr>
<td>Community-Based Adult Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
</tr>
<tr>
<td>• Accidental Injury, Inpatient Facility</td>
<td>Outside L.A. County: Not covered for Members 21 years and older, except</td>
</tr>
<tr>
<td></td>
<td>in cases of emergency and where the benefit is required to treat the</td>
</tr>
<tr>
<td></td>
<td>emergency.</td>
</tr>
<tr>
<td></td>
<td>Covered, if within 6 months of injury</td>
</tr>
<tr>
<td></td>
<td>Covered, for dental work given in an in-patient facility or surgical</td>
</tr>
<tr>
<td></td>
<td>center to members who:</td>
</tr>
<tr>
<td></td>
<td>• Are younger than 7 years of age</td>
</tr>
<tr>
<td></td>
<td>• Have a developmental (growth) issue and are under 21 years of age</td>
</tr>
<tr>
<td></td>
<td>• Require benefit due to medical necessity</td>
</tr>
<tr>
<td>Detoxification (Acute Phase)</td>
<td>Administered by the state</td>
</tr>
<tr>
<td>Benefits/Services</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diabetic Services</td>
<td>Covered, CCS if under 21 years of age</td>
</tr>
<tr>
<td>• Diagnostic X-ray</td>
<td>Covered:</td>
</tr>
<tr>
<td>• Must use contracted Radiology provider</td>
<td>• Lead testing for children</td>
</tr>
<tr>
<td></td>
<td>Prior Authorization required for selected CT/MRI/MRA/PET/SPECT</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered or approved CCS if under 21 years of age, carve out</td>
</tr>
<tr>
<td>Directly Observed Therapy (DOT)</td>
<td>Administered by the state – carve out</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Covered:</td>
</tr>
<tr>
<td>• Prior Authorization is required</td>
<td>preauthorization required for specific equipment</td>
</tr>
<tr>
<td>Not covered:</td>
<td>L.A. County: Covered, preauthorization required</td>
</tr>
<tr>
<td>• Items used only for comfort or hygiene</td>
<td></td>
</tr>
<tr>
<td>• Items used only for exercise</td>
<td></td>
</tr>
<tr>
<td>• Air conditioners, filters or purifiers</td>
<td></td>
</tr>
<tr>
<td>• Spas, swimming pools</td>
<td></td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services</td>
<td>Preventative care services are covered including:</td>
</tr>
<tr>
<td>• Only for Members under 21 years of age</td>
<td>• Health screenings</td>
</tr>
<tr>
<td></td>
<td>• Physical exams</td>
</tr>
<tr>
<td></td>
<td>• Hearing screenings</td>
</tr>
<tr>
<td></td>
<td>• Dental screenings</td>
</tr>
<tr>
<td></td>
<td>• Vaccines</td>
</tr>
<tr>
<td></td>
<td>• Health education</td>
</tr>
<tr>
<td></td>
<td>• Blood tests, including lead screenings (State Administered)</td>
</tr>
<tr>
<td>Emergency Room (In and Outside of California)</td>
<td>Covered</td>
</tr>
<tr>
<td>• Outpatient Facility Services</td>
<td>Covered</td>
</tr>
<tr>
<td>• Professional</td>
<td></td>
</tr>
<tr>
<td>Endoscopic Studies</td>
<td>Covered</td>
</tr>
<tr>
<td>Experimental Procedures</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Family Planning Services and Supplies</td>
<td>Covered:</td>
</tr>
<tr>
<td>Not covered:</td>
<td>• Birth control</td>
</tr>
<tr>
<td>• Sterilization reversal</td>
<td>• Education and counseling</td>
</tr>
<tr>
<td>• Hysterectomy for sterilization</td>
<td>• Pregnancy tests</td>
</tr>
<tr>
<td>• Fertility treatments</td>
<td>• Sexually transmitted disease screening</td>
</tr>
<tr>
<td></td>
<td>• Sterilization</td>
</tr>
<tr>
<td>Fetal Monitoring</td>
<td>Covered</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>Covered; i administered by the genetic disease branch of DHCS Paid by the State</td>
</tr>
<tr>
<td>Health Education</td>
<td>Covered</td>
</tr>
</tbody>
</table>

**MEDI-CAL MANAGED CARE PROGRAM**
### MEDI-CAL MANAGED CARE PROGRAM

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Aids</td>
<td>Covered,</td>
</tr>
<tr>
<td>Hearing Screens</td>
<td>Covered,</td>
</tr>
<tr>
<td>Hemodialysis Chronic Renal Failure</td>
<td>Covered,</td>
</tr>
<tr>
<td>Hepatitis B Vaccine/Gamma Globulin</td>
<td>Covered</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Hospice</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Hospital Base Physicians (in lieu of acute inpatient or SNF)</td>
<td>Covered</td>
</tr>
<tr>
<td>Hospitalization</td>
<td></td>
</tr>
<tr>
<td>- Inpatient Services</td>
<td>Covered</td>
</tr>
<tr>
<td>- Outpatient Services</td>
<td>Covered</td>
</tr>
<tr>
<td>- Intensive Care Services</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>- Private room covered only if medically necessary</td>
</tr>
<tr>
<td>Immunization Administration</td>
<td></td>
</tr>
<tr>
<td>- Pediatric Vaccines</td>
<td>Covered under Vaccines For Children (VFC) or CHDP under 22 years of age</td>
</tr>
<tr>
<td>- Adult Vaccines</td>
<td>Covered</td>
</tr>
<tr>
<td>Infant Apnea Monitor (Outpatient)</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Infertility Diagnosis and Treatment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Injectable Medications (Outpatient and self administered)</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient Alcohol and Drug Abuse</td>
<td>Administered by the state</td>
</tr>
<tr>
<td>Interpreter Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Lab and Pathology Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Lithotripsy</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Major Organ Transplants (Except Kidneys and Corneas)</td>
<td>Administered by the state</td>
</tr>
<tr>
<td>Mammography</td>
<td>Covered</td>
</tr>
<tr>
<td>Mastectomy</td>
<td>Covered</td>
</tr>
<tr>
<td>Maternity Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Pre- and Post-natal care</td>
</tr>
<tr>
<td></td>
<td>- Nurse/Midwife services</td>
</tr>
<tr>
<td></td>
<td>- Childbirth and Cesarean section</td>
</tr>
<tr>
<td></td>
<td>- Newborn exam</td>
</tr>
<tr>
<td></td>
<td>- Alpha–fetoprotein (AFP) screening - covered by the State</td>
</tr>
<tr>
<td>Benefits/Services</td>
<td>Coverage</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nutritionist/Dietician</td>
<td>Covered under CPSP (California Peri-Natal Services Program) program, preauthorization required</td>
</tr>
<tr>
<td>Obstetrical/Gynecological Services</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility Fees</td>
<td>Covered</td>
</tr>
<tr>
<td>• Inpatient Professional Fees</td>
<td>Covered</td>
</tr>
<tr>
<td>• Outpatient Professional Fee</td>
<td>Covered</td>
</tr>
<tr>
<td>• Professional Fee</td>
<td>Covered</td>
</tr>
<tr>
<td>• Obstetrical CPSP Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Office Visit Supplies, including splints, casts, bandages and dressings</td>
<td>Covered</td>
</tr>
<tr>
<td>Ophthalmology Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Optometric and Optician Services</td>
<td></td>
</tr>
<tr>
<td>Outside L.A. County: Not covered for Members 21 years and older, except in cases of emergency where the benefit is required to treat the emergency Inside L.A. County: Not covered</td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td></td>
</tr>
<tr>
<td>• Inpatient or SNF</td>
<td>Physical Therapy: Covered, preauthorization required</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>Occupational Therapy: Covered, no preauthorization required</td>
</tr>
<tr>
<td>• Professional</td>
<td>Speech Therapy: Covered, no preauthorization required</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td>Covered</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>Covered</td>
</tr>
<tr>
<td>Prosthetics and Orthotics (including artificial limbs and eyes)</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Psychology Services</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>(Psychological testing when clinically indicated to evaluate a mental health condition)</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology Services</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility Component</td>
<td>Covered</td>
</tr>
<tr>
<td>• Outpatient Facility Component</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>• Professional Component</td>
<td>Covered</td>
</tr>
<tr>
<td>Reconstructive Surgery (not cosmetic)</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>Routine Physical Examinations</td>
<td>Covered, except when required by job, school, camp or sports program</td>
</tr>
</tbody>
</table>
## MEDI-CAL MANAGED CARE PROGRAM

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>• Long-term care limited to month Member enters facility plus month following</td>
<td></td>
</tr>
<tr>
<td>Specialist Consultations</td>
<td>Covered</td>
</tr>
<tr>
<td>TMJ</td>
<td>Covered, preauthorization required</td>
</tr>
<tr>
<td>TMS – Transcranial Magnetic Stimulation</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transfusions (blood and blood products)</td>
<td>Covered</td>
</tr>
<tr>
<td>Transgender Services</td>
<td>Covered</td>
</tr>
<tr>
<td>Urgent Care Center</td>
<td>Covered</td>
</tr>
<tr>
<td>Vision Care</td>
<td>Covered</td>
</tr>
<tr>
<td>• Medically Necessary</td>
<td>Vision Service Plan (VSP)</td>
</tr>
<tr>
<td>• Frames</td>
<td>Vision Service Plan (VSP)</td>
</tr>
<tr>
<td>• Lenses</td>
<td>Vision Service Plan (VSP)</td>
</tr>
<tr>
<td>Vision Screening (refraction)</td>
<td>Vision Service Plan (VSP)</td>
</tr>
</tbody>
</table>

### Medi-Cal Covered and Non-Covered Services

#### Services Requiring Prior Authorization

Medi-Cal services that require Prior Authorization include the following:

- Ambulance Services – Nonemergency
- Applied Behavioral Analysis
- Cataract Spectacles and Lenses
- Diagnostic X-ray and Lab
- Durable Medical Equipment and Supplies
- Home Health Care
- Hospice
- Infant Apnea Monitor
- Lithotripsy
- Nutritionist/Dietician
- Physical, Occupational and Speech Therapy
- Podiatry Services
- Prosthetics and Orthotics
- Psychological Testing
- Radiology, Outpatient
- Reconstructive Surgery
- Rehabilitation Services
- Skilled Nursing Facility

Please Note: This is not a comprehensive list. For a full listing, please see the list of Services Requiring Prior Authorization located under Prior Authorization and Preservice Review on the Provider Resources page of our website at: [www.anthem.com/ca](http://www.anthem.com/ca). For information on how to access this page, please refer to Chapter 1: How to Access Information, Forms and Tools on our Website.
Medi-Cal Covered and Non-Covered Services
Non-Covered Services
Anthem does not cover the following:

- **Dental Care**
  - Dental Implants
  - Orthodontic Services
  - Treatment of the teeth or gums, tooth extraction (except for care given if teeth are injured)
  - Treatment more than 6 months after an injury

- **Inpatient Behavioral Health**
  - Mental Illness
  - Psychological Testing
  - Substance Abuse, including drugs, alcohol and cigarettes

- **Medical Equipment**
  - Items used for comfort or hygiene
  - Items used for exercise
  - Items used for making a room or home comfortable, such as air conditioning or air purifiers
  - Exercise equipment

- **Pregnancy and Maternity Care**
  - Fertility Treatments
  - Sterilization for Members under 21 years of age
  - Surgery to Reverse Sterilization

- **Professional Services**
  - Circumcision, if it is not medically necessary
  - Cosmetic surgery
  - Custodial care
  - Major organ transplants
  - Routine physical exams required for a job, school, camp or sports program
  - Weight loss services, programs or supplies
  - Vaccines needed for travel outside the U.S.

**Please Note:** This is not a comprehensive list. For answers to detailed questions about covered and non-covered services, please contact the appropriate Customer Care Center at the numbers listed at the beginning of this chapter.
CHAPTER 4B: MEDI-CAL ACCESS PROGRAM COVERED AND NON-COVERED SERVICES

Access for Infants and Mothers (AIM) Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm

MediCal Access Program (MAP): Covered and Non-Covered Services

Overview

The Medi-Cal Access Program (MAP) program was created for middle-income families who don't have health insurance or whose income is too high to qualify for no-cost Medi-Cal. The program encompasses the following:

- Program coverage includes comprehensive health care services, hospital delivery and 60 days postpartum care
- Once delivered, the baby is automatically eligible for enrollment in the Healthy Families Program

To qualify for Medi-Cal Access Program, a woman must meet the following criteria:

- Pregnant, but not more than 30 weeks pregnant as of the application date
- California resident
- Not in Medi-Cal or Medicare Parts A and B as of the application date
- Not covered by private insurance costing less than $500 for maternity coverage deductions and copayments
- Within MAP income guidelines

MAP: Covered and Non-Covered Services

Ambulance Services

In emergencies, Anthem covers ambulance transport to the first hospital available for emergency care. The service also includes non-emergency transport from 1 hospital to another hospital or facility, or facility to home, as long as the following conditions are met:

- Medical necessity
- Requested by in-network Provider
- Prior Authorization

Please Note: Public transport via car, taxi or airplane is not covered.

MAP: Covered and Non-Covered Services

Behavioral Health - Inpatient

Behavioral health care services are covered when ordered by an in-network Provider for the diagnosis and treatment of a behavioral health condition. Basic behavioral health care inpatient services are limited to 30 days per benefit year. Additional days may be authorized by Anthem.

Inpatient behavioral health care services include treatment for Severe Mental Illness (SMI), which encompasses, but is not limited to, the following:

- Anorexia Nervosa
- Bipolar Disorder
Inpatient behavioral health care services also include treatment for **Serious Emotional Disturbances** (SED), including problems with eating, sleeping, or hurting oneself or others.

**Please Note:** For the treatment of **Severe Mental Illness** or **Severe Emotional Disturbances**, there is no limitation on the number of treatment days.

### MAP: Covered and Non-Covered Services
#### Behavioral Health - Outpatient

Behavioral health care services are covered when ordered by a participating Provider for the diagnosis and treatment of a behavioral health condition. **Basic** behavioral health care outpatient services are limited to 20 visits per benefit year. That number may increase when outpatient treatment days are substituted for inpatient hospitalization. The conditions covered include the following:

- Treatment for Members who have experienced family dysfunction or trauma, including child abuse or neglect, domestic violence, substance abuse, divorce or bereavement
- Treatment for **Severe Mental Illness** (SMI), including:
  - Anorexia Nervosa
  - Bipolar Disorder
  - Bulimia Nervosa
  - Major Depressive Disorders
  - Obsessive Compulsive Disorder
  - Panic Disorders
  - Pervasive Developmental Disorder or Autism
  - Schizophrenia
  - Schizoaffective Disorder

Outpatient behavioral health care services also include treatment for **Serious Emotional Disturbances** (SED), including problems with eating, sleeping, or hurting oneself or others.

**Please Note:** For the treatment of **Severe Mental Illness** or **Serious Emotional Disturbances**, there is no limitation on the number of treatment days.
MAP: Covered and Non-Covered Services

Dental Services
Dental services are limited to the treatment of natural teeth or jaw as the result of an accidental injury if the injury occurs while the Member is covered under this plan. Services must begin within 90 days of the date of injury or as soon as medically possible.

MAP: Covered and Non-Covered Services

Diagnostic X-Ray and Laboratory Services
Coverage requires Prior Authorization and includes all diagnostic laboratory services, diagnostic imaging and radiology services. Tests include, but are not limited to, the following:

- CT
- MRA
- MRI
- Pap smears
- PET
- SPECT
- Screening for cervical cancer
- Screening for HIV
- Tests for the management of diabetes

MAP: Covered and Non-Covered Services

Family Planning
Voluntary family planning services are covered, including the following:

- Counseling and surgical procedures for sterilization, as permitted by state and federal law
- Coverage for diaphragms and other FDA-approved contraceptive devices
- Voluntary termination of pregnancy

Please Note: Treatment for infertility is not a covered service.

MAP: Covered and Non-Covered Services

Hospital – Inpatient
Inpatient hospital coverage includes all medically necessary services, including, but not limited to, the following:

- Anesthesia
- Blood Transfusions
- Intensive Care
- Laboratory, Pathology and Radiology Services
- Nursing Care
- Operating Rooms, Delivery Rooms and Special Treatment Rooms
- Physical Therapy
- Prescription Drugs
Please Note: All inpatient care requires Prior Authorization, except for childbirth and mastectomy-related services.

MAP: Covered and Non-Covered Services
Hospital – Outpatient

Outpatient hospital coverage includes, but is not limited to, the following:

- Ancillary Services, such as physical, occupational and speech therapies
- Blood Transfusions
- Emergency Room Services
- General Anesthesia
- Laboratory and Radiology Services
- Operating Rooms and Treatment Rooms
- Prescription Drugs
- Radiation Therapy

MAP: Covered and Non-Covered Services
Maternity Care

Maternity care coverage includes all necessary professional and hospital services. Coverage includes the following:

- Prenatal Care
  - Prenatal testing
  - Prenatal diagnosis of genetic disorders in cases of high-risk pregnancy
- Labor and Deliver Care, including midwife services
- Postpartum Care
  - Counseling for nutrition, health education and social support
  - Newborn Examinations
  - Nursery Care

Please Note: Members have the right to stay in the hospital for at least 48 hours after a vaginal delivery and at least 96 hours after a cesarean section. An earlier discharge of a mother and her newborn child from the hospital must be made by the attending Provider in consultation with the mother.

We do not cover maternity care for a Paid Surrogate Mother who enrolled in the program with an effective date on or after February 1, 2012.

MAP: Covered and Non-Covered Services
Pharmacy

Prescription drugs are an AIM covered benefit when ordered by a licensed Provider. This benefit also includes the following drug categories:

- Contraceptive drugs
- Drugs for smoking cessation
- Formulas and special food products for treatment of phenylketonuria (PKU)
MAP: Covered and Non-Covered Services

**Vision Services**

Vision services are limited to those associated with cataracts:
- Cataract spectacles
- Cataract contact lenses
- Conventional eyeglasses or contact lenses if medically necessary after cataract surgery
- Intraocular lenses

MAP: Covered and Non-Covered Services

**Covered Services Grid**

The following table lists all benefits provided by the Access for Infants and Mothers Program HMO and EPO.

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Abuse - Inpatient</td>
<td>Limited to the removal of toxic substances</td>
</tr>
<tr>
<td>Alcohol and Drug Abuse - Outpatient</td>
<td>Limited to 20 visits per benefit year</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Emergency ambulance transportation and non-emergency transportation to transfer a member from a hospital to another hospital or facility or facility to home. Non-emergency transportation must be medically necessary and approved by Anthem</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Diagnosis and treatment of behavioral health conditions may be limited to a specific number of treatment days, depending on the condition. Basic inpatient treatment is limited to 30 days per benefit year. Basic outpatient treatment is limited to 20 visits per benefit year.</td>
</tr>
<tr>
<td>Behavioral Health – Severe Mental Illness (SMI) and Serious Emotional Disturbance (SED)</td>
<td>Inpatient and outpatient mental health care for SMI and SED, unlimited days</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td>Processing, storage and administration of blood and blood products in the inpatient and outpatient setting</td>
</tr>
<tr>
<td>Cataract Spectacles and Lenses</td>
<td>Cataract spectacles, contact lenses or intraocular lenses that replace the natural lens after surgery; requires prior authorization</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>May be used in lieu of short-term rehabilitation therapy; subject to limitations of short-term therapy</td>
</tr>
</tbody>
</table>
### AIM: HMO and EPO

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Injury Treatment</td>
<td>Accidental injury to natural teeth or jaw</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Self-management training, diabetes equipment and supplies</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Lab Services</td>
<td>CT, MRI, MRA, PET and SPECT scans require prior authorization</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Custom-made durable medical equipment requires prior authorization</td>
</tr>
<tr>
<td>Emergency Health Care</td>
<td>24-Hour care provided by any hospital, in or out of the Anthem network or service area</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Voluntary family planning services covered, including voluntary termination of pregnancy</td>
</tr>
<tr>
<td>Health Education</td>
<td>Self-help information, including smoking cessation and the signs of drug or alcohol abuse</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Evaluations and fittings require prior authorization; limited to 1 hearing aid replacement every 36 months</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Limited to services prescribed by doctor and requires prior authorization</td>
</tr>
<tr>
<td>Hospice</td>
<td>Limited to terminally ill Members and requires prior authorization</td>
</tr>
<tr>
<td>Hospital - Inpatient</td>
<td>All services except for childbirth and mastectomy require prior authorization</td>
</tr>
<tr>
<td>Hospital - Outpatient</td>
<td>Except for emergency services, all outpatient hospital services require prior authorization</td>
</tr>
<tr>
<td>Nutrition Services</td>
<td>Includes nutritional assessments for direct care and treatment of illness; except for diabetes, requires prior authorization</td>
</tr>
<tr>
<td>Orthotic and Prosthetics</td>
<td>Coverage includes medically necessary replacement prosthetic and orthotic devices as prescribed by a licensed practitioner; requires prior authorization</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapy</td>
<td>Requires prior authorization as long as therapy is provided</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>Prescription drugs limited to a 30-day supply, maintenance drugs limited to a 90-day supply.</td>
</tr>
<tr>
<td>Professional Services</td>
<td>Office visits, preventive services, immunizations, surgery, anesthesia, radiation and chemotherapy</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>EPO requires prior authorization for mastectomy-related services</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>Limited to 100 days per benefit year; requires prior authorization</td>
</tr>
<tr>
<td>Transplants</td>
<td>Requires prior authorization</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Vision services are limited to those associated with cataracts</td>
</tr>
</tbody>
</table>
MAP: Covered and Non-Covered Services

Non-Covered Services

Services received from a non-participating or out-of-state Provider without an authorized referral will not be covered, except for medical emergencies.
CHAPTER 4C: MAJOR RISK MEDICAL INSURANCE PROGRAM (MRMIP) COVERED AND NON-COVERED SERVICES

Major Risk Medical Insurance Program Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 8:30am-7pm

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Overview

The Major Risk Medical Insurance Program (MRMIP) was designed to help insure the very high-risk and those unable to secure private health coverage. The program is defined by the following:

- The program provides 36 months of access to health insurance
- The program has calendar-year deductibles
- The program requires copays for covered services and prescription drugs

To qualify for Major Risk Medical Insurance Programs, applicants must meet the following criteria:

- California resident
- Effective January 1, 2014 any applicants who have been denied individual coverage will now be the only eligibility criteria to be considered under Title 10 2698.200 (b)(1)(D) which is outlined below for your reference.

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Ambulance Services

In emergencies, Anthem covers ambulance transport to the first hospital available for emergency care. The service also includes nonemergency transport from one hospital to another hospital or facility or facility to home as long as the following conditions are met:

- Medical necessity
- Requested by in-network Provider
- Prior Authorization

Please Note: Public transport via car, taxi or airplane is not covered.

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Behavioral Health – Inpatient and Outpatient

For information about Anthem’s Behavioral Health services, please see Chapter 5: Behavioral Health Services.

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Dental Services

Dental services are limited to the treatment of natural teeth or jaw as the result of an accidental injury if the injury occurs while the Member is covered under this plan. Services must begin within 90 days of the date of injury or as soon as medically possible.
Major Risk Medical Insurance Program: Covered and Non-Covered Services

Diagnostic X-Ray and Laboratory Services

Some covered services require Prior Authorization. Covered services include all outpatient diagnostic laboratory services, diagnostic imaging and radiology services. Tests include, but are not limited to, the following:

- CT
- MRA
- MRI
- PET
- SPECT

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Family Planning

Family planning coverage includes the following:

- Emergency Contraception
- FDA-Approved Contraceptive Drugs and Devices
- Sterilization including Tubal Ligation and Vasectomy
- Voluntary Termination of Pregnancy

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Hospital Services - Inpatient

MRMIP inpatient hospital services require Prior Authorization and include all services regularly provided by a hospital, including, but not limited to, the following:

- Semiprivate room (private room when medically necessary)
- Artificial limbs or eyes
- Blood transfusions
- Care in special units
- Diagnostic laboratory and X-ray services
- Drugs supplied by the hospital, including oxygen
- General anesthesia
- Nursing care
- Operating rooms, delivery rooms and special treatment rooms
- Radiation, chemotherapy and dialysis treatment
- Respiratory, physical, occupational and speech therapies
- Surgical implants

Please Note: No Prior Authorization is required for childbirth, mastectomy or reconstructive surgery after a mastectomy.
Major Risk Medical Insurance Program: Covered and Non-Covered Services

Hospital Services - Outpatient

Certain MRMIP outpatient hospital services require Prior Authorization and include all services regularly provided by a hospital or ambulatory surgical center. These services include, but are not limited to, the following:

- Blood transfusions
- Dressings, casts and use of cast room
- Drugs, including oxygen
- Emergency room
- General anesthesia
- Hospital services reasonably provided on an ambulatory basis, including radiology and laboratory
- Operating rooms and treatment rooms
- Radiation, chemotherapy and dialysis
- Surgeries in an ambulatory surgical center

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Pharmacy

When ordered by a licensed Provider, prescription drugs are a MRMIP-covered benefit. Coverage guidelines are as follows:

- $5 copay for generic drugs, limited to a 30-day supply
- $5 copay for generic drugs, limited to a 60-day supply through Express Scripts Home Delivery Service, the Anthem mail order pharmacy
- $15 copay for brand name drugs, limited to a 30-day supply
- $15 copay for brand name drugs, limited to a 60-day supply through Express Scripts Home Delivery Service, the Anthem mail order pharmacy

This benefit also includes, but is not limited to, the following drug categories:

- Contraceptive drugs
- Drugs for smoking cessation
- Formulas and special food products for treatment of phenylketonuria (PKU)
- Glucagon
- Insulin and insulin syringes
- Prescription prenatal vitamins
- Prescription fluoride supplements

The pharmacy benefit does not cover the following:

- Cosmetic and hair medications
- Dietary supplements, except for treatment of phenylketonuria (PKU)
- Fertility drugs
- Weight-loss drugs
Major Risk Medical Insurance Program: Covered and Non-Covered Services

Preventive Care

Covered preventive care services require a co-pay and include, but are not limited to, the following:

- Breast exams
- Cytology exams
- Disease Management for asthma, diabetes and cardiovascular conditions
- Family planning
- Health education
- Hearing exams for children
- Human Immunodeficiency Virus testing (HIV)
- Human Papillomavirus screening (HPV)
- Immunizations (children and adults, including those needed for travel)
- Mammograms
- Newborn blood tests
- Ovarian and cervical cancer screenings
- Pap smears
- Pelvic exams
- Prenatal care
- Prostate exams
- Sexually Transmitted Disease testing (STD)
- Transgender Services
- Vision care for children
- Well-baby and well-child visit

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Vision Care

MRMIP does not cover vision services.
## Major Risk Medical Insurance Program: Covered and Non-Covered Services

### Major Risk Medical Insurance Program: Covered Services Grid

The following table lists all benefits provided by the Major Risk Medical Insurance Program (MRMIP).

<table>
<thead>
<tr>
<th>Benefits/Services</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>Ground or air ambulance to or from a hospital for medically necessary services</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Inpatient behavioral health services, limited to 10 days each calendar year</td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab Services</td>
<td>Outpatient diagnostic X-ray and laboratory services</td>
</tr>
<tr>
<td>Durable Medical Equipment and Supplies</td>
<td>Must be certified by a physician and required for care of an illness or injury</td>
</tr>
<tr>
<td>Emergency Health Care Services</td>
<td>Initial treatment of acute illness or accidental injury, includes hospital, professional services and supplies</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Home health services through a home health agency or visiting nurse association</td>
</tr>
<tr>
<td>Hospice</td>
<td>Hospice care for Members not expected to live more than 12 months if the disease or illness follows its natural course</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>Therapeutic use of drugs or other substances ordered by a physician and administered by a qualified Provider</td>
</tr>
<tr>
<td>Physical, Occupational &amp; Speech Therapies</td>
<td>Services of physical, occupational and speech therapists as medically appropriate on an outpatient basis</td>
</tr>
</tbody>
</table>
| Pharmacy                          | Maximum 30-day supply per prescription when filled at a participating pharmacy  
                                      | Maximum 60-day supply for mail order                                         |
| Physician Office Visits           | Physician services for medical necessity                                |
| Pregnancy and Maternity Care      | Inpatient normal delivery and complications of pregnancy                 
                                      | Maternity care for a Paid Surrogate Mother who enrolled in the program       |
| Skilled Nursing Facilities        | Skilled Nursing Care                                                     |
| Transgender Services              | Covered                                                                  |
| Vision Services                   | MRMIP does not cover vision services                                    |
The following table lists all co-payments, deductibles and maximum benefits provided by the Major Risk Medical Insurance Program (MRMIP).

<table>
<thead>
<tr>
<th>Co-Payments and Limits</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td>$500 Annual Deductible per Member</td>
</tr>
<tr>
<td></td>
<td>$500 Annual Deductible per Household</td>
</tr>
<tr>
<td>Copayment</td>
<td>Member’s amount due and payable to the Provider</td>
</tr>
<tr>
<td>Yearly Maximum Copayment</td>
<td>Member’s annual maximum copayment when using participating Providers:</td>
</tr>
<tr>
<td></td>
<td>$2,500 per Member</td>
</tr>
<tr>
<td></td>
<td>$4,000 per Family</td>
</tr>
<tr>
<td>Annual Benefit Maximum</td>
<td>Members must pay for services received after the combined total of all benefits paid under MRMIP reaches $75,000 in a single calendar year</td>
</tr>
<tr>
<td>Lifetime Benefit Maximum</td>
<td>Members must pay for services received after the combined total of all benefits paid under MRMIP reaches $750,000 in the Member’s lifetime</td>
</tr>
</tbody>
</table>
CHAPTER 4D: STATE & COUNTY SERVICES AND PROGRAMS

Automated Eligibility Verification System: 1-800-456-2387
California Children's Services (CCS) 1-800-288-4584 (L.A. County)
Community-Based Adult Services (CBAS) 1-800-776-5746
County Medical Services Program: 1-805-557-6463
Denti-Cal: 1-800-423-0507
Medi-Cal Service Center: 1-800-541-5555

Behavioral Health Services: www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx
California Children's Services: www.dhcs.ca.gov/services/ccs
California Early Start: www.dds.ca.gov/earlystart
Family Planning Services: www.dhcs.ca.gov/services/ofp
HIV Counseling/Testing: www.cdph.ca.gov/programs/aids
Women, Infants and Children: www.cdph.ca.gov/programs/wicworks

State & County Services and Programs: Covered and Non-Covered Services

Overview

To ensure continuity and coordination of care for our Members, Anthem enters into agreements with locally-based state and county public health services and programs. Providers are responsible for notifying Utilization Management when a referral is made to any of the agencies or programs listed below. This notification ensures that case manager nurses and social workers can follow up with Members to coordinate care. It also ensures that Members receive all necessary services while keeping the Provider informed.

State & County Services and Programs: Covered and Non-Covered Services

Behavioral Health, Alcohol and Other Drug Program

For information about Anthem’s Behavioral Health services, please see Chapter 5: Behavioral Health Services.

The following state and county behavioral health services for those with severe level of impairment: are available upon referral:

- 24-Hour Treatment Services
- Case Management
- Comprehensive Evaluation and Assessment
- Group Services
- Medication Education and Management
- Outpatient Substance Use Disorders Services
- Pre-Crisis and Crisis Services
- Residential Services
- Residential Treatment Services
- Services for Homeless Persons
- Vocational Rehabilitation
- Wraparound Services
• Voluntary Inpatient Detox

For more detailed information on these programs, go to the state's Department of Mental Health website: www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx.

State & County Services and Programs: Covered and Non-Covered Services
California Children's Services (CCS)

The California Children's Services (CCS) program is designed for children and young adults under the age of 21 with certain chronic and disabling conditions. Providers should refer Members to the program; CCS staff will determine whether the Member is eligible for services.

To contact CCS, please go to the program website to find the phone and fax numbers for the appropriate county CCS office: www.dhcs.ca.gov/services/ccs.

California Children's Services offers services to children and young adults with the following conditions:

• AIDS
• Cancer
• Cataracts
• Cerebral palsy
• Chronic kidney disease
• Cleft lip/palate
• Congenital heart disease
• Diabetes
• Hearing loss
• Hemophilia
• Intestinal disease
• Liver disease
• Muscular Dystrophy
• Rheumatoid arthritis
• Seizures
• Severe burns
• Severe crooked teeth
• Severe head, brain or spinal cord injuries
• Sickle cell anemia
• Spina bifida
• Thyroid conditions
• Tumors

The CCS program accepts referrals from any source, including health care providers, parents, legal guardians, school nurses, health plans of other interested parties. Referral to CCS may be made verbally or in writing. To consider a request, CCS requires the following information:

• Date of Referral
• Insurance Information
• First and Last Name of Child
- Home Address of Child
- Date of Birth
- Client Index Number (CIN)
- Diagnosis
- Home and Work Numbers of Parent/Legal Guardian
- Name and Address of Individual/Agency Requesting Services

CCS also requires medical records that support the CCS-eligible diagnosis. If an **Anthem** representative assists a Provider's office in completing a referral to CCS, we may request medical records to facilitate this process.

**Please note:** State statutes and contracts require that CCS Program services be carved out of our **Medi-Cal Programs**. As a result, upon suspicion or identification of a CCS-eligible condition, the Provider must refer the child to the local CCS Program or contact us to assist with the referral. If a Provider renders services to the child in question without contacting Anthem or CCS beforehand, the Provider will not be reimbursed for those services.

**State & County Services and Programs: Covered and Non-Covered Services**

**California Early Start**

**California Early Start** is a statewide interagency system of coordinated early intervention services for infants and toddlers with disabilities. Eligibility requirements include the following:

- Infants and toddlers from birth to 36 months
- Children with significant developmental delays
- Children at high risk of having a substantial developmental disability

The services provide early intervention and related services based on the assessed needs of the child. These services are delivered within the child's everyday routines and activities.

For more information, go to the [California Early Start website](www.dds.ca.gov/earlystart).

**State & County Services and Programs: Covered and Non-Covered Services**

**Child Health and Disability Prevention (CHDP) Program**

The **Child Health and Disability Prevention Program (CHDP)** is a preventive health program that offers a full range of health assessment services and referrals for diagnosis and treatment of suspected problems. The program also offers coordination of care to assist families with medical appointment scheduling, transportation and access to diagnostic and treatment services.

Referral candidates include the following:

- **Medi-Cal** recipients from birth to 21 years of age
- **Non-Medi-Cal** eligible children from birth to 19 years of age for periodic health assessments
- Children enrolled in **Head Start** and **State Preschool**

For more information, please see the [Child Health and Disability Prevention Program page](www.dhcs.ca.gov/services/chdp) of the DHCS website at: [www.dhcs.ca.gov/services/chdp](http://www.dhcs.ca.gov/services/chdp).
State & County Services and Programs: Covered and Non-Covered Services

Directly Observed Therapy (DOT) for Tuberculosis

This program provides support services to prevent further transmission of infection and development of disease resistance. The program provides health care management services for the following:

- Patients at risk for noncompliance with tuberculosis treatment
- Patients on intermittent therapy or when treatment has failed
- Patients who demonstrate drug resistance to Isoniazid or Rifampin
- Patients who have relapsed after completing prior regimens

For more information, call DHCS at 1-916-445-4171.

State & County Services and Programs: Covered and Non-Covered Services

Family Planning Services

Health education and certain contraceptive medical devices are provided through community-based programs, including private nonprofit agencies and county health departments.

For more information, go to the DHCS website for the Office of Family Planning: www.dhcs.ca.gov/services/ofp.

State & County Services and Programs: Covered and Non-Covered Services

HIV Counseling and Testing

This program integrates HIV prevention counseling with testing for the disease. The following services are available upon referral:

- Confidential HIV testing
- Early intervention services
- HIV/AIDS resources

For more information, go to the Office of AIDS page of California’s Department of Public Health website: www.cdph.ca.gov/programs/aids.

State & County Services and Programs: Covered and Non-Covered Services

Immunization Services

This program integrates local immunization coalitions and registries and is designed to educate the community about childhood immunization.

For more information, go to the Child Health and Disability Prevention Program page of the DHCS website at www.dhcs.ca.gov/services/chdp.

State & County Services and Programs: Covered and Non-Covered Services

Women, Infants and Children Program (WIC)

The Women, Infant and Children Program (WIC) is a supplemental nutrition program that helps pregnant women, new mothers and young children eat well and stay healthy. Referral candidates include the following:
• Children under 5 years of age, including foster children
• Eligible pregnant women and breastfeeding mothers
• Families with low to medium income

The program provides or arranges for the following:

• Information about nutrition and health
• Support and information about breastfeeding
• Support in finding health care and other community services
• Supplemental food services, including healthy food vouchers

For more information, go to the Women, Infant and Children Program page of the California DPH website at: www.cdph.ca.gov/programs/wicworks.
CHAPTER 5: BEHAVIORAL HEALTH SERVICES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
AIM/MRMIP Customer Care Center: 1-877-687-0549

Behavioral Health Services

Overview

Behavioral Health Services are an integral part of health care management at Anthem Blue Cross (Anthem). Our mission is to coordinate the physical and behavioral health care of Members by offering a wide range of targeted interventions, education and enhanced access to care to ensure improved outcomes and quality of life for members. Anthem works collaboratively with hospitals, group practices and independent behavioral health care providers, as well as community agencies and California’s Community Mental Health Centers and other resources to successfully meet the needs of members with mental health, substance use and intellectual and developmental disabilities.

Behavioral Health Services

Goals

The goals of Anthem’s Behavioral Health program are to:

- Ensure and expand service accessibility to eligible members
- Promote the integration of the management and delivery of physical and behavioral health services
- Achieve quality initiatives, including those related to HEDIS, NCQA and California Department of Health Care Services (DHCS) performance requirements
- Work with Members, Providers and community supports to provide recovery tools and create an environment that supports Members’ progress toward their recovery goals
- Ensure utilization of the most appropriate, least restrictive medical and behavioral health care in the right place at the right time

Behavioral Health Services

Objectives

The objectives of the Anthem Behavioral Health program are to:

- Promote continuity and coordination of care among physical and behavioral health care practitioners
- Enhance member satisfaction by implementing individualized and holistic support and care plans that allow Members to achieve their recovery goals
- Provide Member education on treatment options and pathways toward recovery
- Provide high quality case management and care coordination services that identify Member needs and address them in a personal and holistic manner
• Work with care providers to ensure the provision of medically necessary and appropriate care and services, including inpatient care, alternative care settings and outpatient care at the least restrictive level
• Enhance Provider satisfaction and success through collaborative and supportive relationships built on mutually agreed upon goals, outcomes and incentives
• Promote collaboration between all health care partners to achieve recovery goals through education, technological support and the promotion of recovery ideals
• Use evidence-based guidelines and clinical criteria and promote their use in the Provider community
• Maintain compliance and accreditation standards with local, state and federal requirements
• Anthem-contracted Providers deliver behavioral health and substance use disorder services in accordance with best practice guidelines, rules and regulations, and policies and procedures set forth by the State of California.

Behavioral Health Services
Guiding Principles of Anthem’s Behavioral Health Program

Recovery is a Member-driven process in which people find their paths to work, learn and participate fully in their communities. Resiliency is the ability to live a fulfilling and productive life despite the continued presence of a disability. Physical and behavioral health services are rendered in a manner that allows the achievement of recovery for Members experiencing mental illness and substance use disorders. Treatment supports the development of resiliency for those facing mental illness, serious emotional disturbance and/or substance use disorder issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) released a consensus statement on mental health recovery reflecting the desire that all behavioral health services be delivered in a manner that promotes individual recovery and builds resiliency. The ten fundamental components of recovery identified by SAMHSA are:

• Self-direction: Members lead, control and determine their own paths of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life.
• Individualized care: There are multiple pathways to recovery based on an individual’s unique strengths and resiliency, as well as his or her needs, preferences and experiences, including past trauma and cultural background.
• Empowerment: Members have the authority to choose from a range of options and to participate in all decisions, including the allocation of resources, which will affect their lives and are educated and supported in so doing.
• Holistic: Recovery embraces all aspects of life, including housing, employment, education, mental and health care treatment and services, complementary and naturalistic services (e.g., recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person.
• Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.
• **Strengths-based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities and inherent worth of individuals.

• **Peer support:** Mutual support, including the sharing of experiential knowledge, skills and social learning, plays an invaluable role in recovery.

• **Respect:** Community, systems and societal acceptance and appreciation of consumers — including protecting their rights and eliminating discrimination and stigma — are crucial to achieve recovery.

• **Responsibility:** Members have a personal responsibility for their own self-care and journeys of recovery.

• **Hope:** Recovery provides the essential and motivating message of a better future — that people can and do overcome the obstacles that confront them. Hope is internalized but can be fostered by peers, family, friends, Providers and others. Hope is the catalyst of the recovery process.

**Resiliency** is the ability of an individual or family to cope and adapt to the challenges and changes brought on by distress or disability. Becoming resilient is a dynamic developmental process that requires patience and effort to pursue steps that enhance positive responses to adverse circumstances. Accepting and managing one’s life in a manner that displays optimism for personal successes manifested by traits of self-efficacy and high self-esteem is achieved by building resiliency. Resilience is learned and developed.

**Behavioral Health Services**

**Systems of Care**

Services provided to people with serious emotional disturbances and their families are best delivered based on the **System of Care Values and Principles** that are endorsed by **SAMHSA** and the **Center for Mental Health Services (CMHS)**. Services should be:

• Person-centered and family-focused with the needs of the person and family dictating the types and mix of services provided.

• Community-based with the focus of services as well as management and decision-making responsibility resting at the community level.

• Culturally competent with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.

• Comprehensive, covering an array of services that address physical, emotional, social, educational and cultural needs.

• Personalized as evidenced by an individualized service plan formulated to meet unique needs and potential.

• Delivered in the least restrictive, most normative environment that is clinically appropriate.

• Integrated and coordinated between agencies and include mechanisms for planning, developing and coordinating services inclusive of case management or similar mechanisms to ensure that multiple services are delivered in a coordinated, therapeutic manner and adapted in accordance with the changing needs of the person and their family.

• Delivered without regard to race, religion, national origin, sex, physical disability or other characteristics.

• Oriented to recovery, providing services that are flexible and evolve over time.
CHAPTER 5: Behavioral Health Services

Behavioral Health Services

Coordination of Behavioral Health and Physical Health Treatment

Key elements of the model for coordinated and integrated physical and behavioral health services include:

- Ongoing communication and coordination between Primary Medical Providers (PCPs) and specialty providers, including behavioral health (mental health and substance use) providers.
- Screening by PCPs for mental health, substance use and co-occurring disorders.
- Discussions by behavioral health Provider of physical health conditions.
- Referrals to PCPs or specialty Providers, including behavioral health providers, for assessment and/or treatment for consumers with co-occurring disorders and/or any known or suspected and untreated physical health disorders.
- Development of patient-centered treatment plans involving members as well as caregivers and family members when appropriate.
- Case management and disease management programs to support the coordination and integration of care between Providers.

Fostering a culture of collaboration and cooperation helps sustain a seamless continuum of care between physical and behavioral health and positively impacts Member outcomes. To maintain continuity of care, patient safety and Member well-being, communication between behavioral health and physical care providers is critical, especially for Members with comorbidities receiving pharmacological therapy.

Behavioral Health Services

Provider Roles and Responsibilities

At Anthem, our behavioral health care benefit is fully integrated with the rest of our health care programs. This coordination of health care resources requires certain roles and responsibilities for behavioral health Providers, including the following:

- Participate in the care management and coordination process for each Anthem Member under your care.
- Seek Prior Authorization for all services that require it.
- Provide Anthem and the Member’s PCP with a summary of the Member’s initial assessment, primary and secondary diagnosis, and prescribed medications if the Member is at risk for hospitalization. This information must be provided after the initial treatment session.
- Provide, at a minimum, a summary of the findings from the Member’s initial visit to Anthem and the PCP. This must be provided within 5 calendar days of the visit for Members not at risk for hospitalization. This notification must include the behavioral health Provider’s contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.
- Notify Anthem and the Member’s PCP of any significant changes in the Member’s status and/or change in the level of care.
- Ensure that Members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within 7 calendar days from the date of the Member’s discharge.
Behavioral Health Services Provider Roles and Responsibilities

At Anthem, our behavioral health care benefit is fully integrated with the rest of our health care programs. This coordination of health care resources requires certain roles and responsibilities for behavioral health Providers, including the following:

- Participate in the care management and coordination process for each Anthem Member under your care.
- Seek Prior Authorization for all services that require it.
- Provide Anthem and the Member’s PCP with a summary of the Member’s initial assessment, primary and secondary diagnosis, and prescribed medications if the Member is at risk for hospitalization. This information must be provided after the initial treatment session.
- Provide, at a minimum, a summary of the findings from the Member’s initial visit to Anthem and the PCP. This must be provided within 5 calendar days of the visit for Members not at risk for hospitalization. This notification must include the behavioral health Provider’s contact information, visit date, presenting problem, diagnosis and a list of any medications prescribed.
- Notify Anthem and the Member's PCP of any significant changes in the Member's status and/or change in the level of care.
- Ensure that Members receiving inpatient psychiatric services are scheduled for an outpatient follow-up and/or continuing treatment prior to discharge. This treatment must be provided within 7 calendar days from the date of the Member’s discharge.
- Offer hours of operation that are no less than the hours of operation offered to commercial Members.
- Encourage Members to consent to the sharing of substance abuse treatment information.

Behavioral Health Services Provider Roles & Responsibilities: Transition after Acute Psychiatric Care

To assist in the transition of Anthem Members from an acute psychiatric facility to home or an alternative setting, Anthem recommends scheduling a transition appointment. A licensed behavioral health practitioner should conduct this therapy session, which must take place after discharge, but before the Member actually leaves the facility. The process is as follows:

- The acute care facility obtains authorization for the transition appointment by working with Anthem’s care manager.
- The care manager provides a care coordination transition plan
- The licensed Provider completes, signs and faxes the transition plan to the utilization review team following the appointment. (The appropriate fax number is listed at the top of the form)
- Anthem will authorize payment.
CHAPTER 5: Behavioral Health Services

Anthem Blue Cross

Medi-Cal, Medi-Cal Access Program and MRMIP

Behavioral Health Services

Provider Success

We believe the success of Providers is necessary to achieve our goals. We are committed to supporting and working with qualified Providers to ensure that we jointly meet quality and recovery goals. Our commitment includes:

- Improving communication of the clinical aspects of behavioral health care to improve outcomes and recovery
- Supporting providers in delivering integrated, coordinated physical and behavioral health services to meet the needs of the whole person
- Simplifying precertification rules, referrals, claims and payment processes to help Providers reduce administrative time and focus on the needs of members

Behavioral Health Services

Health Plan Clinical Staff

All clinical staff are licensed and have at least four years of prior clinical experience. Our Medical Director is board certified in psychiatry and licensed in the State of California. Our highly trained and experienced team of clinical care managers, case managers and support staff provide high quality care management and care coordination services to our Members and strive to work collaboratively with all Providers.

Behavioral Health Services

Coordination of Physical and Behavioral Health Services

As a network Provider, you are required to notify a Member’s PCP when a Member first enters behavioral health care and anytime there is a significant change in care, treatment, medications or need for medical services. You must secure the necessary release of information from the Member or the Member’s legal guardian. You should provide initial and summary reports to the PCP on at least a quarterly basis. The minimum elements to include are:

- Patient demographics
- Date of initial or most recent behavioral health evaluation
- Recommendation to see PCP, if medical condition identified or need for evaluation by a medical practitioner has been determined for the Member (e.g., EPSDT screen, complaint of physical ailments)
- Diagnosis and/or presenting behavioral health problem(s)
- Prescribed medication(s)
- Behavioral health clinician’s name and contact information
Behavioral Health Services

Case Management

Anthem’s behavioral health case management programs are designed to improve Member health outcomes by integrating with our medical care programs and making reliable and proven protocols available to Providers.

We view case management as a continuum of services and supports that are matched on an individualized basis to the needs of the Member. Members who are identified as at-risk for hospitalization due to behavioral health or substance use disorders are offered ongoing case management support. In addition, Members who are discharged from inpatient stays are provided case management support for a minimum of 180 days post discharge.

Anthem provides clinical teams staffed with California-based behavioral health and medical case managers working in close collaboration with community and Provider-based case managers. The main functions of the Anthem behavioral health case managers include, but are not limited to:

- Use health risk appraisal data gathered by Anthem from Members upon enrollment to identify Members who will benefit from engagement in individualized care coordination and case management.
- Use “trigger report data” based upon medical and behavioral health claims to identify Members at risk.
- Consult and collaborate with our medical case managers and disease management clinicians regarding Members who present with comorbid conditions.
  
  **Comorbid is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.**
- Refer Members to Provider-based case management for ongoing intensive case management and then continue involvement with the Member and the Provider to coordinate care, when needed, among different agencies, medical providers, etc.
- Work directly with the Member and Provider based upon the severity of the Member’s condition.
- Document all actions taken and outcomes achieved for Members in Anthem's information system to ensure accurate and complete reporting.

Behavioral Health Services

Member Records and Treatment Planning: Comprehensive Assessment

Member records must meet the following standards and contain the following elements, if applicable, to permit effective service provision and quality reviews:

Information related to the provision of appropriate services to a Member must be included in his or her record with documentation in a prominent place whether there is an executed declaration for mental health treatment.

Providers must submit a comprehensive assessment that provides a description of the Member’s physical and mental health status at the time of admission to services. It should include:

- Psychiatric and psychosocial assessment, including:
  - Description of the presenting problem
  - Psychiatric history and history of the Member’s response to crisis situations
Behavioral Health Services

Member Records and Treatment Planning: Personalized Support and Care Plan

A patient-centered support and care plan based on the psychiatric, medical substance use and community functioning assessments found in the initial comprehensive assessment must be completed for any Member who receives behavioral health services. There must be documentation in every case that the Member and, as appropriate, his or her family members, caregivers or legal guardian, participated in the development and subsequent reviews of the treatment plan.

The support and care plan must be completed within the first 14 days of admission to behavioral health services and updated every 180 days or more frequently as necessary based on the Member’s progress toward goals or a significant change in psychiatric symptoms, medical condition and/or community functioning.

There must be a signed release of information to provide information to the member PCP or evidence that the Member refused to provide a signature. There must be documentation that referral to appropriate medical or social support professionals have been made.
A Provider who discovers a gap in care is responsible to help the Member get that gap in care fulfilled, and documentation should reflect the action taken in this regard.

For Providers of multiple services, one comprehensive treatment/care/support plan is acceptable as long as at least one goal is written and updated as appropriate for each of the different services that are being provided to the Member.

The treatment/support/care plan must contain the following elements:

- Identified problem(s) for which the Member is seeking treatment
- Member goals related to each problem(s) identified, written in Member-friendly language
- Measurable objectives to address the goals identified
- Target dates for completion of objectives
- Responsible parties for each objective
- Specific measurable action steps to accomplish each objective
- Individualized steps for prevention and/or resolution of crisis, which includes identification of crisis triggers (situations, signs and increased symptoms); active steps or self-help methods to prevent, de-escalate or defuse crisis situations; names and phone numbers of contacts who can assist the Member in resolving crisis; and the Member’s preferred treatment options, to include psychopharmacology, in the event of a mental health crisis
- Actions agreed to be taken when progress toward goals is less than originally planned by the Member and Provider
- Signatures of the Member, as well as family members, caregivers or legal guardian as appropriate.

Behavioral Health Services

Member Records and Treatment Planning: Progress Notes

Progress Notes must document the status of the goals and objectives indicated on the treatment plans and should include:

- Correspondence concerning the Member’s treatment and signed and dated notations of telephone calls concerning the Member’s treatment
- Indication of active follow-up actions for referrals given to the Member and actions to fill gaps in care
- A brief discharge summary must be completed within 15 calendar days following discharge from services or death
- Discharge summaries for psychiatric hospital and residential treatment facility admissions that occur while the member is receiving behavioral health services
- Treatment and care plan and progress notes should be signed by the supervising physician

Behavioral Health Services

Psychotropic Medications

Prescribing Providers must inform all Members considered for prescription of psychotropic medications of the benefits, risks and side effects of the medication, alternate medications and other forms of treatment. If obesity is also a problem, the medical record needs to reflect that a healthy diet and exercise plan has been prepared and given to the Member or if appropriate a referral to a nutritionist or...
obesity medical professional. If diabetes is a problem, the medical record needs to reflect a discussion with the member about his or her condition, and his or her treating provider should be identified in the documentation with coordination efforts with that provider indicated as well. The medical record is expected to reflect such conversations as having occurred. The medical record is expected to indicate the prescription data has been shared with the Member’s PCP.

Members on psychotropic medications may be at increased risk for various disorders. As such, it is expected that Providers are knowledgeable about side-effects and risks of medications and regularly inquire about and seek for any side-effects from medications. This especially includes:

- Follow-up to inquire about suicidality or self-harm in children placed on antidepressant medications as per Food and Drug Administration and American Psychiatric Association guidelines
- Regular and frequent weight checks and measurement of abdominal girth especially for those on antipsychotics or mood stabilizers
- Glucose tolerance test or hemoglobin A-1C tests especially for those members on antipsychotics or mood stabilizers
- Triglyceride and cholesterol checks especially for those members on antipsychotics and mood stabilizers
- ECG checks for members placed on medications with risk for significant QT-prolongation.
- Ongoing checks for movement disorders related to antipsychotic use and psychotic disorders.

Guidelines for such testing and follow-up are provided by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry, among others. Summary guidelines are referenced in our Clinical Practice Guidelines located on our website at www.anthem.com. While the prescriber is not expected to personally conduct all of these tests, the prescriber is expected to ensure that these tests occur where indicated and to initiate appropriate interventions to address any adverse results. These tests and the interventions must be documented in the Member’s medical record.

Please Note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual Member benefits and eligibility for services are determined in accordance with the requirements set forth by the State of California. With respect to the issue of coverage, each Member should review his/her Evidence of Coverage for details concerning benefits, procedures and exclusions prior to receiving treatment. The Evidence of Coverage supersedes the preventive health guideline recommendations.

**Behavioral Health Services Utilization Management**

As a corporation and as individuals, Utilization Management (UM) decisions are governed by the following statements:

- UM-decision making is based only on appropriateness of care and service and existence of coverage.
- Practitioners or other individuals are not specifically rewarded for issuing denial of coverage care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denial of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.
### Behavioral Health Services

#### Timeliness of Decisions on Requests for Authorization

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>1. Urgent, Pre-Service Requests: Within 72 hours of request</th>
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<tr>
<td></td>
<td>2. Urgent Concurrent Requests: Within 24 hours of request</td>
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<td></td>
<td>3. Routine, Non-Urgent Requests: 14 days Retrospective Review Requests: Within 30 days of request</td>
</tr>
</tbody>
</table>

#### Behavioral Health Services

#### Access to Care Standards

This grid outlines standards for timely and appropriate access to quality behavioral health care.

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>1. Emergent: Immediately</th>
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<tbody>
<tr>
<td></td>
<td>2. Emergent, Non-Life-Threatening/Crisis Stabilization; Within 24 hours of request</td>
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<tr>
<td></td>
<td>Urgent: Within 48 hours of referral / request</td>
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<td>3. Outpatient treatment by a BH provider post-inpatient discharge:</td>
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<td></td>
<td>• 7 calendar days</td>
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<td></td>
<td>• Routine Outpatient: Within 10 days of request</td>
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<tr>
<td></td>
<td>• Outpatient following discharge from an IP Hospital: Within 7 days of discharge</td>
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</tbody>
</table>

#### Definitions

**Emergent:** Treatment is considered to be an on-demand service and does not require precertification. Members are asked to go directly to emergency rooms for services if they are either unsafe or their conditions are deteriorating.

**Urgent:** Means a service need that is not emergent and can be met by providing an assessment and services within 48 hours of the initial contact. If the Member is pregnant and has substance use problems, she is to be placed in the urgent category.

**Routine:** Means a service need that is not urgent and can be met by receiving treatment within 10 calendar days of the assessment without resultant deterioration in the individual's functioning or worsening of his or her condition.

### Behavioral Health Services

#### How to Provide Notification or Request Preauthorization

You may request preauthorization for nonroutine outpatient mental health services that require prior authorization via phone by calling **1-888-831-2246** 24 hours a day, seven days a week, 365 days a year. Please be prepared to provide clinical information in support of the request at the time of the call.
You may request preauthorization via fax; email or the Provider portal where available for certain levels of care. Fax forms are located on the Provider Resources page of our website at www.anthem.com. For information on how to access the Provider Resources page, please see Chapter 1: How to Access Information, Forms and Tools on Our Website. The fax numbers to use when providing notification or requesting prior authorization for behavioral health services are:

**Outpatient requests: 1-888-831-2246; Option 1; then Option 2**

**Email:** Medi-CalBHUM@wellpoint.com

**Inpatient requests:** Contact the local County Department of Mental Health

**Note:** All requests for precertification for psychological and neuropsychological testing should be submitted via fax at 1-855-473-7902. Psychological and neurological testing request forms can also be mailed to:

Behavioral Health Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles; CA 90060-0007

**Behavioral Health Services**

**Behavioral Health Clinical Authorization and Protocols**

*Anthem’s* clinical authorization process is designed to be flexible, providing primary responsiveness to our Members’ needs while simultaneously allowing *Anthem’s* clinical team to gather information for appropriate medical necessity determinations.

Authorization of medically necessary services within the required timeframes is the responsibility of *Anthem’s* licensed behavioral health clinicians. Whenever a clinician questions the appropriateness of the requested level of care, the review is referred to one of *Anthem’s* board-certified psychiatrists.

Our multidisciplinary team of behavioral health care clinicians includes the following:

- Licensed psychologists
- Licensed professional counselors
- Licensed social workers
- Registered psychiatric nurses

These professionals conduct reviews of behavioral health and substance abuse services to monitor and evaluate treatment requests and progress. They manage utilization, control behavioral health care costs and achieve optimal clinical outcomes through a collaborative approach that considers both utilization review data and nationally recognized clinical practice guidelines to determine the appropriate level of care.

**Behavioral Health Services**

**Necessity Determination and Peer Review**

- When a Provider requests initial or continued precertification for a covered service, our Utilization Managers obtain necessary clinical information and review it to determine if the request meets applicable medical necessity criteria.
If the information submitted does not appear to meet such criteria, the Utilization Manager submits the information for review by the Medical Director or other appropriate practitioner as part of the peer review process.

The reviewer or the requesting Provider may initiate a peer-to-peer conversation to discuss the relevant clinical information with the clinician working with the member.

If an adverse decision is made by the reviewer without such a peer-to-peer conversation having taken place (as may occur when the Provider is unavailable for review), the Provider may request such a conversation. In this case, we will make a Medical Director or other appropriate practitioner available to discuss the case with the requesting Provider. This conversation may result in the decision being upheld or changed.

Members requesting Providers and applicable facilities are notified of any adverse decision within notification timeframes that are based on the type of care requested and in conformance with regulatory and accreditation requirements.

**Behavioral Health Services**

**Billing Professional & Ancillary Claims**

The **Primary Care Provider** (PCP) is expected to treat Members with situational behavioral health problems, the most common of which are depression and anxiety disorders. For those **Medi-Cal** Members whose behavioral health problems do not respond to treatment in a primary care setting, referrals must be made to the local county mental health system for assessment and ongoing services.

**Behavioral Health Services**

**Professional Billing Requirements**

Providers rendering behavioral health services should bill **Anthem** using behavioral health CPT codes. All claims for behavioral health services should be billed to **Anthem**. For more information about proper professional billing procedures, please refer to **Chapter 14: Billing Professional & Ancillary Claims** or call 1-866-398-1922.

**Behavioral Health Services**

**Non-Medical Necessity Adverse Decisions (Administrative Adverse Decision)**

If you received an Administrative Adverse Determination and think that this decision was in error, please see **Chapter 14: Grievances and Appeals** for information and instructions on appeals, grievances and payment disputes.

**Behavioral Health Services**

**Provider Appeals, Grievances and Payment Disputes**

If you did not receive a precertification for a requested service and think that this decision was in error, please see **Chapter 14: Grievances and Appeals** for information and instructions on appeals, grievances and payment disputes.

**Behavioral Health Services**

**Avoiding an Adverse Decision**

Most administrative adverse decisions result from nonadherence to or a misunderstanding of utilization management policies. Familiarizing yourself and your staff with notification and precertification policies and acting to meet those policies can eliminate the majority of these decisions. Other administrative adverse decisions result from misinformation about the Member’s status or benefits.
Adverse decisions of a medical nature are rare. Such adverse decisions usually involve a failure of the clinical information to meet evidenced-based national guidelines. We are committed to working with all Providers to ensure that such guidelines are understood and easily identifiable for Providers. Peer-to-peer conversations (between a Medical Director and the Provider clinicians) are one way to ensure the completeness and accuracy of the clinical information.

**Medical record reviews** are another way to ensure that clinical information is complete and accurate. Providers who can appropriately respond in a timely fashion to peer-peer and medical record requests are less likely to encounter dissatisfaction with the utilization management process. We are committed to ensuring a process that is quick and easy and will work with participating Providers to ensure a mutually satisfying process.

**Behavioral Health Services**

**Clinical Practice Guidelines**

All providers have access to evidence-based clinical practice guidelines for a variety of behavioral health disorders commonly seen in primary care, including attention deficit hyperactivity disorder, bipolar disorder for children and adults, major depressive disorder, identification and treatment of antenatal depression, postpartum depression, and substance abuse disorders. These clinical practice guidelines are located online at [www.anthem.com/CA](http://www.anthem.com/CA)

**Behavioral Health Services**

**Emergency Behavioral Health Services**

PCPs should immediately refer any Member who is in crisis or who is a threat to self or others for emergency care. An emergency referral for behavioral health services does not require prior authorization or pre-service review.

**Behavioral Health Services**

**Non-Emergency Behavioral Health and Substance Abuse Services**

Having behavioral health and substance abuse benefits are vital to Members and their dependents when they need help for eating disorders, depression, anxiety, and drug and alcohol dependence.

Key features of our program include:

- Access to a specialty network of **Behavioral Health Providers**, including physicians and therapists
- Access to contracted facilities, including both acute care and freestanding specialty hospitals
- **National Council for Quality Assurance** criteria-credentialed network, including programs for partial, intensive outpatient and residential treatment
- Review for facility-based behavioral health and substance abuse treatment, using research-based medical necessity criteria for all levels of care and age ranges
- Care management by licensed, experienced case managers

Outpatient behavioral health and substance abuse care may be given by any of the following Providers:

- Comprehensive Mental Health Centers (UMHC)
- Psychiatrists
- Psychiatric Nurse Practitioners
- Psychologists
CHAPTER 5: Behavioral Health Services
Medi-Cal, Medi-Cal Access Program and MRMIP

- Licensed Clinical Social Workers
- Outpatient Behavioral Health Facilities

PCPs may treat Members with situational behavioral health disorders, the most common of which are depression and anxiety. For Members whose behavioral health does not respond to treatment in a primary care setting, contact us for referral and authorization information regarding assessment and ongoing services at:

**Medi-Cal Customer Care Center:** 1-800-407-4627 (Outside L.A. County)
**Medi-Cal Customer Care Center:** 1-888-285-7801 (Inside L.A. County)
**MAP/MRMIP Customer Care Center:** 1-877-687-0549

**Behavioral Health Services**

**Prior Authorization**

All facility-based behavioral health and substance abuse services is carved out to the local County Department of Mental Health and the county Alcohol and Other Drug Programs:

- Inpatient Admissions
- Intensive Outpatient Program (IOP)
- Partial Hospitalization Program (PHP)

**Behavioral Health Services**

**Referral Criteria to Behavioral Health Specialists**

PCPs are required to refer Members who are experiencing acute symptoms of a chronic behavioral health disorder, exhibiting an acute onset of symptoms, or are in a crisis state. Please refer to the **Benefits Matrix** for the range of services covered.

PCPs are also required to make referrals for Members whose symptoms of anxiety and mild depression persist or become worse. Any Member suspected of developing toxicities to medications that have been prescribed by a psychiatrist will need to be referred back to the behavioral health system for observation and monitoring of medications.

PCPs should refer any Member with the following established diagnosis or suspected onset of symptoms indicative of these disorders to a behavioral health specialist:

- Adjustment disorder
- Behavioral disorders of children and adolescents
- Bipolar disorders
- Eating disorders
- Multiple diagnosis
- Psychoses, Involutional, Depressive
- Schizophrenia
- Unipolar depression
Behavioral Health Services
Criteria for Provider Type Selection

Psychiatrist Referrals
The following criteria should be met before referring a Member to a psychiatrist:

- Member is taking psychoactive medication
- Member is referred by PCP or under PCP treatment for relevant problem
- Member, if a child, had prior treatment for same problem without medication and problem is severe or disabling in some area of life
- Problem is cognitive and Member has had previous inpatient or day treatment
- Problem is cognitive and overall dysfunction is severe or disabling
- Problem recurrent or greater than six months and Member has prior treatment
- Problem recurrent of greater than six months and dysfunction severe or disabling in any area of functioning
- Problem is somatic and referral was not from PCP
- Problem is somatic, Member is under PCP care, and problem is severe or disabling in some area of functioning

Referrals to a Psychologist or Licensed Clinical Social Worker (LCSW)
The following criteria should be met before referring a Member to a psychologist or Licensed Clinical Social Worker:

- Identifiable stressor is present
- Member is not taking psychoactives
- Member not referred by PCP, not under PCP treatment for relevant problem
- Problem not recurrent, not greater than six months’ duration
- Problem not severe or disabling in any area of functioning

Behavioral Health Self-Referrals:
Members may self-refer to any behavioral health care Provider in Anthem’s network or to a psychiatrist. If the Member is unable or unwilling to access timely services through community Providers, call Anthem’s Customer Care Center for assistance.
CHAPTER 5A: BEHAVIORAL HEALTH SERVICES FOR MEDI-CAL PROGRAMS

Behavioral Health Services
Medi-Cal Access Program (MAP): Covered and Non-Covered Services

Inpatient

Behavioral health care services are covered when ordered by an in-network Provider for the diagnosis and treatment of a behavioral health condition. Basic behavioral health care inpatient services are limited to 30 days per benefit year. Additional days may be authorized by Anthem.

Inpatient behavioral health care services include treatment for Severe Mental Illness (SMI), which encompasses, but is not limited to, the following:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorders
- Obsessive Compulsive Disorder
- Panic Disorders
- Pervasive Developmental Disorder or Autism
- Schizophrenia
- Schizoaffective Disorder

Inpatient behavioral health care services also include treatment for Serious Emotional Disturbances (SED), including problems with eating, sleeping, or hurting oneself or others.

Please Note: For the treatment of Severe Mental Illness or Severe Emotional Disturbances, there is no limitation on the number of treatment days.

Outpatient

Behavioral health care services are covered when ordered by a participating Provider for the diagnosis and treatment of a behavioral health condition. Basic behavioral health care outpatient services are limited to 20 visits per benefit year. That number may increase when outpatient treatment days are substituted for inpatient hospitalization. The conditions covered include the following:

- Treatment for Members who have experienced family dysfunction or trauma, including child abuse or neglect, domestic violence, substance abuse, divorce or bereavement
- Treatment for Severe Mental Illness (SMI), including:
  - Anorexia Nervosa
  - Bipolar Disorder
  - Bulimia Nervosa
  - Major Depressive Disorders
  - Obsessive Compulsive Disorder
  - Panic Disorders
Outpatient behavioral health care services also include treatment for Serious Emotional Disturbances (SED), including problems with eating, sleeping, or hurting oneself or others.

Please Note: For the treatment of Severe Mental Illness or Serious Emotional Disturbances, there is no limitation on the number of treatment days.

Behavioral Health Services

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Inpatient

Inpatient behavioral health care services are limited to 10 days per calendar year unless the Member is being treated for the following:

- Serious Emotional Disturbance (SED), or
- Severe Mental Illness (SMI)

If the Member is being treated for SED or SMI, there is no limit on the number of inpatient care days.

Behavioral Health Services

Major Risk Medical Insurance Program: Covered and Non-Covered Services

Outpatient

Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) are limited to 15 visits per calendar year.

Behavioral Health Services

State & County Services and Programs: Covered and Non-Covered Services

The following state and county behavioral health services are available upon referral:

- 24-Hour treatment services
- Case management
- Comprehensive evaluation and assessment
- Pre-crisis and Crisis services
- Group services
- Medication education and management
- Residential services
- Services for homeless persons
- Vocational rehabilitation
- Wraparound services

For more detailed information on these programs, go to the state's Department of Mental Health website: www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx.
Behavioral Health Services

Medi-Cal Covered and Non-Covered Services

Medi-Cal Expansion Background
Effective January 1, 2014, the income eligibility level for Medi-Cal services and benefits in California expanded to reflect a new national benchmark of 138 percent of the federal poverty level (FPL) as a result of the Affordable Care Act (ACA). This expansion extends coverage to an expanded group of the lowest income Americans but primarily applies to those nonelderly and nondisabled adults who were previously ineligible for Medi-Cal.

ACA Expansion Includes New Behavioral Health Services and Benefits
Newly eligible Anthem Blue Cross (Anthem) members will receive the same benefits and services as current members. In addition, we will provide new behavioral health benefits and services to those existing and new members who qualify for these benefits. Starting January 1, 2014, Anthem will directly coordinate the following substance use disorder services through individual county alcohol and other drug programs:

- Voluntary inpatient detoxification
- Outpatient drug-free services
- Narcotic treatment services

Anthem will also offer the following new behavioral health benefits to members:
- Individual and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient drug therapy monitoring services
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation
- SBIRT (screening, brief intervention and referral to treatment)
- Applied Behavioral Analysis (BHT) for children under age 21 with a confirmed diagnosis of Autism.
- Specialty behavioral health services, including but not limited to inpatient services, partial hospital, intensive outpatient and psychosocial rehabilitation services previously provided to existing members by County Mental Health Plans will continue to be available through the County Health Plans. New and existing members may also receive substance use disorder services from their local County Health Services. Contact information for individual county Mental Health Departments is located on the state Department of Health Care Services website, www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx

Behavioral Health Services Prior Authorization
Prior Authorization is required for all behavioral health services covered by Anthem except for:
- Psychiatric Diagnostic Interview (90791, 90792)
- Psychiatry services for Medication Management for Par providers
- Mental Health Assessment By a Non-Physician (H0031)

To request prior authorization for behavioral health services, please call:
- Phone: 1-888-831-2246; Option 1; then Option 2
- FAX: 1-855-473-7902
- Email: Medi-CalBHUM@wellpoint.com
For More Information
If you have questions about the new behavioral health benefits or overall ACA-mandated expansion, please call our Customer Care Center at 1-800-407-4627 (Inside L. A. County: 1-888-452-2273). Contact Behavioral Health Network Management by email at BHNetworks@wellpoint.com with any questions about your contract.

Behavioral Health Services
Sensitive Services: Adolescent Sensitive Services
Members between 12 and 18 years of age can go to any doctor or clinic, in or out of the Anthem network, without consent from their parents or legal guardian, for the following Sensitive Services:

- Outpatient behavioral health for:
  - Sexual or physical abuse
  - When they may hurt themselves or others
  - Drug and alcohol abuse

Behavioral Health Services
Additional Services: Mental Health
Mental health services are covered for Medi-Cal members. Anthem covers outpatient mental health services for those with mild to moderate levels of functional impairment. For those with severe levels of impairment are provided services by the local County Mental Health Department.

Certain mental health services are covered on a limited basis for the Medi-Cal Access Program and MRMIP members. Details of these service coverages are described in each program’s Member Handbook.

Medi-Cal Members
Contact the local county Mental Health Department to report and obtain authorization for any inpatient admission to a participating hospital pertaining to a mental health diagnosis.
CHAPTER 6: LONG TERM SERVICES AND SUPPORTS (LTSS)

Long Term Services and Supports
Overview
Anthem covers a wide variety of Long Term Services and Supports (LTSS) that help elderly individuals and/or individuals with disabilities with their daily needs for assistance and improve the quality of their lives.
Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in the homes and communities, but also in facility-based settings such as nursing facilities.
These services fall into four categories and are defined as follows:

- In Home Support Services (IHSS)
- Community-Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Long Term Services and Supports/Skilled Nursing Facility

Long Term Services and Supports
In-Home Support Services (IHSS)
This California state program that provides in-home care to the elderly and persons with disabilities allowing them to safely remain in their homes.

Eligibility
To qualify for IHSS, an enrollee must be aged, blind or disabled and in most cases, have income below the level to qualify for SSI/State Supplementary Program.

County Public Authority
The County Public Authority social worker is responsible for assessing, approving and authorizing hours, services and tasks based on the needs of the beneficiary. They are responsible for screening and enrolling service providers, conducting criminal background checks, conducting Provider orientation and retaining enrollment documentation. In addition, they maintain a Provider registry and can provide assistance in finding eligible Providers and perform quality assurance activities.

Types of services provided include:
- Domestic and Related Services (house cleaning/chores, meal preparation & clean-up, laundry, grocery shopping, heavy cleaning)
- Personal Care (i.e. bathing & grooming, dressing, feeding)
- Paramedical Services (i.e., administration of medication, puncturing skin, range of motion exercises)
- Other Services (i.e., accompaniment to medical appointments, yard hazard abatement, protective supervision)
**Who is Eligible for In-Home Supportive Services (IHSS)**

All IHSS beneficiaries must:

- Be a California resident and a U.S. citizen/legal resident and be living in their own home
- Be eligible to receive Supplemental Security Income/State Supplemental Payment (SSI/SSP) or Medi-Cal benefits
- Be 65 years of age or older, legally blind or disabled by Social Security standards
- Submit a health care certification form (SOC 873) from a licensed health care professional indicating that they need assistance to stay living at home.

**IHSS- Referral – How a beneficiary or provider access IHSS**

The county department of Public Social Services (DPSS) determines eligibility and hours of service. The beneficiary can apply to IHSS by calling **1-888-944-IHSS** (inside Los Angeles County) or **1-213-744-4477** (outside Los Angeles County).

The Personal Assistance Service Council (PASC) assists beneficiaries with finding homecare workers and providers other support services for IHSS beneficiaries. They can be reached at **1-877-565-4477**.

**Long Term Services and Supports**

**IHSS Member Control/Responsibility**

IHSS allows the Member to self direct his or her care by being able to hire, fire and manage his or her homecare workers. A trusted friend or family member could become screened, qualified and compensated as a Member’s IHSS Provider/Caregiver. The Member could also elect to involve the IHSS Provider/Caregiver as a member of his or her Care Team.

County agencies administering the IHSS program will maintain their current roles, and Anthem will not be able to reduce the IHSS hours authorized by the county. If a member or provider needs assistance they can contact their Anthem Care Coordinator.

**Long Term Services and Supports**

**Community Based Adult Services (CBAS)**

Facility-based outpatient program serving individuals 18 years old and over who have functional impairment that puts them at risk for institutional care. The program delivers the following adult day care services:

- Skilled nursing
- Social services
- Physical and Occupational Therapies
- Personal care
- Family/caregiver training and support
- Meals
- Transportation
The primary objectives of the CBAS program are to: restore and maintain optimal capacity for self-care to the elderly or other adults with physical and mental disabilities and delay or prevent inappropriate or personally undesirable institutionalization in long-term care facilities.

Long Term Services and Supports

CBAS - Eligibility

CBAS services may be provided to Medi-Cal beneficiaries over 18 years of age who:

- Meet Nursing Facility A or B requirements
- Have organic/Acquired or Traumatic Brain Injury and/or Chronic Mental Health conditions
- Have Alzheimer’s disease or other dementia
- Have Mild Cognitive Impairment
- Have a Developmental Disability

Anthem will conduct an assessment to determine final program eligibility.

CBAS Centers still determine levels of service after authorization. Those currently enrolled in the CBAS program will remain in the program as long as they are enrolled in a Medi-Cal health plan. CBAS providers continue to follow the already established policies and procedures.

Long Term Services and Supports

CBAS - Referral

To receive CBAS services, a beneficiary must first be enrolled in a Medi-Cal health plan. To begin the referral process, please contact Anthem’s Member Services Department to begin the process. See the contact section of the manual for the contact number.

CBAS providers must obtain an authorization from Anthem.

Long Term Services and Supports

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) is California 1915c Home and Community-Based Services (HCBS) waiver program that operates as an alternative to nursing home placement for those 65 years of age and over with disabilities. The MSSP is an intensive case management program that coordinates social and health care services in the community for those wishing to remain in the community and delay or prevent institutional placement.

Types of services provided:

- Case management
- Personal care services
- Respite care (in–home and out-of-home)
- Environmental accessibility adaptations
- Housing assistance/Minor home repair
- Transportation
• Chore services
• Personal Emergency Response System (PERS)/Communication device
• Adult Day Care/Support Center/Health Care
• Protective supervision
• Meal services (Congregate/Home Delivered)
• Social reassurance/Therapeutic Counseling
• Money management
• Translation/Interpretation

MSSPs work closely with local organizations and agencies that provide Long Term Services & Supports (LTSS) and home- and community-based services.

**Long Term Services and Supports**

**MSSP – Referral**

After the CCI begins, in order to receive MSSP services, a beneficiary must first be enrolled in a Medi-Cal health plan like Anthem. To begin the referral process for a beneficiary, please contact our Care Coordinators for assistance or Member Services Department. Contact numbers can be found in the contact section of this manual.

**Long Term Services and Supports**

**MSSP Waiver Services**

An MSSP provider may purchase MSSP Waiver Services when necessary to support the well-being of an Anthem member who is an MSSP Waiver Participant.

Prior to purchasing these services, MSSP providers must verify, and document all efforts to determine the availability of alternative resources (e.g. family, friends and other community resources) for the member.

Approved Purchased Waiver Services are listed and defined in the MSSP Provider Site Manual located on the California Department of Aging website at [www.aging.ca.gov](http://www.aging.ca.gov). To access the MSSP manual on this site, select Providers and Partners > Multipurpose Senior Services Program > MSSP Site Manual and Appendices.

MSSP providers may enter into contract with subcontractors and vendors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order.

Anthem requires MSSP providers to maintain written subcontractor/vendor agreements for the following minimum array of Purchased Waiver Services:

• Adult Day Support Center (ADSC) and Adult Day Care (ADC)
• Housing assistance
• Supplemental personal care services
• Care management
• Respite care
• Transportation
• Meal services
• Protective services
• Special communications

MSSP subcontractors and vendors are bound by the following:

• All MSSP subcontractors and vendors must have the proper license, credentials, qualifications or experience to provide services to any Anthem member receiving MSSP services.
• All reimbursements must come from the MSSP provider with whom the subcontractor or vendor has a signed agreement.
• No MSSP subcontractor or vendor may seek any payment for MSSP services from any Anthem member or from Anthem itself.

MSSP providers are responsible for coordinating and tracking MSSP purchased Waiver Services for any Anthem member receiving MSSP services.

For information about how to submit claims for MSSP services, please see Reimbursement to Multipurpose Senior Services Program Providers at the end of this chapter.

For members that are under the MSSP waiver and the MSSP is receiving a monthly payment, authorization is not required.

For members on the waiting list in need of services, please contact Anthem for an authorization. An authorization will ensure that they will be no issues when a claim is submitted for payment for covered benefits.

Long-Term Services and Supports

Transition and Discharge Planning

When long-term services and supports are necessary, Anthem works with the Provider and Member (or their designated representative) to plan the transition/discharge to an appropriate setting for extended services. These services can be delivered in a nonhospital facility such as:

• Nursing Facilities, Subacute Care Facilities (NF/SCF)
• Respite Care – In Home or Out of Home
• Home and Community Based Services (HCBS)
• Home health care program (i.e. home I.V. antibiotics)

When the Member and family together with the Provider identify medically necessary and appropriate services for the Member, then Anthem will assist in providing a timely and effective plan that meets the Member’s needs and goals.

Long Term Services and Supports

Responsibilities of the LTSS Provider

• Assisted living facilities and nursing homes must retain a copy of the Member’s Anthem plan of care on file with the member’s records.
• Assisted living facilities are required to promote and maintain a homelike environment and facilitate community integration.
• All facility-based Providers and home health agencies must notify an Anthem case manager within 24 hours when a Member dies, leaves the facility or moves to a new residence or moves outside the service area or state.
• LTSS Providers can participate in the Member’s Interdisciplinary Care Team (ICT), dependent on the Member’s need and preference.
Long Term Services and Supports

Interactive Voice Response Requirements of Providers

The following Providers are required to have 24-hour service:

- Assisted living facilities /Services
- Emergency response systems
- Nursing homes/Skilled Nursing Facilities

Such Providers will provide advice and assess care as appropriate for each Member’s medical condition. Emergent conditions will be referred to the nearest emergency room.

Long-Term Services and Supports

Identifying and Verifying the Long-Term Care Member

Upon enrollment, Anthem will send a welcome package to the Member. This package includes an introductory letter, a Member ID card and a Member Handbook. Each Anthem Member will identify himself or herself prior to receiving services by presenting an Anthem ID card, which includes a Member number. You can check Member eligibility online via the State of California, using any of the following:

- Our 24/7 Automated Eligibility Voice System (AEVS) 1-800-546-2387
- www.medi-cal.ca.gov/Eligibility/Login.asp

If you have questions regarding eligibility and or benefits, contact customer care at:

- 1-888-285-7801 (Inside L.A. County)
- 1-800-407-4627 (Outside of L.A. County)

Long-Term Services and Supports

Nursing Home Eligibility

Anthem will review the member’s eligibility and benefits to determine if a member qualifies for Nursing Facility placement. This review will include the initial Level of Care (LOC) (including custodial nursing home vs. Skilled Nursing Facility conducted by the Anthem Authorization/Case Manager/Care Coordinator.

For members who reside in a nursing home, the care coordinator will complete the Health Risk Assessment within 60 days of plan enrollment via a face-to-face meeting. During this process, the care coordinator will ensure to incorporate Minimum Data Set 2.0 (MDS 2.0) into the Plan of Care.

Long-Term Services and Supports

Covered Health Services

Anthem provides the covered services listed below and will authorize these covered services. Any modification to covered services will be communicated through a Provider newsletter, Provider manual update and/or contractual amendment. The scope of benefits includes the following:

Home and Community Services

- Adult attendant services
- Adult day health center services
- Assisted living services
- Care management services
- Chore services
- Consumable medical supply services
- Environmental accessibility adaptation services
- Escort services
- Family training services
- Financial assessment/risk reduction services
- Home-delivered meal services
- Homemaker services
- Nursing facility services
- Nutritional assessment/risk reduction services
- Occupational therapy
- Personal care services
- Personal emergency response system services
- Physical therapy
- Respiratory therapy
- Respite care services
- Speech therapy

Long Term Services and Supports

Anthem Coordination

The Anthem Coordination model promotes cross-functional collaboration in the development of Member service strategies. Members identified as waiver Members, high risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Service Coordinators accomplish this by screening, assessing and developing targeted and tailored Member interventions while working collaboratively with the Member, practitioner, provider, caregiver and natural supports.

Since many Anthem Members have complex needs that require services from multiple Providers and systems, gaps may occur in the delivery system serving these Members. These gaps can create barriers to Members receiving optimal care. The Anthem service coordination model helps reduce these barriers by identifying the unmet needs of Members and assisting them to find solutions to those needs. This may involve coordination of care, assisting Members in accessing community-based resources or any of a broad range of interventions designed to improve the quality of life and functionality of Members and to make efficient use of available health care and community-based resources.

The scope of the Service Coordination Model includes but is not limited to:

- Annual assessments of characteristic and needs of Member populations and relevant subpopulations
- Initial and ongoing assessment
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments.
- Coordination of care with PCPs and specialty Providers
• Providing a service coordination approach that is “Member-centric” and provide support, access and education along the continuum of care

• Establishing a plan that is personalized to meet a Member’s specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized, including the appropriate level of care, planning for continuity of care and family participation

• Obtaining Member/family/caregiver input and level of participation in the creation of a service plan that includes the development of self-management strategies to increase the likelihood of improved health outcomes that may result in improved quality of life.

**Long Term Services and Supports**

**Consumer Direction**

Consumer direction is a process by which eligible home and community-based services (HCBS) are delivered; it is not a service.

Consumer direction affords Members the opportunity to have choice and control over how eligible HCBS are provided. The program also allows Members to have choice and control over who provides the services and how much workers are paid for providing care—up to a specified maximum amount established by California’s DHCS. Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time without affecting their enrollment.

Consumer direction is offered for Members who, through the needs assessment/reassessment process, are determined by Care Coordinators to need any service specified in DHCS rules and regulations as available for consumer direction. These services include, but are not limited to:

- Attendant/personal care
- In-home respite care

A service that is not specified in DHCS rules and regulations as available for consumer direction shall not be consumer-directed.

If a Member chooses not to direct his or her care, he or she will receive authorized HCBS through contract Providers. Members who participate in consumer direction of HCBS choose either to serve as the employer of record for their workers or to designate a representative to serve as the employer of record on his or her behalf. The Member must arrange for the provision of needed personal care and does not have the option of going without needed services.

Contact numbers for IHSS DPSS and PASC are in the contact section of the manual if we want to direct them to that.

**Long Term Services and Supports**

**Discharge Planning**

Anthem assists with discharge planning, either to the community or through a transfer to another facility, if the Member or responsible party so requests. If the Member or responsible party requests a discharge to the community, the Care/Service Coordinator will:

- Collaborate with the skilled nursing facility (SNF) Social Worker to convene a planning conference with the SNF staff to identify all potential needs in the community
- Facilitate a home visit to the residence where the Member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge
• Convene a discharge planning meeting with the Member and family, using the data complied through
discussion with the SNF staff as well as home visit, to identify Member preferences and goals

• Involve and collaborate with community originations such as Community Developmental Disability
Organizations (CDDOs), Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this
process to assist Members as they transition to the community

• Finalize and initiate execution of the transition plan

Although our Member-centric approach is driven by the Member, the transition implementation is a joint
effort between the SNF Social Worker and the Anthem Care Coordinator.

Long Term Services and Supports
Medical and Nonmedical Absences

Members are allowed up to ten days per confinement for reservation of a bed when a SNF, SNF/MH, or
ICF/MR beneficiary leaves a facility and is admitted to an acute care facility when conditions under the
reserve day regulations are met. To ensure accurate payment, the SNF, SNF/MH or ICF/MR must bill hospital
leave days consecutively beginning with the date of admission.

Members are allowed up to 21 days per admission for reservation of a bed when an SNF/MH resident leaves
a facility and is admitted to one of the state mental hospitals, a private psychiatric hospital or a psychiatric
ward in an acute care hospital. To ensure accurate payment, the SNF/MH must bill psychiatric leave days
consecutively, beginning with the date of admission.

If a beneficiary is not admitted to a hospital but goes to a hospital for observation purposes only, it is
considered an approved nursing facility day and not a hospital or therapeutic reserve day.

In the event of a nonmedical absence from a SNF, providers will obtain an authorization with the status
changes on the nursing home member and should bill the end hold/leave of absence Revenue code and
accommodation code. A maximum of 18 home-leave days for SNFs and 21 days for SNF/MHs are allowed
per calendar year. Additional days require precertification. The number of nonmedical reserve days is
restricted to 21 days per year for ICF/MR residents.

Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and
will not reimburse for medical absences without precertification.

Please make sure to bill with the appropriate Revenue Codes within the 018x series. In addition, you would
bill the appropriate accommodation code as well with a Value Code of 24 and billed as a cent(s). Example, if
the accommodation code is 2, then you would bill the Value Code 24 with $0.02.

Long Term Services and Supports
Member Liability (Share of Cost)

Medi-Cal should be the payer of last resort. Anthem will ensure Medicare SNF benefits are exhausted prior
to utilizing Medi-Cal benefits. Anthem will assist the facility in convening a discussion with the Member
and/or responsible party and/or state staff, Adult Protective Service, law enforcement or others as needed.

The SNF is responsible for collecting the Member liability/Share of Cost amount each month and should
represent the liability in box 39 on each claim. Please indicate the Share of Cost by billing the value code 23
with $0.00 or greater amount on the claim when submitting to Anthem. The payment remitted by Anthem
will be reduced by the Member liability amount.
The SNF should also complete and send an MS-2126 to the case worker/care coordinator so the level of care is updated appropriately in the state’s system.

For circumstances in which the Member or responsible party fails to remit payment of the Member’s liability to the SNF, Anthem Care Coordinators will assist the facility in convening a discussion with the Member and/or responsible party and/or state staff, Adult Protective Service, law enforcement or others as needed. The facility administrator or manager should contact the Anthem Care Coordinators with details regarding the lack of payment of Member liability. Details should include:

- The date the last payment was made
- Discussions held with the Member/family to date
- Correspondence with the Member/family to date
- History of late and/or missed payments, if applicable, and
- Any knowledge of family dynamics, concerns regarding the responsible party or other considerations

Upon approval of SNF eligibility, the state’s eligibility office will issue a notice of action that will identify the patient liability for the first month of eligibility and for the subsequent months.

The Provider should then collect the patient liability consistent with the notice of action.

The following situations and responses are provided to assist you with addressing Member liability collection.

**Example 1**: The Member is approved for institutional SNF eligibility as of the 15th of the month.

- State issues notice of action for the month for the amount of $500 and for the following month forward of $1000 per month
- The facility per diem is $150: 150 x 15 = $2,250
- The facility collects the $500 patient liability, represents the amount on the claim form in box 39 and bills Anthem for $2250
- Anthem will reduce the $2250 by $500 and remit $1750

If a Member is discharged to home or expires mid-month, the Provider may retain the patient liability up to the total charges incurred for the month before discharge.

**Example 2**: The Member is approved for institutional nursing facility eligibility as of the first of the month and is discharged during the month.

- Patient liability is $1000
- Per diem is $150
- Member is discharged on day 7: 7 x $150 = $1050
- Provider retains all of the patient liability and represents the amount on the claim to the MCO.
- Member is discharged on day 3: 3x$150 = $450
- Provider refunds $550 to the Member/family or estate
- Provider submits a claim to MCO for 3 days representing the patient liability collected, and MCO reduces the payment by the patient liability and issues a $0 claim payment

If a Member transfers facilities mid-month:

- Eligibility office is contacted regarding impending transfer and expected dates.
• Eligibility office issues a notice of action to the discharging facility for the patient liability it is to collect for the discharge month.
• Eligibility office issues a notice of action to the receiving facility as to the patient liability it is to collect in the first month and for subsequent months.

Long Term Services and Supports
Our Approach to Skilled Nursing Facility Member Liability/Share of Cost

Anthem recognizes the unique challenges faced by skilled nursing facility (SNF) Providers. Anthem has developed intensive training for nursing facilities to address a Member/family that is noncompliant in paying the Member liability, including facilitating a transfer if the issue cannot be resolved.

The paragraphs below outline our plan for working with the SNF and the Member/family to resolve such issues.

1. The SNF administrator or office manager contacts the Anthem Care Coordinator with details regarding the lack of payment of the Member liability, including:
   • The date the last payment was made
   • Discussions held with the Member/family to date
   • Correspondence between the Member/family to date
   • History of late and/or missed payments, if applicable
   • Any knowledge of family dynamics, concerns regarding the responsible party or other considerations

2. An Anthem Care Coordinator and the Nursing Home Social Worker, if applicable, discuss the issue with the Member, determine the barrier to payment and elicit cooperation:
   • The Anthem Care Coordinator guides the discussion using pre-determined talking points, including review of the obligation, potential impact to ongoing eligibility and potential threat to continued residence at the current SNF
   • Anthem talking points will be provided to the State for review and approval as may be applicable
   • The Anthem Care Coordinator screens for any potential misappropriation of funds by family or representative payee

3. The Anthem Care Coordinator will discuss the issue with the identified responsible party if the Member is unable to engage in a discussion regarding payment of the Member liability due to cognitive impairment or other disabilities.

4. The Anthem Care Coordinator or SNF Social Worker will take action if concerns related to misappropriation of funds are raised or suspected and may:
   • Refer the Member to Adult Protective Services and/or law enforcement
   • Submit request to the Social Security Administration to change the representative payee status to the person of the Member’s choosing or the SNF
   • Engage additional family Members
   • Engage the Guardianship Program to establish a conservator or guardian

5. The Anthem Care Coordinator will request copies of the cancelled check or other bank document and/or request copy of receipt issued by the SNF for payment of liability if the Member or responsible party asserts that the required liability has been paid. The Care Coordinator will present evidence of payment to the SNF business office and request confirmation that the issue is resolved. The Anthem Care
Chapter 6: Long Term Services and Supports (LTSS)  
Anthem Blue Cross  
Medi-Cal, Medi-Cal Access Program and MRMIP

Coordinator will also engage the assigned Anthem LTSS Provider Relations Representative to work with the SNF to improve its processes.

6. Anthem will send correspondence that outlines the obligation to pay the Member liability, potential impact to ongoing eligibility and potential threat to continued residence at the current SNF if the responsible party is unresponsive and/or living out of the area.

The correspondence will be submitted to the State for review and approval as required

The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment.

7. Anthem will take the following actions in conjunction with the SNF Social Worker if Member liability remains unsatisfied after the first rounds of discussion or correspondence:

- Convene a formal meeting with the SNF leadership, Member and/or responsible party, Long-term Support Services Ombudsman, Adult Protective Services representative, other representative of the State as applicable and other parties key to the discussion
- Review the patient liability obligation and potential consequences of continued nonpayment
- Attempt to resolve the payment gap with a mutually agreed-upon plan
- Explain options if the Member or responsible party wishes to pursue transfer to another facility or discharge to the community

Anthem, together with the SNF, will engage in any of the following, as may be applicable if the Member liability continues to go unsatisfied:

- Update and escalate intervention by Adult Protective Services or law enforcement
- Refer to State Medicaid Fraud Control Unit or other eligibility of fraud management staff that the State may designate
- Escalate engagement to facilitate a change to representative payee, Power of Attorney or Guardian
- Escalate appointment of a volunteer guardian or conservator
- Initiate discharge planning

Long-Term Care Ethics and Quality Committee

The Long-Term Care Ethics and Quality Committee addresses quality-of-care issues, ethical issues and standards of care. The committee reports to the Quality Management Committee.

The Anthem Quality Management program is a positive one. Our focus is on identification, improvement, education and support so Providers understand and comply with standards that impact the quality of care provided to our Members.

Long Term Services and Supports
Claims and Reimbursement Procedures

Precertification Requirements

Precertification, sometimes referred to as Prior Authorization (PA), is required for all SNF and LTSS services for which Medicaid is the primary payer, including all levels of care, medical and nonmedical absences, hospice services rendered in a SNF, and Reserve Days (leaves of absence). The hospice Provider is responsible for obtaining precertification and is required to pay the SNF room and board charges.

Provider must submit precertification requests with all supporting documentation immediately upon identifying a SNF admission or at least 72 hours prior to the scheduled admission.
Chapter 6: Long Term Services and Supports (LTSS)  
Medi-Cal, Medi-Cal Access Program and MRMIP

MSSPs that are receiving a PMPM for a member are not required to obtain an authorization.

So we can ensure appropriate discharge planning, you must provide notice to Anthem via our precertification process when the following events occur:

- Admission to an acute care or behavioral health care facility
- Admission to hospice

For Members that enter the facility as “Medicaid Pending,” please request a precertification as soon as the state approves the Medicaid eligibility and the Member’s eligibility is reflected on the Anthem website.

The Anthem website and your Provider Manual list those services that require precertification and notification. Our Provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews.

Anthem will follow the criteria established by DHCS authorizing short term or long-term SNF stays.

The certification request can be submitted by:

- Fax the request to 1-866-333-4818
- Calling Care Management at 1-888-831-2246 (Select Option 2)
  - For Members selecting Hospice services, Anthem will pay the hospice for the room and board charges, and the hospice will pay the SNF in accordance with CMS methodology and at the current applicable Medicaid rate

Providers can obtain the status of a precertification request by:

- Visiting our Provider website at www.anthem.com/ca

**Member Liability** (Share of Cost) should be reported on the CMS-1450/UB-04 claim form, Box 39. Your claim may be rejected if Box 39 is not populated. Please make sure to bill Value code 23 with $0.00 or greater amount. Even if multiple claims are submitted monthly and the Member Liability is met with the first claim, subsequent claims should indicate $0 liability with the value code 23.

**Retroactive adjustments**: Anthem understands the unique requirements of nursing facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of the Medicaid approval, the facility should verify eligibility on the Anthem website and then request an auth back to the date of eligibility as established by the state. Please note that it may take the state 24 to 48 hours to transmit an updated eligibility to the Anthem.

**Crossover Claims Procedures**: In most cases, when a resident has met the criteria for a Medicare qualified stay in a certified Medicare bed, the Medicare cost share will be relayed to Anthem via a crossover file provided to Anthem. We will then process and adjudicate the crossover claim. No further action should be necessary by the Provider. Should a crossover claim not be received by Anthem, then a claim can be submitted by the provider with a copy of the EOP from the other carrier for processing.

**Corrected Claims Procedures**: A corrected claim Code XX7 or a replacement claim Code XX8 may be submitted within 60 calendar days of the original claim’s Explanation of Payment (EOP) date. When submitting a corrected claim, ensure that the applicable claim code is indicated on the claim form. Also ensure that corrected claims contain all applicable dates of service and/or Revenue Codes for processing.

**Accommodation Codes**: Accommodation codes are needed to ensure the appropriate reimbursement based on the Medi Cal rates established by the state for each facility. Please bill the appropriate accommodation code as well with a Value Code of 24 and billed as a cent(s). Example, if the accommodation code is 1, then you would bill the Value Code 24 with $0.01.
Accomodation codes are available on the Medi Cal Website at http://files.medic-cal.ca.gov/pubsdoco/manuals_menu.asp, then please access the the manual for Long-Term Care. Within the Long-Term Care Manual you would refer to the section for Accomodation Codes.

**Long Term Services and Supports**

**Reimbursement to Multipurpose Senior Services Program Providers**

MSSP Providers must submit a monthly invoice/report to Anthem no later than the fifth day of each month for all Members for the reimbursement of the PMPM payment. The invoice/report shall be for each Anthem member enrolled in the MSSP as of the first day of the month for which the report is submitted. Anthem will pay the MSSP provider no later than thirty days after receipt of an undisputed claim. The report submitted must include the following:

- The name of the Anthem member receiving the MSSP services
- The member’s Client Index Number (CIN)
- The MSSP Provider’s ID number
- Other items as identified by both the health plan and the MSSP

Anthem pays MSSP Providers a fixed monthly amount for each Anthem member receiving MSSP Waiver Services. This amount is equal to one twelfth (1/12th) of the annual amount budgeted per MSSP Waiver slot allotment in the MSSP Waiver. This amount is provided by the state to Anthem.

MSSP Providers must accept Anthem’s payment as payment in full and final satisfaction of Anthem’s payment obligation for MSSP Waiver Services for each MSSP Waiver Participant enrolled in Anthem.

MSSP Providers may not submit separate claims to different plans for the same MSSP Waiver Participant within the same invoice period.

MSSP Providers must make timely payments to their subcontractors and/or vendors.

The MSSP would then submit an encounter claim to Anthem within 60 days from the date of services. The encounter claim would then be processed as zero payment to the MSSP.

Any questions can be directed to your LTSS provider relations representative. If you do not know your LTSS representative, then you can email LTSSProviders@anthem.com
CHAPTER 7: MEMBER ELIGIBILITY

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (L.A. County Only)
AIM/MRMIP Customer Care Center: 1-877-687-0549

Member Eligibility

Overview

Given the increasing complexities of health care administration, widespread potential for fraud and abuse, and constant fluctuations in program membership, Providers need to be vigilant about Member eligibility. This may mean taking extra steps to verify that any patient treated by Anthem Providers is, in fact, a currently enrolled Anthem Member.

We electronically update Member eligibility each day following notification from the following:

- California Department of Health Care Services (DHCS)
- California Department of Public Health (DPH)
- Contracted Eligibility Agents

To prevent fraud and abuse, Providers should confirm the identity of the person presenting the ID cards. Providers must also verify a Member’s eligibility before services are delivered. Because eligibility can change, it should be verified at every visit. Remember that claims submitted for services rendered to non-eligible Members will not be eligible for payment.

For the Medi-Cal, Medi-Cal Access Program (MAP) and Major Risk Medical Insurance (MRMIP) programs, eligibility can be verified online at Provider Access, our secure Provider portal. Go to: www.anthem.com/ca and take the following steps:

1. Click on OTHER ANTHEM WEBSITES: Providers
2. Click on LOGIN: Select Access
3. Select Medical from the drop-down menu and login to ProviderAccess. (Registration required.)

The site will ask for the following information from the Member's ID card. Required information includes:

- Member ID, including the alpha prefix
- Patient Date of Birth or Patient First and Last Name
- Date of Service (defaults to current date)
- Selection of defined HIPAA services types
- An active Member will show a term date of 12/31/9999

Please Note: To be HIPAA Version 5010 compliant, Providers are no longer able to conduct a "Name Search."

Member Eligibility

Medi-Cal ID Cards

At each Medi-Cal Member visit, Providers must ask to see 2 separate ID cards to verify state and Plan eligibility: The State of California Beneficiary Identification Card and the Anthem Member ID Card.

- Beneficiary Identification Card (BIC): The State of California issues this plastic card after approving the Member's eligibility.
Chapter 7: Member Eligibility

- **Member ID Card**: This card, provided by Anthem, contains Member and Provider information on the front and back.

The State-issued **Beneficiary Identification Card** contains eligibility information that can be accessed by swiping the card in the **Medi-Cal Point of Service** (POS) device at each visit.

The **Anthem Member ID Card** contains the following Member information:

- Member Name
- ID Number
- Group Number
- Effective Date
- Plan Codes
- Primary Care Provider (PCP)
- PCP Address
- PCP Phone Number
- Customer Service Number
- 24/7 NurseLine
- Vision Plan Number
- Dental Plan Number
- Emergency Instructions
- Hospital Inpatient Admission Instructions

**Please Note**: Los Angeles County Members will have a different card than non-Los Angeles County Members.

**Member Eligibility**

**Verifying Medi-Cal Eligibility**

To verify Managed Care **Medi-Cal** Member eligibility, choose 1 of the following:

- **Swipe the Beneficiary Identification Card** in the **Point of Service** (POS) device.
- **Log on to our secure Availity website at**: http://www.availity.com/
- **Log on to the Medi-Cal website at**: www.medi-cal.ca.gov/eligibility/login.asp
  - Enter your **User ID** and **Password**
  - Click **Submit**, which will take you to the **Real Time Internet Eligibility** page
  - Enter Member information, including subscriber ID, birth date, issue date and service date
- **Call our Interactive Voice Response (IVR) automated phone service at 1-800-407-4627 (Outside Los Angeles County) or 1-888-285-7801 (Inside Los Angeles County)**
  - This service is available 24 hours a day, 7 days a week. You may also request fax verification.
  - Please Note: The IVR accepts either your billing National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for Provider identification.
- **Use the Automatic Eligibility Verification System (AEVS) at 1-800-456-2387**

**Member Eligibility**

**Medi-Cal Access Program and Major Risk Medical Insurance Program (MRMIP)**

There is no **State of California Beneficiary Identification Card** for the **Medi-Cal Access Program** (MAP) or the **Major Risk Medical Insurance Program** (MRMIP). Only Medi-Cal uses the state card. The MAP or MRMIP Member will carry a single card: the **Anthem Member ID Card**.

**Member ID Card**: Each program (MAP and MRMIP) has a unique Member identification card. This card contains Member and Provider information.
Chapter 7: Member Eligibility

Medi-Cal, Medi-Cal Access Program and MRMIP

The MAP and MRMIP Member ID Cards contains the following information:

- Member Name
- Customer Service Number
- Pre-service Review Information and Number
- Billing Address
- Pharmacy Information

Member Eligibility

Verifying MAP and MRMIP Eligibility

Providers can verify AIM and MRMIP eligibility in 1 of the following ways:

- Log on to our secure ProviderAccess website at: https://provider2.anthem.com/wps/portal/ebpmybcc
- Call our Interactive Voice Response (IVR) automated phone service at: 1-800-289-6574, 24 hours a day, 7 days a week. You may also request fax verification.
CHAPTER 8: UTILIZATION MANAGEMENT

Medi-Cal Utilization Management: 1-888-831-2246
MAP/MRMIP Utilization Management: 1-877-273-4193
Hours of Operation: Monday to Friday, 8am-5pm

Utilization Management Overview

Utilization Management (UM) is a cooperative effort with network Providers to promote, provide and document the appropriate use of health care resources. At Anthem, our goal is to provide the right care to the right Member at the right time in the appropriate setting.

The UM team takes a multidisciplinary approach to meet the medical and psychosocial needs of our Members. The Anthem decision-making process reflects the most up-to-date UM standards from the National Committee for Quality Assurance (NCQA).

Authorizations are based on the following:

- Benefit coverage
- Established criteria
- Community standards of care

The decision-making criteria used by the UM team is evidence-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We involve practicing physicians in these updates and notify Providers of changes through our Provider Bulletins. These criteria are available to Members, Physicians and other health care providers upon request by contacting the UM Department at 1-888-831-2246, 8 a.m. to 5 p.m., Monday through Friday, excluding holidays.

Based on sound clinical evidence, the UM team provides the following service reviews:

- Prior Authorizations
- Continued Stay Reviews
- Post-Service Clinical Claims Reviews

Decisions affecting the coverage or payment for services are made in a fair, impartial, consistent and timely manner. The decision-making incorporates nationally recognized standards of care and practice from sources including:

- America Academy of Orthopedic Surgeons
- American Academy of Pediatrics
- American College of Cardiology
- American College of Obstetricians and Gynecologists
- Cumulative professional expertise and experience

Once a case is reviewed, decisions and notification time frames will be given for service:

- Approval
- Modification
- Denial
Please Note: We do not reward practitioners and other individuals conducting utilization reviews for issuing denials of coverage or care. There are no financial incentives for UM decision-makers that encourage decisions resulting in underutilization.

If you disagree with a UM decision and want to discuss the decision with the physician reviewer, you can call the appropriate UM department at the contact numbers listed at the beginning of this chapter.

Utilization Management

Services Requiring Prior Authorization

Providers are responsible for verifying eligibility and in ensuring that our Utilization Management department has conducted pre-service reviews for elective nonemergency and scheduled services before rendering those services. Prior Authorization ensures that services are based on medical necessity, are a covered benefit and are provided by the appropriate Providers.

Prior Authorization must be obtained for all out-of-network services or services rendered outside of an emergency room or urgent care setting.

Some Anthem Members are assigned to delegated medical groups or IPAs. Providers should contact the medical group to confirm the need for authorization before elective services.

Services requiring Prior Authorization include, but are not limited to:

- Air Ambulance (nonemergent)
- Behavioral Health Services (except psychiatric assessments and mental health assessment by non-physician). For more information, please see Chapter 5: Behavioral Health Services.
- Cardiac and Pulmonary Rehabilitation
- Cosmetic procedures
- Dental – Medically necessary (facility services and anesthesia services)
- Dialysis Services
- Durable Medical Equipment and Disposable Supplies
- Experimental and Investigational Services
- Formula
- Genetic Testing
- Home Health Care Services
- Hospice
- Infusion Therapies
- Chemotherapy
- Inpatient Hospital Services
  - Nonurgent Inpatient Admissions
  - Long-Term Acute Care Facility (LTAC)
  - Inpatient Skilled Nursing Facility (SNF)
  - Rehabilitation facility admissions
  - Newborn Stay beyond Mother
- Laboratory Tests (specific)
- Out-Of-Network Referrals to Specialists
- Outpatient Surgical Services (delivered in an ambulatory surgical center or outpatient hospital)
• Pharmacy and/or Over-the-Counter (OTC) products
  o Certain preferred medications and all nonpreferred medications may require PA; please contact Express Scripts, Inc. at 1-866-310-3666. Specialty medications, such as Synagis and Botox, will require Prior Authorization through Anthem. Contact the UM Department at 1-888-831-2246 for more information.

• Radiology Services, including MRA, MRI, PET and CT Scans

• Spinal Surgeries
  o Artificial Disc Placement
  o Artificial Disc Removal
  o Artificial Disc Replacement
  o Decompress Spinal Cord
  o Low Back Disc Surgery
  o Lumbar Spine Fusion
  o Remove Spinal Lamina
  o Vertebral Corpectomy

• Kidney and Cornea Transplant Services (excluding other major transplants-not covered)

A more comprehensive list of Services Requiring Prior Authorization can be found under Prior Authorization and Preservice Review on the Provider Resources page of our website at: www.anthem.com/ca. For information on how to access this page, please refer to Chapter 1: How to Access Information, Forms and Tools on our Website.

Utilization Management
Services That Do Not Require Prior Authorization

The following services DO NOT require Prior Authorization (PA) for in-network providers:

• Chiropractic Services – Benefit is limited to Sacramento and San Diego county members only. This is considered a carve-out benefit for all other counties.

• Emergency Services – Notify Anthem of admissions within 24 hours or the next business day of inpatient admission.

• Formulary glucometers and nebulizers

• Family Planning/Well Woman Checkup – Member may self-refer to any Medicaid provider for the following services:
  o Pelvic and breast examinations
  o Lab work
  o Birth Control
  o Genetic counseling
  o FDA-approved devices and supplies related to family planning (such as IUD)
  o HIV/STD screening

• Obstetrical Care - No authorization required for in-network physician visits, and routine testing.

• Pregnancy and newborn deliveries require notification. Please use the Notification of Pregnancy form and the Newborn Enrollment Notification Report, as appropriate.
Chapter 8: Utilization Management

Anthem Blue Cross

Medi-Cal, Medi-Cal Access Program and MRMIP

- No PA required for physician referrals if referring member to an in-network specialist for consultation or a nonsurgical course of treatment
- Standard X-rays and ultrasounds
- In-network speech therapy and occupational therapy

The Pregnancy Notification Report form and Newborn Enrollment Notification Report form may be found via the Provider Resources page on our website: www.anthem.com/ca. Both forms are located under the Clinical and Preventive Care Tools heading in the Forms Library, and both may be printed and faxed. A link to the Online Pregnancy Notification Form is available in the same location as well.

For information on how to access our Provider Resources page, please refer to Chapter 1: How to Access Information, Forms and Tools on our Website.

Utilization Management
Starting the Process

When authorization of a health care service is required, call us with questions and requests, including requests for:

- Routine, nonurgent care reviews
- Urgent or expedited pre-service reviews
- Urgent continued stay reviews

An urgent request is any request for medical care or treatment that cannot be delayed because delay would result in the following:

- Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

The Utilization Management team returns calls:

- Same day when received during normal business hours
- Next business day when the call is received after normal business hours
- Within 24 hours for all routine requests

Providers can also fax the UM team and include requests for:

- Urgent or expedited pre-service reviews
- Nonurgent continued stay reviews

Faxes are accepted during and after normal business hours. Faxes received after hours will be processed the next business day.

Utilization Management
Requesting Authorization

To request a pre-service review or report a medical admission, call the Utilization Management department and have the following information ready:

- Member Name and Identification (ID) Number
Chapter 8: Utilization Management

Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP

• Diagnosis with the ICD-9 / ICD-10 Code
• Procedure with the CPT code
• Date of injury or hospital admission and third party liability information (if applicable)
• Facility name (if applicable)
• Primary Care Provider (PCP) Name
• Specialist or attending physician name
• Clinical justification for the request
• Level of care
• Lab tests, radiology and pathology results
• Medications
• Treatment plan including time frames
• Prognosis
• Psychosocial status
• Exceptional or special needs issues
• Ability to perform activities of daily living
• Discharge plans

All Providers, including physicians, hospitals and Ancillary Providers, are required to provide information to the UM department. Physicians are also encouraged to review their utilization and referral patterns.

Additional information to have ready for the clinical reviewer includes, but is not limited to:

• Office and hospital records
• History of the presenting problem
• Clinical exam
• Treatment plans and progress notes
• Information on consultations with the treating practitioner
• Evaluations from other health care practitioners and Providers
• Photographs
• Operative and pathological reports
• Rehabilitative evaluations
• Printed copy of criteria related to the request
• Information regarding benefits for services or procedures
• Information regarding the local delivery system
• Patient characteristics and information
• Information from responsible family members

Utilization Management

Authorization Request Forms

Providers can request Prior Authorization by completing, printing and faxing the appropriate Request for Pre-Service Review forms found under the Prior Authorization and Preservice Review heading on the Provider Resources page our website at: www.anthem.com/ca. For information on how to access our
Provider Resources page, please refer to Chapter 1: How to Access Information, Forms and Tools on our Website.

Here are some tips for filling out the forms and getting the fastest response to your authorization request:

- Fill out the form online, then print legibly and fax the form to ensure legibility.
- Fill out the form completely; unanswered questions typically result in delays.
- Access the forms online only when needed rather than preprinting and storing them. We revise the forms periodically, and outdated forms can delay your request.

Utilization Management

Requests with Insufficient Clinical Information

When the UM team receives requests with insufficient clinical information, we will contact the Provider with a request for the information reasonably needed to determine medical necessity.

We will make at least one attempt to contact the requesting Provider to obtain this additional information. If we do not obtain a response within the specified time-frame of receipt of the request, we will send issue a Notice of Action: Denial – Not Medically Necessary letter to the Member and Provider.

Utilization Management

Pre-Service Review Time Frame

For routine, nonurgent requests, the UM team will complete pre-service reviews within five business days from receipt of information reasonably necessary to make a decision, not to exceed 14 calendar days from the date of request. Requests that do not meet medical policy guidelines are sent to the physician advisor or medical director for further review.

Providers will be notified of denials or deferrals by phone within one business day from the date of the decision. Providers and Members will receive written notification of denials or deferrals within two business days from the date of the decision.

Utilization Management

Urgent Pre-service Requests

For urgent pre-service requests, the UM team completes the pre-service review within 72 hours from receipt of the request.

Generally speaking, the Provider is responsible for contacting us to request pre-service review for both professional and institutional services. However, the hospital or Ancillary Provider should always contact Anthem to verify pre-service review status for all nonurgent care before rendering services.

Utilization Management

Emergency Medical Conditions and Services

Anthem does not require Prior Authorization for treatment of emergency medical conditions. In the event of an emergency, Members can access emergency services 24 hours a day, 7 days a week. In the event that the emergency room visit results in the Member’s admission to the hospital, Providers must contact Anthem within 24 hours or one business day if the member was admitted on a weekend or holiday.

Members who call their PCP’s office reporting a medical emergency (whether during or after office hours) are directed to dial 911 or go directly to the nearest hospital emergency department. All nonemergent
conditions should be triaged by the PCP or treating physician, with appropriate care instructions given to the Member.

Utilization Management
Emergency Stabilization and Post-Stabilization

The emergency department’s treating physician determines the services needed to stabilize the Member’s emergency medical condition. After the Member is stabilized, the emergency department’s physician must contact the Member’s PCP for authorization of further services. The Member’s PCP is noted on the back of the ID card. If the PCP does not respond within 30 minutes, the needed services will be considered authorized.

All continued inpatient stays are reviewed to determine whether the stay is medically necessary. The transfer process for out-of-network admissions requiring transfer to an Anthem-contracted facility or to a higher level of care includes the following:

- The attending physician determines whether the Member is stable for transfer
- The attending physician discusses the potential transfer with the PCP
- To facilitate the transfer, the PCP is required to contact the treating physician within 30 minutes of the call
- The attending physician must document and sign orders stating that the Member is stable for transfer
- Transfers of children require the signed permission of the parents, except in cases to transfers to a higher level of care

The emergency department should send a copy of the emergency room record to the PCP’s office within 24 hours. The PCP should:

- Review the chart and file it in the Member’s permanent medical record
- Contact the Member
- Schedule a follow-up office visit or a specialist referral, if appropriate

However, as with all nonelective admissions, notification must be made within 24 hours or one business day if the member was admitted on a weekend or holiday. The medical necessity of that admission will be reviewed upon receipt of notification, and a determination of the medical necessity will be rendered within 24 hours of that notification.

All providers who are involved in the treatment of a member share responsibility in communicating clinical findings, treatment plans, prognosis and the psychosocial condition of such member with the member’s PCP to ensure effective coordination of care.

Utilization Management
Referrals to Specialists

The Utilization Management team is available to assist Providers in identifying a network specialist and/or arranging for specialist care. Keep the following in mind when referring Members:

- Prior authorization is not required if referring a Member to an in-network specialist for consultation or a nonsurgical course of treatment.
- Prior authorization is required when referring to an out-of-network specialist.
Authorization from UM is not required for Medi-Cal members who self-refer (see Self-Referral) for sensitive services, even if services are rendered out-of-network.

- Members in MRMIP and AIM HMO may self-refer to in-network specialists.

Provider responsibilities include documenting referrals in the Member’s chart and requesting that the specialist provide updates as to diagnosis and treatment.

**Please Note:** Obtain a Prior Authorization approval number before referring Members to an out-of-network Provider. For out-of-network Providers, we require Prior Authorization for the initial consultation and each subsequent service provided.

### Utilization Management

**Continued Stay Review: Hospital Inpatient Admissions**

Hospitals must notify the UM Department of inpatient medical or behavioral health admissions within 24 hours of admission or by the next business day.

When a Member’s hospital stay is expected to exceed the number of days authorized during pre-service review or when the inpatient stay did not have pre-service review, the hospital must contact us for continued stay review. We require clinical reviews on all Members admitted as inpatients to:

- Acute care hospitals
- Intermediate facilities
- Skilled nursing facilities

We perform these reviews to assess medical necessity and determine whether the facility and level of care are appropriate. Anthem identifies Members admitted as inpatients by:

- Facilities reporting admissions
- Providers reporting admissions
- Members or their representatives reporting admissions
- Claims submitted for services rendered without authorization
- Pre-service authorization requests for inpatient care

The UM team will complete continued-stay inpatient reviews within 24 hours of receipt of the request, consistent with the Member’s medical condition. UM staff will request clinical information from the hospital on the same day they are notified of the Member’s admission and/or continued stay.

### Utilization Management

**Continued Stay Review: Clinical Information for Continued-Stay Review**

Once notification of an inpatient admission is received, if there is insufficient clinical information to determine medical necessity, the provider is contacted with a request for the clinical information reasonably necessary to determine medical necessity. Evidence-based criteria are used to determine medical necessity and the appropriate level of care.

If the information meets medical necessity review criteria, we will approve the request within 24 hours from the time the information is received. We will send requests that do not meet medical policy guidelines to the physician adviser or medical director for further review.

We will notify Providers within 24 hours of the decision. We will send written notification within 2 business days of any denial or modification of the request to the Member and requesting Provider.
Utilization Management
Continued Stay Review: Denial of Service

Only a medical or behavioral health Provider who possesses an active professional license or certification can deny services for lack of medical necessity, including the denial of:

- Procedures
- Hospitalization
- Equipment

When a request is determined to be not medically necessary, the requesting Provider will be notified of the following:

- The decision
- The process for appeal
- How to reach the reviewing physician for peer-to-peer discussion of the case

Providers can contact the physician clinical reviewers to discuss any UM decision by calling the UM department.

Utilization Management
Post-Service Clinical Claims Review

Post-service clinical claims review determines the medical necessity and/or level of care for services that were provided without getting required pre-service or continued stay authorization. For inpatient admissions where no notification was received and no patient days were authorized, facilities are required to submit a copy of the medical record with the claim.

Utilization Management
Self-Referral

Members do not need Prior Authorization and may self-refer for the following “sensitive” services provided by qualified, in-network Providers:

- Family planning services, including:
  - Contraceptive pills, devices and supplies
  - Diagnosis and treatment of sexually transmitted disease
  - Health education and counseling
  - Laboratory tests
  - Limited history and physical examinations
  - Pregnancy testing and counseling
  - Sterilization
- Annual examination with a network obstetrician/gynecologist
- HIV Testing and counseling
- Sexual assault, including rape
- Drug or alcohol abuse for children 12 years of age or older
- Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either:
There is a danger of serious physical or mental harm to the minor or others or
The children are the alleged victims of incest or child abuse.

Utilization Management
Second Opinions

Second opinions are covered services and offered at no cost to our Members. The following are important guidelines regarding second opinions:

- The second opinion must be given by an appropriately qualified health care professional.
- The second opinion must come from a Provider of the same specialty.
- The secondary specialist must be within the Anthem network and may be selected by the Member. When there is no network Provider who meets the specified qualifications, we may authorize a second opinion by a qualified Provider outside of the network upon request by the Member or Provider.

Utilization Management
Additional Services: California Children’s Services

California Children’s Services (CCS) is a state and county-funded program that serves children under the age of 21 who have acute and chronic conditions that may benefit from specialty medical care and case management. State statutes and contracts require that CCS Program services be carved out of our Medi-Cal Program. As a result, upon suspicion or identification of a CCS-eligible condition, the Provider must refer the child to the local CCS Program or contact us to assist with the referral. If a Provider renders services to the child in question without contacting Anthem or CCS beforehand, the Provider will not be reimbursed for those services.

Utilization Management
Additional Services: Mental Health

For information about Anthem’s Behavioral Health services, please see Chapter 5: Behavioral Health Services.

Utilization Management
Additional Services: Vision Care

Vision benefits are offered to all Anthem Medi-Cal Members through the Vision Service Plan (VSP). For questions about vision benefits and Prior Authorization, please call the Vision Service Plan at: 1-800-877-7195 or 1-800-428-4833 (TTY).
CHAPTER 9: HEALTH SERVICES PROGRAMS

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP / MRMIP Customer Care Center: 1-877-687-0549

Health Services Programs
Overview

Anthem health services programs are designed to improve our Members’ overall health and well being by informing, educating and encouraging self-care in the early detection and treatment of existing conditions and chronic disease.

These targeted programs are designed to supplement Providers’ treatment plans and are divided into four categories:

- **Preventive Care Programs**, including the Initial Health Assessment, the Staying Health Assessment Tool and Well Woman programs
- **Health Management Programs**, including ConditionCare, which promotes knowledge and encourages self-care for targeted medical conditions and chronic disease, and New Mother and Baby Post Delivery Outreach, a program designed to identify mothers and babies with post-delivery needs
- **Health Education**, including the 24/7 NurseLine for all health-related questions and an Emergency Room Initiative that instructs Members on the proper use of emergency room services
- **Telehealth**, which enables physicians to utilize videoconferencing equipment to consult with network Specialists at a distance.

We introduce new Members to these programs through a new Member packet, which includes preventive health care guidelines and a Member Services Guide that includes information on how to access health education services.

After that, we utilize a variety of methods and informal settings to inform our Members about available health services, including:

- Direct mailings
- Health education classes
- Telephone calls
- Health fairs and community events

Providers can also refer Members to applicable programs, to our 24/7 NurseLine and to our website: www.anthem.com/ca. Interpreter services and translation of materials into non-English languages and alternative formats are available to support Members’ participation in Health Services Programs at no cost to the member.

Health Services Programs
Preventive Care: Initial Health Assessments

The Initial Health Assessment (IHA) offers a baseline for Providers to assess and manage a Member’s physical condition. Once the Initial Health Assessment has been completed, Providers can encourage our Members to become more actively engaged in their own treatment and preventive health care.

The IHA consists of the following categories of patient information:
• Patient history
• Physical examination
• Developmental and Behavioral assessment

Primary Care Providers (PCPs) must perform an Initial Health Assessment with new Members according to the following timetable:

• For Members 18 months of age and older: Within **120 days** of enrollment
• For Members under 18 months of age: Within **60 days** of enrollment or within the periodicity schedule established by the *American Academy of Pediatrics* for children ages 2 and younger, whichever is less

An Initial Health Assessment is not necessary under the following conditions:

• If the new Member is an existing patient of the PCP (but new to us), with an established medical record showing baseline health status. This record must include a documented IHA within the past 12 months prior to the Member’s enrollment and sufficient information for the PCP to provide treatment.
• If the new Member is not an existing patient, transferred medical records can also meet the requirements for an IHA if a completed health history is included.
• If the new member refuses to schedule an IHA. The refusal must be documented in the Member’s medical record.

Please Note: To assist in collecting baseline data for the Initial Health Assessment, Providers must use the Medi-Cal-only Staying Healthy Assessment Forms, which are located in the Forms Library on the Provider Resources page on our website at www.anthem.com/ca. For information on how to access our Provider Resources page, please refer to Chapter 1: How to Access Information, Forms and Tools on our Website.

Anthem monitors PCP provision of IHAs through medical record review audits.

Health Services Programs
Preventive Care: Services for Children Under 21 Years of Age

For children under 21 years of age, the IHA should consist of the following:

• Assessment of nutritional status
• Dental evaluation
• Developmental and behavioral history
• Hearing screening
• Physical examination
• Vision screening
• Lead screening
• Appropriate immunizations according to age and health history
• Chlamydia screening for all sexually active nonpregnant young women
Health Services Programs
Preventive Care: Staying Healthy Assessment Tool (Medi-Cal Only)

In addition to the Initial Health Assessment, Providers working with Medi-Cal Members must also fill out the Staying Healthy Assessment (SHA) Tool and periodically readminister it according to the SHA periodicity chart. Annual reviews of existing SHAs and counseling are required at subsequent periodic exams. This requirement does not apply to Medi-Cal Access Program or Major Risk Medical Insurance Program Members.

The California Department of Health Care Services (DHCS) recently updated the SHA and Individual Health Education Behavioral Assessment (IHEBA). It is now available in seven age-specific pediatric questionnaires and two adult questionnaires, including one designed for seniors. It was developed to achieve the following:

- Identify and track high-risk behaviors
- Prioritize patient health education needs
- Initiate discussion and counseling on prioritized high-risk behaviors related to lifestyle, behavior, environment, cultural and language

PCP Responsibilities for the Staying Healthy Assessment Program include:

- Reviewing the completed SHA with the patient.
- Exploring patient responses to verify risk factors and determining the extent to which they might harm the patient’s health.
- Based upon a patient’s behavioral risks and willingness to make lifestyle changes, PCPs should provide tailored health education counseling, intervention, referral and follow-up.
- The PCP must document, initial and date all health education interventions and referrals using the Intervention Codes listed on the bottom of each SHA tool.

Newly Added PCP Responsibilities for the Staying Healthy Assessment Program include:

- Receive training on implementing and administering the new SHA
- Attest to receiving training on the implementation, administration and state regulations regarding the use of the new SHA assessment forms
- Complete the DHCS approved Provider PowerPoint™ Presentation Training online at the following link: http://tinyurl.com/StayingHealthy2014. (If the slide show does not start when opening the PowerPoint file, please click on the “Slide Show” tab and select the “From Beginning” icon in the top left-hand corner of your screen to start the narrated training.)

To obtain SHA Assessment Forms:

The SHA assessment forms in all the age-categories and most Medi-Cal threshold languages are posted on the DHCS SHA webpage and are available to download at the following link: http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx

To request hard copies of the SHA assessment forms, including electronic versions of the assessment forms in Farsi or Khmer, please contact your local Regional Health Plan.
Chapter 10: Claims and Billing

Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP

Use of Alternative INEBA Tools

Anthem Blue Cross strongly encourages the use of the SHA. Should you prefer to use and administer an alternative IHIEBA, a request, and justification to do so, must be submitted to Anthem two months in advance of scheduled implementation to receive approval.

For more information about the SHA, please contact your local Regional Health Plan at the appropriate phone number below.

Northern CA: 1-916 589-3001
Central CA: 1-559-353-3500
Southern CA: 1-818-655-1240

You may also call the Customer Care Center at 1-800-407-4627 or in Los Angeles County at 1-888-285-7801.

For complete updated policy guidelines, please visit www.dhcs.ca.gov.

Health Services Programs
Preventive Care: Immunization Program

The Immunization Program was designed to increase both childhood immunization rates and the number of Members who are fully immunized. The most up-to-date immunization guidelines are available as Preventive Health Care Guidelines under the Quality Improvement Program heading on the Provider Resources page of our website at www.anthem.com/ca. For information on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Providers can also request a hard copy of the Preventive Health Care Guidelines by calling the appropriate Customer Care Center at the numbers listed at the beginning of this chapter.

Health Services Programs
Preventive Care: Well Woman

The Well Woman program was developed to remind and encourage women to have regular cervical and breast cancer screenings. The Well Woman Reminder Program sends a screening test reminder mailer to women who are not up-to-date with their recommended cervical and/or breast cancer screenings. Providers are encouraged to refer Members for screenings and/or schedule the exams.

PCP responsibilities for the care of female Members include:

- Educating Members on Preventive Health Care Guidelines for women
- Referring Members for cervical and breast cancer screenings
- Scheduling screening exams for Members

Providers can access the Preventive Health Care Guidelines on our website at: www.anthem.com/ca. The most up-to-date Preventive Health Care Guidelines are located under the Quality Improvement Program heading on the Provider Resources page of our website at www.anthem.com/ca. For information on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.
Health Services Programs

Preventive Care: Childhood Lead Exposure Testing/Free Blood Test Kits

The Centers for Medicare and Medicaid Services requires that all children enrolled in Medicaid be tested for lead exposure at 1 and 2 years of age. Children from 3 to 6 years of age who have not been tested also need screening regardless of their risk factors.

Please Note: Completion of a lead risk assessment questionnaire does not fulfill this screening requirement; a blood draw is also required.

Health Services Programs

Health Management: ConditionCare: Medi-Cal

The more our Members know about their medical conditions and chronic disease, the better they will be able to follow through with treatment therapies and take charge of their own health. That’s the thinking behind our special health services program, ConditionCare, designed to supplement and enhance Provider’s treatment plans, making them easier to understand, easier to follow and more effective.

Through ConditionCare, Members will have access to a team of health professionals, including the following:

- Nurse coaches
- Dietitians
- Health Educators
- Pharmacists
- Social workers

The goal of this program is to serve as a supplement to Providers’ care. The ConditionCare team will coordinate with Providers in the following ways:

- Nurses will communicate that they are not there to take the place of the Member’s physician.
- Nurses will try to get physician instructions from Members in order to support those instructions and increase Member compliance.
- Nurses will encourage Members to bring up any identified issues with their physicians.
- Pharmacists will contact physicians directly to discuss medications issues.

ConditionCare targets the following conditions:

- Asthma (Pediatric and Adult)
- Cardiovascular conditions
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes (Types 1 & 2)

Providers can refer a Member to the program by calling:

Condition Management: 1-877-681-6694
Hours of Operation: 5:30 am - 8:00 pm, Monday to Friday; 6 am-4:30 pm, Saturday
Health Services Programs

**Health Management: ConditionCare for Asthmatic Members**

Anthem works collaboratively with Providers in the identification, management and treatment of children and adult Members with asthma. **ConditionCare for Asthmatic Members** was designed to educate our Members and reinforce Providers’ treatment plans, which should include a written **Asthma Action Plan** to improve self-management skills.

The **ConditionCare** program is based on the **National Institute of Health (NIH)** and the **National Heart, Lung and Blood Institute (NHLBI) Guidelines for the Diagnosis and Management of Asthma**. Find out more about these guidelines at: [www.nhlbi.nih.gov/guidelines/asthma](http://www.nhlbi.nih.gov/guidelines/asthma).

Member enrollment and participation in **ConditionCare for Asthmatic Members** program is based on either an opt-out process for high-risk Members or an opt-in process available to Members who self-refer to the program. Identified Members are automatically enrolled in the program and receive interventions according to risk stratification. A member may opt out of the program at any time by contacting Anthem.

PCPs should follow these **ConditionCare for Asthmatic Members** guidelines:

- Assess Members for asthma using the NIH risk categories.
- Provide each diagnosed Member with a written Asthma Action Plan that describes medication dosage and level of care needed, based on peak-flow readings.
- Encourage the Member to participate in our ConditionCare for Asthmatic Members program.
- Refer Members to asthma education classes by calling our Customer Care Centers.
- Coordinate care with care management, pharmacy and specialists as needed.
- Document all referrals and treatments related to asthma in the Member’s medical record.
- Request asthma education materials by calling our Customer Care Centers at the numbers listed at the beginning of this chapter.

Please Note: The **Asthma Action Plan** is available on the **National Heart, Lung and Blood Institute's** website: [www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.htm](http://www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.htm).

Health Services Programs

**Health Management: ConditionCare for Members with Cardiovascular Conditions**

Anthem designed the **ConditionCare for Members with Cardiovascular Conditions** program as a multidisciplinary approach to heart disease, targeting prevention of coronary artery disease and management of congestive heart failure. The program empowers Members through education and self-management.

PCPs are encouraged to provide each Member with ongoing treatment and perform the appropriate physical and laboratory examinations following guidelines from the **American Heart Association (AHA)** and the **National Institutes of Health (NIH)**. They are also encouraged to:

- Improve quality of care in accordance with the AHA clinical practice guidelines for Congestive Heart Failure (CHF) and Coronary Artery Disease (CAD).
- Improve quality of life for Members with CHF or CAD.
- Refer Members to the ConditionCare Program to facilitate Member/Provider communication and to encourage Members to take a more active role in the management of their disease.
- Reduce exacerbation of conditions and secondary complications.
- Request cardiovascular educational materials by visiting our website at www.anthem.com/ca or calling our Customer Care Center.

The **ConditionCare for Members with Cardiovascular Conditions** program adheres to the following clinical practice guidelines:

- **Cardiovascular Disease**: [American Heart Association (AHA) Guidelines for Primary Prevention of Cardiovascular Disease and Stroke](http://circ.ahajournals.org/cgi/content/full/106/3/388)
- **Congestive Heart Failure**: Diagnosis and Management of Chronic Heart Failure in the Adult — AHA: [http://circ.ahajournals.org/content/112/12/e154.full](http://circ.ahajournals.org/content/112/12/e154.full)

Member enrollment and participation in the **ConditionCare for Members with Cardiovascular Conditions** program is based on either an opt-out process for high-risk Members or an opt-in process available to Members who self-refer. Identified Members are automatically enrolled in the program and receive interventions according to risk stratification. A Member may opt out of the program at any time by contacting **Anthem**.

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**Health Services Programs**

**Health Management: ConditionCare for Members with Chronic Obstructive Pulmonary Disease (COPD)**

**ConditionCare for Members with Chronic Obstructive Pulmonary Disease** (COPD) was designed to augment the care of Members with COPD. **Anthem** works collaboratively with Providers in the identification, management and treatment of this disease. **Anthem** supports the initiative of the **Global Strategy for Diagnosis, Management and Prevention of COPD**, also known as GOLD. For more information on this initiative, go to the GOLD website:


PCPs are encouraged to follow these guidelines:

- Assess and treat Members according to COPD Guidelines.
- Refer Members for appropriate laboratory and screening tests.
- Refer Members to the ConditionCare for Members with Chronic Obstructive Pulmonary Disease program.
- File a Member-specific report with the Member’s risk stratification and the date of the last COPD screening in the medical record.
- Coordinate care management, pharmacy and specialists as needed.
- Document all referrals and treatments related to COPD in the Member’s medical record.
- Request COPD educational materials by visiting our website at [www.anthem.com/ca](http://www.anthem.com/ca) or calling our Customer Care Centers.

Member enrollment and participation in the **ConditionCare for Members with Chronic Obstructive Pulmonary Disease** program is based on either an opt-out process for high-risk Members or an opt-in process available to Members who self-refer. Identified Members are automatically enrolled in the program and receive interventions according to risk stratification. A Member may opt out of the program at any time by contacting **Anthem**.
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Health Services Programs
Health Management: ConditionCare for Diabetic Members

ConditionCare for Diabetic Members was designed to augment the care of children and adult Members with diabetes. Anthem works collaboratively with Providers in the identification, management and treatment of this disease.

Primary Care Providers (PCPs) are to provide each diabetic Member with ongoing treatment and perform the appropriate physical and laboratory examinations following the Diabetes Care Guidelines from the American Diabetes Association.

PCPs are encouraged to follow these guidelines:

- Assess and treat Members according to the Diabetes Care Guidelines.
- Refer Members for appropriate laboratory and screening tests.
- Refer Members to the ConditionCare for Diabetic Members program.
- File a Member-specific report with the Member’s risk stratification and the date of the last diabetic screening in the medical record.
- Coordinate care management, pharmacy and specialists as needed.
- Document all referrals and treatments related to diabetes in the Member’s medical record.
- Access the diabetes guidelines and educational materials located on the Provider Resources page of our website at www.anthem.com/ca. To find these materials, scroll down to the Health Education heading and select Health Education Resources > Diabetes Guidelines. For information on locating the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Member enrollment and participation in the ConditionCare for Diabetic Members program is based on either an opt-out process for high-risk Members or an opt-in process available to Members who self-refer. Identified Members are automatically enrolled in the program and receive interventions according to risk stratification. A Member may opt out of the program at any time by contacting Anthem.

Health Services Programs
Health Management: Future Moms (Medi-Cal and Medi-Cal Access Program)

Future Moms is a program utilizing risk assessment, early intervention and education to help reduce complications during pregnancy. The program is staffed by nurses who are trained as specialized obstetrics case managers. These nurses establish and maintain relationships with Members, helping them become more self-confident and active in their own care. Members are identified through Notification of Pregnancy reports.

Providers may request enrollment in Future Moms by calling:

**Future Moms:** 1-877-681-6694

**Hours of Operation:** 5:30 am – 8 pm, Monday to Friday; 6 am-4: 30 pm Saturday

Each Future Moms Member is assigned a primary registered nurse case manager who provides the Member with continuous support. Once a member is enrolled, the mother-to-be receives a Future Moms Welcome Kit that includes:

- Customized welcome letter
- Futures Moms prenatal book
• **Important Numbers** wallet card
• 28-week mailing with **Labor and Delivery Brochure**
• **Postpartum Nurture Book**
• Customized program letters

**Provider Assessment of Pregnancy Risk**

The PCP or prenatal care physician should assess all pregnant Members for high-risk indicators during the initial prenatal care visit. For all pregnant Members, the provider needs to:

- Complete a **Pregnancy Notification Report** and submit it to our Prenatal Program Coordinator at: 1-877-848-0147.

- Refer Members to prenatal education, childbirth education and breastfeeding classes; Members can register by calling our Customer Care Centers.

- Document all referrals in the Member’s medical record.

- Schedule the Member for a postpartum visit.

**Notification of Pregnancy Reports**

Providers should submit **Pregnancy Notification Reports** to **Anthem** within 7 days of the first prenatal visit or as soon as possible. To submit pregnancy notification online or to print out a copy of the paper-based form, go to: www.anthem.com/ca. These forms are located in the **Forms Library** under **Forms and Tools** on our **Provider Resources** webpage. For information on how to access the **Provider Resources** page of our website, please see Chapter 1: **How to Access Information, Forms and Tools on Our Website**.

Follow the prompts to complete and submit **Online Pregnancy Notification Form**. Providers may also complete the **Pregnancy Notification Report** electronically and then print it out and fax it to us at:

**Pregnancy Notification Fax Number**: 1-800-551-2410

**Breastfeeding**

The **American Academy of Pediatrics**, the **American College of Obstetrics and Gynecology**, and the **American Public Health Association** recognize breastfeeding as the preferred method of infant feeding. Providers should encourage breastfeeding for all pregnant women unless it is not medically appropriate.

To support this goal, Providers should do the following:

- Refer pregnant and postpartum women to our Breastfeeding Support Line at 1-800-231-2999 for information, support and referrals.

- Refer pregnant women to community resources that support breastfeeding such as La Leche League, WIC and breastfeeding classes.

- Assess all pregnant women for health risks that are contraindications to breastfeeding, for example, AIDS and active tuberculosis.

- Provide breastfeeding counseling and support to postpartum women immediately after delivery.

- Assess postpartum women to determine the need for lactation Durable Medical Equipment (DME), such as breast pumps and breast pump kits.

- Document all referrals and treatments related to breastfeeding in the patient’s medical record (pediatricians should document frequency and duration of breastfeeding in baby’s medical record).

- Refer members to breastfeeding classes prior to delivery by calling our Customer Care Center.
- Support continued breastfeeding at the postpartum visit.

**Breastfeeding Support Tools and Services**

Lactation management aids are a covered benefit for Medi-Cal Members. Members can obtain hand-held breast pumps through a prescription without prior authorization. In addition, the following services are available:

- Electric breast pumps are available for Members with medical necessity with a Provider referral and **Prior Authorization**. Contact **Utilization Management** (UM) for more information.
- Arrangement for the provision of human milk for newborns must be made if the mother is unable to breastfeed due to medical reasons and/or the infant cannot tolerate or has medical contraindications to the use of any formula, including elemental formulas. The **Mother’s Milk Bank of Santa Clara Valley Medical Center** is the only human milk bank in the State of California. They can be contacted at: **1-408-998-4550**.

**Health Services Programs**

**Health Management: New Mother and Baby Post Delivery Outreach Program**

The **New Mother and Baby Post-Delivery Outreach Program** is designed to identify mothers and babies with post-delivery support needs. **Anthem** will contact new mothers by telephone within 4 days of receipt of the [Newborn Enrollment Notification Report](#), available in the [Forms Library](#) on the [Provider Resources](#) page at [www.anthem.com/ca](http://www.anthem.com/ca). The purpose of the call is to find out if new mothers have any post-delivery needs, questions or require any resources. **Anthem** will also confirm that the mothers have postpartum and Well Baby appointments scheduled with their Provider within 21-56 days. A second call will be made 14 days after the first call.

The program will allow **Anthem** and its Providers to:

- Establish eligibility for care management programs
- Ensure mothers and babies receive appropriate medical care
- Increase postpartum and Well Child follow-up visits
- Enhance Member engagement
- Increase quality health care outcomes for mothers and their babies
- Raise **Healthcare Effectiveness Data and Information Set** (HEDIS) scores

For this initiative to be effective, Providers should submit the [Newborn Enrollment Notification Report](#) to **Anthem** within 3 days of delivery. The form is available under [Clinical and Preventive Care Tools](#) in the [Forms Library](#) on the [Provider Resources](#) page at [www.anthem.com/ca](http://www.anthem.com/ca). For information on how to access the [Provider Resources](#) page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.

Completed forms should be faxed to **Utilization Management** at: **1-800-754-4708**

If you have any questions about the **New Mother and Baby Post-Delivery Outreach Program**, contact **Anthem's Utilization Management** department at:

**Medi-Cal Utilization Management:** 1-888-831-2246  
**MAP and MRMIP Utilization Management:** 1-877-687-0549 or 1-877-273-4193
Health Services Programs

Health Education: No-Cost Classes

Anthem offers health education services and programs to meet the specific health needs of our Members to promote healthy lifestyles and improve the health of those living with chronic diseases. Health education classes take place at hospitals and/or community-based organizations. Classes are available at no charge to the Member and are accessible upon self-referral or referral by Anthem Providers.

Classes vary from county to county, and include the following:

- Asthma Management
- Breastfeeding Education
- Childbirth/Lamaze
- Cholesterol/Heart Disease Education
- Diabetes Management
- Injury Prevention
- Infant Safety
- Nutrition Counseling
- Parenting/Well Child
- Prenatal Education
- Smoking Cessation/Tobacco Prevention
- Weight Control

Members receive information about health education classes through enrollment materials, newsletters and information made available at their Provider's office. To schedule a health education class, Members should call our Customer Care Centers.

Follow-Up

Anthem sends an Attendance Confirmation Letter to the Member’s PCP with the following information:

- Member’s name
- Member's ID number
- Title of class attended

Providers must document health education services in the Member’s medical record. Documentation must include the following:

- Education topic
- Identification of person providing the education
- Materials distributed to the member
- Notation of any follow-up or recommendations

If a Member does not show up for the registered class, we will mail a No Show Letter to the Member’s PCP. PCPs should file this documentation in the Member’s record for follow-up.
Health Education Materials for Your Office

To access health education materials, including health topic-specific brochures such as Disease Management, Smoking, Pregnancy and Baby’s Health, Exercise & Nutrition and Healthy Lifestyles, please look under Health Education Resources under the Health Education heading on the Provider Resources page of our website: www.anthem.com/ca. Under that same heading, you will also find links to such valuable resources as cultural and linguistic tools, as well as prenatal education brochures. All of these resources may be downloaded right from your office computer. You may also request hard copies of these materials by calling the appropriate Customer Care Center at the number(s) listed at the beginning of this chapter.

For information on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Health Services Programs

Health Education: 24/7 NurseLine

We recognize that questions about health care prevention and management don’t always come up during office hours. 24/7 NurseLine is a 24-hour-a-day, 7-day-a-week phone line staffed by registered nurses. It provides a powerful Provider support system and is an invaluable component of after-hours care. 24/7 NurseLine allows Members to closely monitor and manage their own health by giving them the ability to ask questions whenever they come up.

24/7 NurseLine: 1-800-224-0336
TTY: 1-800-368-4424

Members can call 24/7 NurseLine for:

- Self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments
- Access to specialized nurses trained to discuss health issues specific to our teenage Members
- Information on more than 300 health care topics through the 24/7 NurseLine audio tape library
- Assistance in finding an in-network Provider

Providers can use 24/7 NurseLine as a resource for Members to call for nonemergent questions and information.

Health Services Programs

Health Education: Emergency Room Action Campaign

Too often, our Members use hospital emergency rooms as their first stop for nonemergent conditions. The Emergency Room Action Campaign (ER Action Campaign) was designed to cut down on the number of inappropriate emergency room visits by identifying Members who use the emergency room for the wrong reasons. With this initiative, we can help them understand that nonemergency, preventive and follow-up care should always take place in their PCP’s office.

The ER Action Campaign increases member visits to their PCP by educating members about:

- Seeking care for nonemergency events
- Contacting their PCP first before going to the ER
- Alternatives to ER use
- Importance of follow-up care by their PCPs
Chapter 10: Claims and Billing

Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP

The **ER Action Campaign** is a multipronged communication program which includes:

- **Interactive Voice Response (IVR)** calls made to members who are identified through a clinical analysis of members’ medical claims. The IVR provides a predefined, finite list of barriers for the member to select to identify their reason for going to the ER rather than a PCP.

- Once the call is complete, members are either transferred to the Outbound Call Center (OBC) or are given information on how to contact the **24/7 NurseLine** number. The OBC can help members who need information on their PCP or transportation assistance. The **24/7 NurseLine** can help members determine if they have a medical emergency that requires a visit to the ER and can provide assistance with other concerns, such as filling medications.

- Member responses from the IVR call are used to generate a customized mailing to the member. The mailing addresses the barriers that are identified during the IVR call and provides resources that the member can use instead of going to the ER, such as visiting their PCP.

We rely on the support of the Providers, who remind Members that the PCP’s office and **24/7 NurseLine** should be their first stop for nonemergency conditions. Working together, we can replace the automatic urge to go to the emergency room with the more appropriate action of picking up the phone or returning to the PCP’s office.

**Health Services Programs**

**Health Education: Weight Management Programs**

**Childhood Obesity Initiative**

Given the public health nature of the childhood obesity epidemic, we have developed a multipronged initiative to assist and equip physicians and other health care Providers to screen Members who are overweight or obese. Our goal is to focus on preventive efforts, institute appropriate management, and empower Members to lead healthier lifestyles.

We offer reference tools and materials to assist Providers who care for children to initiate dialogue with families about their child’s weight, nutrition and physical activity and to enhance patient knowledge of these issues. For more information about the **Childhood Obesity Initiative** call **1-866-638-1865** or send an e-mail to: **childhoodobesity@wellpoint.com**.

**Childhood Obesity Physician Tool Kit**

The **Physician’s Tool Kit** includes:

- **Childhood Obesity Desktop Reference Tool**: The “Patient Counseling Guidelines for Families with Overweight Children and Adolescents” gives physicians quick access to data from scientific literature and expert work groups relating to childhood obesity (This reference material is very outdated. We may not want to distribute. Obesity has been transitioned to Enterprise team, Christie Aloneftis and Sarah Sinnett. Both the phone # and shared email address are still valid.)

- **Body Mass Index (BMI) Wheel**: This tool assists physicians and clinical staff in calculating BMI percentiles of their pediatric patients and assessing if they are underweight, normal, overweight or obese.

- **BMI CDC Growth Charts**: These charts assist physicians and clinical staff in plotting the BMI percentiles of their pediatric patients and assessing if they are underweight, normal, overweight or obese

- **Parent Education Materials**
For more information about the Childhood Obesity Physician Tool Kit, call 1-866-638-1865 or send an email to: childhoodobesity@wellpoint.com.

Body Mass Index (BMI) Training

BMI screening is an important first step in identifying children who are overweight or obese. We have developed a statewide BMI training and promotion program that provides education and instruction in measuring, plotting, documenting and tracking BMI. (In person trainings may no longer be available. Need to confirm.)

The training is designed for clinical staff in pediatric and family practice offices, including the following:

- Licensed Vocational Nurses
- Medical Assistants
- Nurse Practitioners
- Registered Nurses

The overall goal of the program is early identification of children who are either overweight or obese in order to provide preventive and management services to those children and their families. A tiered approach to training offers in-person training to providers and their staff upon request and a convenient and web-based online module available at http://www.bmi4kids.info/. For more information about BMI training, call 1-866-638-1865 or send an e-mail to: childhoodobesity@wellpoint.com.

Health Services Programs

Health Education: Smoking Cessation Programs

Anthem supports smoking cessation for Members who want to become smoke-free. The program's goals are to:

- Assist Members in improving their health status and quality of life by becoming more actively involved in their own care
- Encourage Members to quit smoking
- Support Members' tobacco cessation efforts with resources and education

The program is a health education program in the form of a booklet developed by the National Cancer Institute called "Clearing the Air." The booklet provides tips to support tobacco cessation by identifying available resources and offering tools for quitting, such as:

- Winning strategies of successful quitters
- Coping skills for fighting the urge to smoke
- Strategies for success after a relapse
- National Quit Line contact information

National Quit Line: 1-877-44U-QUIT (1-877-448-7848)

Smoking cessation information is made available to members in several ways. Once enrolled, Members receive information on available resources in the Plan's welcome packet. Members can also request the Clearing the Air booklet directly when using the 24/7 NurseLine or when talking to utilization management nurses or social workers.

The booklet is available to download from the following websites:


California Smokers’ Helpline

1-800-NO-BUTTS is the California Department of Health helpline to assist Members who want to quit smoking. Callers receive a choice of services, including self-help materials, a referral list of programs and one-to-one counseling over the phone.

California Smokers' Helpline: 1-800-662-8887 (1-800-No-Butts)
Website:  www.californiasmokershelpline.org

Provider Assessment of Tobacco Use

- Assess Member smoking status and offer quick advice about quitting.
- Use Pregnancy Notification Reports to notify us of pregnant women who smoke. Women are more likely to quit smoking during pregnancy.
- Encourage pregnant women to stop smoking, and to continue this tobacco cessation after pregnancy.

The Pregnancy Notification Report is available in the Forms Library on the Provider Resources page of our website: www.anthem.com/ca. For information on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Health Services Programs

Telehealth

Telehealth uses teleconferencing equipment, specialized medical cameras and computer technology to provide a unique health care delivery option to connect patients, Providers and Specialists who are separated by distance. The system can be used to examine, diagnose, treat and educate patients at remote locations.

Telehealth can connect a Provider's office to a Specialty Center in one of the following ways:

- **Live Video Consult:** The Primary Care Provider (PCP) and Specialist meet at the same time using encrypted video conferencing equipment.
- **Store and Forward:** PCP sends images of the patient’s condition and medical history as an encrypted email to the Specialist for review.

Telehealth offers multiple benefits to Providers and Members:

- The Member can continue to be cared for by their local Provider
- The Member does not need to travel long distances to receive Specialist care
- The PCP receives all records and test results from the encounter
- The PCP consults with the Specialist participating in the Telehealth encounter to design any necessary course of treatment

Telehealth can also be used for nonclinical consults such as community services, continuing medical education and other Provider training sessions.

To find out more about Telehealth, use the following contact information:

**Telehealth Phone:**  1-866-855-2271
**Telehealth Fax:**  1-805-987-0736
**Telehealth Website:**  http://w2.anthem.com/bcc_state/tm/info/index.asp
CHAPTER 10: CLAIMS & BILLING

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm

Claims & Billing Overview

Having a fast and accurate system for processing claims allows Providers to manage their practices and our Members’ care more efficiently.

With that in mind, Anthem has made claims processing as streamlined as possible. The following guidelines should be shared with your office staff, billing service and electronic data processing agents, if you use them.

➢ Submit “clean” claims, making sure that the right information is on the right form.
➢ Submit claims as soon as possible after providing service.
➢ Submit claims within the contract filing time limit.

We return claims submitted with incomplete or invalid information and request that the claim be corrected and resubmitted. Clearinghouses for Electronic Data Interchange (EDI) also reject claims that are incomplete or invalid. Providers are responsible for working with their EDI vendor to ensure that claims that error out from the EDI gateway are corrected and resubmitted.

Billing for Pharmaceuticals

Medi-Cal billings for pharmaceuticals dispensed in both professional and institutional settings should include the following information:

- National Drug Codes (NDCs)
- Healthcare Common Procedure Coding System (HCPCS) Code
- Unit of Measurement
- Unit Quantity

For more information, log on to the state’s Medi-Cal website at: www.medi-cal.ca.gov.

Providers also can contact the Medi-Cal Telephone Service Center at 1-800-541-5555 from 8am-5pm Monday to Friday.

Billing for Medical Supplies

When billing for Members enrolled in Medi-Cal, Providers are required to include a Universal Product Number (UPN), invoices submissions or for Enteral Medical Billing Number (MBN) for claims involving medical supplies. For more information, please refer to the Department of Health Care Services-Medi-Cal (www.medi-cal.ca.gov):

Claims & Billing

Claims Processing – McKesson ClaimsXten

For claims processing, Anthem uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates McKesson editing rules that apply plan payment policies. The rules determine whether a claim should be paid, rejected or require manual processing.
The editing rules evaluate Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the CMS-1500 form. A claim auditing action then determines how the procedure codes and code combinations will be adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. Providers can refer to McKesson ClaimsXten rules by logging onto Provider Access, our secure Provider web portal at www.anthem.com/ca. From the main site, select OTHER ANTHEM WEBSITES: Providers, and then select “Medical” from the drop-down Login menu to get to the Login page for ProviderAccess. The site requires registration. If you have not registered, please select Register for ProviderAccess and follow the prompts to create an account.

ClaimsXten may be updated periodically. Anthem will notify Providers with advance notice as per the Provider Agreement.

Clear Claim Connection

Clear Claim Connection is a web-based tool that enables Providers to review the claim auditing rules and clinical rationale of the claim processing software. Providers may access Clear Claim Connection through the Anthem website in order to prospectively prescreen claims and retrospectively inquire on claim disposition.

Claims submitted correctly the first time are called “clean,” meaning that all required fields have been filled in and that the correct form was used for the specific type of service provided.

A claim may be returned if it is submitted with incomplete or invalid information. If you use the Electronic Data Interchange (EDI), claims will be returned for incomplete or invalid information. They may also be returned if they aren’t submitted with the proper HIPAA-compliant code set. In each case, an error report will be sent to you, and the claim will not be sent through for payment. You and your staff are responsible for working with your EDI vendor to ensure that “errored out” claims are corrected and resubmitted.

Generally, there are two types of forms you’ll need for reimbursement. They are:

- CMS-1500 for professional services
- CMS-1450 (UB-04) for institutional services

These forms are available in both electronic and hard copy/paper formats. Click on the form name (Where?) to link to a copy of the form with a general description of each field and the information required.

Please Note: Not correctly or completely filling out the form causes the claim to be returned, resulting in processing and payment delays.

Claims & Billing

Methods for Submission

There are two methods for submitting a claim:

- Electronically through Electronic Data Interchange (preferred)
- Paper or "hard copy"

Electronic submission through Anthem's Electronic Data Interchange is preferred for accuracy, convenience and speed. Providers will receive notification that an electronic claim has been submitted within 24 hours.

If the claim contains all required information, Anthem enters it into the claims system for processing and sends you either a Remittance Advice (RA) or a Claims Disposition Notice (CDN) when the claim is finalized.
Clean electronic claims are paid within 21 business days; clean paper claims are paid within 30 business days. **Anthem** pays interest on clean claims paid after these time frames.

**Claims & Billing**

**Electronic Claims**

Electronic filing methods are preferred for accuracy, convenience and speed. **Electronic Data Interchange** (EDI) allows Providers and facilities to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions.

If you use EDI, you must submit the following information:

- Billing Provider Name
- Rendering Provider
- Legal Name
- License Number (if applicable)
- Medicare Number (if applicable)
- Federal Provider Tax ID Number
- Medi-Cal ID Number
- National Provider Identifier (NPI)

For EDI claims submissions that require attachments, contact your clearinghouse for guidelines. For more information on EDI, Providers and vendors may call the **Anthem EDI Solutions Helpdesk**:

**Anthem EDI Solutions Helpdesk:** 1-800-470-9630  
**Hours of Operation:** Monday to Friday, 5am-1:30pm  
**EDI Solutions E-mail:** ent.edi.support@anthem.com

For more detailed information, there is a website dedicated to sharing billing information with Providers and EDI vendors, including electronic clearinghouses. This information includes details on how to submit, receive and troubleshoot electronic transactions. To access all EDI manuals, forms and communications, go to: www.anthem.com/edi.

The following are available online:

- EDI registration information and forms  
- EDI contacts and support information  
- EDI communications and electronic submission tips  
- Information on electronic filing benefits and cost-savings  
- Filing instructions for EDI submission of eligibility, benefit and claim status inquiries  
- **Anthem HIPAA Companion Guide** and **EDI User Guide** with complete information on submitting and receiving electronic transactions  
- **Anthem** report descriptions  
- Lists of clearinghouses, software vendors and billing agencies  
- FAQ’s about electronic transactions  
- Information and links to the **Health Insurance Portability and Accountability Act** (HIPAA) website  
- Contractual agreements with our trading partners
Claims & Billing

Paper Claims

Paper claims are scanned for clean and clear data recording. To get the best results, paper claims must be legible and submitted in the proper format. Follow these requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare and Medicaid Services standards.
- Use black or blue ink (do not use red ink, as the scanner may not be able to read it).
- Use the “Remarks” field for messages.
- Do not stamp or write over boxes on the claim form.
- Send the original claim form to Anthem and retain a copy for your records.
- Separate each individual claim form. Do NOT staple original claims together; Anthem will consider the second claim as an attachment and not an original claim to be processed separately.
- Remove all perforated sides from the form; leave a ¼-inch border on the left and right side of the form after removing perforated sides. This helps our scanning equipment scan accurately.
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned.
- Hand written claims need to use all capital letters and do not go out side of boxes into red areas. Use black ink and not markers.
- Don't highlight any fields on the claim forms or attachments; doing so makes it more difficult to create a clear electronic copy when scanned.
- If using a dot matrix printer, do not use “draft mode” since the characters generally do not have enough distinction and clarity for the optical scanner to read accurately.

If you submit paper claims, you must include the following Provider information:

- Provider name
- Rendering Provider Group or Billing Provider
- Federal Provider **Tax Identification Number** (TIN)
- National Provider Identifier (NPI)
- License number (if applicable)
- Medicare number (if applicable)

**Please Note:** Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim. Claims with attachments should be submitted on paper.

Mail paper claims to:

**Anthem Blue Cross**
P.O. Box 60007
Los Angeles, CA 90060-0007
Claims & Billing

Paper Claims Processing

All submitted paper claims are assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. This number contains the Julian date, which indicates the date the claim was received.

Document Control Numbers are composed of 11 digits:

- 2-digit plan year
- 3-digit Julian date
- 2-digit Anthem reel identification
- 4-digit sequential number

Claims entering the system are processed on a line-by-line basis except for inpatient claims, which are processed on a whole-claim basis. Each claim is subjected to a comprehensive series of checkpoints called “edits.” These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

The Provider is responsible for all claims submitted with the Provider number, regardless of who completed the claim. If you use a billing service, you must help ensure that your claims are submitted properly.

Claims & Billing

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit, all numeric identifier. NPIs are only issued to Providers of health services and supplies. As a provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the NPI is intended to improve efficiency and reduce fraud and abuse.

There are several advantages to using the Provider NPI for claims and billing:

- It allows Providers to bill with only one number
- It simplifies the billing process since it is no longer necessary to maintain and use legacy identifiers for each health care plan
- It simplifies making changes to addresses or locations

NPIs are divided into 2 types:

- **Type 1**: Individual Providers, which includes but is not limited to physicians, dentists and chiropractors
- **Type 2**: Hospitals and medical groups, which includes but is not limited to hospitals, residential treatment centers, laboratories and group practices

For billing purposes, claims must be filed with the appropriate NPI for billing, rendering and referring Providers. Providers may apply for an NPI online at the National Plan and Provider Enumeration System (NPPES) website: [https://nppes.cms.hhs.gov](https://nppes.cms.hhs.gov). Or, you can get a paper application by calling NPPES at:

**NPPES:** 1-800-465-3203

The following websites offer additional NPI information:

Chapter 10: Claims and Billing

Anthem Blue Cross

Medi-Cal, Medi-Cal Access Program and MRMIP

- National Plan and Provider Enumeration System (NPPES):
  https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do
- National Uniform Claims Committee:
  www.nucc.org

Claims & Billing

Clinical Submissions Categories

The following is a list of claims categories for which we may routinely require submission of clinical information before or after payment of a claim:

- Claims involving precertification/Prior Authorization/pre-determination (or some other form of utilization review) including but not limited to:
  - Claims pending for lack of precertification or Prior Authorization
  - Claims involving medical necessity or experimental/investigative determinations
  - Claims for Injectables requiring Prior Authorization
- Claims requiring certain modifiers, including local code (HCPCS Level III Interim codes if required
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, benefit determination cannot be made without reviewing medical records, including but not limited to pre-existing condition issues, emergency service-prudent layperson reviews and specific benefit exclusions
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external), including high-dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated)

Other situations in which clinical information might routinely be requested:

- Accreditation activities
- Coordination of benefits
- Credentialing
- Quality improvement/assurance efforts
- Recovery/subrogation
- Requests relating to underwriting (including but not limited to Member or Provider misrepresentation/fraud reviews and Stop Loss coverage issues)

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.

Claims & Billing

Coordination of Benefits

Anthem may coordinate benefits with any other health care program that covers our Members, including Medicare. Indicate “Other Coverage” information on the appropriate claim form. If there is a need to
coordinate benefits, include at least one of the following items from the other health care program when submitting a **Coordination of Benefits (COB)** claim:

- Third Party Remittance Advice (RA)
- Third Party Provider Explanation of Benefits (EOB)
- Notice from third party explaining the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other health care program first. Please make sure that the information you submit **explains all coding** listed on the other carrier’s RA or letter. We cannot process the claim without this specific information.

The filing limits for COB claims are as follows:

- **180 Days**: For hospitals, institutions and professional services Providers
- **365 Days**: For ancillary service Providers
- **Claims follow-up resubmissions are subject to the 90-day resubmission filing limit**

**Claims & Billing**

**Claim Forms and Filing Limits**

Claims must be submitted within the contracted filing limit to be considered for payment. Claims submitted after that time period will be denied.

Determine filing limits as follows:

- **If Anthem** is the primary payer, use the length of time between the last date of service on the claim and **Anthem’s** receipt date.
- **If Anthem** is the secondary payer, use the length of time between the other payer’s notice or **Remittance Advice (RA)** date and Anthem’s receipt date.

**Please Note**: **Anthem** is not responsible for a claim never received. And if a claim is submitted inaccurately, prolonged periods before resubmission may cause you to miss the filing deadline. Claims must pass basic edits in order to be considered received. To avoid missing deadlines, submit “clean” claims as soon as possible after delivery of service.

**Claims & Billing**

**Filing and Reimbursement Limits for Medi-Cal Claims**

In order for Providers to be reimbursed fully for professional **Medi-Cal** claims, those claims must be submitted within 180 days of the date of service. **Please note**: In the event of an inconsistency between information contained in this Provider Manual and the **Agreement** between you or your facility and **Anthem**, the **Agreement** shall govern.

Reimbursement for professional (excluding 365 Days: for ancillary services) claims submitted between 180 and 365 days of date of service will be reduced by the following amounts:

- 25 percent for claims submitted seven through nine months after the month of service or
- 50 percent for claims submitted 10 through 12 months after the month of service.

Pursuant to the **California Welfare and Institutions Code (W&I) Section 14115**, **DHCS** allows for the following four exceptions to the six-month billing limit:

- If the patient has failed to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.
• If a Provider has submitted a bill to a liable third party, the Provider has one year after the month of service to submit the bill for payment.

• If a legal proceeding has commenced in which the Provider is attempting to obtain payment from a third party, the Provider has one year to submit the bill after the month in which the services have been rendered.

• If Anthem finds that the delay in submission of the bill was caused by circumstances beyond the control of the Provider.

**Anthem does not reimburse claims submitted more than one year after the date of service.**

Providers who have questions about claims submittal timelines can call our Customer Care Center at 1-800-407-4627 (outside L.A. County), or 1-888-285-7801 (inside L.A. County) **Monday through Friday from 7 a.m. to 7 p.m.**

**Other Filing Limits**

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Time Limit to File</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third Party Liability (TPL) or Coordination of Benefits (COB)</td>
<td>If the claim has TPL or COB and requires submission to a third party before submitting to us, the filing limit starts from the date on the notice or Remittance Advice (RA) from the third party.</td>
<td>From the date of notice or RA from the third party, follow the applicable claim filing limits.</td>
</tr>
<tr>
<td>Checking Claim Status</td>
<td>Claim status may be checked any time on ProviderAccess, the Provider home page, or by calling the Customer Care Center IVR System.</td>
<td>After 30 business days from the Plan's receipt of a clean claim, submit a <strong>Claim Follow-Up Form</strong>.</td>
</tr>
<tr>
<td>Claim Follow-Up Form or Mailback Form</td>
<td>To submit a corrected claim following the Plan's request for more information, correction to a claim, or to follow up a claim that has not been paid, denied or contested.</td>
<td>Provider must return request information to the Plan within 90 days from the date of the Plan's request for correction.</td>
</tr>
<tr>
<td>Provider Dispute</td>
<td>Providers may request a claim reconsideration in writing with a <strong>Provider Dispute Resolution Request Form</strong>.</td>
<td>The request for claim reconsideration must be received within 365 days from the receipt of the Plan's RA.</td>
</tr>
<tr>
<td>Plan Response to Provider Dispute Resolution Request</td>
<td>The Plan's response time to investigate and make a determination based on guidelines.</td>
<td>The Plan sends acknowledgement within 15 days of receipt of dispute. Determination is made within 45 business days from the Plan's receipt of dispute or amended dispute.</td>
</tr>
</tbody>
</table>
**Claims & Billing**

**Claims Processing**

Once we receive a claim, the claim is assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. DCNs are composed of 11 digits:

- 2-digit Plan year
- 3-digit Julian date
- 2-digit reel identification
- 4-digit sequential

Claims entering the system are processed on a line-by-line basis, except for inpatient claims. Inpatient claims are processed on an entire claim basis. Each claim is subjected to a comprehensive series of checkpoints called "edits." The edits verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review.

**Please Note:** Providers are responsible for all claims submitted with their Provider number, regardless of who completed the claim. Providers using billing services must ensure that their claims are handled properly.

**Claims & Billing**

**Claims Returned for Additional Information**

Anthem will send you a request for additional or corrected information when the claim cannot be processed due to incomplete, missing or incorrect information.

The request includes a form that allows you to return the requested information in an easy-to-follow format. We call this a **Mailback Form**. Providers have 90 days from the date on the **Mailback Form** to submit the corrected claim information. If the Provider does not resubmit within this time frame, the claim is denied.

**Claims & Billing**

**Common Reasons for Rejected and Returned Claims**

Many of the claims returned for further information are returned for common billing errors. The following grid lists the most common errors.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Explanation</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number Incomplete</td>
<td>The state provides ID cards to the Member in addition to our ID card. The Member’s Plan ID number is called the CIN number. It includes a three-digit alpha prefix, followed by 10-14 numerical digits.</td>
<td>Make sure to use the Member’s CIN number from his or her paper ID card, not the number from the state’s card.</td>
</tr>
<tr>
<td>Duplicate Claim Submission</td>
<td>Duplicate claims are submitted before the applicable processing time frame has passed. Overlapping services dates for the same service create a question about duplication.</td>
<td>Wait to resubmit a claim until the appropriate time frame for processing has passed. Then, look up claim status on the Provider website or use the IVR phone system to check claim status.</td>
</tr>
<tr>
<td>Problem</td>
<td>Explanation</td>
<td>Resolution</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>------------</td>
</tr>
<tr>
<td>Authorization Number Missing or Doesn’t Match Services</td>
<td>The authorization number is missing or the approved services do not match the services described in the claim.</td>
<td>Confirm that the authorization number is on the claim form (CMS-1500 Box 24 and CMS 1450 Box 63) and that the approved services match the provided services.</td>
</tr>
<tr>
<td>Missed Filing Limit</td>
<td>The time frame for submitting a claim for reimbursement is determined by the applicable Anthem State Sponsored Business Provider Agreements and the type of services provided: Professional, ancillary or institutional.</td>
<td>Be sure to submit the claim within: 180 days from date of service for professionals (CMS-1500) 180 days from date of service in institutions (CMS-1450)</td>
</tr>
<tr>
<td>Missing Codes for Required Service Categories</td>
<td>Current HCPCS and CPT Manuals must be used because changes are made quarterly or annually. Manuals may be purchased at any technical bookstore or call the American Medical Association to order them.</td>
<td>Make sure all services are coded with the correct codes. Check the codebooks or ask someone in your office familiar with coding.</td>
</tr>
<tr>
<td>Unlisted Code for Service</td>
<td>Some procedures/services do not have an associated code, so an unlisted procedure code is used.</td>
<td>Anthem needs a description of the procedure and medical records when appropriate in order to calculate reimbursement. For DME that is By Report, an invoice and MSRP catalog page is required for dates of service on or after January 01, 2013. For prosthetic devices, hearing aids, or blood products, we require a manufacturer’s invoice.</td>
</tr>
<tr>
<td>By Report Code for Service</td>
<td>Procedure or service information is missing.</td>
<td>Anthem needs a description of the procedure and medical records when appropriate in order to calculate reimbursement. For DME that is By Report, an invoice and MSRP catalog page is required for dates of service on or after January 01, 2013. For prosthetic devices, hearing aids, or blood products, we require a manufacturer’s invoice. For drugs and injections, we require the NDC number.</td>
</tr>
<tr>
<td>Unreasonable Numbers Submitted</td>
<td>Unreasonable numbers, such as “9999,” may appear in the Service Units fields.</td>
<td>Be sure to check your claim for accuracy before submission.</td>
</tr>
<tr>
<td>Submitting Batches of Claims</td>
<td>Stapling claims together can make the subsequent claims appear to be attachments rather than individual claims.</td>
<td>Make sure each individual claim is clearly identified and not stapled to another claim.</td>
</tr>
<tr>
<td>Incorrect Return of Requested Information</td>
<td>When we request additional information, we include a Mailback Form in the request.</td>
<td>Be sure to attach records or the corrected claim to the original Mailback Form. Do not reattach a new claim copy. Send each Mailback Form in a separate envelope to be sure each is identified as an individual response.</td>
</tr>
</tbody>
</table>
### Problem | Explanation | Resolution
--- | --- | ---
Nursing Care | Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. Also, we will not pay claims using different room rates for the same type of room to adjust for nursing care. | Do not submit bills for nursing charges.
Hospital Medicare ID Missing | A Medicare ID number is required for claim processing. Hospitals claim at their appropriate contracted rates. | On the CMS-1450 Form, hospitals must enter their Medicare ID number in Box 64.

**Claims & Billing**

**Claims Filed With Wrong Plan**

If you file a claim with the wrong insurance carrier, **Anthem** will process your claim without denying it for failure to file within the filing time limits if:

- There is documentation verifying that the claim was initially filed in a timely manner
- The corrected claim was filed within 90 days of the date of the other carrier’s denial letter or Remittance Advice (RA) form

**Claims & Billing**

**Payment of Claims**

Once we receive a claim, the following steps are taken:

1. **Anthem** processing systems analyze and validate the claim for Member eligibility, covered services and proper formatting.
2. **Anthem** processing systems validate billing, rendering and referring Provider information against **Anthem** and DHCS files.
3. **Anthem** generates a Remittance Advice (RA), summarizing services rendered and payer action taken.
4. **Anthem** sends the appropriate payment to the Provider.

**Anthem** will finalize a clean electronic claim within 21 days from the date the claim is received. Clean paper claims are paid within 30 days.

**Claims & Billing**

**Electronic Remittance Advice**

**Anthem** offers secure electronic delivery of remittance advices, which explain claims in their final status. This service is offered through **Electronic Data Interchange (EDI)**. For more information, Providers and vendors may call the **Anthem EDI Solutions Helpdesk**:

**Anthem EDI Solutions Helpdesk:** 1-800-470-9630
Chapter 10: Claims and Billing

Claims & Billing

Electronic Funds Transfer

Anthem allows Electronic Funds Transfer (EFT) for claims payment transactions. This means that claims payments can be deposited directly into a previously selected bank account. Providers can enroll in this service by contacting the Anthem EDI Solutions Helpdesk:

Anthem EDI Solutions Helpdesk: 1-800-470-9630

Claims & Billing

Monitoring Submitted Claims

Claims status can be monitored by doing the following:

- Monitor claim status through the Customer Care Center’s Interactive Voice Response (IVR) at the contact numbers listed at the beginning of this chapter.

Please Note: The Interactive Voice Response (IVR) accepts either your National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for Provider ID. Should the system not accept those numbers, it will redirect your call to the Customer Care Center. For purposes of assisting you, we may ask again for your TIN.

Claims & Billing

Claims Follow-Ups/Resubmissions

Providers can initiate follow-up action to determine claim status if there has been no response from Anthem within 30 days of the Plan’s receipt of the claim. To follow up on a claim, go online to the Availity Health Information Network. To register for Availity, take the following steps:

1. Go to www.availity.com
2. Click on Register Now
3. Complete the online registration wizard
4. Print, sign and fax the application
5. You will receive email from Availity with a temporary password and next steps

When resubmitting a claim, take the following steps:

1. Complete all required fields as originally submitted and mark the change(s) clearly.
2. Write or stamp "Corrected Claim" across the top of the form.
3. Attach a copy of the EOB and state the reason for resubmission.
4. Attach all supporting documentation.
5. Send to:
   Claim Follow-Up
   Anthem Blue Cross
   P.O. Box 60007
   Los Angeles, Ca. 90060-0007
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Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP

Claims & Billing

Claims Overpayment Recovery Procedure

Anthem seeks recovery of all excess claims payments from the person or entity to whom the benefit check is made payable. When an overpayment is discovered, Anthem initiates the overpayment recovery process by sending written notification.

If you are notified by Anthem of an overpayment or discover that you have been overpaid, mail the check along with a copy of the notification or other supporting documentation within 30 days to the following address:

Anthem Blue Cross
P.O. Box 92420
Cleveland, OH 44193

If Anthem does not hear from you or receive payment within 30 days, the overpayment amount is deducted from future claims payments. In cases where Anthem determines that recovery is not feasible, the overpayment is referred to a collection service.

Claims & Billing

Claims Disputes

If a Provider does not agree with the outcome of a claim decision, the Provider can file a Provider Dispute Resolution (PDR) request with Anthem. The request must be submitted in writing within 365 days from the date of the Provider’s receipt of our Remittance Advice notice. The Provider Resolution Request Form is available in the Forms Library on the Provider Resources page on our website: www.anthem.com/ca. For information on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

To file a dispute, include the following information:

- The completed Provider Dispute Resolution Request Form with all points of contention itemized and explained
- A copy of the original CMS 1500 or CMS-1450 claim form
- All supporting documents the Provider deems pertinent or that Anthem has requested

Mail the Provider Dispute Resolution Request Form and supporting documentation to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, Ca. 90060-0007

Anthem will send an acknowledgement or receipt to Providers within 15 business days from the date the Provider dispute was submitted. Then we take one of the following steps:

- If the PDR results in reimbursement, we will send an Overturn Letter within 45 business days of the Plan’s receipt of the dispute request. The Provider will also receive a corrected Remittance Advice notice.
- If no reimbursement is made, we will send an Uphold Letter within 45 business days of the Plan’s receipt of the dispute request.
Chapter 10: Claims and Billing

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Claims & Billing

Capitated Group Claims Processing

When claims processing is a delegated activity, Anthem oversees the processing and dispute resolution to ensure that both are conducted in a timely manner and in accordance with state/federal regulations and contractual agreements.

Groups must have written procedures for claims processing available for review. These procedures are outlined in your Anthem Blue Cross State Sponsored Business Group Agreement. These procedures and disclosures must comply with state/federal laws and regulations and our contractual standards and requirements. They must also be made available upon request by Anthem or a regulatory agency.

Group Claims Processing Systems must identify and track all claims activities, including claims disputes and resolutions, and be able to deliver monthly reports. Groups must be able to identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt in the same manner as the claim was submitted.

- If the claim was received electronically, the group must provide acknowledgement within two business days of receipt of the claim.
- If the claim was a paper claim, the group must provide acknowledgement within 15 business days of receipt of the claim.

Groups must pay a clean claim (or a portion thereof) or contest or deny a claim (or a portion thereof) within 45 business days of receipt of the claim (or within contractual timeframes which comply with the timeframes set forth in this section). The group’s request for additional information must be sent to the Provider of service with a due date for the requested information.

- Payment of a clean claim or notification of a denial must be sent, accompanied by a Remittance Advice (RA), to the Provider of service within 45 business days of the date a claim is received.
- The date of payment or notification of denial is the postmarked date of the payment.
- The Provider and Member must be notified if a claim is denied, adjusted or contested. The notification must include an understandable written explanation of the reasons for the denial, adjustment or contested elements.

Groups must have a dispute resolution mechanism in place that allows Providers to file a dispute within 365 days of receipt of an RA. All disputes must be resolved within 45 business days of the group’s receipt of the dispute or as required by applicable state/federal law.

- If a group determines that a claim was overpaid, the group must notify the Provider in writing of the overpayment.
- The written notice must identify the claim, the name of the Member, the date of service and a clear explanation of the basis upon which the group believes the amount paid was in excess of the amount due, including interest and penalties.
- Providers have 30 days from the receipt of the notice of the overpayment to contest or reimburse the overpayment.

The responsibility for claims payment as outlined above continues until all claims have been paid or denied for services rendered pursuant to your Anthem Blue Cross State Sponsored Business Group Agreement.

For questions related to delegation of claims processing activities, contact your group administrator.
Claims & Billing

Capitated Group Encounter Data Reporting

Capitated groups delegated for claims processing must submit all encounter data electronically to us on a monthly basis. Encounters must be reported by the 10th day of the month for all encounters for the preceding 90 days.

For example, encounter data submitted on July 10 should reflect encounters from April 1 through July 1. California’s DHCS requires that all encounter data be submitted on time.

Encounter Data File Format

Provide encounter data to Anthem in a proprietary format, except for L.A. Care Health Plan Members. For those Members, submit encounter data in the latest X12N37 HIPAA-compliant format.

For questions about encounter data reporting, contact the appropriate Customer Care Center and ask to be transferred to the Data Analysis Department. The contact information for our Customer Care Centers is listed at the beginning of this chapter.

Claims & Billing

CMS-1500 Claim Form

All Providers and Vendors should bill us using the most current version of the CMS-1500 claim form.

Claims & Billing

CMS-1500 Claim Form Fields

<table>
<thead>
<tr>
<th>Field #</th>
<th>Title</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 1</td>
<td>Medicaid/Medicare/Other ID</td>
<td>If the claim is for Medi-Cal, put an X in the Medicaid box. If Member has both Medi-Cal and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.</td>
</tr>
<tr>
<td>Field 1a</td>
<td>Insured's ID Number</td>
<td>From the Plan Member's ID card. Be sure to use the Member's CIN number from the paper ID card, not the number from the state's card.</td>
</tr>
<tr>
<td>Field 2</td>
<td>Patient's Name</td>
<td>Enter last name first, then first name and middle initial (if known). Do not use nicknames or full middle names.</td>
</tr>
<tr>
<td>Field 3</td>
<td>Patient's Birth Date</td>
<td>Enter date of birth as MM/DD/YY. If the full date of birth is not available, enter the year, preceded by 01/01.</td>
</tr>
<tr>
<td>Field 4</td>
<td>Insured's Name</td>
<td>&quot;Same&quot; is acceptable if the insured is the patient. (Not required by Medi-Cal)</td>
</tr>
<tr>
<td>Field 5</td>
<td>Patient's Address/Telephone Number</td>
<td>Enter complete address. Include any unit or apartment number. Include abbreviations for road, street, avenue, boulevard, place, etc. Enter patient’s phone number, including area code.</td>
</tr>
<tr>
<td>Field 6</td>
<td>Patient Relationship to Insured</td>
<td>The relationship to the Member, such as self, spouse, children or other. (Not required by Medi-Cal)</td>
</tr>
<tr>
<td>Field #</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 7</td>
<td>Insured’s Address/Phone Number</td>
<td>&quot;Same&quot; is acceptable if the insured is the patient. (Not required by Medi-Cal)</td>
</tr>
<tr>
<td>Field 8</td>
<td>Patient Status</td>
<td>Check patient’s status (single, married, other, employed, full-time student or part-time student). Check all that apply.</td>
</tr>
<tr>
<td>Field 9</td>
<td>Other Insured’s Name</td>
<td>If there is other insurance coverage in addition to the Member’s coverage, enter the name of the insured.</td>
</tr>
<tr>
<td>Field 9a</td>
<td>Other Insured’s Policy or Group Number</td>
<td>Name of the insurance with the group and policy number.</td>
</tr>
<tr>
<td>Field 9b</td>
<td>Other Insured’s Date of Birth</td>
<td>Enter date of birth in the MM/DD/YY format.</td>
</tr>
<tr>
<td>Field 9c</td>
<td>Employer’s Name or School Name</td>
<td>Name of other insured's employer or school.</td>
</tr>
<tr>
<td>Field 9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Name of Plan carrier.</td>
</tr>
<tr>
<td>Field 10</td>
<td>Patient’s Condition Related To</td>
<td>Include any description of injury or accident, including whether it occurred at work.</td>
</tr>
<tr>
<td>Field 10a</td>
<td>Related to Employment?</td>
<td>Y or N. If insurance is related to Workers Compensation, enter Y.</td>
</tr>
<tr>
<td>Field 10b</td>
<td>Related to Auto Accident/Place?</td>
<td>Y or N. Enter the state where the accident occurred.</td>
</tr>
<tr>
<td>Field 10c</td>
<td>Related to Other Accident?</td>
<td>Y or N.</td>
</tr>
<tr>
<td>Field 10d</td>
<td>Reserved for Local Use</td>
<td>If applicable, use for Member copayment.</td>
</tr>
<tr>
<td>Field 11a-b</td>
<td>Insured’s Policy Group of FECA Number, Date of Birth, Sex, Employer or School Name</td>
<td>Complete information about Insured, even if same as Patient.</td>
</tr>
<tr>
<td>Field 14</td>
<td>Date of Current</td>
<td>Injury, Illness or Pregnancy</td>
</tr>
<tr>
<td>Field 21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Enter the appropriate diagnosis code or nomenclature. Check the manual or ask a coding expert.</td>
</tr>
<tr>
<td>Field 24a</td>
<td>Date(s) of Service</td>
<td>If dates of service cross over from one year to another, submit two separate claims: For example, one claim for services in 2012, one claim for services in 2013.</td>
</tr>
<tr>
<td>Field 24b</td>
<td>Place of Service</td>
<td>This is a two-digit code. Use current coding as indicated in the CPT manual.</td>
</tr>
<tr>
<td>Field 24d</td>
<td>Procedure, Services or Supplies</td>
<td>Enter the appropriate CPT codes or nomenclature. Indicate appropriate modifier when applicable. Do NOT use NOC Codes unless there is no specific CPT code available. If using an NOC code, include a narrative description.</td>
</tr>
<tr>
<td>Field 24e</td>
<td>Diagnosis Code</td>
<td>Use the most specific ICD-9 Code available.</td>
</tr>
<tr>
<td>Field 24f</td>
<td>Charges</td>
<td>Charge for each single line item.</td>
</tr>
</tbody>
</table>
### Chapter 10: Claims and Billing

<table>
<thead>
<tr>
<th>Field #</th>
<th>Title</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 24g</td>
<td>Days or Units</td>
<td>If applicable.</td>
</tr>
<tr>
<td>Field 24h</td>
<td>EPSDT Family Plan</td>
<td>Enter Y for EPSDT or N for non-EPSDT.</td>
</tr>
<tr>
<td>Field 25</td>
<td>Federal Tax ID Number</td>
<td>Enter the 9-digit number.</td>
</tr>
<tr>
<td>Field 28</td>
<td>Total Charge</td>
<td>Total of line item charges.</td>
</tr>
<tr>
<td>Field 31</td>
<td>Full Name and Title of Physician or Supplier</td>
<td>Actual signature or typed/printed designation is acceptable.</td>
</tr>
<tr>
<td>Field 32</td>
<td>Provider Servicing Address</td>
<td>Include suite or office number. Include abbreviations for road, street, avenue, boulevard, place or other common street name endings.</td>
</tr>
<tr>
<td>Field 33</td>
<td>Physician's or Supplier's Billing Name</td>
<td>Provider Identification Number (the number Anthem assigns to the Provider.)</td>
</tr>
</tbody>
</table>
CHAPTER 11: BILLING PROFESSIONAL & ANCILLARY CLAIMS

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549

Billing Professional & Ancillary Claims

Overview

This chapter will be divided into two sections:

- Billing Requirements for Professional Claims
- Billing Requirements for Ancillary Claims

Standardized code sets must be used. The Healthcare Common Procedure Coding System (HCPCS), sometimes referred to as the National Codes, provides coding for a variety of services. HCPCS consists of two principal subsystems, referred to as Level 1 and Level 2:

- **Level 1**: The Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA).
  - CPT codes are represented by five numeric digits.
- **Level 2**: Other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and Durable Medical Equipment (DME). These are sometimes called the alphanumeric codes because they consist of a single alphabetical letter followed by four numeric digits.
  - Products, supplies and services NOT included in the CPT codes are represented by a single alphabetical letter followed by four numeric digits.

In addition to the HCPCS (national) codes, the California Department of Health Care Services (DHCS) created a separate set of codes and modifiers for its Medi-Cal Program, sometimes called Local Codes. These codes and modifiers identify services and products specific to Medi-Cal.

Special professional and ancillary billing instructions include the following:

**Physician License Number**: Indicate the rendering physician's state-issued license number in Box 24J of the CMS-1500 form. Missing or invalid license numbers may result in nonpayment.

**Mid-level Practitioners**: Indicate the name and license number in Box 19 of the CMS-1500 form; the supervising physician's license number should be entered in Box 24J. The following are defined as mid-level:

- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives

**Modifier Codes**: Use modifier codes when appropriate with the corresponding Local code (Medi-Cal HCPCS Level III Interim code), HCPCS or CPT codes. For paper claims, all modifiers should be billed immediately following the procedure code in Box 24D of the CMS-1500.

**Prior Authorization Number**: Indicate the Prior Authorization number in Box 23 of the CMS-1500 form. Anthem will deny claims with medical records attached in lieu of the required Prior Authorization number.

There are certain exceptions to the Prior Authorization requirement. Professional and facility claims for emergency services are not denied due to lack of prior authorization. Emergency services are determined by diagnosis codes and/or services billed.
**Member ID Number:** Use the Member’s Client Index Number (CIN) when billing, whether submitting electronically or on paper. It is important to use the Member’s Plan ID card number, not the number on the identification card issued by the state.

**On-Call Services:** Insert On-Call for PCP in Box 23 of the CMS-1500 form when the rendering physician is not the PCP, but is “covering for” or has received permission from the PCP to provide services that day.

**Billing Professional & Ancillary Claims**

**Anesthesia**

Providers submitting anesthesia claims via Electronic Data Interchange (EDI) should use the following guidelines:

- Use the appropriate ASA CPT Anesthesia code (00100-01999) with the appropriate modifier.
- Indicate the actual time of the service rendered in minutes in the 465A record segment, using an MJ qualifier. The MJ qualifier equals the minutes billed.

Providers submitting anesthesia claims on paper should use the following guidelines:

- Use the appropriate ASA CPT Anesthesia code (00100-01999) with the appropriate modifier.
- Indicate the actual time ("hands-on time") of the service rendered in minutes in Field 24G of the CMS-1500 form. This is particularly important for anesthesia code OB 01967.
- Do not report the base units on claims.

**Billing Professional & Ancillary Claims**

**Behavioral Health**

For information about Anthem’s Behavioral Health services, please see Chapter 5: Behavioral Health Services.

**Billing Professional & Ancillary Claims**

**California Children’s Services (CCS)**

Approved California Children’s Services Providers must submit claims on the appropriate form to the local CCS Program according to the terms of their CCS agreement. CCS is the primary payer for CCS-eligible diagnosis; Anthem does not provide authorization for those conditions.

All Providers, both in- and out-of-network, are obligated to follow CCS guidelines, including the following:

- Refer CCS-eligible or potentially eligible conditions to CCS and Anthem within 24 hours or the next business day.
- Use CCS network physicians and hospitals. Non-CCS-paneled hospitals must contact CCS immediately for authorization of inpatient Members who are not stable for transfer to a CCS-paneled hospital.

Anthem will not reimburse claims for CCS-eligible conditions denied by CCS for noncompliance with CCS Program requirements. In addition, Providers may not seek additional payment or compensation from Members for any of the following:

- CCS-covered services
- CCS-denied claims due to failure to submit the application within CCS time frames
- CCS-denied claims due to failure to use CCS network physicians or hospitals
Anthem will reimburse for all health care services unrelated to the CCS-covered condition. We do not reimburse for services related to a potentially medically eligible condition or for care that is related to a condition that has been qualified by the local CCS Program.

For more information of billing requirements for CCS, contact our Utilization Management department at:

Medi-Cal: 1-888-831-2246
MAP and MRMIP: 1-877-273-4193

Billing Professional & Ancillary Claims

Child Health and Disability Prevention Program (CHDP)

The Child Health and Disability Prevention Program (CHDP) is a California state program that provides preventive health services for children and youth enrolled in the Medi-Cal program. These services should be rendered by Vaccines for Children (VFC) program approved and CHDP-certified Providers.

Billing guidelines are as follows:

- Use the CMS-1500 claim form or electronic submission.
- Use National standard CPT-4/HCPCS Codes and the Medi-Cal modifier SL (used with VFC vaccine codes) for all program services.
- Use the Provider's original signature and the correct county-specific Prepaid Project Code, which prevents incorrect reporting of encounter data.
  - Member or parent/guardian
  - The Member's medical record

Anthem has partnered with vendor 4eGuru to provide free access to the Anthem CHDPGateway portal for CHDP PM-160 Information Only submissions.

- Providers must register onto the Anthem CHDPGateway portal at www.chdpgateway.com/anthem/. Registration and use of the portal for CHDP PM-160 “Information Only” form submissions to Anthem is free to Anthem providers.
- Once the provider completes the registration, he/she can log onto the portal again to complete and submit CHDP PM160 Information Only forms.
- Anthem will report this data to the State and appropriate county CHDP department.
- Providers must provide copies of the CHDP PM-160 “Information Only” form to:
  - The Member or parent/guardian
  - The Member's medical record

CHDP Diagnosis Codes

CHDP diagnosis coding tables are divided into the following categories:

- Primary Diagnosis
- History and Physical Examinations
- Health Screening Procedures
- Clinical Laboratory Tests
- Immunizations & Vaccines
When billing for CHDP services, use the following codes for **Primary Diagnosis**:

<table>
<thead>
<tr>
<th>CHDP CPT Codes: Primary Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20.2</td>
<td>For children (newborn to 17 years of age)</td>
</tr>
<tr>
<td>V70.0</td>
<td>For adults (18-21 years of age)</td>
</tr>
</tbody>
</table>

When billing for CHDP services, use the following codes for **History and Physical Examinations**:

<table>
<thead>
<tr>
<th>CHDP CPT Codes: History and Physical Exams</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99385</td>
<td>Adolescent (Ages 18-39) New Patient or Extended Visit</td>
</tr>
<tr>
<td>99384</td>
<td>Adolescent (Ages 12-17) New Patient or Extended Visit</td>
</tr>
<tr>
<td>99383</td>
<td>Late Childhood (Ages 5-11) New Patient or Extended Visit</td>
</tr>
<tr>
<td>99382</td>
<td>Early Childhood (Ages 1-4) New Patient or Extended Visit</td>
</tr>
<tr>
<td>99381</td>
<td>Infant (Birth to 11 Months) New Patient or Extended Visit</td>
</tr>
<tr>
<td>99395</td>
<td>Adolescent (Ages 17-39) Health Assessment Routine Visit</td>
</tr>
<tr>
<td>99394</td>
<td>Adolescent (Ages 12-17) Health Assessment Routine Visit</td>
</tr>
<tr>
<td>99393</td>
<td>Late Childhood (Ages 5-11) Established Patient</td>
</tr>
<tr>
<td>99392</td>
<td>Early Childhood (Ages 1-4) Established Patient</td>
</tr>
<tr>
<td>99391</td>
<td>Infant (Birth to 11 Months) Established Patient</td>
</tr>
</tbody>
</table>

**Please Note:** **Primary Care School-Based Clinics** (SBC) follow the same claims and billing guidelines as PCP services.

When billing for CHDP services, use the following codes for **PCP Health Screening Procedures**:

<table>
<thead>
<tr>
<th>CHDP CPT Codes: Health Screening Procedures</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99173</td>
<td>Snellen Eye Test equivalent visual Acuity Test: 3-18 Years of Age</td>
</tr>
<tr>
<td>92552</td>
<td>Bi-Annual Hearing Tests: Audiometric Pure Tone Audiometry</td>
</tr>
<tr>
<td>86580</td>
<td>PPD Screening-TB: Mantoux Test</td>
</tr>
</tbody>
</table>

When billing for CHDP services, use the following codes for **Clinical Laboratory Tests**:

<table>
<thead>
<tr>
<th>CHDP CPT Codes: Clinical Laboratory Tests</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99830</td>
<td>Hemoglobin or Hematocrit</td>
</tr>
<tr>
<td>81003</td>
<td>Urine &quot;Dipstick&quot;</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis, Routine, Complete</td>
</tr>
<tr>
<td>85660</td>
<td>Sickle Cell Status (Hemoglobin Electrophoresis)</td>
</tr>
<tr>
<td>83655 (26/TC)</td>
<td>Lead Blood Level</td>
</tr>
<tr>
<td>86592</td>
<td>VDRL, RPR, ART</td>
</tr>
</tbody>
</table>
CHAPTER 11: Billing Professional and Ancillary Claims

Anthem Blue Cross

Medi-Cal, Medi-Cal Access Program and MRMIP

<table>
<thead>
<tr>
<th>CHDP CPT Codes: Clinical Laboratory Tests</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>87590</td>
<td>Gonorrhea (GC) Test</td>
</tr>
<tr>
<td>88150</td>
<td>Pap Smear</td>
</tr>
<tr>
<td>84030</td>
<td>Phenylketonuria (PKU) Blood Test (Under 1 Month of Age)</td>
</tr>
<tr>
<td>82947</td>
<td>Blood Glucose Assay</td>
</tr>
<tr>
<td>82465</td>
<td>Total Cholesterol</td>
</tr>
<tr>
<td>87110</td>
<td>Chlamydia Test</td>
</tr>
<tr>
<td>87177</td>
<td>Ova and/or Parasites</td>
</tr>
<tr>
<td>Z5220</td>
<td>Lab Collection and Handling Fee</td>
</tr>
</tbody>
</table>

**Immunizations and Vaccines:**

All Medi-Cal Providers who administer vaccines to children under 19 years of age must be enrolled in the Vaccines for Children (VFC) program. When billing immunizations provided to you by the VFC program, use the following guidelines:

- **Medi-Cal** modifier (I&D code "SL" modifier must be used with the appropriate CPT code on each line of Box 24D of the CMS-1500 form.
- On another line of Box 24D, use the appropriate CPT code for administration fee code of the vaccine or immunization.

When billing immunizations **not covered by the VFC program**, use the following guidelines:

- Use the appropriate CPT code on 1 line of Box 24D and the appropriate administration procedure code on the next line of Box 24D.
- Do **not** use the "SL" modifier.

When billing for CHDP services, use the following codes for Immunizations and Vaccines:

**Please Note:** For Members between the ages of 19 and 21, use the appropriate CPT codes and corresponding administration fee codes for CHDP vaccines. **Do not** use the "SL" modifier. Both services are reimbursable.

<table>
<thead>
<tr>
<th>CHDP CPT Codes: Immunizations and Vaccines (PCPs)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90632</td>
<td>Hepatitis A Vaccine, adult dosage, intramuscular</td>
</tr>
<tr>
<td>90633</td>
<td>Hepatitis A Vaccine, pediatric/adolescent dosage (2 dose schedule), intramuscular</td>
</tr>
<tr>
<td>90634</td>
<td>Hepatitis A Vaccine, pediatric/adolescent dosage (3 dose schedule), intramuscular</td>
</tr>
<tr>
<td>90636</td>
<td>Hepatitis A and Hepatitis B Vaccine (HepA-HepB), adult dosage, intramuscular</td>
</tr>
<tr>
<td>90645</td>
<td>Haemophilus Influenza B Vaccine (Hib), HbOC conjugate (4 dose schedule), intramuscular</td>
</tr>
<tr>
<td>90646</td>
<td>Haemophilus Influenza B Vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular</td>
</tr>
<tr>
<td>90647</td>
<td>Haemophilus Influenza B Vaccine (Hib), PRP-OMP conjugate (3 dose schedule), intramuscular</td>
</tr>
<tr>
<td>CHDP CPT Codes: Immunizations and Vaccines (PCPs)</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>90648 Haemophilus Influenza B Vaccine (Hib), PRP-T conjugate (4 dose schedule), intramuscular</td>
<td></td>
</tr>
<tr>
<td>90649 Human Papilloma Virus (HPV), Types 6, 11, 16, 18 (quadrivalent), (3 dose schedule), intramuscular. To include &quot;permissive use&quot; in males</td>
<td></td>
</tr>
<tr>
<td>90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90657 Influenza virus vaccine, split virus, for children 6-35 months of age, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and older, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90669 Pneumococcal conjugate vaccine, polyvalent, for children under 5 years, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90680 Rotavirus Vaccine (Rota Teq), oral (3 dose)</td>
<td></td>
</tr>
<tr>
<td>90681 Rotavirus Vaccine, oral (2 dose schedule)</td>
<td></td>
</tr>
<tr>
<td>90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DTaP-IPV), when administered to children 4-6 years of age, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for use in individuals 6 months to 4 years of age, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90700 Diphtheria, tetanus toxoids, acellular pertussis vaccine (DTaP), for use in individuals younger than 7 years, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90702 Diphtheria and tetanus toxoids (DT) absorbed for use in individuals younger than 7 years, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90703 Tetanus toxoid absorbed, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90705 (Not a benefit) Measles virus vaccine, live, for subcutaneous use</td>
<td></td>
</tr>
<tr>
<td>90706 Rubella virus vaccine, live, for subcutaneous use</td>
<td></td>
</tr>
<tr>
<td>90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use</td>
<td></td>
</tr>
<tr>
<td>90712 Poliovirus vaccine, any types, OPV, live, for oral use</td>
<td></td>
</tr>
<tr>
<td>90713 Poliovirus vaccine, inactivated, IPV, for subcutaneous use</td>
<td></td>
</tr>
<tr>
<td>90714 Tetanus and diphtheria toxoids (Td), absorbed, preservative-free, for use in individuals 7 years and older, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP), for use in individuals 7 years and older, intramuscular</td>
<td></td>
</tr>
<tr>
<td>90716 Varicella virus vaccine, live, for subcutaneous use</td>
<td></td>
</tr>
<tr>
<td>90720 Diphtheria, tetanus toxoids and whole cell pertussis vaccine and Haemophilus influenza B vaccine (DTP-Hib), intramuscular</td>
<td></td>
</tr>
<tr>
<td>90721 Diphtheria, tetanus toxoids and acellular pertussis vaccine and Haemophilus influenza B vaccine (DtaP-HIB), intramuscular</td>
<td></td>
</tr>
<tr>
<td>90723 Diphtheria, tetanus toxoids and acellular pertussis vaccine, Hepatitis B and poliovirus vaccine, inactivated (DtaP-HepB-IPV), intramuscular</td>
<td></td>
</tr>
<tr>
<td>90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immuno-suppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular</td>
<td></td>
</tr>
<tr>
<td>90733 Meningococcal polysaccharide vaccine (any groups), for subcutaneous use</td>
<td></td>
</tr>
</tbody>
</table>
CHDP CPT Codes: Immunizations and Vaccines (PCPs) | Description
--- | ---
90734 | Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), intramuscular
90743 | Hepatitis B vaccine, adolescent (2-dose schedule), intramuscular
90744 | Hepatitis B vaccine, pediatric/adolescent dosage (3-dose schedule), intramuscular
90746 | Hepatitis B vaccine, adult dosage, intramuscular
90748 | Hepatitis B and Haemophilus influenza B vaccine (HepB-Hib), intramuscular

When billing for VFC/CHCP services, use the following Administration Fee Codes:

| VFC/CHDP CPT Codes: | Description |
--- | ---
90460 | Immunization administration through 18 years of age via any route of administration with counseling by physician or other qualified health care professional, first vaccine/toxoid component
90461 | Immunization administration through 18 years of age via any route of administration with counseling by physician or other qualified health care professional, each additional vaccine/toxoid component (list separately in addition to code for primary procedure)
90471 | Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injections, 1 vaccine (single or combination vaccine/toxoid)
90472 | Each additional injection (single or combination vaccine/toxoid), per day (list separately in addition to code for primary procedure)
90473 | Immunization administration by intranasal or oral route, 1 vaccine (single or combination vaccine/toxoid)
90474 | Each additional vaccine (single or combination vaccine/toxoid). List separately in addition to code for primary procedure. Use 90474 in conjunction with 90471 or 90473.

Billing Professional & Ancillary Claims

Comprehensive Perinatal Services Program (CPSP)

Only Comprehensive Perinatal Services Program (CPSP)-certified Providers can bill for CPSP services. All claims must contain CPSP-specific codes.

Maternity Services:

All perinatal service Providers must offer CPSP services to our Members. If the Provider is not CPSP-certified and the Member chooses to participate in CPSP services, the Member must be referred to a CPSP Provider for those supplemental services.

For health care programs in which global billing in indicated, use the following guidelines:

- If all OB care is provided by a single physician or even multiple physicians within the same practice, global billing must be used.
If all OB care is not provided in the same practice, follow the Antepartum Care billing as described in the following section.

**Antepartum Codes**

For billing antepartum care, use the following guidelines:

- If the Provider treats a pregnant woman one to three times, report each visit using the appropriate level of Evaluation and Management (E&M) care: CPT 99201-99215.
- If the Provider treats a pregnant woman more than three times, but fewer than seven times, use Code 59425, antepartum care only, four to six visits, and bill only one unit.
- If the Provider allows seven or more visits, use Code 59426, antepartum care only, seven or more visits, and bill only one unit.
- Codes are used to bill only the total number of times you see the Member for all antepartum care during her pregnancy; do not multiple bill with combinations of visits.
- Do not bill antepartum care-only codes in addition to any other procedure codes that include antepartum care, such as global OB codes.

**Billing Professional & Ancillary Claims**

**Global Codes**

For claims from other health care programs received with global codes, Anthem will send the Provider an Information Request, Mailback Letter, asking the Provider to rebill using itemized codes. After that, the Provider has 90 days from the date on the information request letter to submit the corrected claim.

**Maternity Procedure Codes for Medi-Cal Providers**

For billing maternity services, use the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Definition</th>
<th>Billing Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z1032</td>
<td>Initial pregnancy-related office visit.</td>
<td>1 time only.</td>
</tr>
<tr>
<td>Z1032 with the ZL Modifier</td>
<td>Use if initial pregnancy-related office visit is within the first 16 weeks of gestation.</td>
<td>1 time only.</td>
</tr>
<tr>
<td>Z1034</td>
<td>Antepartum follow-up visit (nonglobal), subsequent to the initial pregnancy-related office visit, per visit billing.</td>
<td>2nd-9th visit (bill each visit separately.)</td>
</tr>
<tr>
<td>Z1036</td>
<td>10th antepartum office visit (nonglobal) Any additional visits.</td>
<td>Billed once per pregnancy. Should be billed with regular Evaluation &amp; Management codes, as appropriate.</td>
</tr>
<tr>
<td>Z1038</td>
<td>Postpartum: 1 follow-up office visit (nonglobal).</td>
<td>1 time only.</td>
</tr>
</tbody>
</table>
CHAPTER 11: Billing Professional and Ancillary Claims

Delivery Procedure Codes For All Providers:

For billing Delivery Procedures, use the following codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>Vaginal delivery only.</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean delivery only.</td>
</tr>
</tbody>
</table>

For CPSP-Certified Medi-Cal Providers, use the following procedure codes and requirements:

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Definition</th>
<th>Billing Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Combined Initial Assessments</td>
<td>Billed only once per pregnancy. This covers the first 30 minutes of each assessment for nutrition, psychosocial and health education. To bill this code, all 3 assessments must be complete within 4 weeks of the first pregnancy visit.</td>
</tr>
<tr>
<td>Z6500</td>
<td>Initial comprehensive nutrition, psychosocial and health education assessment and development of care plan.</td>
<td></td>
</tr>
<tr>
<td>Z6200</td>
<td>Initial nutrition assessment and development of care plan. First 30 minutes</td>
<td>May be billed once per pregnancy in lieu of Z6500</td>
</tr>
<tr>
<td>Z6202</td>
<td>Each subsequent 15 minutes</td>
<td>Maximum of 1 ½ hours or 6 units</td>
</tr>
<tr>
<td>Z6204</td>
<td>Individual, follow-up antepartum nutrition assessment, treatment or intervention, 15 minutes each.</td>
<td>Maximum of 2 hours or 8 units</td>
</tr>
<tr>
<td>Z6206</td>
<td>Group, per patient, follow-up antepartum nutrition assessment, treatment or intervention, 15 minutes each.</td>
<td>Maximum of 3 hours or 12 units</td>
</tr>
<tr>
<td>Z6208</td>
<td>Individual, postpartum nutrition assessment, treatment or intervention including development of care plan, 15 minutes each.</td>
<td>Maximum of 1 hour or 4 units</td>
</tr>
<tr>
<td>Z6210</td>
<td>Prenatal vitamins and mineral supplements (30-day supply).</td>
<td>Up to 90-day supply at a time</td>
</tr>
<tr>
<td></td>
<td>Psychosocial</td>
<td></td>
</tr>
<tr>
<td>Z6300</td>
<td>Individual initial psychosocial assessment and development of care plan. First 30 minutes</td>
<td>May be billed once per pregnancy in lieu of Z6500.</td>
</tr>
<tr>
<td>Z6302</td>
<td>Each subsequent 15 minutes</td>
<td>Maximum of 1 ½ hours or 6 units</td>
</tr>
</tbody>
</table>
## Code | Service Definition | Billing Rules
--- | --- | ---
Z6304 | Individual follow-up antepartum psychosocial assessment, treatment or intervention, 15 minutes each | Maximum of 3 hours or 12 units
Z6306 | Group, per patient, follow-up antepartum psychosocial assessment, treatment or intervention, 15 minutes each | Maximum of 4 hours or 16 units
Z6308 | Individual follow-up post partum psychosocial assessment, treatment or intervention including development of care plan, 15 minutes each | Maximum of 1 ½ hours or 6 units

### Health Education

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Definition</th>
<th>Billing Rules</th>
</tr>
</thead>
</table>
Z6400 | Client orientation, health education, each 15 minutes | Maximum of 2 hours or 8 units |
Z6402 | Individual initial health education assessment and development of care plan | First 30 minutes |
Z6404 | Each subsequent 15 minutes | May be billed once per pregnancy in lieu of Z6500 |
Z6406 | Individual, follow-up health education assessment, treatment or intervention, 15 minutes each | Maximum of 2 hours or 8 units |

### Billing Sterilization Claims

When billing for sterilization claims, use the following guidelines:

- Use the **CMS-1500** form and follow appropriate coding guidelines.
- Attach a copy of the completed **Sterilization Consent Form PM330** to the claim for either gender.

The **Sterilization Consent Form PM330** is published by the State of California. To get a copy, go to their website: [http://files.medi-cal.ca.gov/pubsdoco/forms.asp](http://files.medi-cal.ca.gov/pubsdoco/forms.asp). Then, take the following steps:

1. Scroll down to **Consent Forms**
2. Click on **Consent to Sterilization**
Billing Professional & Ancillary Claims

Dental Services

The only dental services that should be billed are emergency dental services. Routine dentistry is a state-covered benefit.

Billing Professional & Ancillary Claims

Emergency Services

Emergency services are defined in the Provider's contract and by state and local law. Related professional services offered by physicians during an emergency visit are reimbursed according to the Provider's contract. For emergency services billing, indicate the Injury Date in Box 14 of the CMS 1500 form.

Please Note: Members should be referred back to the Primary Care Provider (PCP) of record for follow-up care. Unless clinically required, follow-up care should never occur in a hospital emergency department.

Billing Professional & Ancillary Claims

Initial Health Assessments (IHA)

Based on the Member's age, the Primary Care Provider (PCP) provides an Initial Health Assessment (IHA) within 60-120 days from the Member's date of enrollment with Anthem. This assessment consists of a complete age and gender-appropriate history, a physical and the preventive services recommended by our Clinical Practice Guidelines.

When billing for preventive services, use the following ICD-9 diagnosis codes:

- V20.2 for children (newborn to 18 years of age)
- V70.0 for adults (19 years and older)

Refer to the following Adult Preventive Care Procedure Codes for CPT office visit codes for the Initial Health Assessment and Adult Preventive Care:

Preventive Medicine Services, New Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>Infant (under 1 year of age)</td>
</tr>
<tr>
<td>99382</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99383</td>
<td>Late Childhood (ages 5-11)</td>
</tr>
<tr>
<td>99384</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99385</td>
<td>18-39 years</td>
</tr>
<tr>
<td>99386</td>
<td>40-64 years</td>
</tr>
<tr>
<td>99387</td>
<td>65 years and older</td>
</tr>
</tbody>
</table>
Preventive Medicine Services, Established Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>Infant (under 1 year of age)</td>
</tr>
<tr>
<td>99392</td>
<td>Early Childhood (ages 1-4)</td>
</tr>
<tr>
<td>99393</td>
<td>Late Childhood (ages 5-11)</td>
</tr>
<tr>
<td>99394</td>
<td>Adolescent (ages 12-17)</td>
</tr>
<tr>
<td>99395</td>
<td>18-39 years</td>
</tr>
<tr>
<td>99396</td>
<td>40-64 years</td>
</tr>
<tr>
<td>99397</td>
<td>65 years and older</td>
</tr>
</tbody>
</table>

Adult Preventive Care Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82270</td>
<td>Fecal Occult Blood Test (lab procedure code only)</td>
</tr>
<tr>
<td>82465</td>
<td>Total Serum Cholesterol (lab procedure code only)</td>
</tr>
<tr>
<td>86580</td>
<td>TB Screening (PPD)</td>
</tr>
<tr>
<td>90658</td>
<td>Flu Shot</td>
</tr>
<tr>
<td>90732</td>
<td>Pneumovax</td>
</tr>
<tr>
<td>90718</td>
<td>Td-Diphtheria-Tetanus Toxoid-0.5 ml</td>
</tr>
<tr>
<td>88150</td>
<td>Pap Smear (lab procedure code only)</td>
</tr>
<tr>
<td>76091</td>
<td>Mammogram (specialty center)</td>
</tr>
<tr>
<td>84153</td>
<td>PSA (lab procedure code only)</td>
</tr>
</tbody>
</table>

Billing Professional & Ancillary Claims

Newborns

Newborns of Medi-Cal Members are covered under the mother using the mother’s Client Index Number (CIN) for the month of birth and the following month – or until such time as the California Department of Health Care Services issues a dedicated CIN for the newborn.

Medi-Cal Newborns:

Services rendered before the newborn's CIN is issued should be billed using the mother's CIN, and the name, date of birth and other information about the newborn. Providers should encourage Medi-Cal Members to contact their social worker immediately and fill out all required paperwork to accurately enroll the newborn and prevent any lapse in coverage.
Billing Professional & Ancillary Claims

Self-Referable Services

Members may self-refer to any of the following services without Prior Authorization if their benefits allow. Members associated with capitated medical groups must self-refer to services within the group.

- Abortions (in-network only)
- Annual Well-Woman Exam (in-network only)
- Diagnosis and treatment of Sexually Transmitted Diseases (STD)
- Family Planning Services (services to prevent or delay pregnancy)
- Prenatal Services (in-network only)
- Testing for the Human Immunodeficiency Virus (HIV)

Please Note: Self-referable services may be rendered by a willing Provider, even a Provider without a contract, unless limited by state of federal regulation. We reimburse contracted Providers according to the Provider’s contract; noncontracted Providers are reimbursed at reasonable and customary rates.

For billing self-referable services, use the following codes:

Family Planning Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>996.32</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>V15.7</td>
<td>Contraception</td>
</tr>
<tr>
<td>V25.01</td>
<td>Prescription of oral contraceptives</td>
</tr>
<tr>
<td>V25.02</td>
<td>Initiation of other contraceptive measures: Fitting of diaphragm, prescription of foams, creams or other agents</td>
</tr>
<tr>
<td>V25.09</td>
<td>Family planning advice</td>
</tr>
<tr>
<td>V25.1</td>
<td>Insertion of IUD</td>
</tr>
<tr>
<td>V25.2</td>
<td>Sterilization; admission for interruption of fallopian tubes or vas deferens</td>
</tr>
<tr>
<td>V25.3</td>
<td>Menstrual extraction; menstrual regulation</td>
</tr>
<tr>
<td>V25.40</td>
<td>Contraceptive surveillance, unspecified</td>
</tr>
<tr>
<td>V25.41</td>
<td>Contraceptive pill</td>
</tr>
<tr>
<td>V25.42</td>
<td>Intrauterine contraceptive device: Checking reinsertion or removal of IUD</td>
</tr>
<tr>
<td>V25.43</td>
<td>Implantable subdermal contraceptive</td>
</tr>
<tr>
<td>V25.49</td>
<td>Other contraceptive method</td>
</tr>
<tr>
<td>V25.5</td>
<td>Insertion of implantable subdermal contraceptive</td>
</tr>
<tr>
<td>V25.8</td>
<td>Other specified contraceptive management: post-vasectomy sperm count</td>
</tr>
<tr>
<td>V25.9</td>
<td>Unspecified contraceptive management</td>
</tr>
<tr>
<td>V26.0</td>
<td>Tuboplasty or vasoplasty after previous sterilization</td>
</tr>
<tr>
<td>V26.1</td>
<td>Artificial insemination</td>
</tr>
</tbody>
</table>
### ICD-9

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V26.22</td>
<td>Aftercare following sterilization reversal</td>
</tr>
<tr>
<td>V26.51</td>
<td>Tubal ligation status</td>
</tr>
<tr>
<td>V26.52</td>
<td>Vasectomy status</td>
</tr>
<tr>
<td>V26.9</td>
<td>Unspecified procreative management</td>
</tr>
<tr>
<td>V45.51</td>
<td>Intrauterine contraceptive device</td>
</tr>
<tr>
<td>V45.52</td>
<td>Subdermal contraceptive implant</td>
</tr>
<tr>
<td>V45.59</td>
<td>Other</td>
</tr>
</tbody>
</table>

### Family Planning Procedure Codes

<table>
<thead>
<tr>
<th>HCPCS/CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11975</td>
<td>Norplant Implant</td>
</tr>
<tr>
<td>11976</td>
<td>Norplant Removal</td>
</tr>
<tr>
<td>11977</td>
<td>Removal with reinsertion, implantable contraceptive capsules</td>
</tr>
<tr>
<td>00840</td>
<td>Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy</td>
</tr>
<tr>
<td>00851</td>
<td>Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy, tubal ligation/transection</td>
</tr>
<tr>
<td>00921</td>
<td>Anesthesia for intraperitoneal procedures in lower abdomen including urinary tract, vasectomy, unilateral or bilateral</td>
</tr>
<tr>
<td>55250</td>
<td>Vasectomy</td>
</tr>
<tr>
<td>57170</td>
<td>Diaphragm fitting</td>
</tr>
<tr>
<td>58300</td>
<td>IUD insertion</td>
</tr>
<tr>
<td>58301</td>
<td>IUD removal only</td>
</tr>
<tr>
<td>58600</td>
<td>Ligation or transection of fallopian tubes, abdominal or vaginal approach, unilateral or bilateral</td>
</tr>
<tr>
<td>58615</td>
<td>Occlusion of fallopian tubes by device (examples: band, clip, Falope ring) vaginal or suprapubic approach</td>
</tr>
<tr>
<td>X1500</td>
<td>Diaphragm, Foam, Cream, Jelly, Film, Condoms, Sponge, Cervical Cap or Basal Body Thermometer (must be billed with description of item)</td>
</tr>
<tr>
<td>X1512</td>
<td>CU-7 (Copper-7), Lippes Loop</td>
</tr>
<tr>
<td>X1514</td>
<td>IUD (Progestasert)</td>
</tr>
<tr>
<td>X1520</td>
<td>Norplant</td>
</tr>
<tr>
<td>X1522</td>
<td>ParaGard</td>
</tr>
<tr>
<td>X1532</td>
<td>Mirena Interuterine System (IUS)</td>
</tr>
<tr>
<td>X6051</td>
<td>Depo Provera</td>
</tr>
</tbody>
</table>
### HCPCS/CPT Codes

<table>
<thead>
<tr>
<th>HCPCS/CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X7490</td>
<td>Medroxyprogesterone Acetate/Estradiol Cypionate, injection</td>
</tr>
<tr>
<td>X7610</td>
<td>Estrogens, Conjugated, tablets</td>
</tr>
<tr>
<td>X7706</td>
<td>Oral contraceptives</td>
</tr>
<tr>
<td>X7720</td>
<td>Levonorgestrel, Ethinyl Estradiol, tablets, Emergency Contraception Kit</td>
</tr>
<tr>
<td>X7722</td>
<td>Levonorgestrel, tablets</td>
</tr>
<tr>
<td>X7728</td>
<td>Norelgestromin/Ethinyl Estradiol, transdermal patch</td>
</tr>
<tr>
<td>X7730</td>
<td>Etonogestrel/Ethinyl Estradiol, vaginal ring</td>
</tr>
<tr>
<td>81025</td>
<td>Pregnancy Test</td>
</tr>
<tr>
<td>84703</td>
<td>Chorionic gonadotropin assay</td>
</tr>
<tr>
<td>89320</td>
<td>Semen analysis, complete (volume, count, motility and differential)</td>
</tr>
</tbody>
</table>

### Sexually Transmitted Disease Codes

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>003.1-003.9</td>
<td>HIV-related</td>
</tr>
<tr>
<td>010.00-018.96</td>
<td>HIV-related</td>
</tr>
<tr>
<td>031.2-031.9</td>
<td>HIV-related</td>
</tr>
<tr>
<td>038.0-039.9</td>
<td>HIV-related</td>
</tr>
<tr>
<td>042</td>
<td>HIV infection with specified conditions</td>
</tr>
<tr>
<td>046.3-046.9</td>
<td>HIV-related</td>
</tr>
<tr>
<td>053.10-054.9</td>
<td>HIV-related</td>
</tr>
<tr>
<td>054</td>
<td>Herpes</td>
</tr>
<tr>
<td>070.0-070.9</td>
<td>Hepatitis B/C</td>
</tr>
<tr>
<td>079.4-079.99</td>
<td>Papillomavirus. HIV. Chlamydia</td>
</tr>
<tr>
<td>079.53</td>
<td>HIV Type 2</td>
</tr>
<tr>
<td>090-097</td>
<td>Syphilis</td>
</tr>
<tr>
<td>098</td>
<td>Gonorrhea</td>
</tr>
<tr>
<td>099.0</td>
<td>Cancroid</td>
</tr>
<tr>
<td>099.5</td>
<td>Chlamydia trachomatis</td>
</tr>
<tr>
<td>112.0-112.9</td>
<td>Candidiasis</td>
</tr>
<tr>
<td>114.0-115.9</td>
<td>Coccidiomycosis, Histoplasmosis</td>
</tr>
<tr>
<td>131.0-131.9</td>
<td>Trichomoniasis</td>
</tr>
<tr>
<td>616</td>
<td>PID</td>
</tr>
</tbody>
</table>
### Sexually Transmitted Disease Procedure Codes

<table>
<thead>
<tr>
<th>HCPCS/CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>54050</td>
<td>Destruction of lesions, penis (for example, condyloma, papilloma, molluscum contagiosum, herpetic vesicle) simple; chemical</td>
</tr>
<tr>
<td>54055</td>
<td>Destruction of lesions, penis (for example, condyloma, papilloma, molluscum contagiosum, herpetic vesicle) simple; electrosiccation</td>
</tr>
<tr>
<td>54056</td>
<td>Destruction of lesions, penis (for example, condyloma, papilloma, molluscum contagiosum, herpetic vesicle) simple; cryosurgery</td>
</tr>
<tr>
<td>54057</td>
<td>Destruction of lesions, penis (for example, condyloma, papilloma, molluscum contagiosum, herpetic vesicle) simple; laser surgery</td>
</tr>
<tr>
<td>54060</td>
<td>Destruction of lesions, penis (for example, condyloma, papilloma, molluscum contagiosum, herpetic vesicle) simple; surgical excision</td>
</tr>
<tr>
<td>54065</td>
<td>Destruction of lesions, penis (for example, condyloma, papilloma, molluscum contagiosum, herpetic vesicle) extensive (for example, laser surgery, electrosurgery, cryosurgery, chemosurgery)</td>
</tr>
<tr>
<td>80074</td>
<td>Acute hepatitis panel; panel must include the following: Hepatitis A antibody IgM antibody, Hepatitis B core antibody, IgM antibody, Hepatitis B surface antigen Hepatitis C antibody</td>
</tr>
<tr>
<td>86255</td>
<td>Chlamydia (fluorescent antibody screen)</td>
</tr>
<tr>
<td>86592</td>
<td>VDRL-RPR (Syphilis)</td>
</tr>
<tr>
<td>86593</td>
<td>VDRL, quantitative</td>
</tr>
<tr>
<td>86631</td>
<td>Chlamydia (antibody)</td>
</tr>
<tr>
<td>86687</td>
<td>HIV (HTLV I)</td>
</tr>
<tr>
<td>86688</td>
<td>HIV (HTLV II)</td>
</tr>
<tr>
<td>86689</td>
<td>HIV (HTLV or HIV antibody, confirmatory test; for example, Western blot)</td>
</tr>
<tr>
<td>86694</td>
<td>Herpes (nonspecific test)</td>
</tr>
<tr>
<td>86695</td>
<td>Herpes (Type I)</td>
</tr>
<tr>
<td>86701</td>
<td>HIV-1</td>
</tr>
<tr>
<td>86702</td>
<td>HIV-2</td>
</tr>
<tr>
<td>86703</td>
<td>HIV-1 and HIV-2 single assay</td>
</tr>
<tr>
<td>86781</td>
<td>FTA-ABS (Syphilis, confirmatory test)</td>
</tr>
<tr>
<td>86580</td>
<td>TB Screening (PPD)</td>
</tr>
<tr>
<td>87070</td>
<td>Cancroid</td>
</tr>
<tr>
<td>87081</td>
<td>GC Culture/Throat Culture</td>
</tr>
<tr>
<td>87110</td>
<td>Chlamydia (culture)</td>
</tr>
<tr>
<td>87206</td>
<td>Chlamydia (fluorescent antibody screen); Herpes (direct immuno fluorescent)</td>
</tr>
<tr>
<td>87207</td>
<td>Herpes (special stain for inclusion bodies)</td>
</tr>
<tr>
<td>87270</td>
<td>Chlamydia trachomatis AG IF</td>
</tr>
<tr>
<td>87320</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; Chlamydia trachomatis</td>
</tr>
<tr>
<td>87340</td>
<td>Hepatitis B surface antigen (HbsAg)</td>
</tr>
<tr>
<td>HCPCS/CPT</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>87490</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique</td>
</tr>
<tr>
<td>87491</td>
<td>Chlamydia trachomatis, amplified probe technique</td>
</tr>
<tr>
<td>87591</td>
<td>Neisseria gonorrhoeae, amplified probe technique</td>
</tr>
<tr>
<td>86592</td>
<td>Syphilis test, qualitative (for example, VDRL, RPR, ART)</td>
</tr>
<tr>
<td>86593</td>
<td>Syphilis test, quantitative</td>
</tr>
<tr>
<td>86631</td>
<td>Antibody; Chlamydia</td>
</tr>
<tr>
<td>86632</td>
<td>Antibody; Chlamydia, IgM</td>
</tr>
<tr>
<td>86692</td>
<td>Antibody; Hepatitis, delta agent</td>
</tr>
<tr>
<td>86694</td>
<td>Antibody; Herpes simplex, non-specific type test</td>
</tr>
<tr>
<td>86696</td>
<td>Antibody; Herpes simplex, type 2</td>
</tr>
<tr>
<td>86701</td>
<td>Antibody; HIV-1</td>
</tr>
<tr>
<td>86702</td>
<td>Antibody; HIV-2</td>
</tr>
<tr>
<td>87492</td>
<td>Infectious agent detection by nucleic acid (DNA or RNA) and the following:</td>
</tr>
<tr>
<td>87510</td>
<td>Chlamydia trachomatis, quantification</td>
</tr>
<tr>
<td>87511</td>
<td>Gardnerella vaginalis, direct probe technique</td>
</tr>
<tr>
<td>87512</td>
<td>Gardnerella vaginalis, amplified probe technique</td>
</tr>
<tr>
<td>87515</td>
<td>Hepatitis B virus, direct probe technique</td>
</tr>
<tr>
<td>87516</td>
<td>Hepatitis B virus, amplified probe technique</td>
</tr>
<tr>
<td>87517</td>
<td>Hepatitis B virus, quantification</td>
</tr>
<tr>
<td>87520</td>
<td>Hepatitis C, direct probe technique</td>
</tr>
<tr>
<td>87521</td>
<td>Hepatitis C, amplified probe technique</td>
</tr>
<tr>
<td>87522</td>
<td>Hepatitis C, quantification</td>
</tr>
<tr>
<td>87525</td>
<td>Hepatitis G, direct probe technique</td>
</tr>
<tr>
<td>87526</td>
<td>Hepatitis G, amplified probe technique</td>
</tr>
<tr>
<td>87527</td>
<td>Hepatitis G, quantification</td>
</tr>
<tr>
<td>87528</td>
<td>Herpes simplex virus, direct probe technique</td>
</tr>
<tr>
<td>87529</td>
<td>Herpes simplex virus, amplified probe technique</td>
</tr>
<tr>
<td>87530</td>
<td>Herpes simplex virus, quantification</td>
</tr>
<tr>
<td>87534</td>
<td>HIV-1, direct probe technique</td>
</tr>
<tr>
<td>87535</td>
<td>HIV-1, amplified probe technique</td>
</tr>
<tr>
<td>87536</td>
<td>HIV-1, quantification</td>
</tr>
<tr>
<td>87537</td>
<td>HIV-2, direct probe technique</td>
</tr>
<tr>
<td>87538</td>
<td>HIV-2, amplified probe technique</td>
</tr>
</tbody>
</table>
Billing Professional & Ancillary Claims

Sensitive Services

Sensitive services are provided for family planning and include the following:

- Abortion
- Alcohol and Drug Treatment for Minors Over Age 12
- Contraceptive Management
- Treatment of Sexually Transmitted Diseases, including AIDS/HIV

For billing purposes, Prior Authorization for these services is waived. Members may receive these services from either in-network or out-of-network Providers. Sterilization claims for either gender must include an attachment of the DHCS PM 330 consent form.

Sensitive Services Codes

<table>
<thead>
<tr>
<th>HCPCS/CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99170</td>
<td>Anogenital examination with colposcopic magnification in childhood for suspected trauma</td>
</tr>
<tr>
<td>46608</td>
<td>Anoscopy with removal of foreign body</td>
</tr>
<tr>
<td>57415</td>
<td>Removal of impacted vaginal foreign body (separate procedure) under anesthesia</td>
</tr>
<tr>
<td>59840</td>
<td>Dilation and Curettage used to induce a first trimester abortion, for termination of pregnancy in the first 12-14 weeks of gestation</td>
</tr>
<tr>
<td>59841</td>
<td>Dilation and Curettage used to induce a second trimester abortion, for termination of pregnancy after 12-14 weeks of gestation</td>
</tr>
<tr>
<td>X1516</td>
<td>Natural (laminaria) hygroscopic sticks used in the cervical dilation process</td>
</tr>
<tr>
<td>X1518</td>
<td>Synthetic hygroscopic sticks used in the cervical dilation process</td>
</tr>
<tr>
<td>X7724</td>
<td>RU-486</td>
</tr>
<tr>
<td>X7726</td>
<td>Misoprostol</td>
</tr>
</tbody>
</table>
Sensitivity Service Procedure Codes for Minors 12-18 years of age (plus 364 days)

<table>
<thead>
<tr>
<th>HCPCS/CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z0336</td>
<td>Medical abortion</td>
</tr>
</tbody>
</table>

Billing Professional & Ancillary Claims

Telehealth

Professional and hospital Providers can receive reimbursement beyond the office visit/consultation for phone line charges associated with a Telehealth live video consultation. Please use the following guidelines:

- Telecommunication charges for live video Telehealth encounters will be reimbursed approximately $.50 per minute up to 90 minutes.
- Only the site that initiates the live video Telehealth encounter may bill.
- Report this service on the claim form with Code T1014.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Code</th>
<th>Modifier</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation Site</td>
<td>Q3014</td>
<td>GT: Live Video, GQ: Store and Forward</td>
<td>$20</td>
</tr>
</tbody>
</table>
To find out more about **Telehealth**, use the following contact information:

- **Telehealth Phone:** 1-866-855-2271
- **Telehealth Fax:** 1-805-987-0736
- **Telehealth Website:** [http://w2.anthem.com/bcc_state/tm/info/index.asp](http://w2.anthem.com/bcc_state/tm/info/index.asp)

**Please Note:** The most current version of a “Telehealth Provider Manual is available at [www.anthem.com/CA](http://www.anthem.com/CA).

### Billing Professional & Ancillary Claims

#### Ancillary Billing Requirements by Service Category

The majority of **ancillary claims** are submitted for the following:

- Ambulance Services
- Disposable and Incontinence Medical Supplies
- Durable Medical Equipment (DME)
- Laboratory and Diagnostic Imaging

For ancillary claims, use the **CMS-1500** form and adhere to the following guidelines:

- Billing requirements per contract: Our billing requirements apply to all member claims, except some services administered through Medi-Cal and other state contract programs.
- System edits: Edits are in place for both electronic and paper claims; therefore, claims not submitted in accordance with requirements cannot be readily processed and most likely will be returned.
- Valid coding: For claims submitted to Anthem, valid HCPCS, CPT or Revenue Codes are required for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
- Split-year claims: For services that begin before [December 2014], but extend beyond [December 2014], split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and co-payment maximums.
- Contract change during course of treatment: When a Provider’s reimbursement is affected by a contract change during a course of treatment, the Provider is required to split the dates of service in order to be reimbursed at the new rate.
- Itemization: Itemization of services is required when the "from" and "through" service date is the same.
- Medical records: Medical records for certain procedures might be requested for determination of medical necessity.
- Modifiers: Use modifiers in accordance with specific billing instructions.
- Unlisted procedures: When services or procedures are performed that do not have a corresponding CPT Code, use designated code numbers for unlisted procedures. When an unlisted procedure code is used, we will need a description of the service to calculate the appropriate reimbursement and
may request medical records. If it is determined that a valid Local or National Code exists for an unlisted code, the claim will not be paid.

- **CPT Code 99070:** This code, which applies to supplies and materials provided by the Provider over and above those usually included with the office visit or other services, is not accepted by Anthem. Health care professionals are required to use HCPCS Level II Codes, which give a detailed description of the service provided. We will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be payable separately.

### Billing Professional & Ancillary Claims

#### Ambulance Services

Ambulance services, including those for municipalities, must be billed on the **CMS-1500** form and include the following information:

- **Transportation Authorization Request** (TAR), required for all nonemergency transportation
- **Medi-Cal Members** must call Customer Service and request approval for all nonemergency transportation.
  
  - **Medi-Cal Customer Care Center:** 1-800-407-4627 (Outside L.A. County)
  - **Medi-Cal Customer Care Center:** 1-888-285-7801 (Inside L.A. County)

- **Medi-Cal Local Codes** must be used in the Medi-Cal code fields
- Nonemergency transport is not covered for **AIM Members**
- **MRMIP Members** are covered for nonemergency transport with the same restrictions as those laid out for Medi-Cal Members above.
  
  - **MRMIP Customer Care Center:** 1-877-687-0549
  - **MRMIP** nonemergency transportation billing is done with **National Codes**
  - Appropriate modifiers are required that describe the "to" and "from" locations


### Medi-Cal Level II National Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0380</td>
<td>BLS mileage (per mile)</td>
</tr>
<tr>
<td>A0390</td>
<td>ALS mileage (per mile)</td>
</tr>
<tr>
<td>A0430</td>
<td>Ambulance service, conventional air services, transport, 1 way (fixed wing)</td>
</tr>
<tr>
<td>A0431</td>
<td>Ambulance service, conventional air services, transport, 1 way (rotary wing)</td>
</tr>
<tr>
<td>A0432</td>
<td>Paramedic Intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers</td>
</tr>
<tr>
<td>A0433</td>
<td>Advanced Life Support, Level 2 (ALS 2)</td>
</tr>
<tr>
<td>A0434</td>
<td>Specialty Care Transport (SCT)</td>
</tr>
<tr>
<td>A0435</td>
<td>Fixed wing air mileage, per statute mile</td>
</tr>
<tr>
<td>A0436</td>
<td>Rotary wing air mileage, per statute mile</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A0800</td>
<td>Ambulance transport provided between the hours of 7pm and 7am</td>
</tr>
<tr>
<td>A0998</td>
<td>Ambulance response and treatment, no transport</td>
</tr>
<tr>
<td>A0999</td>
<td>Unlisted ambulance service</td>
</tr>
<tr>
<td>X0010</td>
<td>Med trans ambulance wait time over 15 minutes</td>
</tr>
<tr>
<td>X0012</td>
<td>Compressed air for infant respirators</td>
</tr>
<tr>
<td>X0014</td>
<td>Extra attendant rn 1\textsuperscript{st} hour</td>
</tr>
<tr>
<td>X0016</td>
<td>Extra attendant rn, 2\textsuperscript{nd} and 3\textsuperscript{rd} hours (each)</td>
</tr>
<tr>
<td>X0018</td>
<td>Extra attendant rn each additional hour</td>
</tr>
<tr>
<td>X0020</td>
<td>Cost of IV fluids</td>
</tr>
<tr>
<td>X0022</td>
<td>ECG in ambulance</td>
</tr>
<tr>
<td>X0030</td>
<td>Ambulance service basic life support</td>
</tr>
<tr>
<td>X0032</td>
<td>Med trans ambulance 1 pt</td>
</tr>
<tr>
<td>X0034</td>
<td>Med trans ambulance mileage 1 way per mile</td>
</tr>
<tr>
<td>X0036</td>
<td>Med trans ambulance oxygen per tank</td>
</tr>
<tr>
<td>X0200</td>
<td>Response to call-non litter case, 1 patient</td>
</tr>
<tr>
<td>X0202</td>
<td>Response to call-non litter case, 2 patients</td>
</tr>
<tr>
<td>X0204</td>
<td>Response to call-non litter case, 3 patients</td>
</tr>
<tr>
<td>X0206</td>
<td>Response to call-non litter case, 4 patients</td>
</tr>
<tr>
<td>X0208</td>
<td>Med trans nurg wheelchair use</td>
</tr>
<tr>
<td>X0210</td>
<td>Response to call litter case</td>
</tr>
<tr>
<td>X0212</td>
<td>Response to call litter case</td>
</tr>
<tr>
<td>X0214</td>
<td>Waiting time over 15 minutes, each 15 minutes</td>
</tr>
<tr>
<td>X0216</td>
<td>Ambulance/mileage</td>
</tr>
<tr>
<td>X0218</td>
<td>Night call 7pm-7am</td>
</tr>
<tr>
<td>X0220</td>
<td>Oxygen per tank</td>
</tr>
<tr>
<td>X0222</td>
<td>Ambulance unlisted</td>
</tr>
<tr>
<td>X0400</td>
<td>Resp to Call Ambulance Ac/Ltc Trans Only</td>
</tr>
<tr>
<td>X0402</td>
<td>Ambulance mileage 1 way per mile Ac/Ltc Trans Only</td>
</tr>
<tr>
<td>X0404</td>
<td>Respca lit pat pit van Ac Ltc Trans Only</td>
</tr>
<tr>
<td>X0406</td>
<td>Little wheelvan mile 1 way per mile Ac/Ltc</td>
</tr>
<tr>
<td>X0408</td>
<td>Little wheelvan mile 1 way per mile Ac/Ltc</td>
</tr>
<tr>
<td>X0410</td>
<td>Wheelchair use Ac/Ltc Trans Only</td>
</tr>
<tr>
<td>X0412</td>
<td>Oxygen per tank Ac/Ltc Trans Only</td>
</tr>
</tbody>
</table>
### Medi-Cal Level III Local Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X0002</td>
<td>Med trans ambulance 2 pt each pt</td>
</tr>
<tr>
<td>X0006</td>
<td>Med trans ambulance emer run</td>
</tr>
<tr>
<td>X0008</td>
<td>Neonatal intensive care incubator</td>
</tr>
</tbody>
</table>

### Medi-Cal Modifiers

#### Medi-Cal Level II National Modifiers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GM</td>
<td>Multiple patients on a single ambulance trip</td>
</tr>
<tr>
<td>QM</td>
<td>Ambulance service provided under arrangement by a Provider of services</td>
</tr>
<tr>
<td>QN</td>
<td>Ambulance service furnished directly by a Provider of services</td>
</tr>
</tbody>
</table>

#### Medi-Cal Level III Local Modifiers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TP</td>
<td>Medical transport, unloaded vehicle</td>
</tr>
<tr>
<td>TQ</td>
<td>Basic life support transport by a volunteer ambulance</td>
</tr>
<tr>
<td>Z1</td>
<td>Additional air mileage in excess of 10% of standard airway mileage distances. (Reason for additional mileage must be documented on the claim.)</td>
</tr>
</tbody>
</table>
Ambulance Service Modifiers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Diagnostic or therapeutic site</td>
</tr>
<tr>
<td>E</td>
<td>Residential, custodial facility</td>
</tr>
<tr>
<td>G</td>
<td>Hospital-based dialysis facility</td>
</tr>
<tr>
<td>H</td>
<td>Hospital</td>
</tr>
<tr>
<td>I</td>
<td>Transfer point between ambulances (helipad to vehicle)</td>
</tr>
<tr>
<td>J</td>
<td>Nonhospital based dialysis facility</td>
</tr>
<tr>
<td>N</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office</td>
</tr>
<tr>
<td>R</td>
<td>Residence</td>
</tr>
<tr>
<td>S</td>
<td>Scene of accident</td>
</tr>
<tr>
<td>X</td>
<td>Intermediate stop at physician’s office on way to hospital</td>
</tr>
</tbody>
</table>

Billing Professional & Ancillary Claims

Disposable and Incontinence Medical Supplies

The California Department of Health Care Services (DHCS) has implemented Health Insurance Portability and Accountability Act (HIPAA)-mandated changes to Medi-Cal billing requirements for disposable and incontinence medical supplies. For billing, use the following guidelines:

- Providers must bill disposable incontinence and medical supplies with HCPCS Level II Codes for contracted items using either electronic billing or the CMS-1500 form.
- Providers may not use Local “99” Codes for disposable incontinence and medical supplies.
- Providers must include the Universal Product Number (UPN) for contracted incontinence and medical supplies.

Billing Professional & Ancillary Claims

Durable Medical Equipment

Durable Medical Equipment (DME) is a covered service when prescribed to preserve bodily functions or prevent disability. All custom-made DME, also referred to as By Report, requires Prior Authorization. Other DME and supplies may also require pre-service review.

For DME, billing guidelines and requirements include the following:

- For Medi-Cal, use Local or HCPCS Codes.
- Use miscellaneous codes when an HCPCS Code does not exist for a particular item. An example: Code E1399, which represents customized equipment.
- Attach the manufacturer’s invoice to the claim if using a miscellaneous, By Report or unlisted code. The invoice must be from the manufacturer, not the office making the purchase.
- Attach a copy of the manufacturer’s suggested retail price (MSRP) (a catalog page)
• Unlisted codes will not be accepted if valid HCPCS Codes exist for the DME and supplies.
• Catalog pages are not acceptable as manufacturer's invoices.
• Procedure Code L9999 is obsolete.
• Many Local Codes are no longer acceptable for submission.

The correct way to bill for **DME and DME supplies sales tax** is the following:

1. Bill the code for the service with the appropriate modifier for rental or purchase for the amount charged, less the sales tax
2. Bill the **S9999** code on a different line with charges only for the sales tax

An example:

<table>
<thead>
<tr>
<th>PT</th>
<th>Modifier</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0570</td>
<td>Applicable modifier code to designate a DMR rental is RR</td>
<td>$100.00</td>
</tr>
<tr>
<td>S9999</td>
<td>Sales tax will be paid as billed</td>
<td>$ 8.00</td>
</tr>
</tbody>
</table>

**DME Rentals**

DME rentals require medical documentation from the prescribing physician. Most DME is dispensed on a rental basis only, such as oxygen tanks or concentrators. Rented items remain the property of the DME Provider until the purchase price is reached. Please note the following guidelines:

- DME Providers may use normal equipment collection guidelines. We are not responsible for equipment not returned by Members.
- Charges for rentals exceeding the reasonable charge for a purchase will be rejected.
- Rental extensions may be obtained only on approved items.

**DME Purchase**

- DME may be reimbursed on a rent-to-purchase basis over a period of 10 months unless specified otherwise at the time the review by our **Utilization Management** department.

**DME Wheelchairs/Scooters**

All **Medi-Cal** wheelchair claims undergo claims examination. The claims examiners follow **Medi-Cal** guidelines when calculating payments for By Report (customized) wheelchair claims. For dates of service on or after January 1, 2013, claim submissions for unlisted/By Report wheelchairs, wheelchair accessories, and replacement parts for patient-owned equipment submitted must be accompanied by both of the following:

- Manufacturer's purchase invoice
- Manufacturer's suggested retail price (MSRP) from a catalog page. The MSRP must be an amount that was published by the manufacturer on or prior to the date of service.

**Documentation must include:**

- Catalog Number
- Item Description
- Manufacturer Name
- Model Number
- Marked Catalog Page(s) and Invoice Line so it can be matched to the claim line
CHAPTER 11: Billing Professional and Ancillary Claims

- If applicable, completion of the **Reserved for Local Use** field (Box 19) of the **CMS-1500** form with the the name of the employed or contracted qualified rehabilitation professional. Wheelchair claims from **manufacturers billing as Providers** must include:
- Suggested retail price (MSRP) from a catalog page dated before the date of service.

**DME Modifiers**

For a list of **DME Modifier Codes**, see **Appendix 1** of the HCPCS 2006 publication available from the **American Medical Association (AMA)** or log onto the AMA website: **www.ama-assn.org**.

**Billing Professional & Ancillary Claims**

**Laboratory, Radiology and Diagnostic Services**

The billing requirements for outpatient laboratory, radiology and diagnostic services include, but are not limited to:

- **Clinical Laboratory Tests**
- **Pathology**
- **Radiology**

These billing requirements include services rendered in relation to an outpatient visit for these tests, including, but not limited to:

- Equipment Use
- Facility Use, including nursing care
- Laboratory
- Professional Services, if applicable
- Supplies

**Please Note**: Outpatient **radiation therapy** is excluded from this service category and should be billed under the requirements of the **Other Services** category.

**Billing Professional & Ancillary Claims**

**CMS-1500 Claim Form**

All professional Providers and vendors should bill us using the most current version of the **CMS-1500** claim form.

**Billing Professional & Ancillary Claims**

**CMS-1500 Claim Form Fields**

<table>
<thead>
<tr>
<th>Field #</th>
<th>Title</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 1</td>
<td>Medicaid/Medicare/Other ID</td>
<td>If the claim is for Medi-Cal, put an X in the Medicaid box. If Member has both Medi-Cal and Medicare, put an X in both boxes. Attach a copy of the form submitted to Medicare to the claim.</td>
</tr>
<tr>
<td>Field 1a</td>
<td>Insured's ID Number</td>
<td>From the Plan Member's ID card. Be sure to use the Member's CIN number from the PAPER ID card, not the number from the state's card.</td>
</tr>
<tr>
<td>Field #</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 2</td>
<td>Patient's Name</td>
<td>Enter last name first, then first name and middle initial (if known). Do not use nicknames or full middle names.</td>
</tr>
<tr>
<td>Field 3</td>
<td>Patient's Birth Date</td>
<td>Enter date of birth as MM/DD/YY. If the full date of birth is not available, enter the year, preceded by 01/01.</td>
</tr>
<tr>
<td>Field 4</td>
<td>Insured's Name</td>
<td>&quot;Same&quot; is acceptable if the insured is the patient. (Not required by Medi-Cal)</td>
</tr>
<tr>
<td>Field 5</td>
<td>Patient's Address/Telephone Number</td>
<td>Enter complete address. Include any unit or apartment number. Include abbreviations for road, street, avenue, boulevard, place, etc. Enter patient’s phone number, including area code.</td>
</tr>
<tr>
<td>Field 6</td>
<td>Patient Relationship to Insured</td>
<td>The relationship to the Member, such as self, spouse, children or other. (Not required by Medi-Cal)</td>
</tr>
<tr>
<td>Field 7</td>
<td>Insured's Address/Phone Number</td>
<td>&quot;Same&quot; is acceptable if the insured is the patient. (Not required by Medi-Cal)</td>
</tr>
<tr>
<td>Field 8</td>
<td>Patient Status</td>
<td>Check patient’s status (single, married, other, employed, full-time student or part-time student). Check all that apply.</td>
</tr>
<tr>
<td>Field 9</td>
<td>Other Insured's Name</td>
<td>If there is other insurance coverage in addition to the Member’s coverage, enter the name of the insured.</td>
</tr>
<tr>
<td>Field 9a</td>
<td>Other Insured's Policy or Group Number</td>
<td>Name of the insurance with the group and policy number.</td>
</tr>
<tr>
<td>Field 9b</td>
<td>Other Insured's Date of Birth</td>
<td>Enter date of birth in the MM/DD/YY format.</td>
</tr>
<tr>
<td>Field 9c</td>
<td>Employer's Name or School Name</td>
<td>Name of other insured’s employer or school.</td>
</tr>
<tr>
<td>Field 9d</td>
<td>Insurance Plan Name or Program Name</td>
<td>Name of Plan carrier.</td>
</tr>
<tr>
<td>Field 10</td>
<td>Patient's Condition Related To</td>
<td>Include any description of injury or accident, including whether it occurred at work.</td>
</tr>
<tr>
<td>Field 10a</td>
<td>Related to Employment?</td>
<td>Y or N. If insurance is related to Workers Compensation, enter Y.</td>
</tr>
<tr>
<td>Field 10b</td>
<td>Related to Auto Accident/Place?</td>
<td>Y or N. Enter the state where the accident occurred.</td>
</tr>
<tr>
<td>Field 10c</td>
<td>Related to Other Accident?</td>
<td>Y or N.</td>
</tr>
<tr>
<td>Field 10d</td>
<td>Reserved for Local Use</td>
<td></td>
</tr>
<tr>
<td>Field 11a-b</td>
<td>Insured's Policy Group of FECA Number, Date of Birth, Sex, Employer or School Name</td>
<td>Complete information about Insured, even if same as Patient.</td>
</tr>
<tr>
<td>Field 14</td>
<td>Date of Current</td>
<td>Injury, Illness or Pregnancy</td>
</tr>
<tr>
<td>Field 21</td>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>Enter the appropriate diagnosis code or nomenclature. Check the manual or ask a coding expert.</td>
</tr>
<tr>
<td>Field 24a</td>
<td>Date(s) of Service</td>
<td>If dates of service cross over from 1 year to another, submit 2 separate claims: For example, 1 claim for services in 2012, 1 claim for services in 2013.</td>
</tr>
<tr>
<td>Field 24b</td>
<td>Place of Service</td>
<td></td>
</tr>
<tr>
<td>Field #</td>
<td>Title</td>
<td>Explanation</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 24d</td>
<td>Procedure, Services or Supplies</td>
<td>Enter the appropriate CPT codes or nomenclature. Indicate appropriate modifier when applicable. Do NOT use NOC Codes unless there is no specific CPT code available. If using an NOC code, include a narrative description.</td>
</tr>
<tr>
<td>Field 24e</td>
<td>Diagnosis Code</td>
<td>Use the most specific ICD-9 Code available.</td>
</tr>
<tr>
<td>Field 24f</td>
<td>Charges</td>
<td>Charge for each single line item.</td>
</tr>
<tr>
<td>Field 24g</td>
<td>Days or Units</td>
<td>If applicable.</td>
</tr>
<tr>
<td>Field 24h</td>
<td>EPSDT Family Plan</td>
<td>Enter Y for EPSDT or N for non-EPSDT.</td>
</tr>
<tr>
<td>Field 25</td>
<td>Federal Tax ID Number</td>
<td>Enter the 9-digit number.</td>
</tr>
<tr>
<td>Field 28</td>
<td>Total Charge</td>
<td>Total of line item charges.</td>
</tr>
<tr>
<td>Field 31</td>
<td>Full Name and Title of Physician or Supplier</td>
<td>Actual signature or typed/printed designation is acceptable.</td>
</tr>
<tr>
<td>Field 32</td>
<td>Provider Servicing Address</td>
<td>Include suite or office number. Include abbreviations for road, street, avenue, boulevard, place or other common street name endings.</td>
</tr>
<tr>
<td>Field 33</td>
<td>Physician's or Supplier's Billing Name</td>
<td>Provider Identification Number (the number Anthem assigns to the Provider).</td>
</tr>
</tbody>
</table>
CHAPTER 12: BILLING INSTITUTIONAL CLAIMS

Billing Institutional Claims Overview

All Medicare-approved facilities should bill using the most current version of the CMS-1450 form, which is the UB-04.

To be sure that claims are processed in an orderly and consistent manner, standardized code sets must be used. The Healthcare Common Procedure Coding System (HCPCS), sometimes called the National Codes, provides coding for a variety of services. HCPCS consists of 2 principal subsystems, referred to as Level 1 and Level 2:

- Level 1: The Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by 5 numeric digits.
- Level 2: Other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and Durable Medical Equipment (DME). These are sometimes called the alphanumeric codes because they consist of a single alphabetical letter followed by 4 numeric digits.

In addition to the HCPCS codes, the California Department of Health Care Services (DHCS) created a separate set of codes for its Medi-Cal Program, sometimes called Local Codes. These codes identify services and products specific to Medi-Cal.

Billing Institutional Claims Institutional Inpatient Coding

Use the following codes for inpatient billing:

- ICD-9 Procedure Codes: To order the current ICD-9 Code Book, call: 1-800-633-7467

Please Note: Surgical supply charges require a modifier. Use UA for procedures without anesthesia or UB for procedures with anesthesia.

Billing Institutional Claims Institutional Outpatient Coding

Use the following codes for outpatient billing:

- HCPCS Codes: Refer to the current edition of CMS Common Procedure Coding System published by the Centers for Medicare and Medicaid Services (CMS). To order, call: 1-800-633-7467
Please Note: Claims must be submitted with both HCPCS and CPT codes. Use of Revenue Codes alone on an outpatient claim may result in a claim delay or denial due to lack of information.

Please Note: Use the Member's Client Index Number (CIN) when billing, whether submitting electronically or on paper.

Billing Institutional Claims

Ambulance Services

Ambulance services, including those for municipalities, must be billed on the CMS-1500 form with the following information:

- **Transportation Authorization Request** (TAR), required for all nonemergency transportation
- **Medi-Cal Members** must call Customer Service and request approval for all nonemergency transportation.
  - Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
  - Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
- **Medi-Cal Local Codes** must be used in the Medi-Cal code fields
- Nonemergency transport is not covered for AIM Members
- **MRMIP** Members are covered for non emergency transport with the same restrictions as those laid out for Medi-Cal Members above.
  - MRMIP Customer Care Center: 1-877-687-0549
- **MRMIP** nonemergency transportation billing is done with National Codes
- Appropriate modifiers are required that describe the "to" and "from" locations

Billing Institutional Claims

CCS Referrals

CCS special billing requirements include the following:

- **Utilization Management** approval is required for all admissions
- Include ICD-9-CM procedure codes for the delivery in form Locators 80 (principal procedure) through 81 (other procedures).
- Applicable maternity procedure codes are 720-74.99, 75.50-75.52, 75.61-75.62 and 75.69
- Applicable Boarder Baby Revenue Codes are 0170-0173 and 0179

Newborns whose mothers are covered by Medi-Cal and who have a CCS-eligible condition must be referred to CCS in a timely manner and as directed by the local CCS field office or our Utilization Management department. Do not assume that when professional services are CCS-authorized that the facility component will automatically be granted authorization as well. Facilities must ensure they are paneled and approved for the procedures or services they are rendering on a CCS-eligible condition to ensure compensation for services.

The maternity care rate covers the entire admission except for admissions that are approved for extension beyond what is contractually indicated on continuous inpatient days. In such cases, the inpatient acute care requirements apply for each approved and medically necessary service day for the entire admission.
The **Boarder Baby** requirements are specific only to the days that baby remains in the hospital nursery after the mother is discharged. However, they do not apply to accommodations in the **Neonatal Intensive Care Unit**. **Prior Authorization** is required for the extended **Boarder Baby** service period, and a separate billing must be submitted after the mother is discharged.

**Billing Institutional Claims**

**Durable Medical Equipment**

**Durable Medical Equipment** (DME) is covered when prescribed to preserve bodily functions or prevent disability. All custom-made DME requires Prior Authorization, and some DME services may require pre-service review. DME codes that indicate the equipment is "By Report" will require additional information for pre-service review as well as for claim processing.

For DME, billing requirements include the following:

- For **Medi-Cal**, use **Local or HCPCS Codes**
- Use miscellaneous codes (such as E1399, which represents customized equipment) when a HCPCS does not exist for a particular item
- Attach the manufacturer's invoice and MSRP (Catalog Page) to the claim if using a miscellaneous or unlisted code (the invoice must be from the manufacturer, not the office making the purchase)
- Unlisted codes will not be accepted if valid **HCPCS Codes** exist for the DME and supplies
- Catalog pages are not acceptable as manufacturer's invoices
- Many **Local Codes** have been remediated and are no longer acceptable for submission
- The correct way to bill for DME/supplies sales tax is the following:
  - Bill the code for the service with the appropriate modifier for rental or purchase for the amount charged, less the sales tax
  - Bill the **S9999** code on a different line with charges only for the sales tax

An example:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Modifier</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0570</td>
<td>Applicable modifier code to designate a DMR rental is RR</td>
<td>$100.00</td>
</tr>
<tr>
<td>S9999</td>
<td>Sales tax will be paid as billed</td>
<td>$ 8.00</td>
</tr>
</tbody>
</table>

**DME rentals**

Medical documentation from the prescribing doctor is required for DME rentals. Most DME is dispensed on a rental bases only, such as oxygen tanks or concentrators. Rented items remain the property of the DME Provider until the purchase price is reached. Please note the following guidelines:

- DME Providers may use normal equipment collection guidelines. We are not responsible for equipment not returned by Members.
- Charges for rentals exceeding the reasonable charge for a purchase will be rejected.
- Rental extensions may be obtained only on approved items.
DME purchase

- DME may be reimbursed on a rent-to-purchase basis over a period of 10 months unless specified otherwise at the time of review by Utilization Management.

DME Wheelchairs/Scooters

All Medi-Cal wheelchair claims undergo claims examination. The claims examiners follow Medi-Cal guidelines when calculating payments for By Report (customized) wheelchair claims. By Report claims on the CMS-1500 form must be accompanied by either:

- Manufacturer's purchase invoice
- Manufacturer's suggested retail price (MSRP) from a catalog dated prior to the date of service. Documentation must include:
  - Catalog number
  - Item description
  - Manufacturer name
  - Model number
  - Marked catalog page(s) and Invoice Line so it can be matched to the claim line

If applicable, completion of the Reserved for Local Use field (Box 19) of the CMS-1500 form must be accompanied by either:

- Suggested retail price (MSRP) from a catalog page dated before the date of service.
- Initial date of availability must be documented in the Reserve for Local Use field (Box 19) of the CMS-1500 form

DME Modifiers

For a list of DME Modifier Codes, see Appendix 1 of the HCPCS 2006 publication available from the American Medical Association (AMA) or log onto the AMA website: www.ama-assn.org.

Billing Institutional Claims

Emergency Room Visits

The billing requirements for emergency room visits apply to all emergency cases treated in the hospital emergency room (for patients who do not remain overnight) and cover all diagnostic and therapeutic services, including, but not limited to, the following:

- Equipment Use
- Facility Use, including nursing care
- Laboratory
- Pharmaceuticals
- Radiology
- Supplies

Reimbursement for emergency room services relates to the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis. Special billing instructions include:

- ICD-9-CM principal diagnosis codes are required for all services provided in an emergency room setting
Each service date must be billed as a separate line item.

Medi-Cal Local Codes are: Z7502 or Z7500 (Z7500 must be billed with Revenue Code 450 to be considered ER).

Please Note: Refer all Members back to the Primary Care Provider for follow-up care. Unless clinically required, follow-up care should never occur in the hospital's emergency department.

Billing Institutional Claims

Reporting Provider Preventable Conditions on Present on Admission Claims

Medi-Cal providers are required to report provider-preventable conditions (PPCs) with POA claims. This reporting is required for claims for Medi-Cal payment or when treatment is given to a Medi-Cal member for which payment would be available. Providers do not need to report PPCs that existed before the provider initiated treatment for the Medi-Cal member. The new federal regulations prevent Anthem from paying providers for the treatment of PPCs. To ensure compliance, DHCS will investigate all reports of PPCs to determine if payment adjustment is necessary.

Please note: Reporting PPCs for a Medi-Cal member does not prevent or exclude the reporting of adverse events to the California Department of Public Health pursuant to Health and Safety Code Section 1279.1.

Scope of POA and PPC Claims

The following is a list of preventable conditions where payment is prohibited:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
  - Crushing Injuries
  - Burns
  - Electric Shock
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
  - Coronary Artery Bypass Graft (CABG)—Mediastinitis
  - Bariatric Surgery
Chapter 12: Billing Institutional Claims

Anthem Blue Cross

Medi-Cal, Medi-Cal Access Program and MRMIP

- Laparoscopic Gastric Bypass
- Gastroenterostomy
- Laparoscopic Gastric Restrictive Surgery
  - Orthopedic Procedures
    - Spine
    - Neck
    - Shoulder
    - Elbow
- Deep Vein Thrombosis (DVT) / Pulmonary Embolism (PE). Not included for Medicaid for pediatric and obstetric populations.
  - Total Knee Replacement
  - Hip Replacement

Additionally, Anthem may not pay for the following events:
- Surgery on the wrong patient
- Wrong surgery on a patient
- Wrong site surgery

Table of Indicator Codes for PPC Forms

This table includes the Indicator Codes to be used on the PPC form. Using the codes correctly ensures that you are reimbursed as appropriate.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Reimbursable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>The condition was present on admission.</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>The condition was not present on admission.</td>
<td>No</td>
</tr>
<tr>
<td>W</td>
<td>The provider determined that it was not possible to document if the condition was present on admission.</td>
<td>Yes</td>
</tr>
<tr>
<td>U</td>
<td>The documentation was insufficient to determine if the condition was present on admission.</td>
<td>No</td>
</tr>
</tbody>
</table>

Indicator Codes Usage and Examples

Indicator Code usage is different for electronic and paper claims:

For electronic claims, the PPC Indicator Codes follow the Diagnosis Code in the appropriate 837i 2300 HI segment. The Indicator Codes must be within 2300 HI01-09 through HI12-09 in accordance with the number of diagnosis codes billed.

Examples of Diagnosis Codes with PPC data:

HI*BK: 5770:....:Y~

HI*BJ: 78906~

HI*BF: 3051:....:Y*BF:4019:....:Y*BF:3384:....:Y*BF:77210:....:Y*BF:V5869~
Chapter 12: Billing Institutional Claims

Anthem Blue Cross

Medi-Cal, Medi-Cal Access Program and MRMIP

For paper claims, the PPC Indicator Code is the eighth digit of Field Locator (FL) 67, Principal Diagnosis and Secondary Diagnosis fields, FL 67 A-Q. If the diagnosis is exempt from PPC reporting, leave this field blank.

To view the PPC report form, please visit the DHCS website:

- Enter www.medi-cal.ca.gov into the URL of your search engine.
- Click the Forms link.
- Scroll to the Provider-Preventable Conditions (PPCs) section and open or save the PDF form DHCS 7107.

Billing Institutional Claims
Recommended Fields for CMS-1450

<table>
<thead>
<tr>
<th>Field</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (R)</td>
<td>Blank</td>
<td>Facility name, address and telephone number</td>
</tr>
<tr>
<td>2</td>
<td>Blank</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>PAT. CNTL #</td>
<td>Member's account number</td>
</tr>
<tr>
<td>3b</td>
<td>MED. REC #</td>
<td>Member's record number, which can be up to 20 characters</td>
</tr>
<tr>
<td>4(R)</td>
<td>TYPE OF BILL</td>
<td>Enter the Type of Bill (TOB ) Code</td>
</tr>
<tr>
<td>5</td>
<td>FED. TAX NO.</td>
<td>Enter the Provider's Federal Tax ID number</td>
</tr>
<tr>
<td>6</td>
<td>STATEMENT COVERS PERIOD</td>
<td>&quot;From&quot; and &quot;Through&quot; date(s) covered by the claim being submitted</td>
</tr>
<tr>
<td>7</td>
<td>Blank</td>
<td>Leave Blank</td>
</tr>
<tr>
<td>8a-b (R)</td>
<td>PATIENT NAME</td>
<td>Member's name</td>
</tr>
<tr>
<td>9a-e (R)</td>
<td>PATIENT ADDRESS</td>
<td>Complete address (number, street, city, state, ZIP code, telephone number)</td>
</tr>
<tr>
<td>10 (R)</td>
<td>BIRTH DATE</td>
<td>Member's date of birth in MM/DD/YY format</td>
</tr>
<tr>
<td>11 (R)</td>
<td>SEX</td>
<td>Member's gender</td>
</tr>
<tr>
<td>12 (R)</td>
<td>ADMISSION DATE</td>
<td>Member’s admission date to the facility in MM/DD/YY</td>
</tr>
<tr>
<td>13 (R)</td>
<td>ADMISSION HOUR</td>
<td>Member's admission hour to the facility in military time (00-23) format</td>
</tr>
<tr>
<td>14 (R)</td>
<td>ADMISSION TYPE</td>
<td>Type of admission</td>
</tr>
<tr>
<td>15 (R)</td>
<td>ADMISSION SRC</td>
<td>Source of admission</td>
</tr>
<tr>
<td>16 (R)</td>
<td>DHR</td>
<td>Member's discharge hour from the facility in military time (00-23) format</td>
</tr>
<tr>
<td>17 (R)</td>
<td>STAT</td>
<td>Patient status</td>
</tr>
<tr>
<td>18-28</td>
<td>CONDITION CODES</td>
<td>Enter Condition Code (81) XO-X9</td>
</tr>
<tr>
<td>29</td>
<td>ACDT STATE</td>
<td>Accident State. Leave blank.</td>
</tr>
<tr>
<td>30</td>
<td>Blank</td>
<td>Leave blank</td>
</tr>
<tr>
<td>31-34 (R)</td>
<td>OCCURRENCE CODE OCCURRENCE DATE</td>
<td>Occurrence Code (42) and date, if applicable</td>
</tr>
<tr>
<td>Field</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>35-36</td>
<td>OCCURRENCE SPAN (CODE, FROM AND THROUGH)</td>
<td>Enter dates in MM/DD/YY format</td>
</tr>
<tr>
<td>37</td>
<td>Blank</td>
<td>Leave blank</td>
</tr>
<tr>
<td>38</td>
<td>Blank</td>
<td>Enter the responsible party name and address, if applicable</td>
</tr>
<tr>
<td>39-41</td>
<td>VALUE CODES (CODE AND AMOUNT)</td>
<td>Enter Value Codes</td>
</tr>
<tr>
<td>42 (R)</td>
<td>REV. CD.</td>
<td>Revenue Codes, required for all institutional claims</td>
</tr>
<tr>
<td>43 (R)</td>
<td>DESCRIPTION</td>
<td>Description of services rendered</td>
</tr>
<tr>
<td>44 (R)</td>
<td>HCPS/RATE/HIPPS CODE</td>
<td>Enter the accommodation rate per day for inpatient services or HCPS/CPT Code for outpatient services</td>
</tr>
<tr>
<td>45 (R)</td>
<td>SERV. DATE</td>
<td>Date of services rendered</td>
</tr>
<tr>
<td>46 (R)</td>
<td>SERV. UNITS</td>
<td>Number/units of occurrence for each line or service being billed</td>
</tr>
<tr>
<td>47 (R)</td>
<td>TOTAL CHARGES</td>
<td>Total charge for each line of service being billed</td>
</tr>
<tr>
<td>48</td>
<td>NON-COVERED CHARGES</td>
<td>Enter any non-covered charges</td>
</tr>
<tr>
<td>49</td>
<td>Blank</td>
<td>Leave blank</td>
</tr>
<tr>
<td>50</td>
<td>PAYOR NAME</td>
<td>Payer Identification. Enter any third party payers.</td>
</tr>
<tr>
<td>51 (R)</td>
<td>HEALTH PLAN ID</td>
<td>Medicare Provider ID Number/unique Provider ID Number. The billing Provider number is required</td>
</tr>
<tr>
<td>52 (R)</td>
<td>REL. INFO</td>
<td>Release of information certification indicator</td>
</tr>
<tr>
<td>53</td>
<td>ASG BEN.</td>
<td>Assignment of benefits certification indicator</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Prior payments</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td>Estimated amount due</td>
</tr>
<tr>
<td>56 (R)</td>
<td>NPI</td>
<td>Enter the NPI number</td>
</tr>
<tr>
<td>57 (R)</td>
<td>OTHER PRIV ID</td>
<td>Enter the other Provider ID, if applicable</td>
</tr>
<tr>
<td>58 (R)</td>
<td>INSURED'S NAME</td>
<td>Member's name</td>
</tr>
<tr>
<td>59 (R)</td>
<td>P. REL</td>
<td>Patient's relationship to insured</td>
</tr>
<tr>
<td>60 (R)</td>
<td>INSURED'S UNIQUE ID</td>
<td>Insured's ID Number: Certificate number on the Member's ID card For newborns, use the mother's ID number for services during the month of birth and the month following</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td>Insured Group Name: Enter the name of any other health plan</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td>Enter the Policy Number of any other health plan</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Authorization Number or authorization information</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>The Control Number assigned to the original bill</td>
</tr>
<tr>
<td>Field</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td>Name of organization from which the insured obtained the other policy</td>
</tr>
<tr>
<td>66 (R)</td>
<td>DX/PROC Qualifier</td>
<td>Enter the diagnosis and procedure core qualifier (ICD version indicator)</td>
</tr>
<tr>
<td>67 (R)</td>
<td>DX</td>
<td>Principal Diagnosis Codes. Enter the ICD-9 diagnostic codes, if applicable</td>
</tr>
<tr>
<td>67a-q(R)</td>
<td>DX</td>
<td>Other Diagnosis Codes: Enter the ICD-9 diagnostic codes, if applicable</td>
</tr>
<tr>
<td>68</td>
<td>Blank</td>
<td>Leave blank</td>
</tr>
<tr>
<td>69</td>
<td>ADMIT DX</td>
<td>Admission Diagnosis Code: Enter the ICD-9 code</td>
</tr>
<tr>
<td>70a-c</td>
<td>PATIENT REASON DX</td>
<td>Enter the Member's reason for this visit, if applicable</td>
</tr>
<tr>
<td>71</td>
<td>PPS CODE</td>
<td>Prospective Payment System (PPS) Code: Leave blank</td>
</tr>
<tr>
<td>72</td>
<td>ECI</td>
<td>External Cause of Injury Code</td>
</tr>
<tr>
<td>73</td>
<td>Blank</td>
<td>Leave blank</td>
</tr>
<tr>
<td>74 (R)</td>
<td>PRINCIPAL PROCEDURE CODE/DATE</td>
<td>ICD-9 principal procedure code and dates, if applicable</td>
</tr>
<tr>
<td>74a-e(R)</td>
<td>OTHER PROCEDURE CODE/DATE</td>
<td>Other Procedure Codes</td>
</tr>
<tr>
<td>75</td>
<td>Blank</td>
<td>Leave blank</td>
</tr>
<tr>
<td>76 (R)</td>
<td>ATTENDING</td>
<td>Enter the attending physician's ID number</td>
</tr>
<tr>
<td>77 (R)</td>
<td>OPERATING</td>
<td>Enter the Provider Number if you use a surgical procedure on this form</td>
</tr>
<tr>
<td>78-79</td>
<td>OTHER</td>
<td>Enter any other Provider numbers, if applicable</td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>Use this field to explain special situations</td>
</tr>
<tr>
<td>81a-c(R)</td>
<td>CC</td>
<td>Enter additional or external codes, if applicable</td>
</tr>
</tbody>
</table>
CHAPTER 13: MEMBER TRANSFERS & DISENROLLMENT

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm

Member Transfers & Disenrollment

Overview

At Anthem, our Members have the freedom to choose their most important connection to quality health care: their doctor. We strongly encourage our Members to select a Primary Care Provider (PCP) and remain with that Provider because we believe in the positive impact of having a medical ‘home.’ This home establishes a centralized hub from which all health care can be coordinated, without regard for how many other caregivers become involved.

Occasionally, Members may encounter obstacles as they attempt to create an effective relationship with their PCP. These obstacles may involve cultural and language difficulties, geographical access, or simply personal preferences. Members who want to change their PCP may do so at any time for any reason.

Members have the right to change health care plans by following specific rules and timelines. If a Member requests disenrollment, Anthem will provide information and assistance in the disenrollment process.

We notify PCPs of Member transfers through monthly enrollment reports. PCPs can find these reports online at our secure ProviderAccess website at https://provider2.anthem.com/wps/portal/ebpmybcc or by calling our Customer Care Center. The effective date of a PCP transfer will be the first day of the following month.

Disenrollment requests can also come from the state, Anthem and Providers. Providers have the right to request that a Member be reassigned to another PCP under certain conditions and following specific guidelines.

Member Transfers & Disenrollment

Member-Initiated PCP Transfers

Members have the right to change their Primary Care Provider (PCP) at any time. When our Members enroll in any of our programs, they can choose a PCP or allow their PCP to be assigned. After that, if they want to make a change, Members are instructed to call our Customer Care Center to request an alternate PCP.

Anthem accommodates Member requests for transfers whenever possible. Our staff will work with the Member to make the new selection, focusing on special needs. Our policy is to maintain Continued Access to Care and Continuity of Care during the transfer process.

When a Member calls to request a PCP change:

- The Customer Care Center (CCC) representative checks the availability of the Member’s choice. If the member can be assigned to the selected PCP, the CCC representative will do so. If the PCP is not available, the CCC representative will assist the Member in finding an available PCP. If the Member advises the CCC that he or she is hospitalized, the PCP change will take effect upon discharge.

- Anthem notifies PCPs of Member transfers through monthly enrollment reports. PCPs can access these reports by calling our Customer Care Center or by going to our secure ProviderAccess website at https://provider2.anthem.com/wps/portal/ebpmybcc.
The effective date of a PCP transfer will be the first day of the following month. We may assign a Member retroactively.

**Member Transfers & Disenrollment**

**Member Transfers to Other Plans**

Members can voluntarily disenroll and choose another health care plan at any time, subject to a restricted disenrollment period. Approved disenrollments become effective no later than the first day of the second month following the month in which the Member files the request. Disenrollment may result in any of the following:

- Enrollment with another health care plan
- Termination of eligibility
- Return to traditional or original fee-for-service Medi-Cal for continuity of care if the Member's benefits fall into a voluntary aid code

If a Member asks a Provider how to disenroll from Anthem, the Provider should direct the Member to call the **Customer Care Center** in their area:

- **Medi-Cal Health Care Options (Outside L.A. County):** 1-800-430-4263
  
  The Member must complete a **Request for Disenrollment Form** and mail it to:

  **Health Care Options**
  
  P.O. Box 989009
  
  West Sacramento, CA 95798-9850

- **Medi-Cal L.A. Care (Los Angeles County Only):** 1-888-452-2273
  
  The Member must complete a **Plan Partner Change Form** and mail it to:

  **L.A. Care Health Plan**
  
  555 West Fifth Street
  
  Los Angeles, CA 90013

When our **Customer Care Center** receives a call from a Member who wants to disenroll from our health care plan, the following steps will be taken:

1. The **Customer Care Center** will attempt to find out the reason for the request.
2. They will resolve the situation, if possible.
3. If the Member agrees to allow us to attempt resolution, we initiate the appropriate process, which may include **Grievances and Appeals**.
4. If the Member declines, our **Customer Care Center** gives the Member the phone numbers for **Health Care Options** (HCO) or **L.A. Care**.
5. The **Customer Care Center** informs the Member that the disenrollment process will take approximately 15-45 days. The Member may also request an expedited disenrollment under certain circumstances.
Member Transfers & Disenrollment

PCP-Initiated Member Transfers

PCPs may request Member reassignment to a different PCP for the following reasons:

- The Member is abusive to the PCP, exhibiting disruptive, unruly, threatening or uncooperative behavior
- The Member is abusive to staff, exhibiting disruptive, unruly, threatening or uncooperative behavior
- The Member misuses or loans his or her membership card to another person
- The Member fails to follow prescribed treatment plans

The process for disenrollment begins by downloading the **Provider Request for Member Deletion from PCP Assignment** form located in the **Forms Library** on the **Provider Resources** page of our website at www.anthem.com/ca. For information on how to access the **Provider Resources** page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.

To request disenrollment, the PCP must do the following:

- Complete the **Provider Request for Member Deletion from PCP Assignment** form and mail or fax *(preferred)* the form to the address or fax number on the form.
- Continue to manage the Member’s care, as required, until we can reassign the Member to another PCP, or not more than 30 days from the day we receive the **Provider Request for Member Deletion from PCP Assignment** form, whichever comes first.
- The change will become effective the day **Anthem** enters it into the system.

Prior to disenrollment, **Anthem** will make every attempt to resolve issues and keep the Member in our health care plan. If these attempts fail, we will either reassign the Member to another PCP or forward the disenrollment request form to the appropriate state agency requesting Member reassignment to another health care plan.

**Anthem** may also request disenrollment for a Member who has moved out of the service area. When a Member moves out of our service area, he or she is responsible for notifying the state of the new permanent address. After that, DHCS will disenroll the Member from **Anthem**.

Member Transfers & Disenrollment

State Agency-Initiated Member Disenrollment

Contracted state agencies inform **Anthem** of membership changes by sending daily and monthly enrollment reports. These reports contain all active membership data and incremental changes to eligibility records. **Anthem** disenrolls Members who are not listed on the monthly full replacement file effective as of the designated disenrollment date. Reasons for disenrollment may include:

- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Change in eligibility status
- County or residence changes
- Death of the Member
- Health care plan mergers or reorganizations
- Incarceration
- Loss of benefits
- Permanent change of residence out of service area
- Voluntary disenrollments
CHAPTER 14: GRIEVANCES & APPEALS

Grievances & Appeals

Overview

We encourage Anthem Providers and Members to seek resolution of issues through our grievance and appeals process. The issues may involve dissatisfaction or concern about another Provider, the Plan or a Member.

We want to assure Providers that they have the right to file an appeal with us for denial, deferral or modification of a claims disposition or post-service request. They also have the right to appeal on behalf of a Member for denial, deferral or modification of a Prior Authorization or Request for Concurrent Review. These appeals are treated as Member appeals and follow the Member appeal process.

Grievances are tracked and trended, resolved within established time frames, and referred to peer review when necessary. Anthem’s grievance and appeals process meets all requirements of state law and accreditation agencies.

The building blocks of this process are the grievance and the appeal.

**Grievance:** Any expression of dissatisfaction about any matter other than an "action" to Anthem by a Member or Provider.

**Appeal:** A formal request for Anthem to change a decision upheld by Anthem through the grievance and appeal process.

Please Note: Anthem does not discriminate against Providers or Members for filing a grievance or an appeal. Providers are prohibited from penalizing a Member in any way for filing a grievance.

Provider grievances and appeals are classified into the following 3 categories:

- Grievances relating to the operation of the Plan, including:
  - Benefit Interpretation
  - Claim Processing
  - Reimbursement
- Provider appeals related to adverse determinations
- Provider appeals of nonmedical necessity claims determinations

Member grievances and appeals can include, but are not limited to, the following:

- Access to health care services
- Care and treatment by a Provider
- Issues having to do with how we conduct business

If a Provider or Member has a grievance, Anthem would like to hear from them, either by phone or in writing. Grievances may be filed by calling the Customer Care Center or in writing and submitted to the Grievances and Appeals Department. Providers may file a written grievance by using the Physician/Provider Grievance Form located in the Forms Library of the Provider Resources page of our
website at www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

To mail the form, use the following address:

Attn: Grievances & Appeals Department
Anthem Blue Cross
P.O. Box 60007
Los Angeles, Ca. 90060-0007

Providers can also fax the form to: 1-888-387-2968.

Please Note: Anthem offers an expedited grievance and appeal to members for decisions involving urgently needed care. Whether standard or expedited, grievances and appeals are reviewed by a person who is not subordinate to the initial decision-maker.

Grievances & Appeals
Provider Grievances Relating to the Operation of the Plan

A Provider may be dissatisfied or concerned about another Provider, a Member or an operational issue, including claims processing and reimbursement. Provider grievances may be submitted orally or in writing and include the following:

- Provider’s name
- Date of the incident
- Description of the incident

Timelines for the Provider grievance and appeal process:

<table>
<thead>
<tr>
<th>Provider Grievance</th>
<th>May be filed up to 180 calendar days from the date the Provider became aware of the issue.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Appeal</td>
<td>May be filed up to 365 calendar days from the date on the Notice of Action letter advising of an Adverse Determination.</td>
</tr>
</tbody>
</table>

Anthem will send a written acknowledgement to the Provider within 5 calendar days of receiving a grievance or within 5 business days of receiving an appeal. We may request medical records or an explanation of the issues raised in the grievance in the following ways:

- By telephone
- By fax with a signed and dated letter
- By mail with a signed and dated letter

The timeline for responding to the request for more information is as follows:

- **Standard Grievances or Appeals**: Providers must comply with the request for additional information within 10 calendar days of the date that appears on the request.

Providers are notified in writing of the resolution, including their right of appeal, if any. According to state law, we may not be able to disclose the final disposition of certain grievances due to peer review confidentiality laws.
When to Expect Resolution for a Grievance or Appeal

- **Provider Grievances**: *Anthem* sends a written resolution letter to the Provider **within 30 calendar days** of the receipt of the grievance.

- **Provider Appeals**: *Anthem* sends a written resolution letter to the Provider **within 45 working days** of the receipt of the appeal.

Grievances & Appeals

Provider Dispute

When a Provider expresses dissatisfaction about an **Adverse Determination** involving a clinical issue, the case is automatically handled as a provider dispute rather than a grievance.

**Adverse Determination**: A denial, modification or reduction of services based on eligibility, benefit coverage or medical necessity.

A **Clinical Reviewer** of the same or similar specialty reviews the Provider appeal. This clinical reviewer will be someone who was not involved in any previous level of review in the decision-making process. In addition, the clinical reviewer may not be subordinate to any person involved in the initial determination. The clinical reviewer will review the case, contact the Provider as necessary to discuss possible appropriate alternatives and render a decision.

Claims denials are also considered an **Adverse Determination**. Providers who want to challenge a claims decision may submit a **Provider Dispute Resolution Request Form**.

**Provider Dispute Resolution Appeal**: The process by which a Provider may challenge the disposition of a claim that has already been decided.

The **Provider Dispute Resolution Request Form** is located in the **Forms Library** of the Provider Resources page of our website at [www.anthem.com/ca](http://www.anthem.com/ca). For directions on how to access the Provider Resources page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.

Requests for provider disputes must be submitted using the following guidelines:

- The request must be made in **writing** to *Anthem* **within 365 calendar days** of a claim disposition and include all pertinent information.

**Provider Dispute Resolution Appeals** are resolved **within 45 working days** of receipt of the written request.

Grievances & Appeals

Provider Appeals: Arbitration

If the Provider is not satisfied with the outcome of a review conducted through the Provider Appeal Process, there are additional steps that can be taken through arbitration, in accordance with the **Anthem State Sponsored Business Provider Agreement**. For more information, please call the appropriate Customer Care Center at the contact numbers listed at the beginning of this chapter.

Grievances & Appeals

Member Grievances: Filing a Grievance

To help ensure that our Members' rights are protected, all **Anthem** Members are entitled to a grievance and appeals process. If a Member wants to file a grievance, the process is to call the Customer Care Center, write a letter to the Grievance and Appeal Department, or fill out a **Member Grievance Form** and mail it to us, telling us about the problem. Grievance forms are available at the places where Members receive their
health care, such as their PCP’s office, as well as on our website at www.anthem.com/ca via the following websteps:

- Select **OTHER ANTHEM WEBSITES: Medicaid**
- Select **Medi-Cal, MRMIP or MAP (AIM)** from one of the blue tabs and scroll down to the **Member Grievance Forms** option and click to open

One does not need to be a Member to file a grievance or appeal. Other representatives include the following:

- Relative
- Guardian
- Conservator
- Attorney
- Member's Primary Care Provider

The grievance submission must include the following information:

- Who is part of the grievance
- What happened
- When it happened
- Where it happened
- Why the Member was not happy with the health care services
- Attach documents that will help us look into the problem

The grievance form should be mailed to:

**ATTN:** Appeals and Complaints Department  
Anthem Blue Cross  
P.O. Box 60007  
Los Angeles, Ca. 90060-0007

If the Member cannot mail the form or letter, we will assist the Member by documenting a verbal request.

**Please note:** If the Member’s grievance is related to an “**Action**” already taken, it is considered an **appeal**.

**Action:** The denial or limited authorization of a requested service, including the type or level of service.

**Actions may include the following:**

- Denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for service
- Failure to provide services in a timely manner, as defined by the State
- Failure of **Anthem** to act within required timeframes
Chapter 14: Grievances & Appeals

Timelines for the Member Grievance and Appeal Process:

<table>
<thead>
<tr>
<th>Member Grievance</th>
<th>180 calendar days after the date of the incident that gave rise to the grievance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Appeal: Medi-Cal</td>
<td>90 calendar days after the date of the Notice of Action letter notifying the Member of a denial, deferral or modification of a request for services</td>
</tr>
<tr>
<td>Member Appeal: MRMIP &amp; AIM (MediCal Access Program)</td>
<td>180 calendar days after the date on the Notice of Action letter notifying the Member of a denial, deferral or modification of a request for services</td>
</tr>
</tbody>
</table>

Please Note: Anthem will resolve any grievance or appeal, internal or external, at no cost to the Member. Interpreter services and translation of materials into non-English languages and alternative formats are available to support Members with the grievance and appeals process, at no cost to the member.

Grievances & Appeals

Member Grievances and Appeals: Acknowledgement

After we receive the Member’s grievance by phone, fax or mail, we will send an acknowledgment letter within 5 calendar days from the date we receive the grievance or appeal. If we receive a request for an expedited grievance or appeal, the medical director, without delay, will review the request to determine if the request involves an imminent and/or serious threat to the health of the Member, including, but not limited to, severe pain, and potential loss of life, limb or major bodily function. This determination is made within one working day of the receipt of the expedited request.

If the Medical Director determines a request involves medical care or treatment, for which the application of the standard time period is appropriate, the grievance and appeal clinical associate immediately notifies the Member by telephone, if possible, of the determination. In addition, the grievance and appeal clinical associate immediately sends an acknowledgement letter to the Member which indicates the receipt of the expedited request, the date of the receipt and notification that the request was reviewed for urgency but will be handled as a standard grievance or appeal.

If the Medical Director determines the request is for medical care or treatment in which the application of the time period for making a standard determination would be detrimental to the member, the grievance and appeal associate immediately notifies the Member by telephone, if possible, that the request was received. An acknowledgement letter is mailed immediately to the member as well. This letter indicates the receipt of the expedited appeal request, the date of the receipt or the request, and the member’s right to immediately notify the Department of Managed Health Care (DMHC) of the expedited appeal.

Grievances & Appeals

Member Grievances: Resolution

Anthem will investigate the Member’s grievance to develop a resolution. This investigation includes the following steps:

- **Anthem** will have the grievance reviewed by appropriate staff and, if necessary, the **Medical Director**.
- **Anthem** may request medical records or an explanation from the Provider(s) involved in the case.
- **Anthem** will notify Providers of the need for additional information either by phone, mail or fax. Written correspondence to Providers will include a signed and dated letter.
- Providers are expected to comply with requests for additional information within **10 calendar days** for standard grievances and appeals and **within 24 hours** for an expedited grievance or appeal.
The Member will receive a **Grievance Resolution Letter** within 30 calendar days of the date we receive the grievance. The letter will:

- Describe their grievance
- Tell them what will be done to solve the problem
- Tell them how to ask for a second review of the grievance
- Tell them how to ask for internal appeal of our decision

**Grievances & Appeals**

**Member Appeals**

Appeals are divided into 2 categories: **Standard Appeals** and **Expedited Appeals**.

**Standard Appeals**: Standard Appeals are the appropriate process when a Member or his/her representative requests that Anthem reconsider the denial of a service or payment for services, in whole or in part.

**Expedited Appeals**: Expedited Appeals are the appropriate process when the amount of time necessary to participate in a standard appeal process could jeopardize the Member’s life, health or the ability to maintain or regain maximum function.

**Grievances & Appeals**

**Member Appeals: Standard Appeals**

Members may request a standard appeal by calling our **Customer Care Center** at:

- Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
- Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
- MAP/MRMIP Customer Care Center: 1-877-687-0549

**Grievances & Appeals**

**Member Appeals: Response to Standard Appeals**

Anthem may request medical records or a Provider explanation of the issues raised in a standard appeal by the following means:

- By Phone
- By Fax, with a signed and dated letter
- By Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within **10 calendar days**.

**Grievances & Appeals**

**Member Appeals: Resolution of Standard Appeals**

Standard appeals are resolved within **30 calendar days** from the date of receipt of the initial written or oral request. Members are notified in writing of the appeal resolution, including their right to further appeal, if any. An additional **14 calendar days** may be granted when certain circumstances are met (see 42 CFR 438.40 (c)). The request for an appeal must be filed in **writing**.
Grievances & Appeals

Member Appeals: Expedited

Anthem will inform the Member of the time available for providing information, and that limited time is available for expedited appeals.

Members may request an expedited appeal by calling our Customer Care Center at the numbers listed above under Member Appeals: Standard Appeals.

If Anthem denies a request for an expedited appeal, Anthem must:

- Transfer the appeal to the time frame for standard resolution.
- Make a reasonable effort to give the Member prompt oral notice of the denial and follow up within 2 calendar days with a written notice.

Grievances & Appeals

Member Appeals: Response to Expedited Appeals

Anthem may request medical records or a Provider explanation of the issues raised in an expedited appeal by the following means:

- By Phone
- By Fax, with a signed and dated letter
- By Mail, with a signed and dated letter

Providers are expected to comply with the request for additional information within 24 hours.

Grievances & Appeals

Member Appeals: Resolution of Expedited Appeals

Anthem resolves expedited appeals as quickly as possible and within 72 hours. The Member is notified by telephone of the resolution, if possible, and with a written resolution letter within 72 hours from the receipt of the appeal request.

Grievances & Appeals

Member Appeals: Other Options for Filing Grievances

After exhausting Anthem’s grievance appeal process, if a Member is still dissatisfied with a decision, the Member has the right to request an Independent Medical Review from the following entities:

- L.A. Care Health Plan: Los Angeles County Members only
- California Department of Social Services, State Hearing Division: Members may request a State Fair Hearing at any time during the grievance process
- Medi-Cal Managed Care Office of the Ombudsman at the California Department of Health Care Services: Members may submit a grievance
- California Department of Managed Health Care: Members may request an Independent Medical Review (IMR) if eligible or an expedited review or an urgent grievance or appeal. If the Member has requested a State Fair Hearing, he or she cannot also request an IMR.
Chapter 14: Grievances & Appeals

Grievances & Appeals

Medi-Cal Member Appeals: State Fair Hearing

Medi-Cal members may request a **State Fair Hearing** with the California Department of Social Services (CDSS) at any point prior to, during or after exhausting Anthem’s grievance or appeal processes. For grievances not related to a Notice of Action, members must file a request for a **State Fair Hearing** within ninety (90) days from the date the incident or action occurred which caused the member to be dissatisfied. For grievances regarding a Notice of Action, members may file an appeal with Anthem and a **State Fair Hearing** with the CDSS at the same time. The **State Fair Hearing** must be filed within 90 days from the date of the Notice of Action. However, an **Independent Medical Review (IMR)** with the Department of Managed Health Care (DMHC) may not be requested if a **State Fair Hearing** has already been requested for a Notice of Action. The request may be submitted by writing to the State of California at:

**Department of Social Services**
**State Hearing Division**
P.O. Box 944243, MS19-37
Sacramento, CA 94244-2430

Or by calling the department toll free at **1-800-952-5253**.

Once the state receives the Member’s request, the process is as follows:

- The state sends a notice of the hearing request to Anthem.
- Upon receipt of the request, all documents related to the request and are forwarded to the state.
- The state notifies all parties of the date, time and place of the hearing. Representatives from our administrative, medical and legal departments may attend the hearing to present testimony and arguments. Our representatives may cross-examine the witnesses and offer rebutting evidence.
- An **Administrative Law Judge** renders a decision in the hearing within 90 business days of the date the hearing request was made.
- If the judge overturns Anthem’s position, we must adhere to the judge’s decision and ensure that it is carried out.

Please note: The **State Fair Hearing** process is applicable to Medi-Cal enrollees only. **Anthem** Members enrolled in the Medi-Cal Access Program (MAP) or MRMIP **may not** request a **State Fair Hearing**. However, they **may** request an **Independent Medical Review**.

Grievances & Appeals

**Member Appeals: Discrimination**

Members who contact us with an allegation of discrimination are immediately informed of the right to file a **Grievance**. This also occurs when one of our representatives working with a Member identifies a potential act of discrimination. The Member is advised to submit an oral or written account of the incident and is assisted in doing so if he or she requests assistance.

We document, track and trend all alleged acts of discrimination. A **Grievances & Appeals** associate will review and trend cultural and linguistic grievances in collaboration with a cultural and linguistic specialist.
Grievances & Appeals

Medi-Cal Member Appeals: Continuation of Benefits for Anthem Members during an Appeal

Medi-Cal Members may continue benefits while their Appeal or State Fair Hearing is pending in accordance with federal regulations when all of the following criteria are met:

- Member or his provider on the member’s behalf must request the Appeal within 10 days of our mail date of the adverse action notification or prior to the effective date on the written notice of the adverse action; and
- The Appeal involves the termination, suspension or reduction of a previously authorized course of treatment; and
- Services were ordered by an authorized Provider; and
- The original period covered by the initial authorization has not expired, and Member requests extension of benefits.
CHAPTER 15: CREDENTIALING & RE-CREDENTIALING

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549

Credentialing and Recredentialing
Credentialing Program Structure

The National Credentials Committee (NCC) is the authorized entity for the development and maintenance of National Credentialing Policy. Policies approved by NCC will govern credentialing of network practitioners and Health Delivery Organizations (HDOs), including but not limited to scope, criteria, confidentiality, delegation and appeals. Policies established by the National Credentials Committee will be presented to Anthem’s Credentials Committee for input, review and adoption.

The NCC establishes a local credentialing and peer review body known as the Credentials Committee. The Credentials Committee (CC) is authorized by the NCC to evaluate and determine eligibility for practitioners and HDOs to participate in the credentialed networks and be listed in the Provider directories.

Credentialing and Recredentialing
Credentialing Program Scope

Anthem credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors and optometrists providing services covered under Anthem’s Medi-Cal Managed Care (Medi-Cal) and doctors of dentistry providing Health Services covered under Medi-Cal including oral maxillofacial surgeons.

Anthem also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master’s level clinical social workers who are state licensed; master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified or registered by the state to practice independently. Medical Therapists (e.g., physical therapists, speech therapists and occupational therapists) and other individual health care practitioners listed in Anthem’s Network directory are also credentialed.

Anthem credentials the following HDOs: hospitals; home health agencies; skilled nursing facilities; (nursing homes); freestanding surgical centers; lithotripsy centers treating kidney stones and freestanding cardiac catheterization labs if applicable to certain regions; and behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting. Additional facilities and ancillary Providers, including long-term care services and support Providers, are also subject to credentialing and recredentialing.

Credentialing and Recredentialing
Credentials Committee

The decision to accept, retain, deny or terminate a practitioner’s participation in a Network or Plan Program is conducted by a peer review body, known as Anthem’s Credentials Committee (CC).

The CC will meet at least once every 45 days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will chair the CC and serve as a voting member (the Chair of the CC). The
CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to Anthem Covered Individuals and who falls within the scope of the credentialing program, having no other role in Anthem’s Network Management. The Chair of the CC may appoint additional Network practitioners of such specialty type as deemed appropriate for the efficient functioning of the CC.

The CC will access various specialists for consultation as needed to complete the review of a practitioner’s credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant’s participation or terminate a practitioner from participation in one or more Networks or Plan Programs require a majority vote of the voting members of the CC in attendance, the majority of whom are Network Providers.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within 30 calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than 14 calendar days in which to provide additional information. Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Credentialing and Recredentialing
Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its Plan Programs or Networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.
Credentialing and Re-Credentialing

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in the Anthem Network. This application may be a state-mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a Universal Credentialing Datasource, is utilized. CAQH is building the first national Provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their website at www.CAQH.org.

Anthem will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the 180 calendar-day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

<table>
<thead>
<tr>
<th>Verification Element</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will treat Covered Individuals.</td>
<td></td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or AOA-accredited hospital, or a Network hospital previously approved by the committee.</td>
<td></td>
</tr>
<tr>
<td>DEA, CDS and state controlled substance certificates</td>
<td></td>
</tr>
<tr>
<td>The DEA/CDS must be valid in the state(s) in which practitioner will treat Covered Individuals. Practitioners who see members in more than one state must have a DEA/CDS for each state.</td>
<td></td>
</tr>
<tr>
<td>Malpractice insurance</td>
<td></td>
</tr>
<tr>
<td>Malpractice claims history</td>
<td></td>
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<tr>
<td>Board certification or highest level of medical training or education</td>
<td></td>
</tr>
<tr>
<td>Work history</td>
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<tr>
<td>State or Federal license sanctions or limitations</td>
<td></td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
<td></td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
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</table>

B. Health Delivery Organizations (HDOs)

<table>
<thead>
<tr>
<th>Verification Element</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
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</tr>
<tr>
<td>License to practice, if applicable</td>
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<tr>
<td>Malpractice insurance</td>
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<tr>
<td>Medicare certification, if applicable</td>
<td></td>
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<tr>
<td>Department of Health Survey Results or recognized accrediting organization certification</td>
<td></td>
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<tr>
<td>License sanctions or limitations, if applicable</td>
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</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
<td></td>
</tr>
</tbody>
</table>
Credentialing and Recredentialing

Re-credentialing

The recredentialing process incorporates reverification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem’s credentialing standards.

During the recredentialing process, Anthem will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of Anthem’s Credentialing Program are required to be recredentialed every three years unless otherwise required by contract or state regulations.

Credentialing and Recredentialing

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem’s screening criteria, the credentialing process will commence. To assess whether participating Anthem Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem’s Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

Recredentialing of HDOs occurs every three years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in the Anthem Network must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem may request and will accept additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Credentialing and Recredentialing

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 calendar days of the time they are made available from the various sources, including, but not limited to, the following:

1. Office of the Inspector General (OIG)
2. Federal Medicare/Medicaid Reports

3. Office of Personnel Management (OPM)

4. State licensing Boards/Agencies

5. Covered Individual/Customer Services Departments

6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)

7. Other internal Anthem Departments

8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response, including but not limited to: review by the Chair of Anthem’s CC, review by the Anthem’s Medical Director, referral to the CC or termination. Anthem’s credentialing departments will report Providers to the appropriate authorities as required by law.

**Credentialing and Recredentialing Appeals Process**

Anthem has established policies for monitoring and recredentialing practitioners and HDOs who seek continued participation in the Anthem Network or Plan Program. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat practitioners and HDOs and applying Providers fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in the Anthem Network or Plan Program for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in the Anthem Network or Plan Program and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner’s or HDO’s suspension or loss of licensure, criminal conviction, or Anthem’s determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to Covered Individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

**Credentialing and Recredentialing Reporting Requirements**

When Anthem takes a professional review action with respect to a practitioner’s or HDO’s participation in the Anthem Network, Anthem may have an obligation to report such to the NPDB and/or Healthcare Integrity and Protection Data Bank (HIPDB). Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB Guidebook will govern.
Credentialing and Recredentialing

Eligibility Criteria – Health Care Practitioners

Initial applicants must meet the following criteria in order to be considered for participation:

A. Possess a current, valid, unencumbered, unrestricted and nonprobationary license in the state(s) where he/she provides services to Covered Individuals

B. Possess a current, valid and unrestricted Drug Enforcement Agency (“DEA”) and/or Controlled Dangerous Substances (“CDS”) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS for each state

C. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP

D. For MDs, DOs, DPMs and oral and maxillofacial surgeons, the applicant must have current, in-force board certification (as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) or American Board of Oral and Maxillofacial Surgery (ABOMS) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement

1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC or CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice. OR
   b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
   c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in Anthem Network AND the applicant’s professional activities are spent at that institution at least 50 percent of the time.

2. Practitioners meeting one of these three alternative criteria (a, b, c) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO) or an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network/Participating Provider to provide inpatient care.
Credentialing and Recredentialing

Criteria for Selecting Practitioners – New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
2. Application attestation signed date within 180 calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);
9. Possess a current, valid and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS must be valid in the state(s) in which the practitioner will treat Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS for each applicable state. Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA, the credentialing process may proceed if all of the following are met:
   a. It can be verified that this application is pending.
   b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained.
   c. The applicant agrees to notify Anthem upon receipt of the required DEA.
   d. Anthem will verify the appropriate DEA/CDS via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA within a 90-day timeframe will result in termination from the Network.
      ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if ALL the following criteria are met:
         • It can be verified that this application is pending and,
         • The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained,
         • The applicant agrees to notify Anthem upon receipt of the required DEA,
         • Anthem will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA within a 90 calendar day timeframe will result in termination from the Network, AND
         • Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

13. No gap in work history greater than six months in the past five years with the exception of those gaps related to parental leave or immigration where 12-month gaps will be acceptable. Other gaps in work history of six to 24 months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two years.

14. No history of criminal/felony convictions or a plea of no contest;

15. A minimum of the past 10 years of malpractice case history is reviewed.

16. Meets Credentialing Standards for education/training for specialty(ies) in which practitioner wants to be listed in an Anthem Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral/maxillofacial surgeons;

17. No involuntary terminations from an HMO or PPO;

18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
   a. Investment or business interest in ancillary services, equipment or supplies;
   b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. Voluntary surrender of state license related to relocation or nonuse of said license;
   d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
   e. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window.
   g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner who does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner’s name and specialty.

**Credentialing and Recredentialing**

**Currently Participating Applicants (Recredentialing)**

1. Submission of complete recredentialing application and required attachments that must not contain intentional misrepresentations;

2. Recredentialing application signed date within 180 calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on recredentialing application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
6. * No current license probation;
7. * License is unencumbered;
8. No new history of licensing board reprimand since prior credentialing review;
9. * No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report);
10. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of current restrictions;
11. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network/Participating Provider of similar specialty at a Network hospital who provides inpatient care to Covered Individuals needing hospitalization;
12. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
14. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
15. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
16. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
17. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
   a. Investment or business interest in ancillary services, equipment or supplies;
   b. Voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. Voluntary surrender of state license related to relocation or nonuse of said license;
   d. An NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
   e. Nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   f. Previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five-year post residency training window;
   g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
18. No QI data or other performance data including complaints above the set threshold.
19. Recredentialed at least every three years to assess the practitioner’s continued compliance with Anthem standards.

*It is expected that these findings will be discovered for currently credentialed Providers and Facilities through ongoing sanction monitoring. Providers and Facilities with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Provider or Facility that does not meet one or more of the criteria for recredentialing.

Credentialing and Recredentialing

Additional Participation Criteria and Exceptions for Behavioral Health Practitioners (Non-Physician) Credentialing

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
   b. Program must have been accredited within three years of the time the practitioner graduated.
   c. Full accreditation is required; candidacy programs will not be considered.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (‘COAMFTE”) listings. The institution must have been accredited within three years of the time the practitioner graduated.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three years of the time of the practitioner’s graduation.
b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.

c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.

d. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a Provider as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the practitioner will treat Covered Individuals.

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three years of the time of the practitioner’s graduation.
   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master’s level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists who are not board certified or listed in the National Register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable predoctoral training OR
      ii. Documentation of applicable formal one year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
      iv. Minimum of five years of experience practicing neuropsychology at least 10 hours per week

Credentialing and Recredentialing

Eligibility Criteria – Health Delivery Organizations (HDOs)

All HDOs must be accredited by an appropriate, recognized accrediting body. In the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with Anthem’s standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect
quality or care or patient safety. HDOs are recredentialed at least every three years to assess the HDO’s continued compliance with Anthem’s standards.

**General Criteria for HDOs:**

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the CC to determine if Anthem’s quality and certification criteria standards have been met.

**Additional Participation Criteria for HDO by Provider Type**

### MEDICAL FACILITIES

<table>
<thead>
<tr>
<th>Facility Type (MEDICAL CARE)</th>
<th>Acceptable Accrediting Agencies</th>
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</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>TJC, HFAP, NIAHO</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ</td>
</tr>
<tr>
<td>Freestanding Cardiac Catheterization Facilities</td>
<td>TJC, HFAP (may be covered under parent institution)</td>
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<tr>
<td>Lithotripsy Centers (Kidney stones)</td>
<td>TJC</td>
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<tr>
<td>Home Health Care Agencies</td>
<td>TJC, CHAP, ACHC</td>
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<tr>
<td>Skilled Nursing Facilities</td>
<td>TJC, CARF</td>
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<td>Nursing Homes</td>
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### BEHAVIORAL HEALTH

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<th>Acceptable Accrediting Agencies</th>
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<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>TJC, HFAP NIAHO,</td>
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<tr>
<td>Residential Care—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO CARF</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO CARF for programs associated with an acute care facility or Residential Treatment Facilities.</td>
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<tr>
<td>Service</td>
<td>Accreditation Standards</td>
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<tr>
<td>Intensive Structured Outpatient Program—</td>
<td>TJC, HFAP NIAHO</td>
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<tr>
<td>Psychiatric Disorders</td>
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<td>CARF if program is a</td>
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<td>center providing</td>
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<td>psychiatric services</td>
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<td>Acute Inpatient Hospital—Chemical</td>
<td>TJC, HFAP, NIAHO</td>
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<tr>
<td>Dependency/Detoxification and Rehabilitation</td>
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<td>Acute Inpatient Hospital—Detoxification Only</td>
<td>TJC, HFAP, NIAHO</td>
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<td>Facilities</td>
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<td>Residential Care—Chemical Dependency</td>
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<td>Partial Hospitalization/Day Treatment—</td>
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<td>Chemical Dependency</td>
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<td>CHAMPUS or CARF</td>
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<td>treatment center that</td>
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<td>provides drug abuse and</td>
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<td>alcoholism treatment</td>
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<td>services to adults or</td>
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<td>adolescents</td>
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<td>Intensive Structured Outpatient Program—</td>
<td>TJC, NIAHO</td>
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<td>Chemical Dependency</td>
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<td>health care organization</td>
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<td>that provides drug</td>
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<td>adults or adolescents</td>
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CHAPTER 16: ACCESS STANDARDS & ACCESS TO CARE

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549

Access Standards & Access to Care

Overview

This chapter outlines Anthem's standards for timely and appropriate access to quality health care. We adhere to standards set by the following organizations:

- National Committee for Quality Assurance (NCQA),
- American College of Obstetricians and Gynecologists (ACOG)
- L.A. Care
- Department of Health Care Services (DHCS)
- California Department of Managed Health Care (DMHC)

These guidelines help ensure that medical appointments, emergency services and continuity of care for new and transferring Members are provided fairly, reasonably and within specific time frames. Anthem monitors Provider compliance with access to care standards on a regular basis. Failure to comply with proper instructions, standards or survey requests may result in corrective action.

We recognize that there may be cultural and linguistic barriers that affect Providers' ability to communicate with Members, making it difficult for Members to understand or comply with instructions or procedures. To find resources and tools to help effectively address such barriers, we encourage Providers to access Anthem's Cultural Diversity and Linguistics Training guide, called Caring for Diverse Populations. This information can be found under Health Education heading on the Provider Resources page of our website at: www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Access Standards & Access to Care

Initial Health Assessments

The Initial Health Assessment (IHA) is a complete medical history, a head-to-toe physical examination, and an assessment of health behaviors. The IHA should include the following specific screenings:

- **Dental Screening/Oral Assessment**: For all children age 3 and under, providing them with a dental referral if needed
- **Immunizations**: Providers must document in the Member's medical record all age-appropriate immunizations
- **Tuberculosis Screening**: All Members must be screened for TB

PCPs are strongly encouraged to review their monthly eligibility list provided by Anthem and proactively contact their assigned Members to make an appointment for an IHA within the following time frames:

- Adults and Children over 18 Months to 20 years of age = within 120 days of enrollment
- Children under 18 Months = within 60 days of enrollment
The PCP’s office is responsible for making and documenting all attempts to contact assigned Members. Members’ medical records must reflect the reason for any delays in performing the IHA, including any refusals by the Member to have the exam.

**Access Standards & Access to Care**

**Medical Appointment Standards: General Appointment Scheduling (Outside of Los Angeles County)**

PCPs and Specialists must make appointments for Members from the time of request as follows:

<table>
<thead>
<tr>
<th>Medical Appointment Standards (Outside of Los Angeles County)</th>
<th>General Appointment Scheduling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Examination</td>
<td>Immediate access, 24 hours/7 days a week</td>
</tr>
<tr>
<td>Urgent (sick) Examination</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Non Urgent (sick) Examination</td>
<td>Within 48-72 hours of request or as clinically indicated</td>
</tr>
<tr>
<td>Routine Primary Care Examination (non urgent)</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Non Urgent Consults/Specialty Referrals</td>
<td>Within 15 business days of request</td>
</tr>
<tr>
<td>Non Urgent Care with non-physician mental health providers (where applicable)</td>
<td>Within 10 business days of request</td>
</tr>
<tr>
<td>Non-Urgent Ancillary</td>
<td>Within 15 business days of request</td>
</tr>
</tbody>
</table>

**Services for Members under the Age of 21 Years**

<table>
<thead>
<tr>
<th>Initial Health Assessments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children under the age of 18 months</td>
<td>Within 60 days of enrollment (or within American Academy of Pediatrics (AAP) guidelines whichever is less)</td>
</tr>
<tr>
<td>Children aged 19 months to 20 years of age</td>
<td>Within 120 days of enrollment</td>
</tr>
<tr>
<td>Preventive Care Visits</td>
<td>Within 14 days of request</td>
</tr>
</tbody>
</table>

**Services for Members 21 Years of Age and Older**

<table>
<thead>
<tr>
<th>Initial Health Assessments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Visits</td>
<td>Within 14 days of request</td>
</tr>
<tr>
<td>Routine Physicals</td>
<td>Within 30 days of request</td>
</tr>
</tbody>
</table>

**Prenatal and Post-Partum Visits**

<table>
<thead>
<tr>
<th>1st and 2nd Trimester</th>
<th>Within 7 days of request</th>
</tr>
</thead>
<tbody>
<tr>
<td>3rd Trimester</td>
<td>Within 3 days of request</td>
</tr>
<tr>
<td>High-Risk Pregnancy</td>
<td>Within 3 days of identification</td>
</tr>
<tr>
<td>Post-Partum</td>
<td>Between 21 and 56 days after delivery</td>
</tr>
</tbody>
</table>
Access Standards & Access to Care

Medical Appointment Standards: Los Angeles County Only

<table>
<thead>
<tr>
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<td>Urgent (sick) Examination</td>
<td>Within 24 hours of request</td>
</tr>
<tr>
<td>Nonurgent (sick) Examination</td>
<td>Within 48 hours of request</td>
</tr>
<tr>
<td>Nonurgent Routine Examination</td>
<td>Within 10 days of request</td>
</tr>
<tr>
<td>Standing Referral</td>
<td>Within 3 business days of request</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members Under the Age of 18 Months</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Health Assessments</td>
<td>Within 60 days of enrollment (or within American Academy of Pediatrics (AAP) guidelines whichever is less)</td>
</tr>
<tr>
<td>Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services/Child Health and Disability Prevention (CHDP) or Preventive Care Visits</td>
<td>Within 2 weeks of request</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services for Members 18 Months of Age or Older</th>
<th></th>
</tr>
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</tr>
<tr>
<td>Post-Partum</td>
<td>Between 21 and 56 days after delivery</td>
</tr>
</tbody>
</table>

Access Standards & Access to Care

Wait Times

When a Provider's office receives a call from an Anthem Member during regular business hours for assistance and possible triage, the Provider or another health care professional must either take the call or call the Member back within 30 minutes of the initial call.

Access Standards & Access to Care

Non-Discrimination Statement

Providers must post a statement in their offices that details hours of operation that do not discriminate against Anthem Members. This includes wait times for the following:

- Waiting times for appointments
- Waiting times for care at facilities
- Languages spoken
Access Standards & Access to Care
Interpreter Services

Anthem will ensure that Members requiring interpreter services will have access to a telephone interpreter 24 hours a day, 7 days a week. Services include, but are not limited to, assistance during office visits. To request interpreter services during business hours, Providers and Members can call the Customer Care Center at 1-800-407-4627. To request interpreter services after hours, Providers and Members can call our 24/7 NurseLine at 1-800-224-0336, (TTY) 1-800-368-4424.

Then, take the following steps:

1. Give the Customer Care Associate the Member’s ID number
2. Explain the need for an interpreter and state the language
3. Wait on the line while the connection is made

Please Note: 72 hours are needed to schedule face-to-face interpreter services, and 24 hours are required to cancel.

For more information about our free interpreting services, please see our Free Interpreting Services page on our Provider Resources webpage at www.anthem.com/ca. For information on how to access this page, please see Chapter 1: How to Access Information, Forms and Tools on our Website.

Access Standards & Access to Care
Medical Appointment Standards: Missed Appointment Tracking

When Members miss appointments, Providers must do the following:

- Document the missed appointment in the Member’s medical record.
- Make at least three attempts to contact the Member to determine the reason for the missed appointment.
- Provide a reason in the Member’s medical record for any delays in performing an examination, including any refusals by the Member. Documentation of the attempts to schedule an Initial Health Assessment must be available to Anthem or state reviewers upon request.

Access Standards & Access to Care
After-Hours Services

It is Anthem policy and the State of California’s requirement that our Members have access to quality health care services 24 hours a day, 7 days a week. That kind of access means our PCPs must have a system in place to ensure that Members can call after hours with medical questions or concerns. We monitor PCP compliance with after-hours access standards on a regular basis. It is recommended that PCPs advise their answering services to participate in any after-hours monitoring. Failure to comply may result in corrective action.

PCPs must adhere to the following after-hours protocols:

- Forward Member calls directly to the PCP or on-call Provider or instruct the Member that the Provider will contact the Member within 30 minutes AND
- Ask the Member if the call is an emergency. In the event of an emergency, they must immediately direct the Member to Dial 911 or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for Members with language barriers.
- Return all calls.
Answering machine messages:

- May be used in the event that staff or an answering service is not immediately available.
- Must instruct Members with emergency health care needs to Dial 911 or proceed directly to the nearest hospital emergency room, AND
- Must provide instructions on how to contact the PCP or on-call Provider in a nonemergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PCP’s practice.

We offer the following suggested text for answering machines:

"Hello, you have reached [insert physician office name]. If this is an emergency, hang up and dial 911 or go to the nearest hospital emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact phone or pager number]. You will receive a return call from the on-call physician within [timeframe]."

Please Note: Anthem prefers that PCPs use an in-network Provider for on-call services. When that is not possible, PCPs must use their best efforts to help ensure that the covering on-call Provider abides by the terms of the Anthem Provider contract.

Access Standards & Access to Care

24/7 NurseLine

Members can also call our 24/7 NurseLine, a 24 hours a day, 7 days a week information phone line any time of the day or night to speak to a registered nurse. Nurses provide health information and options for any of the following:

- Authorization requests
- Emergency instructions
- Health concerns
- Local health care services
- Medical conditions
- Prescription drugs
- Transportation needs
- Access to interpreter services

24/7 NurseLine: 1-800-224-0336 (24 hours a day, 7 days a week)
(TTY): 1-800-368-4424

Access Standards & Access to Care

Continuity of Care

Anthem provides continuity of care for Members with qualifying conditions when health care services are not available within the network or when the Member or Provider is in a state of transition.

**Qualifying Condition:** A medical condition that may qualify a Member for continued access to care and continuity of care. These conditions include, but are not limited to:

- Acute conditions (cancer, for example)
- Degenerative and disabling conditions, which includes conditions or diseases caused by a congenital or acquired injury or illness that require a specialized rehabilitation program or a high level of service, resources or coordination of care in the community
- Newborns who are covered between the ages of birth and 36 months
- Pregnancy, regardless of trimester, through immediate postpartum care
- Surgery that has been prior approved and scheduled to occur within 180 days of the contract's termination or within 180 days of the effective date of coverage for a newly-covered enrollee
- Serious chronic conditions (hemophilia, for example)
- Terminal illness

**States of transition may be any of the following:**
- The Member is newly enrolled
- The Member is disenrolling to another health plan
- The Provider’s contract terminates

All new enrollees receive **Evidence of Coverage** (EOC) membership information in their enrollment packets. This also provides information regarding Members’ rights to request continuity of care if the Member transitions to another health plan. A terminated Provider or Provider group who actively treats Members must continue to treat Members until the Provider’s date of termination. **Anthem** makes every effort to notify Members at least 30 days prior to termination.

Providers help ensure continuity and coordination of care through collaboration. This includes the confidential exchange of information between PCPs and specialists as well as behavioral health Providers. In addition, **Anthem** helps coordinate care when the Provider's contract has been discontinued to help smooth the transition to a new Provider.

Providers must maintain accurate and timely documentation in the Member’s medical record including, but not limited to:
- Consultations
- Prior Authorizations
- Referrals to Specialists
- Treatment plans

All Providers share responsibility in communicating clinical findings, treatment plans, prognosis and the Member’s psychosocial condition as part of the coordination process. **Utilization Management** nurses review Member and Provider requests for continuity of care. These nurses facilitate continuation with the current Provider until a short-term regimen of care is completed or the Member transitions to a new practitioner.

**Please Note:** Only **Anthem** can make adverse determination decisions regarding continuity of care.

Adverse determination decisions are sent in writing to the Member and Provider within 2 business days of the decision. Members and Providers can appeal the decision by following the procedures in the **Grievances and Appeals** chapter in this manual. Reasons for continuity of care denials include, but are not limited to the following:
- Continuity of care is not available with the terminating Provider
- Course of treatment is complete
- Member is ineligible for coverage
- Not a qualifying condition
- Request is for change of PCP only and not for continued access to care
Requested services are not a covered benefit
- Services rendered are covered under a global fee
- Treating Provider is currently contracted with our network

Access Standards & Access to Care

Emergency Department Protocol Reporting Process

Anthem has a system in place to report any difficulties experienced with the 24/7 NurseLine or our emergency care systems. Please contact us at the following numbers to report any failures:

<table>
<thead>
<tr>
<th>Program</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal (Outside Los Angeles County)</td>
<td>1-800-407-4627</td>
</tr>
<tr>
<td>Medi-Cal (Inside Los Angeles County)</td>
<td>1-888-285-7801</td>
</tr>
<tr>
<td>Medi-Cal Access Program (MAP)</td>
<td>1-877-687-0549</td>
</tr>
<tr>
<td>Major Risk Medical Insurance Program (MRMIP)</td>
<td>1-877-687-0549</td>
</tr>
</tbody>
</table>

Corrective action plans will be requested from contracted network hospitals with emergency departments that fail to meet Anthem contractual obligations or follow our Emergency Department and Emergency Room protocols.
CHAPTER 17: PROVIDER ROLES & RESPONSIBILITIES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm

Provider Roles & Responsibilities

Overview

At Anthem, our goal is to provide quality health care to the right Member at the right time in the appropriate setting.

To achieve this goal, our Primary Care Providers (PCPs), Specialists and Ancillary Providers must fulfill their roles and responsibilities with the highest integrity. We lean on their extensive health care education and experience. And we rely on their dedication to our Members, who look to them to get well and stay well.

Provider Roles & Responsibilities

Primary Care Providers

Anthem Primary Care Providers (PCPs) are the principal point of contact for our Members. Their role is to provide Members with a medical “home,” the first stop in the health care process and a centralized hub for a wide variety of ongoing health care needs.

The PCP’s role is to:

- Coordinate the Member’s health care, 24 hours a day, 7 days a week
- Develop the Member’s care and treatment plan, including preventive care
- Maintain the Member's current medical record, including documentation of all services provided by the PCP and any specialty or referral services
- Adhere to wait times, as outlined within the Provider contract and Provider Manual
- Refer Members for specialty care
- Coordinate with outpatient clinical services
- Provide complete information about proposed treatments and prognosis for recovery to our Members or their representatives
- Facilitate interpreter services by presenting information in a language that our Members or their representatives can understand
- Ensure that Members' medical and personal information is kept confidential as required by state and federal laws

The PCP’s scope of responsibilities includes providing or arranging for:

- Routine and preventive health care services
- Emergency care services
- Hospital services
- Ancillary services
- Specialty referrals

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Medi-Cal, Medi-Cal Access Program and MRMIP

Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP
• Interpreter services
• Community services
• Coordination with outpatient clinical services, such as therapeutic, rehabilitative or palliative services

**Please note:** Services should always be provided without regard to race, religion, sex, color, national origin, age or physical/behavioral health status.

**Anthem** Members may select any contracted PCP as their primary physician as long as that PCP is taking new patients. We furnish each PCP with a current list of assigned Members and from time to time provide medical information about our Members’ potential health care needs. In this way, Providers can more effectively provide care and coordinate services.

**PCPs See Only Assigned Members**

All Providers must verify eligibility before providing services, supplies or equipment. Eligibility may change monthly, so a Member eligible on the last day of the month may not be eligible on the first day of the following month. **Anthem** is not responsible for changes incurred by ineligible patients. Providers can confirm eligibility by the following methods:

- **Calling **Anthem’s Customer Care Centers:**
  - Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
  - Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
  - MAP/MRMIP Customer Care Center: 1-877-687-0549
    - Use the IVR (Interactive Voice Response) system to verify PCP assignment
    - Speak to a customer service representative
- **Logging in to** www.availity.com. Then, take the following steps to reach the “Register Now” option:
  1. Select “Start Registration”
  2. Fill out the online form for your username and password for site access to eligibility details.

You may experience delays in claims payments if you treat Members who are not assigned to you on the date of service. If it is necessary to provide services to an **Anthem** Member not assigned to you, it is important to get **Prior Authorization** before providing services. If you are a noncontracted Provider, you will also need **Prior Authorization** before providing services to our Members.

**Provider Roles & Responsibilities**

**Referrals**

PCPs coordinate and make referrals to Specialists, Ancillary Providers and community services. Providers should refer Members to network facilities and Providers. When this is not possible, Providers should follow the appropriate process for requesting out-of-network referrals.

**Please Note:** Specialty referrals to in-network Providers do **not** require **Prior Authorization**.
All PCPs:

- Are expected to help Members schedule appointments with other Providers and health education programs.
- Are expected to track and document appointments, clinical findings, treatment plans and care received by Members referred to Specialists or other health care Providers to ensure continuity of care.
- Are responsible for screening and evaluation procedures for detection and treatment of or referral for any known or suspected behavioral health problems and disorders.
- Refer Members to Specialists or specialty care, behavioral health services, health education classes and community resource agencies, when appropriate.
- Coordinate with the Woman, Infants and Children (WIC) program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- Coordinate with the local tuberculosis (TB) control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT).
- Refer Members to Specialists or specialty care, behavioral health services, health education classes and community resource agencies, including the California Department of Developmental Services regional centers, which are responsible for the Early Start Program (ESP) for children up to 3 years of age with developmental disabilities. Community resources also include the Child Health and Disability Prevention Program (CHDP), and California Children's Services (CCS).

Please Note: Whenever your office refers a Member to any of these community-based agencies, complete and fax the Notification of Referral/Linked and Carved-Out Services form to Utilization Management at:

Utilization Management: 1-888-334-0874
1-866-333-4827 (Fax)

The Notification of Referral/Linked and Carved-Out Services form can be found in the Forms Library on the Provider Resources page of our website at www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Provider Roles & Responsibilities

Out-Of-Network Referrals

We recognize that there may be instances when an out-of-network referral is justified. Medi-Cal's Utilization Management team will work with the PCP to determine medical necessity; after that, out-of-network referrals will be authorized on a limited basis. The Utilization Management department may be contacted at:

Medi-Cal Utilization Management: 1-805-384-3629
1-866-333-4827 (Fax)

Hours of Operation: Monday to Friday, 8am-5pm

Provider Roles & Responsibilities

Interpreter Services

Providers must notify Members of the availability of interpreter services and strongly discourage the use of friends and family Members, especially children, acting as interpreters. Multilingual staff should self-assess their non-English language speaking and understanding skills prior to interpreting on the job. You can find the current recommended Employee Language Skills Self-Assessment Tool on the Provider Resources page.
of our website at: www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

For those instances when you cannot communicate with a Member due to language barriers, interpreter services are available at no cost to you or the Member. Face-to-face interpreters for Members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. A 24-hour cancellation notice is required.

To request interpreter services, Providers and Members should call the appropriate Anthem Customer Care Center. The numbers are listed at the beginning of this chapter.

Provider Roles & Responsibilities
Initial Health Assessments

The Initial Health Assessment (IHA) is a complete medical history, a head-to-toe physical examination and an assessment of health behaviors. The IHA should include the following specific screenings:

- **Dental Screening/Oral Assessment**: For all children age 3 and under, providing them with a dental referral if needed
- **Immunizations**: Providers must document in the Member's medical record all age-appropriate immunizations
- **Tuberculosis Screening**: All Members must be screened for TB

PCPs are strongly encouraged to review their monthly eligibility list provided by Anthem and proactively contact their assigned Members to make an appointment for an IHA within the following time frames:

- **Adults and Children over 18 Months**: **Within 120 days** of enrollment
- **Children under 18 Months**: **Within 60 days** of enrollment

The PCP’s office is responsible for making and documenting all attempts to contact assigned Members. Members’ medical records must reflect the reason for any delays in performing the IHA, including any refusals by the Member to have the exam.

Provider Roles & Responsibilities
Transitioning Members between Facilities or Back Home

PCPs initiate or help with the discharge or transfer of:

- Members at an inpatient facility to the appropriate level of care facility (including skilled nursing or rehabilitation facility) when medically indicated or home
- Members who are hospitalized in an out-of-network facility to an in-network facility or to home with home health care assistance (within benefit limits) when medically indicated

The coordination of Member transfers from non-contracted out-of-network facilities to contracted in-network facilities is a priority that may require the immediate attention of the PCP. Contact Medi-Cal Utilization Management to assist in this process:

**Medi-Cal Utilization Management**: 1-805-384-3629  
1-866-333-4827 (Fax)

**Hours of Operation**: Monday to Friday, 8am-5pm
Provider Roles & Responsibilities

Specialists

Specialists, licensed with additional training and expertise in a specific field of medicine, supplement the care given by Primary Care Providers (PCPs) and are charged with the same responsibilities. That includes the responsibility for ensuring that necessary Prior Authorizations have been obtained before providing services.

Access to specialty care begins in the PCP’s office. The PCP will refer a Member to a Specialist for conditions beyond the PCP’s scope of practice that are medically necessary. Specialty Care Providers diagnose and treat conditions specific to their area of expertise.

The following guidelines are in place for our Specialists:

- For urgent care, the Specialist should see the Member within 24 hours of receiving the request.
- For routine care, the Specialist should see the Member within 2 weeks of receiving the request.

In some cases, a Member may self-refer to a Specialist. These cases include, but are not limited to:

- Family planning and evaluation
- Diagnosis, treatment and follow-up of Sexually Transmitted Diseases (STDs)

Please Note: Specialists are responsible for ensuring that necessary pre-authorizations have been obtained prior to providing services.

For some medical conditions, it makes sense for the Specialist to be the PCP. Members may request that the Specialist be assigned as their PCP if:

- The Member has a chronic illness
- The Member has a disabling condition
- The Member is a child with special health care needs

Provider Roles & Responsibilities

Behavioral Health Providers

For information about Anthem’s Behavioral Health services and Transition after Acute Psychiatric Care, please see Chapter 5: Behavioral Health Services.

Provider Roles & Responsibilities

Medi-Cal Comprehensive Perinatal Services Program

The Comprehensive Perinatal Services Program (CPSP) is a voluntary Medi-Cal program that provides individualized perinatal services during pregnancy and 60 days following delivery by, or under the personal supervision of, a physician approved by CPSP. The program emphasizes nutritional services, health education and postpartum treatment and intervention.

PCPs and Obstetrics/Gynecology specialists are responsible for assessing Member needs and referring all pregnant Members to the following:

- Community prenatal services
- Women, Infants and Children Program (WIC)
- Substance abuse programs
Prenatal education classes

Women with high-risk factors should be referred to a CPSP Provider by calling the appropriate Customer Care Center at the numbers listed at the beginning of this chapter.

Provider Roles & Responsibilities
Hospital Scope of Responsibilities

PCPs refer Members to contracted hospitals for conditions beyond the PCP’s scope of practice that are medically necessary. Hospital care is limited to Anthem benefits. Hospital professionals diagnose and treat conditions specific to their area of expertise. Hospital responsibilities include the following:

Supply Medications

Hospital Provider must provide Members with an adequate supply of medications upon discharge from the emergency room or an inpatient setting to allow reasonable time for the Member to access a pharmacy to have prescriptions filled.

Notification of Admission and Services

The hospital must notify Anthem or the review organization of an admission or service at the time the Member is admitted or service is rendered. If the Member is admitted or a service is rendered on a day other than a business day, the hospital must notify us of the admission or service the morning of the next business day following the admission or service.

Notification of Prior Authorization Decisions

If the hospital has not received notice of Prior Authorization at the time of a scheduled admission or service, as required by the Utilization Management Guidelines and the Hospital Agreement, the hospital should contact Anthem and request the status of the decision.

Any admission or service that requires Prior Authorization and has not received the appropriate review may be subject to post-service review denial. Generally, the Provider is required to perform all Prior Authorization functions with Anthem; however, the hospital may also ensure that Prior Authorization has been granted before services are rendered – or risk post-service denial.

Provider Roles & Responsibilities
Ancillary Scope of Responsibilities

PCPs and specialists refer Members to contracted network Ancillary Providers for conditions beyond the PCP’s or specialist’s scope of practice that are medically necessary. Ancillary professionals diagnose and treat conditions specific to their area of expertise. Ancillary care is limited to Anthem benefits.

We have a wide network of participating health care professionals and facilities. All services provided by the health care professional, and for which the health care professional is responsible, are listed in the Ancillary Agreement.
Chapter 17: Provider Roles and Responsibilities

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Provider Roles & Responsibilities
Responsibilities Applicable to ALL Providers

There are a number of responsibilities applicable to all Anthem Providers. The responsibilities include the following:

- After-Hours Services
- Disenrollees
- Eligibility Verification
- Collaboration
- Confidentiality
- Continuity of Care
- Licenses and Certifications
- Mandatory Reporting of Abuse
- Medical Records Standards & Documentation
- Office Hours
- Open Clinical Dialog/Affirmative Statement
- Oversight of Non-Physician Practitioners
- Pre-Service Reviews
- Prohibited Activities
- Provider Contract Terminations
- Termination of Ancillary Provider/Patient Relationship
- Updating Provider Information

Provider Roles & Responsibilities
Office Hours

To maintain continuity of care, Providers are required to be available to provide services for a minimum of 24 hours each week. Office hours must be clearly posted and Members must be informed about the Provider’s availability at each site. There are strict guidelines for providing access to health care 24 hours a day, 7 days a week:

- Providers must be available 24 hours a day by telephone.
- During those times when a Provider is not available, an on-call Provider must be available to take calls.

Provider Roles & Responsibilities
After-Hours Services

All PCPs must have an after-hours system in place to ensure that our Members can call with medical concerns or questions after normal office hours. The answering service or after-hours personnel must forward Member calls directly to the PCP or on-call physician or instruct the Member that the Provider will be in contact within 30 minutes.

Emergencies

The answering service or after-hours personnel must ask the Member if the call is an emergency. In the event of an emergency, the Member must be immediately directed to Dial 911 or to proceed directly to the nearest hospital emergency room.

If the PCP’s staff or answering service is not immediately available, an answering machine may be used. The answering machine message must instruct Members with emergency health care needs to dial 911 or go directly to the nearest hospital emergency room. The message must also give Members an alternative contact number so they can reach the PCP or on-call Provider with medical concerns or questions.
Language-Appropriate Messages

Non-English speaking Members who call their PCP after hours should expect to get language appropriate messages. In the event of an emergency, these messages should direct the Member to Dial 911 or proceed directly to the nearest hospital emergency room. In a nonemergency situation, Members should receive instruction on how to contact the on-call Provider. If an answering service is used, the service should know where to contact a telephone interpreter. All calls taken by an answering service must be returned.

Network On-Call Providers

Anthem prefers that our PCPs use network Providers for on-call services. When that is not possible, the PCP must help ensure that the covering on-call physician or other professional provider abides by the terms of our Provider contract.

Anthem will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Members can also call our 24/7 NurseLine information line, 24 hours a day, 7 days a week, to speak to a registered nurse. These nurses provide health information regarding illness and options for accessing care, including emergency services.

24/7 NurseLine: 1-800-224-0336 - 24 hours a day, 7 days a week
1-800-368-4424 (TTY)

Anthem will monitor PCP compliance with after-hours access standards on a regular basis. Failure to comply may result in corrective action.

Provider Roles & Responsibilities

Licenses and Certifications
Providers must maintain all licenses, certifications, permits, accreditations or other prerequisites required by Anthem and federal, state and local laws to provide medical services.

Provider Roles & Responsibilities

Eligibility Verification

All Providers must verify Member eligibility immediately before providing services, supplies or equipment. Eligibility may change monthly so a Member eligible on the last day of the month may not be eligible on the first day of the following month. Anthem is not responsible for charges incurred by ineligible patients.

Provider Roles & Responsibilities

Collaboration

Providers share the responsibility of giving respectful care and working collaboratively with Anthem specialists, hospitals, Ancillary Providers and Members and their families. Providers must permit Members to participate actively in decisions regarding medical care, including, except as limited by law, their decision to refuse treatment.
Provider Roles & Responsibilities

Continuity of Care

The PCP maintains frequent communication with specialists, hospitals and Ancillary Providers to ensure continuity of care. *Anthem* encourages Providers to maintain open communication with their patients regarding appropriate treatment alternatives, regardless of their benefit coverage limitations. The PCP is responsible for providing an ongoing source of primary care appropriate to the Member’s needs.

We have established comprehensive mechanisms to ensure continued access to care for Members when Providers leave our health care program. Under certain circumstances, Members may finish a course of treatment with the terminating Provider. For more information, refer to the *Access Standards and Access to Care* chapter.

Provider Roles & Responsibilities

Medical Records: Standards

Medical records must be maintained in a manner that ensures effective and confidential Member care and quality review. At *Anthem*, we perform medical record reviews upon signing a Provider contract and, at minimum, every 3 years thereafter to ensure that Providers are in compliance with these standards.

Medical records must be stored and retrieved in a manner that protects patient information according to the *Confidentiality of Medical Information Act*. This act prohibits a provider of health care from disclosing any individually identifiable information regarding a patient’s medical history, treatment, or behavioral and physical condition, without the patient’s or legal representative’s consent or specific legal authority.

Records required through a legal instrument may be released without patient or patient representative consent. Providers must be familiar with the security requirements of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) and be in compliance.

In addition, Providers must provide access to medical records for the following:

- Medical record reviews by *Anthem* or the Provider's contracted *External Quality Review Organization* (EQRO). Providers must have procedures in place to provide timely access to medical records in the Providers’ absence.
- Public health communicable disease reporting, Providers must provide all medical records or information as requested and in the time frame established by state and federal laws.

Provider Roles & Responsibilities

Mandatory Reporting of Child Abuse, Elder Abuse or Domestic Violence

Providers must ensure that office personnel have specific knowledge of local reporting requirements and procedures to make telephone and written reports of known or suspected cases of abuse. All health care professionals must immediately report actual or suspected child abuse, elder abuse or domestic violence to the local law enforcement agency by telephone. In addition, Providers must submit a follow-up written report to the local law enforcement agency within the time frames as required by law.
Chapter 17: Provider Roles and Responsibilities

Medi-Cal, Medi-Cal Access Program and MRMIP

Provider Roles & Responsibilities

Updating Provider Information

Anthem Providers are required to inform us of any material changes to their practice, including:

- Change in professional business ownership
- Change in business address or the location where services are provided
- Change in federal 9-digit Tax Identification Number (TIN)
- Change in specialty
- If the Provider provides services to children
- Languages spoken
- Change in demographic data (for example: phone numbers, open/closed status, language of mid-level staff and office hours)
- Legal or governmental action initiated against a health care professional, including, but not limited to, an action for professional negligence, for violation of the law, or against any license or accreditation which, if successful, would impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement
- Other problems or situations that impair the ability of the health care professional to carry out the duties and obligations under the Provider Agreement care review and grievance resolution procedures
- Notification that you are accepting new patients

Use the Provider Change Request Form to notify Anthem of changes. The form is available in the Forms Library > General Forms on the Provider Resources page of our website: www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

If we determine that the quality of care or services provided by a health care professional is not satisfactory, as evidenced by Member satisfaction surveys, Member complaints or grievances, utilization management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicators, Anthem may terminate the Provider Agreement.

Provider Roles & Responsibilities

Oversight of Non-Physician Practitioners

All Providers using non-physician practitioners must provide supervision and oversight of such non-physician practitioners consistent with state and federal laws. The supervising physician and the non-physician practitioner must have written guidelines for adequate supervision, and all supervising providers must follow state licensing and certification requirements.

Non-physician practitioners include the following categories:

- Advanced Registered Nurse Practitioners
- Certified Nurse Midwives
- Physician Assistants

These non-physician practitioners are licensed by the state and working under the supervision of a licensed physician as mandated by state and federal regulations.
Chapter 17: Provider Roles and Responsibilities

Provider Roles & Responsibilities
Open Clinical Dialogue/Affirmative Statement

Nothing within the Provider's Provider Agreement or this Provider Manual should be construed as encouraging Providers to restrict medically necessary covered services or limit clinical dialogue between Providers and their patients. Providers can communicate freely with Members regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Provider Roles & Responsibilities
Provider Contract Affiliation Change

Anthem Primary Care Physicians (PCP's) may have multiple Provider Medical Group (PMG) affiliations. To ensure continuity of care, membership will remain with the assigned PCP unless the PCP does not have another Anthem PMG affiliation.

This means that a PCP may change his or her PMG affiliation and assigned Members would transfer to follow the PCP under the new affiliation.

The only exception to this policy shall occur when the PCP is an employee of the PMG. In this case, the Member’s affiliation will remain with the PMG. The Member may, however, elect to change this PMG affiliation to the PCP's new affiliation in order to facilitate continued care under the Member's established PCP.

Continuity of Care Provision for a PMG-Employed Physician: If the PMG does not have the appropriate PCP specialty to serve the Members that were assigned to a departing employed physician, Anthem has the right to move the affected Member to the PCP’s new PMG affiliation or an appropriate PMG. For example, if the only pediatrician affiliated with the PMG terminates his employment – or his employment is terminated – Anthem will move Members to an alternate PMG affiliation to ensure the affected Members have access to appropriate pediatric care. If the PCP changes PMG affiliation and relocates his practice further than 10 miles, Anthem also has the right to select a new PCP for the affected membership.

Network Education Representatives (NER) are the primary account managers for all Provider services associated with an assigned PMG. The NERs also serve as liaisons between Anthem and the Provider Network for the many Providers who exist outside of the PMG, including hospital, ancillary and individual Providers.

The NER is responsible for coordinating all additions, changes and terminations from the PCP and PMG.

Provider Roles & Responsibilities
Provider Contract Termination

When a participating Provider notifies Anthem that the Provider is terminating the contract with the network, we notify all Members that the Provider will no longer be available. A terminating Provider who is actively treating Members must continue to treat Members until the Provider’s date of termination. That date is the end of the 90-day period following written notice of termination or time lines determined by the medical group contract.

Once we receive a Provider’s notice to terminate a contract, we notify Members impacted by the termination. Anthem sends a letter to inform affected Members of:

- The impending termination of their Provider
Chapter 17: Provider Roles and Responsibilities

- Their right to request continued access to care
- The Member Advocate telephone number to make PCP changes
- Referrals to Utilization Management for continued access to care consideration

Members under the care of Specialists can also submit requests for continued access to care, including continued care after the transition period, by calling the Anthem Customer Care Center:

Anthem Customer Care Center: 1-800-407-4627
1-888-757-6034 (TTY)

Provider Roles & Responsibilities
Provider Terminations from Groups

When a Provider who is part of a Participating Medical Group (PMG) and/or Independent Practice Association (IPA) decides to terminate from the Anthem network, the following guidelines must be followed:

- The Provider should notify all affiliated PMGs/IPAs within a minimum of 90 days' notice.
- The PMGs/IPAs should notify Anthem. The Provider's termination will be effective 90 days after we receive notification.
- The Provider's decision to terminate from Anthem could impact participation in other Anthem lines of business and may prevent the Provider from participating with us in the future.

Provider Roles & Responsibilities
Termination of the Ancillary Provider/Patient Relationship

Under certain circumstances, an Ancillary Provider may terminate the professional relationship between the Ancillary Provider and a Member as provided for and in accordance with the provisions of this manual. However, Ancillary Providers may not terminate the relationship because of the Member’s medical condition or the amount, type or cost of covered services required by the Member.

Provider Roles & Responsibilities
Disenrollees

When a Member disenrolls and requests transfer to another health plan, Providers are expected to work with Anthem case managers who are responsible for helping the Member make the transition. This transition must occur without disruption of any regimen of care that qualifies as a Continuity of Care condition. The case manager will coordinate with the Member, the Member’s Providers and the case manager at the new health plan to help ensure an orderly transition.

Provider Roles & Responsibilities
Provider Rights

Anthem Providers, acting within the lawful scope of practice, shall not be prohibited from advising a Member or advocating on behalf of a Member for any of the following:

- The Member's health status, medical care or treatment options, including any alternative treatment that may be self-administered
- Any information the Member needs in order to decide among all relevant treatment options
• The risks, benefits and consequences of treatment or nontreatment
• The Member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions
• To receive information on the Grievances & Appeals and State Fair Hearing procedures
• To have access to policies and procedures covering authorization of services
• To be notified of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested
• To challenge, on behalf of our Members, the denial of coverage or payment for medical assistance
• To be free from discrimination for the participation, reimbursement or indemnification of any Provider who is acting within the scope of his/her license or certification under applicable law solely based on that license or certification

Anthem Provider selection policies and procedures do not discriminate against particular Providers who serve high-risk populations or specialize in conditions that require costly treatment.

Provider Roles & Responsibilities
Prohibited Activities

All Providers are prohibited from:
• Billing eligible Members for covered services
• Segregating Members in any way from other persons receiving similar services, supplies or equipment
• Discriminating against Anthem Members or Medicaid participants

Provider Roles & Responsibilities
Financial Requirements for Participating Medical Groups

Anthem engages in financial monitoring of its Participating Medical Groups (PMGs) in order to protect our Members from Provider group insolvency that may result in the interruption of delivery of health care services.

It is the policy of Anthem to take appropriate action to limit its exposure to unwarranted financial risks from its business relationships with delegated PMGs. This action begins with a screening analysis of the PMG by appropriate Anthem units and includes a financial review by Health Management Organization (HMO) Finance. The review also involves tracking the financial performance of the PMG, particularly those experiencing adverse financial trends.

State Regulations

State regulations require that health plans monitor the financial position of its capitated PMG or delegated Risk-Bearing Organizations (RBOs) to determine whether they demonstrate compliance with the financial solvency requirements mandated in Title 28, Section 1300.75.4 of the California Code of Regulations (CCR). The PMGs also must meet, at all times, the financial performance standards or covenants hereunder listed, which are mandated by the Medical Services Agreement. The PMG must furnish the following to Anthem:
• Annual financial information
• Quarterly financial information
Other data as may be required by law and Anthem and as stated under Financial Audit Requirements – Access to Financial Data

Pursuant to the Anthem Medical Services Agreement, each PMG is required to submit audited financial statements to us no later than 150 days (5 months) following the end of its fiscal year. The annual financial statements shall be attested by an independent Certified Public Accountant (CPA). The PMG also may be required, if necessary, to submit tax returns, along with the internally prepared financial statements and other related reports.

In addition to the fiscal year-end financial statements, the PMG also agrees to provide Anthem with quarterly financial statements within 45 days after the close of each fiscal quarter, or as often as deemed necessary by Anthem to ensure appropriate monitoring. The financial data enables us to assess the financial status of the PMG and/or its capacity to fulfill its financial obligations under the Medical Services Agreement.

Financial Performance Standards

Regulations require the financial statement to be prepared in accordance with Generally Accepted Accounting Principles (GAAP) and include the following:

- Balance sheet
- Cash flow statement
- Income statement
- Disclosures

In accordance with the Medical Services Agreement, the PMG is required to maintain adequate financial reserves to cover all assumed risks.

The PMG is required, at all times, to comply with the solvency standards mandated by regulations, including, but not limited to, unanticipated claims for referral services that are the potential responsibility of the PMG. The PMG shall meet or exceed the Anthem financial performance standards as follows:

- Cash ratio must be at least 60% (cash and/or equivalents, plus marketable securities divided by current liabilities).
- Total stockholders’ equity is required to equal at least 2% of total revenue or 4% of total medical expenses, whichever is higher.
- The PMG must maintain a working capital ratio of at least 1.5:1.
- The PMG must maintain a debt-to-equity ratio (financial leverage) of not more than 250%.
- The PMG must provide, for incurred but not reported (IBNR) claims liability, of at least 2 months of average annual claims expenses or base this on an actuarially sound formula approved per regulations.
- PMGs are required to submit the financial data requirements specified in this operations manual when requested.

In the event the PMG does not meet any of the regulatory solvency and performance standards, the PMG shall, within 30 days upon request by Anthem, provide a Stand-by Letter of Credit as a contingency reserve in an amount acceptable to Anthem in order to mitigate risk. Pursuant to regulations, the PMG is required to submit a corrective action plan to the Department of Managed Health Care (DMHC) with a copy to Anthem if it fails to meet the Solvency Grading Criteria.
Financial Audit Requirements – Access to Financial Data

The PMG agrees to provide Anthem representatives or employees’ access to and a copy of appropriate PMG books and records upon request and within a reasonable time frame to allow the onsite review, analysis or validation of the PMG financial information. Accounting books and records will include, but are not limited to, the following:

- Accounts receivable aging schedules, including:
  - Claims inventory aging schedule
  - Details of accounts due
  - IBNR claims lag schedule
  - Risk and incentive receivables
  - Specific general ledger account details
  - Other data related to the financial statements

- General ledger
- Journal entries (with appropriate backup documentation
- Subsidiary ledger

Other financial information includes, but is not limited to, the following:

- Bank statements/reconciliations
- Certification of bank deposits
- Trial balance

The PMG also agrees to submit the following:

- Annual financial review questionnaire
- Corrective action plans (if appropriate), together with pro-forma or projected financial statements with detailed assumptions and other special reports as determined by Anthem
- Representation or financial statement certification
- Statement of renewal of relevant insurance policies

Solvency Grading Criteria

The above financial requirements are needed to ensure that Anthem receives sufficient financial data for monitoring the PMG’s financial status based on established Anthem financial performance covenants (performance standards) and/or solvency grading criteria mandated in Title 28, Section 1300.75.4 of the CCR. These include maintaining, at all times, a positive tangible net equity, positive working capital and the cash-to-claims ratio. It also requires that each PMG be required to estimate, accrue and document its methodology for IBNR claims liability on a monthly basis. These solvency requirements are in addition to meeting the standard for timely claims resolution mandated by Title 28, Sections 1300.71 and 1300.71.38 of the regulations.

Please Note: The PMG’s failure to substantially comply with the Anthem performance standards and solvency regulations, including the submission of all appropriate monthly, quarterly and annual financial report requirements, may constitute a material breach of the Medical Services Agreement.
To ensure that Anthem can act on solvency issues accordingly, the PMG is required to inform Anthem HMO Finance no later than 5 business days from discovering that it has experienced any event, which materially alters its financial condition or threatens its solvency.

Provider Roles & Responsibilities

Hospital Financial Review

Concurrent with the policy to mitigate the risk with PMGs, a set of financial performance standards has also been adopted to evaluate the financial position of hospitals participating in the Anthem Managed Care Program. Hospitals usually are contractually required to receive monthly capitated or per diem payments from Anthem on behalf of enrolled members. The performance standards are used as guideposts in the analysis of the hospital's financial capacity.

In addition to the financial metrics applicable to PMGs, the following are specifically applied in the financial review of hospitals:

- Return on assets, initially set at =>1.2 percent
- Return on equity, initially set at =>10 percent
- Net operating income, initially set at positive
- Days' cash on hand, initially set at =>100 days
- Viability index, initially set at max of <100 percent and preferably trending lower
- Volume and length of stay indicators
- Other profit measurements, such as profit per inpatient discharge, profit per outpatient visit and operating margin

Anthem also obtains from the State of California relevant hospital utilization statistics and other financial data on hospital operations.

Please Note: Like PMGs, delegated hospitals are contractually required to provide Anthem with quarterly and annual financial statements (and others) to apprise us on those experiencing severe financial difficulties or emerging financial issues that could adversely impact their capacity to deliver health care services.

In a financial review, nonhospital revenues and non-operating expenses are measured to ascertain the degree of relationship to the Hospital’s financial condition and/or its short-term survivability as a business enterprise. Furthermore, Anthem wants to determine the Hospital’s compliance with current laws that require substantial cash flow adjustments or test the hospital's capacity to access external funds, such as AB394 (staff ratio) and SB1953 (seismic mandate). It is also important to analyze the value of fixed assets deployed in generating revenues on a per-licensed-bed basis. Hospitals receiving Medi-Cal SB855 funding assistance or disproportionate share payments and other government assistance programs should be evaluated as to their degree of vulnerability without such financial aid.

Please Note: At the front end, Anthem may require the Hospital to submit a standby Letter of Credit amounting to $300,000 or as may be determined by HMO Finance and the Healthcare Management Department in order to mitigate financial risk. Unlike PMGs, hospitals are not subject to the DMHC solvency criteria SB260.

Section 128740 of the California Health and Safety Code and Title 22 of the CCR require hospitals to file quarterly financial and utilization reports with the Office of Statewide Health Planning and Development (OSHPD) within 45 days after the end of the quarter. Adjusted reports reflecting changes as a result of their
audited financial statements may be filed within 4 months of the close of the Hospital’s fiscal year. Failure to file the required report would subject the Hospital to pay a civil penalty of $100 a day for each day of delay.

**Claims Timeliness Regulation and Reporting Requirements**

The PMG is required to comply with claims settlement practices and the dispute resolution mechanism (implemented under Section 1300.71 and 1300.71.38 of Title 28 of the CCR). This is to ensure that all claims and disputes from any physician, hospital, medical facility and other health care entities are processed and resolved in an appropriate and timely manner.

The PMG shall, per regulations, submit a claims report, which includes the percentage of claims that have been timely reimbursed, contested or denied during the quarter by PMG in accordance with the requirements of Sections 1371 and 1371.35 of the California Health and Safety Code and Section 1300.71 of Title 28 of the CCR and any other applicable state and federal laws and regulations. If less than 95 percent of all complete claims have been reimbursed, contested or denied on a timely basis, the claims report also should also describe the reasons why the PMG claims adjudication process is not meeting the requirements of applicable law, any actions taken to correct the deficiency and the result of such actions. The claims report is for the purpose of monitoring the financial status of the PMG and is not intended to change or alter existing state and federal laws and regulations relating to claims payment settlement practices and timeliness.

The PMG agrees to provide **Anthem** with monthly and quarterly reports of claims processing timeliness and other applicable reports required by **Anthem** and regulations. The timeliness report should be sent to us **within 15 days** after the end of each month.

At the request of **Anthem**, the PMG will provide a claims aging schedule, including both dollars and number of claims outstanding as of a certain period. If necessary, a historical record of a particular Provider’s claims (billings), as well as the record of payments/denials made by the PMG in any form, may also be required during a claims or financial audit, or as often as necessary.

The PMG will provide separate claims aging reports for contracted and noncontracted physicians, hospitals or other health care professionals in a format determined by **Anthem**.

The mailing address for financial requirements is:

- **Attn**: HMO Finance Department
- **Anthem Blue Cross**
- **CAAC10-010H**
- **21555 Oxnard St. Woodland Hills, CA 91367**
Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP

CHAPTER 18: CLINICAL PRACTICE AND PREVENTIVE HEALTH CARE GUIDELINES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm

Clinical Practice and Preventive Health Care Guidelines
Overview

At Anthem, we believe that providing quality health care shouldn't be limited to the treatment of injury or illness. Our goal is to be more proactive in the quest for better overall health.

To accomplish that goal, we offer Providers tools to help them find the best, most cost-effective ways to:

- Provide Member treatment
- Empower Members through education
- Encourage Member lifestyle changes, where possible

We want Providers to have access to the most up-to-date clinical practice and preventive health care guidelines. These guidelines, offered by nationally recognized health care organizations and based on extensive research, include the latest standards for treating the most common, stubborn and serious illnesses, such as diabetes and hypertension. The guidelines also include recommendations for preventive screenings, immunizations and Member counseling based on age and gender.

Clinical Practice and Preventive Health Care Guidelines
Preventive Health Care Guidelines

Anthem considers Preventive Health Guidelines to be an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Members.

The current guidelines, educational materials and health management programs can be found under Quality Improvement Programs on the Provider Resources page of our website at www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

If you do not have Internet access, you can request a hard copy of the Preventive Health Care Guidelines by calling the appropriate Customer Care Center at the numbers listed at the beginning of this chapter.

Please Note: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual Member benefits and eligibility are determined in accordance with the requirements set forth by the State of California. With respect to the issue of coverage, each Member
should review his/her Evidence of Coverage for details concerning benefits, procedures and exclusions prior to receiving treatment. The Evidence of Coverage supersedes the preventive health guideline recommendations.

**Clinical Practice and Preventive Health Care Guidelines**

**Clinical Practice Guidelines**

Anthem considers clinical practice guidelines to be an important component of health care. **Anthem** adopts nationally recognized clinical practice guidelines and encourages physicians to utilize these guidelines to improve the health of our Members. Several national organizations produce guidelines for asthma, diabetes, hypertension and other conditions. The guidelines, which **Anthem** uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every 2 years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

The guidelines are available under **Quality Improvement Programs** on the **Provider Resources** page of our website at [www.anthem.com/ca](http://www.anthem.com/ca). For directions on how to access the **Provider Resources** page of our website, please see **Chapter 1: How to Access Information, Forms and Tools on Our Website**.

The Anthem website offers the most up-to-date clinical resources and guidelines. If you do not have Internet access, you can request a hard copy of the **Clinical Practice Guidelines** by calling our **Customer Care Centers** at the numbers listed at the beginning of this chapter.

The following clinical practice guidelines have been **updated**:

- **Diabetes: American Diabetes Association's (ADA)** 2014 Clinical Practice Recommendations

The following clinical practice guidelines have been added:

- HIV/AIDS
- Chronic Kidney Disease
- Hypertension in Child and Adolescent
- Obesitly in Adults
- Obesity in Children

For information about clinical practice guidelines for Anthem’s **Behavioral Health services**, please see **Chapter 5: Behavioral Health Services**.

**Please Note**: Our recommendation of these guidelines is not an authorization, certification, explanation of benefits or a contract. Actual Member benefits and eligibility for services are determined in accordance with the requirements set forth by the State of California. With respect to the issue of coverage, each Member should review his/her Evidence of Coverage for details concerning benefits, procedures and exclusions prior to receiving treatment. The Evidence of Coverage supersedes the preventive health guideline recommendations.
CHAPTER 19: CASE MANAGEMENT

Medi-Cal Case Management Department: 1-866-595-0145
Medi-Cal Case Management Fax: 1-866-333-4827
Hours of Operation: Monday to Friday, 8:00am-5:00pm

Case Management Overview

Anthem’s Case Management is a process that emphasizes teamwork to assess, develop, implement, coordinate and monitor treatment plans in order to optimize our Members’ health care benefits and promote quality outcomes.

Cases referred to Case Management may be identified by disease or condition, dollars spent or high utilization of services.

Anthem makes the following information available to contracted Providers:

- Anthem criteria for determining which members might benefit from Case Management
- Provider’s responsibility for identifying members who may meet that criteria
- Process for Providers to follow in notifying Anthem when such members are identified

Case Management Role of the Case Manager

The Case Manager, through discussions with the member, the member’s representative and/or providers, collects data and analyzes information about actual and potential health care needs for the purpose of developing a treatment plan. The case manager’s role also includes the responsibility to:

- Facilitate communication and coordination within the health care team.
- Facilitate communication with the Member and his or her representative in the decision-making process.
- Educate the Member and Providers on the health care team about case management, community resources, benefits, cost factors and all related topics so that informed decisions can be made.
- Encourage appropriate use of medical facilities and services, with the goal of improving quality of care and maintaining cost-effectiveness on a case-by-case basis.

The Case Management team includes experienced and credentialed registered nurses, some of whom are Certified Case Managers (CCMs). The team also includes Social Workers. The Case Management social workers add valuable skills that allow us to address not only our Members’ medical needs, but also their psychological, social and financial issues. To support Anthem’s diverse membership, the Case Management team is able to provide culturally and linguistically appropriate community-based referrals as needed.

Interpreter services are also available to support the case management process at no cost to the Member.
Case Management Provider Responsibility

Providers have the responsibility of participating in Case Management, sharing information and facilitating the process by:

- Referring members who could benefit from Case Management.
- Sharing information as soon as possible and as early as the Initial Health Assessment (IHA) if the Primary Care Provider (PCP) identifies complex health care needs.
- Collaborating with Case Management staff on an ongoing basis.
- Recommending referrals to Specialists, as required.
- Monitoring and updating the care plan to promote health care goals.
- Notifying Case Management if members are referred to services provided by the state or some other institution not covered by the Anthem agreement.
- Coordinating county or state-linked services such as public health, behavioral health, schools and waiver programs. The Provider may call Case Management for additional assistance.

Case Management Procedures

When a Member has been identified as having a condition that may require Case Management, the case manager contacts the referring provider and member for an initial assessment. Then, with the involvement of the member, the member’s representative and the provider, the case manager develops an individualized care plan. That plan may involve coordinating services with public and behavioral health departments, schools and other community health resources.

The case manager periodically reassesses the care plan to monitor the following:

- Progress toward goals
- Necessary revisions
- New issues that need to be addressed to help ensure that the Member receives the support needed to achieve care plan goals

Once goals are met or Case Management can no longer impact the case, the case manager closes the member’s case.

Case Management Potential Referrals

Providers, nurses, social workers and members or their representatives may request Case Management services. Examples of cases appropriate for referral include:

- Children or Adults with special health care needs requiring coordination of care and carved out services such as certain mental health services
- HIV/AIDS
- Chronic illnesses such as asthma, diabetes, heart failure or end-stage renal disease
- Complex or multiple-care needs such as multiple trauma or cancer
- Frequent hospitalizations or Emergency Room utilization
Case Management

Members Eligible for Specialized Services

The Case Management team works closely with providers to ensure continuity and coordination of care for our members who are eligible for linked and state-administered services. These services may come from the following:

- California Children's Services (CCS)
- County Mental Health Care
- Early Start/Early Intervention
- Regional Centers

Although these agencies provide specialized services for our members, we and primary care physicians remain responsible for providing or arranging for the provisions of all necessary and preventive medical services.

Whenever your office refers a Member to any of these agencies or services, please complete and fax the Notification of Referral/Linked and Carved-Out Services Form to the Case Management Department. This form can be found under General Forms in the Forms Library on the Provider Resources page of our website at: www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Case Management
Referral Process

Providers, nurses, social workers, and members or their representative may refer members to Case Management in the following ways: By phone or by faxing a Case Management Referral Form to the Case Management office.

Case Management Phone: 1-866-595-0145
Case Management Fax: 1-866-333-4827 (Using the Case Management Referral Form)

The Medi-Cal, MAP and MRMIP Case Management Referral Form is located in the Forms Library on the Provider Resources page of our website at www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

A case manager will respond to a faxed request within 3 business days.
Case Management

Access to Care: Accessing Specialists

Case managers are also available to assist PCPs with accessing specialists. For assistance locating a specialist, call the Customer Care Center at:

- Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
- Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
- MAP/MRMIP Customer Care Center: 1-877-687-0549

Case Management

Transitioning Disenrollees

The case manager is available to assist a member that requests help to transition to another health plan. Providers may contact Case Management if assistance is needed.
CHAPTER 20: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549

Quality Assessment and Performance Improvement
Overview

Anthem’s longstanding goal has been continuous, measurable improvement in our delivery of quality health care. Following federal and state guidelines, we have a Quality Improvement (QI) program to:

- Objectively and systematically monitor and evaluate the quality, safety and appropriateness of medical care and service offered by the health network.
- Identify and act upon opportunities for improvement.

Continuous improvement is our ongoing effort to be better at what we do.

The QI program includes focused studies and reviews that measure quality of care in specific clinical and service areas. All Providers are expected to participate in these studies as part of our mutual goal of providing responsive and cost-effective health care that improves our Members’ lives.

We also participate in national evaluations designed to gauge our performance and the performance of Providers. The National Committee for Quality Assurance (NCQA) provides an important measure of performance in their annual reporting of the Healthcare Effectiveness Data and Information Set (HEDIS®) scores to health care plans throughout the country. This professional evaluation of the health insurance plan rankings serves as a yearly report card and is a tool used by more than 90% of America’s health care plans to rate performance across a wide spectrum of care and service areas, including:

- Clinical performance
- Member satisfaction

The HEDIS results can be used by Members and potential Members to make comparisons before choosing a health care plan. Anthem uses the HEDIS data to identify areas for improvement and shares the results with Providers. We submit the results of the HEDIS assessment and our own quality studies annually to the California Department of Healthcare Services (DHCS).

Finally, we are committed to working collaboratively with network physicians and hospitals to identify preventable adverse events (PAE) that are measurable and preventable as a means of improving the quality of patient care.

Practitioner/Provider Performance Data

Practitioners and providers must allow Medi-Cal, AIM and MRMIP to use performance data in cooperation with our quality improvement program and activities.

Practitioner/Provider Performance Data refers to compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician or a healthcare organization such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF).
Practitioner/Provider Performance Data may be used for multiple plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie provider or facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.

- **Recognition Programs** – Programs designed to transparently identify high value providers and facilities and make that information available to consumers, employers, peer practitioners and other health care stakeholders.

### Quality Assessment and Performance Improvement

#### Quality Improvement Program Documentation

The QI program focuses on developing and implementing standards for clinical care and service, measuring conformity to those standards, and taking action to improve performance. The scope of the QI program includes, but is not limited to, the monitoring and evaluation of:

- Care and service provided in all health delivery settings
- Chronic Disease Management and Prevention; and Maternity Management Programs
- Coordination of medical care
- Community Health
- Service quality
- Case Management of Members with Complex Health Conditions
- Facility Site Review
- Medical Record Review
- Provider/Member satisfaction
- Utilization Management
- Behavioral Health Programs
- Pharmacy and Therapeutics
- Clinical Practice Guidelines

**Anthem** develops an annual work plan of quality improvement activities based on the results of the previous year’s QI Program Evaluation. QI Program revisions are made based on outcomes, trends, accreditation, contractual and regulatory standards and requirements, and overall satisfaction with the effectiveness of the program. The QI Program Evaluation is the reporting method used to evaluate the progress and results of planned activities toward established goals.

Providers support the activities of the QI program by:

- Completing corrective action plans, when applicable
- Participating in the facility and medical record audit process
- Providing access to medical records for quality improvement projects and studies
- Responding in a timely manner to requests for written information and documentation if a quality of care or grievance issue has been filed
- Using Preventive Health and Clinical Practice Guidelines in Member care
Information from these studies is actively shared with Providers and we encourage constructive feedback.

Quality Assessment and Performance Improvement
Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS is a national evaluation and core set of performance measurements that gauge the effectiveness of Anthem and its Providers in providing quality care. Anthem is ready to help when you and your office staff need training to participate in required HEDIS evaluations. Providers can request consultations and training in the following areas:

- Information about the year’s selected HEDIS studies
- How data for those measures will be collected
- Codes associated with each measure
- Tips for smooth coordination of medical record data collection

Our QI staff will contact your office when we need to review or copy any medical records required for HEDIS or QI studies. Requests to Provider offices begin in early February. Anthem requests the records be returned within five business days to allow time to abstract the records and request additional information from other providers, if needed. Office staff must provide access to medical records for review and copying.

Quality Assessment and Performance Improvement
Quality Management

In accordance with National Committee for Quality Assurance (NCQA) standards, Anthem analyzes relevant utilization data against established thresholds for each health plan to detect potential under-utilization and overutilization.

If our findings fall outside specified target ranges and indicate potential underutilization or overutilization that may adversely affect our Members, further analyses will occur based upon the recommendation of Anthem’s Utilization Management Committee (UMC). The follow-up analyses may include gathering the following data from specific Provider and practice sites:

- Care management services needed by Members
- Claims payments for covered services
- Coordination with other Providers and agencies
- Focus studies
- Investigation and resolution of Member and Provider complaints and appeals within established time frames
- Retrospective reviews of services provided without authorization

Quality Assessment and Performance Improvement
Best Practice Methods

Best practice methods are Anthem’s most up-to-date compilation of effective strategies for quality health care delivery. We share best practice methods with Providers during site visits to Provider offices. Community Resource Coordinators (CRCs) and Network Management teams offer Anthem policies and procedures, along with educational toolkits, to help guide improvements. Toolkits may include examples of best practices from other offices, including:
Quality Assessment and Performance Improvement

Member Satisfaction Surveys

Member satisfaction with our health care services is measured every year by the NCQA. The NCQA conducts a member satisfaction survey called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The survey is designed to measure Member satisfaction with services provided by Anthem and our network Providers, including:

- Access to care
- Physician care and communication with patients
- **Anthem** Customer Service

Anthem shares the results of the CAHPS survey with our network Providers annually. Providers should review the results, share them with office staff, and incorporate appropriate changes to their offices in an effort to improve scores.

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

Quality Assessment and Performance Improvement

Provider Satisfaction Surveys

Anthem may conduct Provider surveys to monitor and measure Provider satisfaction with our services and identify areas for improvement. Provider participation in these surveys is highly encouraged and your feedback is very important. We inform Providers of the results and plans for improvement through Provider bulletins, newsletters, meetings or training sessions.

Quality Assessment and Performance Improvement

Medical Records and Facility Site Reviews

As required by California statute, all PCP sites participating in the Medi-Cal program must undergo an initial site inspection and subsequent periodic site inspections, regardless of the status of other accreditation or certification. Obstetrics/Gynecology (OB/GYN) specialty sites participating in our plan (serving as PCPs) must also undergo an initial site inspection and subsequent periodic site inspections.

Anthem conducts these inspections every 3 years in order to determine:

- Provider compliance with standards for providing and documenting health care
- Provider compliance with standards for storing medical records
- Provider compliance with processes that maintain safety standards and practices
- Provider involvement in the continuity and coordination of Member care

Please Note: DHCS and Anthem have the right to enter into the premises of Providers to inspect, monitor, audit or otherwise evaluate the work performed. We perform all inspections and evaluations in such a manner as not to unduly delay work, in accordance with the Provider contract.
Medical records and facility site review tools are available under the **Quality Improvement Program** heading on the **Provider Resources** page of our website: [www.anthem.com/ca](http://www.anthem.com/ca). For directions on how to access the **Provider Resources** page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

**Quality Assessment and Performance Improvement**

**Facility Site Review Process**

A **Facility Site Review** (FSR) inspection is broken down into the following six categories:

1. Access/Safety
2. Personnel
3. Office Management
4. Clinical Services
5. Preventive Services
6. Infection Control

**Anthem's** Quality Improvement team will call the Provider’s office to schedule an appointment date and time before the FSR due date. The team will fax or mail a confirmation letter with an explanation of the audit process and required documentation.

**During** the FSR, our auditor will:

1. Lead a prereview conference with the Provider or office manager to review and discuss the process of facility review and answer any questions as needed.
2. Conduct a review of the facility.
3. Develop a corrective action plan, if applicable.

**After** the FSR is completed, our auditor will meet with the Provider or office manager to:

4. Review and discuss the results of the facility site review and explain any required corrective actions.
5. Provide a copy of the facility site review results and the corrective action plan to the office manager or Provider.
6. Educate the Provider and office staff about our standards and policies.
7. Schedule a follow-up review for any corrective actions identified.

Providers must attain a score of 80% or greater in both the facility site review and the medical record review in order to pass. A **Corrective Action Plan** (CAP) may also be required.

**Quality Assessment and Performance Improvement**

**Facility Site Review: Corrective Actions**

If the facility site review or the medical record review results in a nonpassing or conditional score, **Anthem** will immediately notify Providers of the results, as well as all cited deficiencies and corrective action requirements. The Provider office will develop and submit a CAP as follows:

- Correct critical deficiencies **within 10 days** following the FSR.
- Develop and submit a corrective action plan for all other deficiencies **within 45 days**.
- Sign an attestation when corrective actions are complete.
If deficiencies (other than critical) are not closed within 45 days from the date of the written CAP request or the practitioner is otherwise uncooperative with resolving outstanding issues with the facility site review, the Provider will be considered noncompliant.

Critical elements include making sure sharps containers are present, autoclave spore testing*, universal precautions, medication storage and availability of emergency equipment.* Facilities must demonstrate 100% percent compliance with these elements.

Provider sites that score below 80% in the facility site review for two consecutive reviews must score a minimum of 80% in the next review. Sites that don’t score a minimum of 80% will be removed from the network, and the Provider’s members will be appropriately reassigned to other participating providers.

*When applicable

Quality Assessment and Performance Improvement
Medical Records Documentation Standards

Anthem requires Providers to maintain medical records in a manner that is current, organized and permits effective and confidential Member care and quality review. We perform medical record reviews of all PCPs and Ob/Gyns (acting as PCPs) upon signing of a contract and, at a minimum, every three years thereafter to ensure that network Providers are in compliance with these standards.

Confidentiality

Network providers shall agree to maintain the confidentiality of member information and information contained in a member's medical records according to the Health Information Privacy and Accountability Act (HIPAA) standards. The Act prohibits a Provider of health care from disclosing any individually identifiable information regarding a patient's medical history, mental and physical condition, or treatment without the patient's or legal representative's consent or specific legal authority and will only release such information as permitted by applicable federal, state and local laws and that is:

- Necessary to other providers and the health plan related to treatment, payment or health care operations; or
- Upon the member’s signed and written consent

Security

The medical record must be secure and inaccessible to unauthorized access in order to prevent loss, tampering, disclosure of information, alteration or destruction of the record. Information must be accessible only to authorized personnel within the Provider’s office, Anthem, DHCS or to persons authorized through a legal instrument.

Office personnel will ensure that individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.
Storage and Maintenance

Active medical records shall be secured and must be inaccessible to unauthorized persons. Medical records are to be maintained in a manner that is current, detailed and organized, and that permits effective patient care and quality review while maintaining confidentiality. Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

Electronic recordkeeping system procedures shall be in place to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures and maintain upkeep of computer systems. Security systems shall be in place to provide back-up storage and file recovery, to provide a mechanism to copy documents, and to ensure that recorded input is unalterable.

Availability of Medical Records

The medical records system must allow for prompt retrieval of each record when the Member comes in for a visit. Providers must maintain Members’ medical records in a detailed and comprehensive manner that accomplishes the following:

- Conforms to good professional medical practice
- Facilitates an accurate system for follow-up treatment
- Permits effective professional medical review and medical audit processes

Medical records must be legible, signed and dated.

Providers must offer a copy of a Member’s medical record upon reasonable request by the Member at no charge, and the Provider must facilitate the transfer of the Member’s medical record to another Provider at the Member’s request. Confidentiality of and access to medical records must be provided in accordance with the standards mandated in HIPAA and all other state and federal requirements.

Providers must permit Anthem and representatives of DHCS to review Members’ medical records for the purposes of:

- monitoring the Provider’s compliance with medical record standards
- capturing information for clinical studies or HEDIS
- monitoring quality
- any other reason

Medical Record Documentation Standards

Every medical record is, at a minimum, to include:

- The patient’s name or ID number on each page in the record
- Personal biographical data including home address, employer, emergency contact name and telephone number, home and work telephone numbers, and marital status
- All entries dated with month, day and year
- All entries contain the author’s identification (for example, handwritten signature, unique electronic identifier or initials) and title
- Identification of all Providers participating in the Member’s care, and information on services furnished by these Providers
• A problem list, including significant illnesses and medical and psychological conditions
• Presenting complaints, diagnoses, and treatment plans, including the services to be delivered
• Physical findings relevant to the visit including vital signs, normal and abnormal findings, and appropriate subjective and objective information
• Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions)
• Information on **Advance Directives**
• Past medical history, including serious accidents, operations, illnesses, and for patients 14 years old and older, substance abuse. For children and adolescents, past medical history relates to prenatal care, birth, operation, and childhood illnesses.
• Physical examinations, treatment necessary and possible risk factors for the Member relevant to the particular treatment
• Prescribed medications, including dosages and dates of initial or refill prescriptions
• For patients 14 years and older, appropriate notations concerning the use of cigarettes, alcohol and substance abuse (including anticipatory guidance and health education)
• Information on the individuals to be instructed in assisting the patient
• Medical records must be legible, dated and signed by the physician, physician assistant, nurse practitioner or nurse midwife providing patient care
• An immunization record for children that is up-to-date or an appropriate history for adults
• Documentation attempts to provide immunizations. If the Member refuses immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian shall be documented in the Member’s medical record
• Evidence of preventive screening and services in accordance with **Anthem’s** preventive health practice guidelines
• Documentation of referrals, consultations, diagnostic test results, and inpatient records. Evidence of the Provider’s review may include the Provider’s initials or signature and notation in the patient’s medical record of the Provider’s review and patient contact, follow-up treatment, instructions, return office visits, referrals and other patient information
• Notations of patient appointment cancellations or “No Shows” and the attempts to contact the patient to reschedule
• No evidence that the patient is placed at inappropriate risk by a diagnostic test or therapeutic procedure
• Documentation on whether an interpreter was used and, if so, that the interpreter was also used in follow-up
• Documentation of the Member’s preferred language
Misrouted Protected Health Information

Providers and facilities are required to review all Member information received from Anthem to ensure no misrouted Protected Health Information (PHI) is included. Misrouted PHI includes information about Members that a Provider or facility is not treating. PHI can be misrouted to Providers and facilities by mail, fax, email or Electronic Remittance Advice. Providers and facilities are required to destroy immediately any misrouted PHI or 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. If Providers or facilities cannot destroy or safeguard misrouted PHI, please contact the appropriate Customer Care Center at the number listed at the beginning of this chapter.

Quality Assessment and Performance Improvement

Advance Directives

Anthem recognizes a person’s right to dignity and privacy. Our Members have the right to execute an Advance Directive, also known as a "living will," to identify their wishes concerning health care services in the event that they become incapacitated. Providers may be asked to assist Members in procuring and completing the necessary forms. More information on this process is available under the Standards & Policies heading on the Provider Resources page at www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Advance Directive documents should be on hand in the event a Member requests this information. Member requests for Advance Directive documents should be noted in the Medical Record when applicable.

Quality Assessment and Performance Improvement

Medical Records Review Process

Anthem’s QI team will call the Provider’s office to schedule a medical records review on a date and time that will occur within 30 days of the request. On the day of the review, the QI staff will:

1. Request the number and type of medical records required.
2. Review the appropriate type and number of medical records per Provider.
3. Complete the medical record review.
4. Meet with the Provider or office manager to review and discuss the results of the medical record review or send a final copy within 10 days of the review.
5. Schedule follow-up reviews for any corrective actions identified.

Providers must attain a score of 80% or greater in order to pass the medical record review. A corrective action plan may also be required.

Provider sites that score below 80% in the medical record review for two consecutive reviews must score a minimum of 80% in the next review. Sites that don’t score a minimum of 80% will be removed from the network, and the Provider’s members will be appropriately reassigned to other participating providers.
Quality Assessment and Performance Improvement

Preventable Adverse Events

The breadth and complexity of today’s health care system means there are inherent risks, many of which can be neither predicted nor prevented. However, when there are preventable adverse events, they should be tracked and reduced, with the ultimate goal of eliminating them.

Providers and health care systems, as advocates for our Members, are responsible for the continuous monitoring, implementation and enforcement of applicable health care standards. Focusing on patient safety, we work collaboratively with network Providers and hospitals to identify preventable adverse events and implement appropriate strategies and technologies to avoid them. Our goal is to enhance the quality of care received not only by our Members, but all patients receiving care in these facilities.

Prevention of adverse events may require the disclosure of protected health information. HIPAA specifies that Protected Health Information (PHI) can be disclosed for the purpose of health care operations in relation to quality assessment and improvement activities. Moreover, the information you share with us is legally protected through the peer-review process. As such, it will be maintained in a strictly confidential manner. If you receive a request for medical records, please provide them within 10 days from the date of request.

We will continue to monitor activities related to the list of adverse events from federal, state, and private payers, including “Never Events.”*

Preventable adverse events should not occur. When they do, we firmly support the concept that a health plan and its Members should not pay for resultant services.

In the event that Anthem determines that the quality of care or services provided by a health care professional is not satisfactory, as may be evidenced by Member satisfaction surveys, Member complaints or grievances, medical management data, complaints or lawsuits alleging professional negligence, or any other quality of care indicator, Anthem may exercise any appropriate rights to terminate the Provider Agreement.

Please Note: Medicaid is prohibited from paying for certain Health Care Acquired Conditions (HCAC). This applies to all hospitals.

*Never Events: As defined by the National Quality Forum (NQF) are adverse events that are serious, but largely preventable, and of concern to both the public and health care providers.
CHAPTER 21: ENROLLMENT AND MARKETING RULES

Medi-Cal Enrollment 1-800-430-4263
MAP/MRMIP Enrollment: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm

Enrollment and Marketing Rules

Overview

The delivery of quality health care poses numerous challenges, not least of which is the commitment shared by Anthem and its Providers to protect our Members. We want our Members to make the best health care decisions possible for themselves and their families. And when they ask for our assistance, we want to help them make those decisions without undue influence.

Anthem recognizes that Providers occupy a unique, trusted and respected part of people’s lives. Given the complexity of modern-day health care and the inherent difficulties communicating with some of the populations we serve, there are potentially serious pitfalls when Providers try to assist in the decision-making process. Sometimes, even though the intent is to help make our Members’ lives better, we can overstep.

For that reason, we are committed to following strict enrollment and marketing guidelines created by the California Department of Health Care Services (DHCS) and to honoring the rules for all state health care programs.

Enrollment and Marketing Rules

Enrollment Policies

Anthem and its Providers may not market directly to individuals or families. An example of direct marketing that is not allowed is mailing to individual patients any Anthem or other health plan materials in which they are told to join Anthem or another plan. Any information prospective Members receive about our health care plan comes from the state, from our Regional Health Plans (for Medi-Cal), or from marketing activities approved by the California Department of Health Care Services (DHCS). The state must approve any marketing materials we create. Providers may, however, distribute information about our health care plan after receiving a specific Member request for more information on our benefits and services.

Please Note: As a network Provider, you may not provide prospective Members with an Enrollment Form; you may assist Members (who are patients) in completing the Enrollment Form.

Enrollment and Marketing Rules

Enrollment Process – Medi-Cal

The Medi-Cal enrollment process is managed by Health Care Options (HCO). The enrollment process includes:

1. Verification of eligibility through the application process. For information on the Medi-Cal application process visit www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal-HowtoApply.aspx
2. Individuals and families whose applications are accepted and are confirmed eligible for Medi-Cal receive a pre-enrollment packet that includes a Medi-Cal Enrollment Form and the Plan’s Provider directory.
3. Members must return the signed Enrollment Form within 45 days, including selection of a health care plan and a Primary Care Provider (PCP).
4. If the Member does not choose a health care plan or a PCP within that time frame, the state assigns the Member to a Medi-Cal plan and a PCP.
5. The enrollment company informs Anthem of new Member enrollment and any changes after enrollment in Member eligibility, status or Member information.

To learn more about the enrollment process or to obtain the most current forms and information, visit www.healthcareoptions.dhcs.ca.gov/HCOCSP/Home/. Additional information is available via the following resources:

- California DHCS Medi-Cal Website: www.medi-cal.ca.gov
- Health Care Options 1-800-430-4263

Enrollment and Marketing Rules

Enrollment Process – Medi-Cal Access Program & Major Risk Medical Insurance Plan

The Medi-Cal Access Program (MAP) and Major Risk Medical Insurance Plan (MRMIP) enrollment process begins with a Managed Risk Medical Insurance Board (MRMIB) enrollment contractor. Potential Members must complete the application process to confirm that they qualify for these programs. Application assistance is available through schools, community-based programs and health care providers.

Enrollment and Marketing Rules

Marketing Policies

Anthem Providers are prohibited from making marketing presentations and advising or recommending to an eligible individual that he or she select membership in a particular plan. The California Department of Health Care Services (DHCS) marketing practice policies prohibit network Providers from making the following false or misleading claims:

- That the Primary Care Provider's (PCP) office staff are employees or representatives of the state, county or federal government.
- That Anthem is recommended or endorsed by any state or county agency or any other organization.
- That the state or county recommends that a prospective Member enroll with a specific health care plan.
- That a prospective Member or medical recipient will lose benefits under the Medi-Cal Program or other welfare benefits if the prospective Member does not enroll with a specific health care plan.

These policies also prohibit network Providers from taking the following actions:

- Making marketing presentations or allowing Anthem representatives to make marketing presentations to prospective Members.
- Offering or giving away any form of compensation, reward or loan to a prospective Member to induce or procure Member enrollment in a specific health care plan.
- Engaging in direct marketing to Members that is designed to increase enrollment in a particular health care plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of Members obtained originally for enrollment purposes from confidential state or county data sources or from the data sources of other contractors.
• Employing marketing practices that discriminate against potential Members based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem or medical condition (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract.

• Reproducing or signing an enrollment application for the Member.

• Displaying materials only from the Provider’s contracted managed health care organizations and excluding others.

• Engaging in any marketing activity on behalf of Anthem on state or county premises or at event locations such as health fairs and festivals, athletic events, recreational activities and Plan-sponsored events.

Providers are permitted to:

• Distribute copies of applications to potential Members.

• Assist Members in finding out what programs they qualify for and then direct them to call the appropriate number below for more information:

  - **Anthem Member Outreach Call Center**: 1-800-227-3238
  - **Medi-Cal - L.A. Care (Los Angeles County)**: 1-888-452-2273
  - **Medi-Cal - Health Care Options (HCO)**: 1-800-430-4263
  - **Medi-Cal for Families Information Line**: 1-800-880-5305
  - **Medi-Cal Access Program**: 1-877-687-0549 or (TDD) 1-888-757-6034
  - **MRMIP**: 1-877-687-0549 or (TDD) 1-888-757-6034

• File a complaint with **Anthem** if a Provider or Member objects to any form of marketing, either by other Providers or by **Anthem** representatives. (Please refer to the **Grievances and Appeals** chapter of this manual for more information on the grievance process.)

**Please Note:** Providers are required to obtain approvals prior to using patient-focused and **Anthem**-branded marketing materials created by your office. Before distributing materials to your **Medi-Cal** patients, submit your materials to us through your local **Community Resource Coordinator**. We will review and seek approval from the following agencies, as appropriate:

• **L.A. Care Health Plan**
• **Department of Health Care Services (DHCS)**
• **Department of Managed Health Care (DMHC)**
• **Managed Risk Medical Insurance Board (MRMIB)**
• Other stakeholders, as required
CHAPTER 22: FRAUD, ABUSE AND WASTE

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549
Fraud & Abuse Unit Fax: 1-866-454-3990
Hours of Operation: Monday to Friday, 8am-5pm

Fraud, Abuse and Waste
Overview

We are committed to protecting the integrity of our health care program and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste.

Fraud, Abuse and Waste
Understanding Fraud, Abuse and Waste

Combating fraud, abuse and waste begins with knowledge and awareness.

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- **Abuse**: Any practice inconsistent with sound fiscal, business or medical practices that results in an unnecessary cost to the Medicaid program, including administrative costs from acts that adversely affect Providers or Members.
- **Waste**: Generally defined as activities involving careless, poor or inefficient billing, or treatment methods causing unnecessary expenses and/or mismanagement of resources.

Fraud, Abuse and Waste
Examples of Provider Fraud, Abuse and Waste

The following are examples of Provider fraud, abuse and waste:

- Altering medical records
- Billing for services not provided
- Billing for medically unnecessary tests
- Billing professional services performed by untrained personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling
- Underutilization
- Upcoding
Fraud, Abuse and Waste

Examples of Member Fraud, Abuse and Waste

The following are examples of Member fraud, abuse and waste:

- Disruptive or threatening behavior
- Frequent emergency room visits for nonemergent conditions
- Forging, altering or selling prescriptions
- Letting someone else use the Member’s Medi-Cal ID
- Not telling the truth about the amount of money or resources the Member has in order to get benefits
- Not telling the truth about a medical condition to get medical treatment
- Obtaining controlled substances from multiple Providers
- Relocating to out-of-service area
- Using more than a single Provider to obtain similar treatments and/or medications
- Using a Provider not approved by the Primary Care Provider (PCP)
- Using someone else’s Medi-Cal ID
- Violation of the Pain Management Contract

**Pain Management Contract:** A written agreement between a Provider and Member that the Member will not misrepresent his or her need for medication. If the contract is violated, the Provider has the right to drop the Member from his or her practice.

Fraud, Abuse and Waste

Reporting Provider or Recipient Fraud, Abuse or Waste

If you suspect either a Provider (doctor, dentist, counselor, medical supply company, etc.) or a Member (a person who receives benefits) has committed fraud, abuse or waste, you have the right and responsibility to report it.

Providers can report allegations of fraud, abuse or waste in the following ways:

- Call our Customer Care Center: **1-800-407-4627**
- Fax a completed Fraud Referral Form to the Fraud and Abuse Unit at: **1-866-454-3990**

You can download the Medi-Cal, MRMIP, AIM Fraud Referral Form from the Forms Library on the Provider Resources page of our website: [www.anthem.com/ca](http://www.anthem.com/ca). For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

When reporting on a Provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of Provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and facility, if you have it
- Type of Provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened
When reporting about a Member who receives benefits, include:

- The Member’s name
- The Member’s date of birth, Social Security number or case number if you have it
- The city where the Member lives
- Specific details about the fraud, abuse or waste

Fraud, Abuse and Waste
Anonymous Reporting of Suspected Fraud, Abuse and Waste

Any incident of fraud, abuse or waste may be reported to us anonymously; however, we encourage you to provide as much detailed information as possible, including:

- The name of person reporting and their relationship to the person suspected
- A call-back phone number for the person reporting the incident

Please Note: The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators to maintain that person's anonymity.

Fraud, Abuse and Waste
Investigation Process

We do not tolerate acts that adversely affect Providers or Members. We investigate all reports of fraud, abuse and waste. Allegations and the investigative findings are reported to the California Department of Health Care Services (DHCS), regulatory and law enforcement agencies. In addition to reporting, we take corrective action, such as:

- **Written warning and/or education:** We send certified letters to the Provider or Member that document the issues and the need for improvement. Letters may include education or request for recoveries or may advise of further action.
- **Medical record audit:** We may review medical records to substantiate allegations or validate claims submissions.
- **Special claims review:** A special claims review places payment or system edits on file to prevent automatic claim payment; this requires a medical reviewer evaluation.
- **Recoveries:** We recover overpayments directly from the Provider. Failure of the Provider to return the overpayment may be reflected in reduced payment of future claims or further legal action.

Fraud, Abuse and Waste
Acting on Investigative Findings

We refer all criminal activity conducted by a Member or Provider to the appropriate regulatory and law enforcement agencies.

If a Provider has been convicted of committing, abuse or waste or has been suspended from the Medicaid program, the following steps may be taken:

- The Provider may be referred to the Quality Management Department
- The Provider may be presented to the credentialing committee and/or peer review committee for disciplinary action, including Provider termination
Failure to comply with program policy, procedures or any violation of the contract may result in termination from our plan.

If a Member has committed fraud, exhibited abusive or threatening behavior, or has failed to correct issues, he or she may be involuntarily disenrolled from our health care plan, with state approval. (Refer to Chapter 13: Member Transfers & Disenrollment for more information on disenrollment.)

**Fraud, Abuse and Waste**

**False Claims Act**

We are committed to complying with all applicable federal and state laws, including the federal False Claims Act (FCA).

The FCA is a federal law that allows the government to recover money stolen through fraud by government contractors. Under the FCA, anyone who knowingly submits or causes another person or entity to submit false claims for payment of government funds is liable for three times the damages or loss to the government, plus civil penalties of $5,500 to $11,000 per false claim.

The FCA also contains Qui Tam or “whistleblower” provisions. A “whistleblower” is an individual who reports in good faith an act of fraud or waste to the government or files a lawsuit on behalf of the government. Whistleblowers are protected from retaliation from their employer under Qui Tam provisions in the FCA and may be entitled to a percentage of the funds recovered by the government.
CHAPTER 23: MEMBER RIGHTS & RESPONSIBILITIES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
1-888-757-6034 (TTY)

Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)

MAP/MRMIP Customer Care Center: 1-877-687-0549

Hours of Operation: Monday to Friday, 7am-7pm

24/7 NurseLine: 1-800-224-0336 (For After-Hours Services)

Overview

The Members of our three health care programs, Medi-Cal, Medi-Cal Access Program and the Major Risk Medical Insurance Program, should be clearly informed about their rights and responsibilities in order to make the best health care decisions. That includes the right to ask questions about the way we conduct business, as well as the responsibility to learn about their health care plan.

Members have certain rights and responsibilities when receiving their health care. They also have a responsibility to take an active role in their care. As their health care partner, we are committed to making sure their rights are respected while we provide their health benefits. This also means giving them access to our network providers and the information they need to make the best decisions for their health and welfare.

The following are our Members’ rights and responsibilities as stated in each of the Member handbooks. They are also posted on our website at: www.anthem.com/ca > OTHER ANTHEM WEBSITES: Medicaid >Select Program: Medi-Cal/MRMIP/AIM (Medi-Cal Access Program).

Member Rights & Responsibilities

Medi-Cal

Our Members have the right to:

- Get the information they need to make sure they get the most from their health plan and share their feedback. This includes information on:
  - Our company and services
  - Our network of doctors and other health care providers
  - Their rights and responsibilities.
- Have access to their medical records as state and federal law allows.
- Speak freely and privately with their doctors and other health providers about all health care options and treatments needed for their condition no matter what it costs or whether it is covered under their plan.
- Get written information in alternative formats (including audio CD, large print and Braille) at no cost to them upon request and in a timely way that is correct for the format that they asked for.
- Get member materials in a language other than English at no cost to them.
- Be treated with respect and with regard for their dignity and privacy.
- Expect us to keep private their personal health information. This is as long as it follows state and federal laws and our privacy policies.
• Be free of any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
• Be in charge of their health care.
• Choose their primary care physician (PCP)
• Refuse care from their PCP or other caregivers.
• Work with their doctors in making choices about their health care.
• Do what they think is best for their health care without anyone stopping them. They may make health decisions without fear of their doctor or health plan taking action to get back at them.
• Make an advance directive (also known as a “living will”).
• Get a range of covered services.
• Get family planning services.
• Be treated for STIs.
• Access minor consent services if they are under 18 years of age.
• Get emergency care outside of the Anthem network, as federal law allows.
• Get health care from providers at a Federally Qualified Health Center.
• Get health care at an Indian Health Center.
• Get free interpreter services, including sign language, at no cost to them.
• Tell us how they would like to change this health plan.
• Make a complaint or file an appeal about:
  o Their health plan
  o Any care they receive
  o Any covered service or benefit ruling that their health plan makes
• Ask the Department of Social Services for a State Fair Hearing.
• Ask the Department of Managed Health Care for an independent medical review.
• Choose to leave this health plan.

Members have the responsibility to:
• Give us, their doctors and other health care providers the information needed to help them get the best possible care and all other benefits they are entitled to,
• Understand their health problems as well as they can and work with their doctors or other health care providers to make a treatment plan they all agree on.
• Follow the care plan that they have agreed on with their doctor and other health care providers.
• Follow their doctor’s advice about taking good care of their selves.
• Use the right sources of care.
• Bring their health plan ID card with them when they visit their doctor.
• Treat their doctors and other caregivers with respect.
• Understand their health plan.
• Know and follow the rules of their health plan.
• Know that laws govern their health plan and the types of service they get.
• Know we cannot discriminate against them because of their age, sex, race, national origin, culture, language needs, sexual orientation or health.
Member Rights & Responsibilities
Access for Infants and Mothers

As an Anthem Member, Members have the right to:

- Be informed of their rights and responsibilities.
- Receive information about Anthem services, doctors and specialists.
- Receive information about all their other health care providers.
- Talk honestly with their doctors about all the appropriate treatments for their condition, no matter what the cost or whether their benefits cover them.
- Use interpreters who are not their family members or friends. (The interpreter will be provided at no charge to them.)
- Be treated with respect and with regard for their dignity in all situations.
- Have their privacy protected by Anthem, their doctors and all their other health care providers.
- Know that information about them is kept confidential and used only to treat them.
- Be in charge of their health care.
- Be actively involved in making decisions about their health care.
- Make an Advance Directive.
- Suggest changes in their health plan.
- Complain about Anthem or the health care they receive.
- File a complaint or grievance if their cultural and linguistic needs are not met.
- Appeal a decision from Anthem about the health care they receive.
- Make recommendations about our Rights and Responsibilities Policy.

Members have the responsibility to:

- Give Anthem, their doctors and other health care providers the information needed to treat them, to the best of their ability.
- Understand their condition and help their doctor set treatment goals you both agree on, to the best of their ability.
- Follow the plans they have agreed on with their doctors and their other health care providers.
- Follow the guidelines for healthy living their doctor and their other health care providers suggest.
- Use the emergency room only in cases of emergency or as directed by their provider.

Member Rights & Responsibilities
Major Risk Medical Insurance Program

Members have the right to:

- Be informed of their rights and responsibilities.
- Receive information about Anthem, our services, doctors, specialists and other health care providers.
- Be able to talk honestly with their doctors about all the appropriate treatments for their condition, no matter what the cost or whether their benefits cover them.
- Be actively involved in making decisions about their health care.
- Be treated with respect and dignity in all situations.
- Have their privacy protected by Anthem, their doctors and all their other health care providers.
• Know that information about them is kept confidential. **Anthem** will not share Member health information without their written authorization or unless it is permitted by law.
• Be in charge of their health care.
• Suggest changes in their health plan.
• Complain about **Anthem** or the health care they receive.
• Appeal an adverse decision from **Anthem** about the health care they requested or received.
• Request an **Independent Medical Review** if **Anthem** denies, delays or modifies a health care service because it is not medically necessary.
• Make recommendations about our **Rights and Responsibilities Policy**.
• Use interpreters who are not their family members or friends.
• Request an interpreter at no cost to them.

**Members have the responsibility to:**
• Give **Anthem**, their doctors and other health care providers correct information needed to treat them.
• Understand their medical condition and help their doctor set treatment goals you both agree on.
• Follow the plans they have agreed to with their doctors and other health care providers.
• Follow the guidelines for healthy living suggested by their doctor and their other health care providers.
CHAPTER 24: CULTURAL DIVERSITY & LINGUISTIC SERVICES

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
MAP/MRMIP Customer Care Center: 1-877-687-0549
Hours of Operation: Monday to Friday, 7am-7pm
24/7 NurseLine: 1-800-224-0336 (For After-Hours Services)

Cultural Diversity & Linguistic Services
Overview

At Anthem, we recognize that providing health care services to a diverse population can present challenges. Those challenges arise when Providers need to cross a cultural divide to treat Members who may have different behaviors, attitudes and beliefs concerning health care. Differences in our Members' ability to read may add an extra dimension of difficulty when Providers try to encourage follow-through on treatment plans.

Our Cultural Diversity and Linguistic Services Toolkit, called "Caring for Diverse Populations," was developed to give you specific tools for breaking through cultural and language barriers in an effort to better communicate with your patients.

Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the door to the kind of interaction that makes treatment plans most effective: Has the patient been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the patient self-conscious about his or her ability to read instructions?

This toolkit gives you the information you'll need to answer those questions and continue building trust. It will enhance your ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to your office staff so that all aspects of an office visit can go smoothly.

We strongly encourage you to access the complete toolkit. Called Caring for Diverse Populations, it is located under the Health Education heading on the Provider Resources page of our website: www.anthem.com/ca. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base

- Encounter tips for Providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base

- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of Medical Consumerism training for health educators to share with patients.
Chapter 24: Cultural Diversity and Linguistic Services

Anthem Blue Cross
Medi-Cal, Medi-Cal Access Program and MRMIP

Resources to Communicate Across Language Barriers
- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery
- Tips for talking with people across cultures about a variety of culturally sensitive topics
- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services
- Identifies important legislation impacting cultural and linguistic services, including a summary of the Culturally and Linguistically Appropriate Services standards (CLAS) which serve as a guide on how to meet these requirements

Resources for Cultural and Linguistic Services
- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of your own practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistic Workgroup, a volunteer, multidisciplinary team of Providers, health plans, associations, state and federal agencies, and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE Workgroup may be obtained on the ICE Workgroup website: www.iceforhealth.org.

Cultural Diversity & Linguistic Services
Language Capability of Providers and Office Staff

Anthem strives to have a provider network that can meet the linguistic needs of our Members. An important component of that is having network Providers that are aware of the language capabilities of themselves and their office staff. Providers and their staff can use the Employee Language Self Assessment Tool found in the Caring for Diverse Populations toolkit to help determine their level of proficiency with non-English languages. Please be sure to provide annual updates on the language capabilities of your office staff and at least every three years for yourself using the Provider Change Form available in the Forms Library on the Provider Resources page of our website at www.anthem.com/ca. This information will be reported in the Provider Directory to help Members find a provider and/or office staff that speaks their preferred language. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Cultural Diversity & Linguistic Services
Interpreter Services

For those instances when you cannot communicate with a Member due to language barriers, interpreter services, including over-the-phone and face-to-face interpreters, are available at no cost to you or the
Member. Providers must notify Members of the availability of interpreter services and strongly discourage the use of friends and family, particularly minors, to act as interpreters. It is important that you or your office staff document the Member’s language, any refusal of interpreter services and requests to use a family member or friend as an interpreter in the Member’s medical record. Request/Refusal of Interpreter Services forms are available in threshold languages on the Free Interpreting Services page of our website at www.anthem.com/ca. Providers and members of their staff can find a link to this page under the Health Education heading of our Provider Resources page. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Face-to-face interpreters for Members needing language assistance, including American Sign Language, are available by placing a request at least 72 hours in advance. Over-the-phone interpreters are available 24 hours a day, 7 days a week.

Providers and Members may request telephone or face-to-face interpreter services by calling:

Customer Care Center: 1-888-285-7801 (Inside L.A. County/During Business Hours)
Customer Care Center: 1-800-407-4627 (Outside L.A. County/During Business Hours)
24/7 NurseLine: 1-800-224-0336 (After Hours)

Please Note: For face-to-face interpreter services, advance notice of 72 hours is required, and 24 hours is required to cancel.

For after-hours telephone interpreter services, call 24/7 NurseLine and take the following steps:

1. Give the customer care associate the Member’s ID number.
2. Explain the need for an interpreter and state the language.
3. Wait on the line while the connection is made.
4. Once connected to the interpreter, the associate or 24/7 NurseLine nurse introduces the Medi-Cal Member, explains the reason for the call and begins the dialogue.

Additional information on interpreter services is available on the Free Interpreting Services page of our website at www.anthem.com/ca. Providers and Members of their staff can find a link to this page under the Health Education heading of our Provider Resources page. For directions on how to access the Provider Resources page of our website, please see Chapter 1: How to Access Information, Forms and Tools on Our Website.

Services for Members with Hearing Loss, Visual and/or Speech Impairment

During business hours, Members with hearing loss or speech impairment can call the designated Anthem TTY numbers noted in Chapter 3: Contact List. After regular business hours, Members can call the 24/7 NurseLine TTY number 1-800-368-4424. The California relay service is also available 24 hours a day by calling the numbers noted in Chapter 3: Contact List. Members can also request face-to-face sign language interpreters at no cost to them. Members with visual impairments can request verbal assistance or alternative formats for assistance with printed materials at no cost to the member.

Translation of Materials

Members can request translation of materials into non-English languages and alternative formats at no cost to them by contacting the designated Customer Call Center number in Chapter 3: Contact List.
CHAPTER 25: EXPANDED COVERAGE FOR NEW POPULATIONS

Medi-Cal Customer Care Center: 1-800-407-4627 (Outside L.A. County)
Medi-Cal Customer Care Center: 1-888-285-7801 (Inside L.A. County)
Hours of Operation: Monday to Friday, 7am-7pm

Expanded Coverage for New Populations
Overview

At Anthem, we have expanded our coverage for particularly vulnerable Members to include services from two important programs formerly administered by the state: Seniors and Persons with Disabilities (SPD) and Community-Based Adult Services (CBAS), formerly known as Adult Day Health Care (ADHC).

Anthem works directly with the California Department of Health Care Services (DHCS), which mandates that eligible seniors and persons with disabilities enroll in a Medi-Cal managed care plan. Mandatory enrollment helps ensure that these Members have access to an organized health care delivery system, including a medical "home," care management and all other Member support services.

The state has also asked managed care providers, including Anthem, to administer its Community-Based Adult Services program. This program, which provides services to many of the same seniors and persons with disabilities, stresses partnership with the Member, the family, the Provider and the community in working toward maintaining personal independence.

Expanded Coverage for New Populations
Seniors and Persons with Disabilities

Once enrolled in the Seniors and Persons with Disabilities (SPD) program, our Members have the advantage of belonging to an organized managed care delivery system. That system revolves around the Member's medical "home," where Primary Care Providers (PCPs) supervise care management and Member support services.

The process of becoming part of the Anthem Seniors and Persons with Disabilities program is as follows:

- Potential Members receive enrollment materials and are asked to select a PCP if they did not do so during the selection of a health care plan.
- If the Member does not choose a PCP within 30 days of enrollment, Anthem will select a PCP for the Member, making every effort to preserve the Member's existing Provider, hospital and specialist.
- Members receive an ID card and the same benefits as other Medi-Cal Members, as outlined in the Member Handbook.

The easiest way to determine a Member's SPD eligibility is to look at the eligibility and capitation reports Anthem supplies on a monthly basis via our secure Provider Access website at https://provider2.anthem.com/wps/portal/ebpmybcc. To find this website, from our main homepage at www.anthem.com/ca, please use the following websteps:

1. Click on OTHER ANTHEM WEBSITES: Providers
2. On the Welcome to Anthem page, find the drop-down Login: Select Access menu and click on Medical
3. Click on Login
4. On the Provider Access page, login with your User ID and Password
Please Note: If you do not have a User ID, click Register for Provider Access and follow the instructions to set up your account.

SPD beneficiaries who are part of the mandatory transition to Medi-Cal managed care fall under 1 of the following aid codes:

<table>
<thead>
<tr>
<th>AID CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Aid to the Aged – SSI/SSP</td>
</tr>
<tr>
<td>14</td>
<td>Aid to the Aged – Medically Needy</td>
</tr>
<tr>
<td>16</td>
<td>Pickle Amendment - Aged</td>
</tr>
<tr>
<td>18</td>
<td>Aid to the Aged – In-Home Support Services (IHSS)</td>
</tr>
<tr>
<td>20</td>
<td>Blind – SSI/SSP - Cash</td>
</tr>
<tr>
<td>24</td>
<td>Blind Medically Needy</td>
</tr>
<tr>
<td>26</td>
<td>Blind – Pickle Eligibles</td>
</tr>
<tr>
<td>28</td>
<td>Blind – IHSS</td>
</tr>
<tr>
<td>36</td>
<td>Disabled Widows/Widowers</td>
</tr>
<tr>
<td>60</td>
<td>Disabled-SSI/SSP-Cash</td>
</tr>
<tr>
<td>64</td>
<td>Disabled – Medically Needy</td>
</tr>
<tr>
<td>66</td>
<td>Pickle Amendment - Disabled</td>
</tr>
<tr>
<td>68</td>
<td>Disabled - IHSS</td>
</tr>
<tr>
<td>1E</td>
<td>Continued Eligibility for the Aged</td>
</tr>
<tr>
<td>1H</td>
<td>Aged – FPL Program</td>
</tr>
<tr>
<td>2E</td>
<td>Blind Pending SB 87 Redetermination</td>
</tr>
<tr>
<td>6A</td>
<td>Disabled Adult/Child Blind</td>
</tr>
<tr>
<td>6C</td>
<td>Disabled Adult/Child Disabled</td>
</tr>
<tr>
<td>6E</td>
<td>Continued Eligibility for the Disabled</td>
</tr>
<tr>
<td>6G</td>
<td>250% Working Disabled</td>
</tr>
<tr>
<td>6H</td>
<td>Disabled – FPL Program</td>
</tr>
<tr>
<td>6J</td>
<td>SB 87 Pending Disability. Covers w/o SOC beneficiaries 21-65 who have lost their non-disability linkage to Medi-Cal and are claiming disability.</td>
</tr>
<tr>
<td>6N</td>
<td>No Longer Disabled Beneficiary in Appeal</td>
</tr>
<tr>
<td>6P</td>
<td>PRWORA/No Longer Disabled Children</td>
</tr>
<tr>
<td>6R</td>
<td>SB 87 Pending Disability (SOC). Covers with an SOC those ages 21 to 65 who have lost their non-disability linkage to Medi-Cal and are claiming disability.</td>
</tr>
<tr>
<td>6V</td>
<td>DS Waiver (No SOC)</td>
</tr>
</tbody>
</table>

If you have any questions about SPD aid codes, please call our Customer Care Centers at the numbers listed at the beginning of this chapter.
Expanded Coverage for New Populations
Community-Based Adult Services (CBAS)

The California Department of Health Care Services (DHCS), working in conjunction with other agencies, created Community-Based Adult Services (CBAS) to provide a multifaceted approach to health care for this vulnerable population, many of whom are also seniors and persons with disabilities. Services provided at regional centers include the following:

- Behavioral Health Services
- Hot Meals and Nutritional Counseling
- Physical, Occupational and Speech Therapies
- Professional Nursing Services
- Therapeutic Activities
- Transportation To and From the Member's Residence

The state has mandated that CBAS beneficiaries must enroll in a Medi-Cal Managed Care Plan. The transition to managed care, including that provided by Anthem, is designed to offer a fully-integrated system that includes the following:

- Comprehensive Health Risk Assessments
- Care Coordination
- Case Management
- Ongoing Support Services

By offering these services, our goal is to support independence and provide an alternative to institutionalization for those Members who are capable of living at home with appropriate services. Due to their complex medical conditions, this Member population may require additional assistance, patience and sensitivity in learning how to access Anthem benefits.

Members can refer themselves to Community-Based Adult Services or be referred by a caregiver, family member, nurse practitioner or Provider. After that, the following steps are taken:

1. In accordance with CBAS mandates, an Anthem Case Manager will conduct a Face-To-Face Assessment of the Member.
2. Using an evaluation tool developed and provided by the state, Anthem will approve, reduce or deny the request for services.
3. If approved, Members remain eligible for a benefit period of six months, at which time another assessment is conducted.

Anthem contracts with some 200 Adult Day Health Care Centers as part of the CBAS program. For more information on the CBAS program, please contact our Regional Health Plans at the following numbers:

<table>
<thead>
<tr>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern California:</td>
<td>1-818-655-1255</td>
</tr>
<tr>
<td>Central California:</td>
<td>1-559-488-1380</td>
</tr>
<tr>
<td>Northern California:</td>
<td>1-916-325-4200</td>
</tr>
</tbody>
</table>