



# Network Update

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# Health Care Reform Updates (including Health Insurance Exchange)

## Integrated Care Model for plans purchased on the Health Insurance Marketplace benefits members and physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called Covered California) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. How do you contact Case Management?

CM Telephone Number	CM Email Address	CM Business Hours
Phone: 1-888-613-1130 Fax: 1-800-947-4074	Case.management@anthem.com	Monday – Friday 8:00 a.m. – 9:00 p.m. Saturday 9:00 a.m. – 5:30 p.m.

## Important information available online

We invite you to go to our website to learn about the many ways health care reform and health insurance exchange may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance exchange, and all archived articles, go to [anthem.com/ca](http://anthem.com/ca), select the **Provider** link in the top center of the page, and click **Enter**. From the **Provider Home** page, select the link titled [Health Care Reform Updates and Notifications](#) or [Health Insurance Exchange Information](#).

# Professional Network Update

# Announcements and General Updates

## Regulatory update: Senate Bill 137

It is extremely important that we have accurate and up-to-date information about your practice in our directories. With the recent passage of Senate Bill 137 (SB), which takes effect on July 1, 2016, we are committed to ensuring that provider information and directories we provide our members are as accurate and up-to-date as possible. While we look to you to provide us the specific information we need regarding your practice, we are required to conduct semi-annual outreaches to all practices to confirm the information we have on file is accurate. Without verification from you that our provider directory information is accurate, we will be required to remove your practice from the directories we make available to our members. We appreciate your attention to this matter. In addition to your participating in Anthem Blue Cross' outreach efforts, we ask that you still provide us with updates within 10 days of a change in your practice.

## New pre-certification requirements: Effective for dates of service on or after July 1, 2016

Anthem Blue Cross will be implementing changes to our Prior Authorization list for services aligned with the Clinical UM guideline outlined below. All services will require prior authorization regardless of setting.

Please note that these recommendations do not apply to:

- HMO
- Medicare
- Medicare Advantage (MA)
- Federal Employee Program (FEP)
- State Sponsored Business (SSB)
- Selected National accounts.

## CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity

This document addresses surgical procedures for the treatment of scoliosis and other spinal deformities to include spinal fusion, osteotomy, vertebrectomy (as an example, kyphectomy) and associated instrumentation procedures. Spinal fusion refers to the surgical joining of two or more vertebrae at the involved levels of the spine for the treatment of severe or progressive scoliosis and other spinal deformities in children, adolescents and adults. Osteotomy refers to the cutting of a vertebra to facilitate angular correction. Vertebrectomy implies the removal of part or all of a vertebra at the apex of a severe curve. [For full policy, please refer to Clinical UM Guideline: CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity].

CPT Codes: 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22842, 22843, 22844, 22845, 22846, 22847, 22849

**Note:** *If the service is not prior authorized/pre-certified, records will be requested for post service review based on the same criteria listed in the medical policy or clinical guideline.*

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## Specialty pharmacy updates

In order to reduce unexpected post-service claim denials, Anthem Blue Cross will be adding specialty pharmacy drug codes to the Specialty Pharmacy Prior Authorization list. Listed below, are specialty pharmacy drugs from existing medical policies that will be added to our pre-service review process.

All changes referenced in this notification only apply to Local Plan members. Please note that these recommendations do not apply to BlueCard out-of-area, HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program® (FEP), State Sponsored Business (SSB), or selected National accounts.

The changes listed below will become effective on July 1, 2016.

Medical Policy	Drug Name	Drug Code
DRUG.00079 - Bendamustine Hydrochloride	TREANDA®	J9033
DRUG.00080 - Mepolizumab	Cinquil, Nucala®	J3490, J3590

**Note:** If the service is not prior authorized/pre-certified, records will be requested for post service review based on the same criteria listed in the medical policy or clinical guideline.

### Reminder: Pre-service clinical review of specialty pharmacy claims has transitioned to AIM

As providers are aware, the pre-service clinical review of outpatient specialty pharmacy infusion/injectable drugs has transitioned to AIM Specialty Health® (AIM), on behalf of Anthem Blue Cross, for Fully-Insured members as of September 1, 2015. (ASO members will remain with Anthem Blue Cross at this time.)

Providers can contact AIM through the following processes to submit a request for pre-service clinical review:

**Online Requests** – Pre-service clinical review will be available online via AIM through their web-based application which is available twenty-four hours a day, seven days a week. It is fully interactive, processing requests in real-time using clinical criteria. The AIM web-based application may be accessed online through the Availity Web Portal at [www.availity.co](http://www.availity.co)

## Specialty pharmacy program expands to include level of care reviews – Effective July 1, 2016

Anthem Blue Cross (Anthem) is expanding its Specialty Pharmacy program to include a review of the requested level of care for specialty pharmacy infusions.

Anthem is committed to the Institute for Healthcare Improvement (IHI) Triple Aim Initiative -- a framework developed by the IHI that describes an approach to optimizing health system performance using the following dimensions:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care

We recognize that most members prefer to receive their infusions in their physician's office, infusion center or at home through home infusion therapy. This is more convenient for the member, may result in lower member financial responsibility and, in many cases, is a clinically appropriate setting.

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However, there may be circumstances where a member's medical situation requires that he or she receive infusions in a hospital outpatient facility. Therefore, beginning with dates of service on and after July 1, 2016, Anthem will expand the Specialty Pharmacy program to include a review of the requested level of care. A new clinical guideline **Level of Care: Specialty Pharmaceuticals CG-DRUG-47** will apply to the review process for dates of service beginning July 1, 2016. To view the clinical guideline **Level of Care: Specialty Pharmaceuticals CG-DRUG-47**, go to Anthem Blue Cross' website at <https://www.anthem.com/ca/home-providers.html> > Provider > select >Enter> it will take you to the Provider Home page. *Click on Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements* located in the far left column of the page. For quick access select the "Search" tab and enter "CG-Drug 47". The expanded program will continue to be administered by AIM Specialty Health® (AIM), a separate company.

Providers will continue to request authorization for specialty drugs in one of several ways:

- Access AIM *ProviderPortal*<sup>SM</sup> directly at [providerportal.com](http://providerportal.com). Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at [availity.com](http://availity.com)
- Call the AIM Contact Center toll-free number: 1-877-291-0360, Monday through Friday 7:00 a.m. – 5:00 p.m.

For more information on how to access online authorizations via Availity, reference our **AIM Specialty Health Quick Reference Guide** at [anthem.com/ca](http://anthem.com/ca) > Provider > select >Enter> it will take you to the Provider Home page. Scroll down to Self-Service and Support and click on the link [AIM Specialty Health Quick Reference Guide](#).

What's new beginning with dates of service on and after July 1, 2016:

- When providers select a hospital-based outpatient facility as the level of care, a list of alternate locations, such as infusion centers or home infusion providers will be made available. Medical specialty pharmacy providers will also be listed as an alternate option to supply the infusion medication to physician offices who can administer it to the member.
- If an alternate level of care is not selected, providers will be prompted to indicate the reason hospital-based level of care is medically necessary.
- If a request for hospital-based level of care does not meet medical necessity criteria upon review by a physician reviewer, the request will not be approved. We encourage you to discuss with members the lower level of care options, such as physician office, infusion center or home infusion therapy.

The expanded program applies to local Anthem Blue Cross members who have specialty pharmacy services medically managed by AIM Specialty Health. The expanded program **does not** apply to the following plans:

- HMO
- Medicare Advantage
- Medicaid/Medi-Cal
- Medicare Supplement
- BlueCard
- National Accounts
- Federal Employee Program (FEP)

For more information, such as clinical criteria for specialty drugs and level of care, including frequently asked questions go to [www.aimprovider.com/specialtyrx](http://www.aimprovider.com/specialtyrx).

If you have any questions about these changes, please contact us at [CAContractsupport@anthem.com](mailto:CAContractsupport@anthem.com).

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## Update on precertification of cardiovascular services

As a reminder, effective May 1, 2016, Anthem Blue Cross (Anthem) is expanding its cardiovascular program to require precertification for arterial ultrasound, cardiac catheterization, and percutaneous coronary intervention (PCI).

An additional note about the program: arterial duplex imaging of the extremities (codes 93925, 93926, 93930, 93931) will only be reviewed retrospectively. The decision to perform this imaging is generally made while performing physiologic testing. The results of the physiologic testing are required in order to complete the review of duplex imaging. To initiate a retrospective review, please contact AIM within 10 business days of the duplex imaging, but prior to submitting the claim, by calling AIM at **1-800-554-0580**, logging on to the AIM *ProviderPortalSM* at [aimspecialtyhealth.com/goweb](http://aimspecialtyhealth.com/goweb), or accessing via the Availity Web Portal at [availity.com](http://availity.com).

As a reminder, the clinical guidelines for arterial ultrasound, cardiac catheterization, and PCI outlining the clinical criteria for medical necessity are located on [anthem.com/ca](http://anthem.com/ca).

## Reminder of the most recent updates to the Cancer Care Quality Program

### *Attention Oncologists, Hematologists and Urologists*

As a reminder, Anthem Blue Cross' (Anthem) Cancer Care Quality Program ("Program"), a quality initiative, provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways ("Pathways"). Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.

Effective May 1, 2016, Anthem added the following cancer treatment Pathways for the Cancer Care Quality Program.

New Pathways added to the Program include:

- Kidney (renal) cancer treatment pathways
- Non-small Cell Lung Cancer
  - Osimertinib will be added to 2<sup>nd</sup> line therapy for patients with EGFR T790M positive mutation
  - Nivolumab will be added to 2<sup>nd</sup> line therapy for non-squamous histology
- Multiple Myeloma
  - Bortezomib, lenalidomide, plus dexamethasone will be added to 1<sup>st</sup> line therapy
  - Elotuzumab, lenalidomide, plus dexamethasone will be added to 3<sup>rd</sup> and subsequent lines of therapy
  - Daratumumab will be added to 3<sup>rd</sup> and subsequent lines of therapy
- Breast Cancer: Endocrine therapy
  - Letrozole plus palbociclib will be added to 1<sup>st</sup> line therapy for post-menopausal, ER+ or PR+
  - Fulvestrant plus palbociclib will be added to 2<sup>nd</sup> line therapy for post-menopausal, ER+ or PR+
  - Fulvestrant, palbociclib plus ovarian suppression therapy will be added to 1<sup>st</sup> line therapy for pre-menopausal, ER+ or PR+

The following Pathways are moving from "on" pathway to "off" pathway status:

- Multiple Myeloma
  - Melphalan, prednisone, plus bortezomib (MPB) will be removed for 1<sup>st</sup> line/primary therapy in non-transplant candidates

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- Bortezomib monotherapy will be removed for 2<sup>nd</sup> line therapy
- Bortezomib plus dexamethasone will be removed for 2<sup>nd</sup> line therapy
- Carfilzomib will be removed for 3<sup>rd</sup> line therapy

This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members' benefit plans.

The Pathways developed for this Program are intended to support quality cancer care. To access the full Pathways document, go online to [CancerCareQualityProgram.com](http://CancerCareQualityProgram.com), our dedicated provider website.

*Note: Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway.*

## New Residential Treatment Center benefit for FEP®

Blue Cross Blue Shield Service Benefit Plan® also known as Federal Employee Program, has a new Residential Treatment Center benefit effective January 1, 2016. The new benefit provides RTC services with the following requirements:

- FEP members **must be enrolled and participating in case management** prior to RTC admission and remain in case management through post discharge
- Facility must provide a preliminary treatment plan and a discharge plan prior to admission.
- Care must be medically necessary for treatment of a mental health, substance abuse or medical condition
- Precertification must be obtained prior to admission or the entire admission is denied as non-covered
- The Residential Treatment Center must be licensed and accredited.

*Note: If the above requirements are not met prior to the admission, the entire Residential stay will not be covered.*

Additional information can be found in the Service Benefit Plan Brochure located at [www.fepblue.org](http://www.fepblue.org) or call FEP Customer Service at 1-800-284-9093.

## Revisions to 2016 coverage of mental health, substance use disorder benefits

Anthem Blue Cross (Anthem) has revised some mental health and substance use disorder benefits within currently effective individual, small group, and large group plans effective January 1, 2016. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and California Health and Safety Code section 1374.76 and Covered California regulations require these changes<sup>1</sup>. The revisions likely represent changes from information you or your patients have already received on cost-sharing, treatment limits, and evidence of coverage (EOC) disclosures regarding Anthem's mental health and substance use disorder benefits.

### Revisions to Cost-Sharing

Some cost-sharing for certain mental health and substance use disorder services have changed. When your office contacts Anthem to determine patient cost-sharing amounts, our cost-sharing database will reflect these cost-sharing changes. If you have questions about the correct cost-sharing amount to collect or bill for the type of mental health or substance use disorder services rendered, please login to Availability at [availability.com](http://availability.com) or call the toll-free phone number on the back of the patient's identification (ID) card.

### Revisions to EOCs Concerning Mental Health and Substance Use Disorder Services

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Anthem has also revised EOCs with any cost-sharing changes and text to clarify the types of inpatient and outpatient services and treatment that Anthem provides for mental health and substance use. The most significant text changes can be found in the following EOC sections: Benefits Summary, Mental Health and Substance Abuse (Chemical Dependency) Services, Inpatient Facility Services and Outpatient Facility Services, Out of Network, and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.

### Revisions to Benefit Plans

- Removed the \$350 out of network outpatient benefit maximum in the following large group plans: Premier Plus, Premier, Classic PPO, and Solutions PPO.
- We made cost sharing changes to the following small group plans, primarily by removing the Out of Network Outpatient Facility Benefit Maximum: Platinum Select PPO, Gold Select PPO, Silver Select PPO, Bronze Select PPO, Gold Advantage PPO Silver Advantage PPO
- Changes for individual plans include:
  - Increased or added a Deductible for Inpatient Mental Health or Substance Abuse Facilities in our Bronze 60 PPO and Silver 94 PPO.
  - Changed the Coinsurance to a Copayment or increased the Copayment for Outpatient Facility Mental Health and Substance Use disorder services in our Bronze 60 PPO, Gold 80 HMO, Gold 80 PPO, Platinum 90 HMO, Platinum 90 PPO, Silver 70 HMO, Silver 70 PPO, Silver 73 HMO, Silver 73 PPO, Silver 87 HMO, Silver 87 PPO, Silver 94 HMO, and Silver 94 PPO.
  - Increased the Office Visit Copayment for the Bronze 60 PPO, Gold 80 PPO, Gold 80 HMO, Silver 94 HMO, and Silver 94 PPO.

### Questions? Help is Available

- Login to [availity.com](http://availity.com) to verify benefits and eligibility.
- Questions about these revisions, to get a copy of an EOC or policy and procedure, or would like more information about Anthem's coverage of mental health and substance use disorder services, please call toll-free the number on the back of the patient's ID card.
- General Behavioral Health questions about your Agreement (contract) or fee schedule, can be emailed to [BHNetworks@anthem.com](mailto:BHNetworks@anthem.com).

1. Government Code sections 100503 and 100504(c), Health and Safety Code section 1366.6(e), and 10 CCR section 6460.

### Update to Self-Insured Schools of California (SISC) member benefits

Beginning April 1, 2016, SISC members will have access to a new benefit called Grand Rounds. Their services include connecting patients to in-network local physicians and facilitating remote consultations with world-leading experts.

Grand Rounds was founded by [Dr. Rusty Hofmann](#) after his son survived aplastic anemia and bone marrow failure. He was able to get guidance from the country's experts, and the treatment ultimately saved his life. The mission of Grand Rounds is to provide patients with this type of access and care, regardless of who they know. Dr. Hofmann's story has been featured in [Fortune](#) and the [Huffington Post](#).

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Grand Rounds handles all of the logistics for patients and for physicians. They schedule appointments and ensure that patients are matched to a provider's precise area of expertise. To save your office time, they will gather and forward all relevant medical records for your review before a visit. Grand Rounds' mission is to make sure that members receive the best possible care, which means enabling you to do top-quality work.

Grand Rounds is fully sponsored by SISC, so their services are free for members and covered dependents. The Grand Rounds service is an independently administered benefit that is offered outside of health benefit plan.

In situations where a SISC member will benefit from a consultation and additional guidance for their care, you may refer them to Grand Rounds. As their treating physician, you can be invited to participate in the entire process. Members can visit [www.grandrounds.com/sisc](http://www.grandrounds.com/sisc) or call 1-844-252-3056 to get started. In addition, your HMO members continue to be entitled to a second opinion pursuant to Health & Safety Code Section 1383.15.

## Anthem Blue Cross 2016 HMO Manual

We are pleased to announce the release of the *Anthem Blue Cross 2016 HMO Manual*. For easy access and navigation the manual was copied to a CD. The CD's were mailed on February 29, 2016, with an effective date of **June 6, 2016**. This effective date allows a 90 day notification.

In this Manual, you will find important updates including, *Availity Web Portal (Availity)*, *Performance Data*, *SB-866 Prior Authorization form*, *Coordination of Care Form and Letter Templates*, *Covered Individual (Patient) Responsibility Agreement- Waiver Form* and *Prescription Drug Prior Authorization Request Form*.

For a list of changes, refer to the "*Summary of Material Changes*" section within the Manual CD.

- How to use the CD or request additional copies, email [prov.communications@anthem.com](mailto:prov.communications@anthem.com) or fax to 1-818-234-8959

This Manual is also available online through Anthem Blue Cross' ProviderAccess website for physicians, hospitals and health care professionals that provide services to Anthem Blue Cross Covered Individuals. ProviderAccess links you to financial reports and brings health information, medical policies and more, right to your computer. Go to <https://provider2.anthem.com/wps/portal/ebpmybcc> to login.

- ProviderAccess support - email [provideraccess.pins@anthem.com](mailto:provideraccess.pins@anthem.com) or call 1-866-755-2680.

## Important reminders about providing services to out-of-state BCBS Medicaid members

The [February 2016 edition of the Network Update](#) indicated that Anthem Blue Cross will begin mailing letters to providers when additional information is needed in order to process out-of-state Medicaid claims that are administered by a Blue Cross and Blue Shield (BCBS) health plan. Additional information may require the provider to enroll in the out-of-state member's state Medicaid program, or provide missing Medicaid encounter data. Mailed letters will begin April 18, 2016.

The following frequently asked questions provide additional detail about Medicaid provider enrollment and the billing and reimbursement of claims for out-of-state BCBS Medicaid members:

### Why are providers required to enroll in some out-of-state Medicaid plans?

At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Medicaid is a state-run program, and requirements vary for each state, and thus each BCBS Plan. Some states require providers to enroll in their state Medicaid program in order to be reimbursed for claims for the out-of-state Medicaid member.

If you are required to enroll in another state's Medicaid program in order to be reimbursed, you should receive notification of this requirement when verifying eligibility and benefits for the member. Providers should enroll in the state's Medicaid program before submitting a claim for an out-of-state BCBS Medicaid member to avoid delays in processing.

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To view provider enrollment requirements for each state, visit [Medicaid.gov](http://Medicaid.gov).

### Which states currently require provider enrollment?

Currently, the following states require provider enrollment: Indiana, Kentucky, Pennsylvania, South Carolina, Tennessee and Virginia. Please note this list is subject to change, so it is important to always confirm if provider enrollment is required when verifying eligibility and benefits for Medicaid members.

### What happens if a provider submits a claim for a Medicaid plan that requires provider enrollment, and the provider is not enrolled in the member's state Medicaid program?

If a provider submits a claim for an out-of-state BCBS Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. Beginning April 18, 2016, Anthem Blue Cross will send the provider a letter with information about how to enroll in the member's state Medicaid program online. If the provider does not enroll in the member's state Medicaid plan, the state law may require the member be held harmless.

### How can providers identify an out-of-state BCBS Medicaid member?

Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. BCBS Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most BCBS ID cards, but will contain disclaimer language on the back of the ID card indicating benefit limitations. For example, a card may read, "*This member has limited benefits outside of California*". Providers should always verify eligibility and benefits for these members.

### How should providers submit a claim for an out-of-state BCBS Medicaid member?

Claims should be submitted to Anthem Blue Cross in the same way you would submit a claim for other BCBS members.

### What data elements should be included on the claim for a BCBS Medicaid member?

Providers can check the Medicaid website of the state where the member resides for specific information on Medicaid billing requirements, however, the following data elements should be submitted, when applicable.

Medicaid claims submitted without these data elements will be denied:

- National Drug Code (situational)
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- |   |  |
|---|--|
| ○ Billing Provider (Second) Address Line                          | ○ Ordering Provider Identifier and Identification Code Qualifier   |
| ○ Billing Provider Middle Name or Initial                         | ○ Attending Provider NPI   |
| ○ (Billing) Provider Taxonomy Code                                | ○ Operating Physician NPI  |
| ○ (Rendering) Provider Taxonomy Code                              | ○ Claim or Line Note Text  |
| ○ (Service) Laboratory or Facility Postal Zone or Zip Code        | ○ Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT)) |
| ○ (Ambulance) Transport Distance                                  | ○ Service Facility Name and Location Information   |
| ○ (Service) Laboratory Facility Name                              | ○ Ambulance Transport Information  |
| ○ (Service) Laboratory or Facility State or Province Code         | ○ Patient Weight   |
| ○ Value Code Amount   | ○ Ambulance Transport Reason Code  |
| ○ Value Code  | ○ Round Trip Purpose Description   |
| ○ Condition Code  | ○ Stretcher Purpose Description  |
| ○ Occurrence Codes and Date                                       |  |
| ○ Occurrence Span Codes and Dates                                 |  |
| ○ Referring Provider Identifier and Identification Code Qualifier |  |

### **How will providers be paid for services rendered to an out-of-state BCBS Medicaid member?**

Providers receive payment on their Anthem Blue Cross remittance. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state, which may or may not be equal to what you are accustomed to receiving for the same service in your state. Billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations ([42 CFR 447.15](#)).

You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's plan. You may collect this amount from the member as applicable.

Note that the coinsurance amount is based on the member's state Medicaid fee schedule for that service.

### **Which states have Medicaid programs administered by a Blue Cross and Blue Shield Plan?**

Blue Cross and Blue Shield (BCBS) Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia and Wisconsin as a Managed Care Organization (MCO).

### **Misrouted protected health information (PHI)**

Providers and facilities are required to review all member information received from Anthem Blue Cross (Anthem) to help ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy 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, providers and facilities must contact Anthem's provider services area to report receipt of misrouted PHI.



# Billing

## Action required: Medical providers accepting Workers' Compensation patients

According to the California Department of Workers Compensation, as authorized by California Code of Medical Provider Network (MPN) Regulations Title 8 Chapter 4.5 Subchapter 1 Article 3.5 Section 9767.5.1, an "MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN." MPNs have the exclusive right per California Labor Code 4616 (d) to determine the members of their MPN, however licensed physicians must acknowledge that MPN participation.

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem's Provider Affirmation Portal, go online to the Provider Affirmation Portal to view a complete listing of the MPNs that have selected you for participation in their MPN. Go to [Availity](#) and login. Click on Payer Resources at the top and look for the link to the Anthem Workers Compensation MPN Provider Affirmation Portal. If the MPN Applicant (insurance carrier, self-insured employer, Entities Providing Physician Network Services) has selected you to participate in their MPN, you will find their MPN(s) listed. There you can also affirm participation by simply viewing the page and clicking "submit" at the bottom of the page. You also have an option to "opt out" of each MPN as well.

If you cannot go online, call Anthem Workers' Compensation at 866-700-2168 and we can take action on your behalf in the Provider Affirmation Portal. The regulations (§9767.5.1) allow the physician, an employee of the physician, or if authorized by the physician(s), an agent or representative of a medical group to take action on behalf of a medical provider.

## Contracted provider claim escalation process

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

Our Network Relations Team is available by e-mail at [CAContractSupport@anthem.com](mailto:CAContractSupport@anthem.com) to answer questions you have about the process, if you need clarification.

# Network

## Webinars – The Department of Health Services (DHS) shares information on Opioid abuse

Anthem Blue Cross would like to share some information from the U.S. Department of Health & Human Services that recently published [an overview of the opioid abuse epidemic](#), including information on abuse prevention, treatment for addiction, and responding to an overdose. Additional information on this topic can be found in this recent [White House memorandum](#).

The California Health Care Foundation (CHCF) is sponsoring several educational webinars to share specific resources and strategies to minimize the impact of the opioid epidemic in California. We think some of these will be helpful to our various SafeMedLA Action Teams and hope you will consider participating – below are dates/times and more details.

### Upcoming Webinars:

**April 14** From 12:30-1:30 Learn how to [understand and use prescription and public health data](#). Steve Wirtz Ph.D., California Department of Public Health and Peter Kreiner, Ph.D., Brandeis PDMP (Prescription Drug Monitoring Program) Center of Excellence, will cover where to find data, what the data can and can't tell us, and how to look for trends, with opportunity for questions and discussion.

**April 28** From 12-1:30 Hear about how to [expand access to buprenorphine in primary care practices](#). James Gasper, PharmD, BCPP, Barbara Masters, MA, and Mary Rainwater, LCSW review findings from a new publication: the case for buprenorphine in primary care, key elements for success, and model programs.

**May 11** From 12-1:30 Learn [how to use LiveStories](#) - a software platform that can help you tell compelling stories with pictures, text, data, and heat maps. See [example](#) from RxSafeMarin.

**May 25** From 12-1:30 Learn how to use the data stories you build to [create a campaign](#) that can inform and educate the public, journalists, and decision-makers.

## New requirements for credentialing and certification effective July 1, 2016

Effective July 1, 2016, we will require credentialing for several additional practitioner and health delivery organization (HDO) provider types when those provider types are contracted by Anthem Blue Cross (Anthem). Credentialing involves verification of basic professional conduct and competency criteria including licensure, education and training and sanction activity. Each provider's application will be reviewed by a local credentialing committee or medical director for approval; re-credentialing will occur every three years thereafter.

We will apply these new credentialing requirements to new providers effective July 1, 2016, and a roll-out a plan to credential existing participating providers will begin in July.

Following are the new practitioner and HDO provider types that will require credentialing effective July 1, 2016:

### Practitioner provider types:

- Licensed genetic counselors
- Audiologists
- Acupuncturists (non-medical doctors (MD) or doctors of osteopathic medicine (DO))
- Nurse practitioners, certified nurse midwives and physician assistants

# Professional Network Update

- Registered dietitians

Credentialing will be required for the above practitioners when they are:

- Contracted independently
- contracted at a group practice level and are listed in our directories
- licensed by the state to practice independently

#### HDO provider types:

- Behavioral health facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community mental health centers (CMHC)
  - Crisis stabilization units
  - Intensive family intervention services
  - Intensive outpatient – mental health and/or substance abuse
  - Methadone maintenance clinics
  - Outpatient mental health clinics
  - Outpatient substance abuse clinics
  - Partial hospitalization – mental health and/or substance abuse
  - Residential treatment centers (RTC) – psychiatric and/or substance abuse
- Birthing centers
- Convenient care centers/retail health clinics/walk-in clinics
- Federally qualified health centers (FQHC)
- Intermediate care facilities
- Home infusion therapy
- Rural health clinics
- Urgent care centers

Credentialing will be required for the above HDOs when they are contracted independently by us today or are listed in our directories. (Note that the updated Provider Manual will have a list of HDO types and the corresponding accrediting agencies approved by Anthem.)

#### How to get started

Based on your provider type you will either use the Council for Affordable Quality Healthcare's (CAQH) ProView online service or complete and return a health delivery organization (HDO) application along with required attachments, as explained below\*.

If contracted today independently or listed in our directories, the following providers must use CAQH's ProView.

- Licensed genetic counselors
- Audiologists
- Acupuncturists (non-medical doctors (MD) or doctors of osteopathic medicine (DO))
- Nurse practitioners, certified nurse midwives and physician assistants

ProView is a free, online service that allows health care providers to fill out **one** application to meet the credentialing data needs of multiple organizations. ProView allows healthcare providers to:

- Complete and attest to multiple state credentialing applications in *one* workflow design
- Upload supporting documents directly into ProView to eliminate the need for manual submission and to improve the timeliness of completed applications
- Review and approve practice manager information
- Self-register with the system before a health plan initiates the application process

If you are already using CAQH, please keep your application updated so there is no delay in the credentialing process and your provider directory listing. We will take care of adding you to our CAQH Roster. If you don't currently use CAQH's Global Authorization, please be sure to authorize Anthem to view your credentials.

If you don't currently use CAQH, you may self-register with CAQH at [www.caqh.org](http://www.caqh.org). For questions about CAQH ProView, please contact the CAQH ProView Support Desk:

E-mail: [providerhelp@ProView.CAQH.org](mailto:providerhelp@ProView.CAQH.org)

Phone: 1-888-599-1771

\*HDO and facility providers will not use the Practitioner CAQH ProView application process referenced above. These providers should complete the Health Delivery Organization/Facility Application which will be located at [anthem.com/ca](http://anthem.com/ca) > Providers > Answers@Anthem > Forms.

### Certification Process

In addition to the change in the provider scope for credentialing, we will begin to verify certifications and licensure, as applicable, for the following provider types when contracted as part of a certification review process:

- Certified behavioral analysts
- Certified addiction counselor
- Substance abuse practitioners
- Clinical laboratories
- End stage renal disease (ESRD) service providers (dialysis facilities)
- Portable x-ray suppliers

The certification process will include a review of licensure or certifications, such as Medicare or CLIA, and a review of any federal sanctions. The Credentialing team looks forward to working with you.

### Updates to Blue Physician Recognition program

Anthem Blue Cross (Anthem) is committed to providing members with the tools they need to effectively partner with their doctors and make more informed health care choices. As part of that effort, Anthem is pleased to participate in the Blue Cross and Blue Shield Association's consumer engagement initiative.

The Blue Physician Recognition (*BPR*) Program is designed to reinforce Blue Plans' commitment to quality by providing more meaningful and consistent information on physician quality improvement and recognition on the [Blue National Doctor & Hospital Finder](http://BlueNationalDoctor&HospitalFinder.com) site and on Anthem's online provider directories. A BPR indicator is used to identify physicians, groups and/or practices who have demonstrated their commitment to delivering quality and patient-centered care by participating in local, national, and/or regional quality improvement programs as determined by the local Blue Plan.

# Professional Network Update



Anthem recognizes primary care physicians practicing in the specialties of Family Practice, Internal Medicine and General Practice with a BPR designation if they have achieved recognition from either the National Committee for Quality Assurance (NCQA) or Bridges to Excellence (BTE) based on their successful completion of a care recognition program. Information regarding these recognition programs can be found at <http://www.ncqa.org> or <http://www.hci3.org>.

At a minimum, we will update these recognitions annually to reflect the current status as identified by the Blue Cross and Blue Shield Association's Quality Recognition Extract.

If you have questions regarding the update, please contact your network contracting representative.

## Anthem Blue Cross: "Find a doctor tool"

The [Find a Doctor](#) tool at Anthem Blue Cross is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To ensure Anthem has the most current and accurate information, please take a moment to access the Provider Finder tool ([www.anthem.com/ca](http://www.anthem.com/ca)) and review how you and your practice are being displayed. To report discrepancies please contact Anthem by sending an email to [ProviderDatabaseAnthem@anthem.com](mailto:ProviderDatabaseAnthem@anthem.com).

## Providers update your Anthem Blue Cross provider demographic information via the Availity Web Portal

You can now submit on-line changes for your practice profile (i.e. address changes, name change, tax ID changes, provider leaving a group, phone/fax numbers, directory listings for medical groups, physicians/other healthcare professionals, opening/closing a practice location, etc.) using the electronic **Provider Maintenance Form** which now can be found under the: *Payer Resources Page / Anthem / Physician Change Requests / Provider Maintenance Form* on the Availity Web Portal Main Menu.

Please note that your Provider Agreement requires that any change in your practice must be reported to Anthem Blue Cross within ten (10) days of the change.

- Any request to update provider demographic or practice information may take up to 20 days to be reflected in Provider Finder.
- Contractual agreement guidelines may supersede effective date of request
- Please provide 120 days' prior notice for contract termination requests
- You will receive an auto-reply e-mail acknowledging receipt of your request

## Anthem Blue Cross cost transparency

As an Anthem Blue Cross (Anthem) participating provider, you may have received our recent 2015 correspondence, or read the articles in our September, November or February Network Updates on Anthem Cost Transparency. In response to consumer demand for transparency in health care costs, Anthem released *Estimate Your Costs*, a tool available to members on our [anthem.com](http://anthem.com) website that includes functionality allowing members to estimate their out-of-pocket impact and view the estimated costs for many procedures.

We also enclosed summary of the methodology used to generate the cost information housed in the National Consumer Cost Tool (NCCT), the source data used to display costs in *Estimate Your Costs*. The treatment categories for which costs are displayed and the methodology are defined by the Blue Cross Blue Shield Association. As indicated in the correspondence, NCCT cost data is updated twice annually; the most recent update just completed in November last year, and the next update scheduled for May 2016. Please look for more information in our 2016 provider newsletters posted to [anthem.com/ca](http://anthem.com/ca).

# Professional Network Update

We are pleased to announce that starting with the November 2015 refresh participating Anthem provider costs are now available in a secure section of the Availity provider portal. Authorized representatives of participating facilities and professional practices can login to Availity at [availity.com](http://availity.com), and register to view the costs for their facility or practice. Costs will be made available to our participating providers no less than 30 days before they become available to our members on [anthem.com/ca](http://anthem.com/ca) in the *Estimate Your Costs* function.

Should you wish to review the methodology, you may request a copy by sending an e-mail request to the Anthem California contract support team at [CAContractSupport@anthem.com](mailto:CAContractSupport@anthem.com).

## Sign-up now for our *Network eUPDATE* today – it's free!

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our *Network eUPDATES*.

*Network eUPDATE* is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates
- System changes
- Fee Schedules
- Medical policy updates
- Claims and billing updates
- .....and much more



[Registration](#) is fast and easy. There is no limit to the number of subscribers who can register for *Network eUPDATES*, so you can submit as many e-mail addresses as you like.

## Network leasing arrangements

Anthem Blue Cross (Anthem) has network leasing arrangements with a variety of organizations, which we call *Other Payors*. Other payors and affiliates use the Anthem network.

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem members. As such, they're entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payors* list on ProviderAccess®, which can be accessed through the Anthem website at [www.anthem.com/ca](http://www.anthem.com/ca). If you don't have internet access, please contact us at 1-855-238-0095 for assistance.

# Professional Network Update

# Guidelines and Quality Programs

## HEDIS® 2016: Comprehensive diabetes care – eye exam

One of the measures we collect is the Comprehensive Diabetes Care measure. This measure focuses on ensuring that our diabetic members (type 1 and type 2) who are between the ages of 18 to 75 are receiving appropriate testing and care. One of the indicators for this measure is ensuring that our diabetic members are receiving annual eye exams:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2015 –OR--
- A *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional in 2014

Documentation in the member's medical record must include **one** of the following:

1. A note or letter prepared by an ophthalmologist, optometrist, PCP, or other health care professional indicating that an ophthalmoscopic exam was completed:
  - By an eye care professional
  - Date of when the procedure was performed
  - The results
2. A chart or photograph of retinal abnormalities indicating:
  - Date when the fundus photography was performed
  - Evidence that an eye care professional reviewed the results
3. Documentation
  - Negative retinal or dilated exam by an eye care professional in 2014
  - Where results indicated retinopathy was not present

**We have found that documentation from the Eye Care Provider is sometimes missing in the PCP record. This may be because the member has gone to an Out of Network Eye Care Provider or may not have been referred for an annual eye exam. Our 2014 results show that on average, less than 50% of our diabetic members are getting annual eye exams, particularly in our Central & West States. We encourage you to refer our diabetic members for annual eye exams and request the records from the Eye Care Provider.**

For more information on HEDIS, go to the "Provider" home page at [anthem.com/ca](http://anthem.com/ca). Click on the "Provider" link at the top of the landing page (under the "Other Anthem Websites" section). Select your state and click enter. On the Provider home page under the Health and Wellness tab (on the blue toolbar) select the Quality Improvement and Standards link, then scroll down to "HEDIS Information".

Thank you for your continued cooperation and support of HEDIS.

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

## Required Behavioral Health follow-ups

Every year, the National Committee for Quality Assurance (NCQA) requires health plans to collect Healthcare Effectiveness Data and Information Set (HEDIS®) quality outcome measures and report the rates. These rates can then be used by individuals and employer groups to make health plan membership decisions. Within the behavioral health area, there are three measures that are evaluated based on claims/encounter documentation that providers submit to the health plan.

HEDIS Measure	Why is the Measure Important	Follow-up Time Periods
<b>Follow-up Care for Children Prescribed ADHD Medication (ADD):</b> The percentage of children <i>newly prescribed</i> attention deficit/hyperactivity disorder (ADHD) medication who had <i>at least three follow-up care visits</i> within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Patients need to be monitored regularly in face to face visits to make sure that they are receiving the right treatment and that the child's condition is being managed.	<i>Initiation Phase:</i> Within 30 days of receiving medication  <i>Continuation and Maintenance:</i> At least 2 visits between 30 day initiation and 270 days (9 months) after initiation
<b>Antidepressant Medication Management (AMM):</b> The percentage of members 18 years of age and older who were <i>treated with</i> antidepressant medication, had a <i>diagnosis of major depression and who remained on an antidepressant medication treatment.</i>	Patients may show improvement within two weeks of initiating antidepressants, but they may need longer to demonstrate full response. The likelihood of response to treatment increases if there is follow-up contact within three months of diagnosis or initiation of treatment. Most people who are treated for an initial depression episode may need to stay on medications for at least six to twelve months.	Those who remained on antidepressant medication: <ul style="list-style-type: none"> <li>• For at least 84 days (12 weeks)</li> <li>• For at least 180 days (6 months)</li> </ul>
<b>Follow-up After Hospitalization for Mental Illness (FUH):</b> The percentage of discharges for members 6 years of age and older who were <i>hospitalized</i> for treatment of selected mental illness diagnoses <b>and</b> who had an <i>outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.</i>	Access to follow-up care with a mental health provider within 7 days of hospital discharge for mental illness is a strong predictor of a reduction in hospital readmission. The facility might help stabilize the patient with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend the improvement outside of the hospital. Ensuring that there is continued care outside of the hospital and compliance with outpatient follow-up care can help detect post-hospital problems early and can provide continued support that helps to improve the treatment outcomes and reduces health care costs.	Within 7 days after hospital discharge  Within 30 days after hospital discharge

### Anthem is helping

- The Pharmacy team sends educational materials on depression and ADHD treatment to members who have recently initiated medication therapy.
- The Pharmacy team provides refill reminder notifications for depression medications.
- The Behavioral Health Care Management team can assist with any appointment scheduling or modifications, remind patients of their scheduled appointment, and support any ongoing case management needs.

# Professional Network Update

## How you can help

- Ensure that a claim or encounter is submitted for all monitoring and follow-up appointments and services and the dates of service are clearly indicated.
- Educate your patients on the importance of follow-up visits and the importance of continuing the prescribed medication(s) even if they are feeling better, as well as the importance of notifying you of any side effects.
- If a patient needs assistance finding a behavioral health provider, they can call Anthem or look on [www.anthem.com](http://www.anthem.com), "Find a Doctor" tool. Your patients may also request case management assistance.
- For individuals who have been admitted to the hospital, connect with them and start the discharging planning early including making sure that a follow-up appointment with a behavioral health provider has been scheduled prior to discharge.
- Coordinate with the patient's support system including family members.
- Routinely use depression assessment tools, such as the PHQ-9 (Patient Health Questionnaire), as a tool to support follow-up discussions, which can include screening for medication side effects and reinforcing treatment expectations.
- Use the Vanderbilt Assessment Scales, developed through the Attention Deficit Hyperactivity Disorder (ADHD) Collaborative as a tool to drive ADHD discussion and follow-up. The Vanderbilt Assessment scales are available & can be downloaded from the National Institute for Children's Health Quality (NICHQ) website: <http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales>. An ADHD resource tool kit is also available: <http://www.nichq.org/childrens-health/adhd/resources/adhd-toolkit>.

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

## Clinical practice and preventive health guidelines available on the Web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to the "Provider" home page at [anthem.com/ca](http://anthem.com/ca). From there, select "Provider" and your state > then Health & Wellness > Practice Guidelines.

## ConditionCare Program benefits patients and physicians

Anthem Blue Cross members have additional resources available to help them better manage chronic conditions. The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

### Engagement methods vary by risk level but can include:

- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Coaches and other health professionals.

### Physician benefits:

- **Save time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.

# Professional Network Update

- **Inform** the physician with updates and reports on the patient's progress in the program.

Please visit the [anthem.com/ca](http://anthem.com/ca) website to find more information about the program such as program guidelines, educational materials and other resources. Also on our website is the **Patient Referral Form**, which you can use to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call 1-877-681-6694. Our nurses are available Monday-Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 5:30 p.m.

# Medi-Cal Managed Care Updates

## MAY is Asthma Awareness Month

Did you know that one in 12 people in California have asthma? You and your staff can help mitigate symptoms with some simple suggestions.

May is Asthma Awareness Month; here are some ideas for your office:

- **Remind** your patients about the importance of refilling and taking their controller medications daily.
- **Evaluate** and follow asthma treatment efficacy by conducting spirometry testing once a year.
- **Order and place** asthma educational materials in your office such as posters, coloring books and member hand-outs. These can be placed in waiting or patient rooms. You can call your local Anthem Blue Cross Regional office for member education materials on asthma at no cost.

**Formulary Reminder:** Advair is non-formulary for Anthem Blue Cross Medi-Cal Managed Care (Medi-Cal) patients, except those with COPD. Dulera, Montelukast, and Symbicort are the preferred ICS/LABA combinations for asthma treatment. If a patient cannot use the preferred Symbicort or Dulera, the doctor can submit a *prior-authorization* form explaining these reasons. The phone number for Medi-Cal prior authorizations is: **1-866-363-4126**.

For additional information on asthma and for educational materials visit the following websites:

Centers for Disease Control and Prevention:

[www.cdc.gov/publications](http://www.cdc.gov/publications)  
[www.cdc.gov/asthma/](http://www.cdc.gov/asthma/)  
[www.cdc.gov/asthma/world\\_asthma\\_day.htm](http://www.cdc.gov/asthma/world_asthma_day.htm)

American Lung Association:

[www.lung.org](http://www.lung.org)

Asthma and Allergy Foundation of America:

[www.aafa.org](http://www.aafa.org)

American Academy of Allergy, Asthma & Immunology:

[www.aaaai.org/home.aspx](http://www.aaaai.org/home.aspx)

## Black Infant Health 2016 focus for California Department of Public Health

Infant mortality is considered an indicator for maternal, child, and community health. Over the past century, there have been incredible improvements made in birth outcomes, yet infants born to African-American women continue to die at over two times the rate of infants born to white women.

The California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) Division's Black Infant Health Program is requesting assistance from providers in recruiting eligible African-American women into the program. The CDPH/MCAH recommends that BIH be the top priority for enrolling self-identified African-American women who are over 18 and up to 26 weeks gestation. The BIH Program aims to improve health among African-American mothers and babies by reducing the Black/White disparities by helping women become empowered to make healthy choices for themselves, their families and their communities.

This program uses a group-based approach with complementary participant-centered case management to help pregnant and parenting women develop life skills, set and attain health goals, learn strategies to manage stress and build social support, and to develop a longer-term life plan that can guide her continued progress after BIH.

# Professional Network Update

Each BIH Local Health Jurisdiction (LHJ) is staffed with a Community Outreach Liaison (COL) dedicated to recruitment and outreach activities. Staff can refer potential participants to BIH by contacting the COL in their jurisdiction at the following link (note: not every county has a BIH program, so contact the county program that is closest to your area).

<http://www.cdph.ca.gov/programs/bih/Pages/BlackInfantHealthCoordinatorDirectory.aspx>

Additional information about the BIH program is located at:

<http://www.cdph.ca.gov/programs/bih/Documents/Profile%20BIH.pdf>

If you have any questions, please contact Robin Qualls, at (916) 650-0385.

**Source:** State of California—Health and Human Services Agency California Department of Public Health (Medi-Cal Managed Care Health Plan Letter dated 12/24/15).

## Free language assistance program

Our members count on you for medical care and treatment; but, they may experience language barriers that make it difficult to ask questions or communicate concerns. Anthem Blue Cross (Anthem) is committed to reducing the impact of language barriers on quality health care, so we make it easy for our members and your patients to obtain language assistance.

### Telephonic Interpreters

During business hours, providers and members can call the Anthem's Customer Care Center using the number located on the back of the member's ID card. After-hours, they can call the 24/7 NurseLine at 1-800-224-0336. When requesting interpreter assistance:

- Give the customer care associate the member's ID number.
- Explain the need for an interpreter and state the language.
- Wait on the line while the connection is made.
- Once connected to the interpreter, the Anthem associate or Nurse introduces the Anthem member, explains the reason for the call, and begins the dialogue.

### Face-to-Face Interpreters Including Sign Language

Providers and members may call the Customer Care Center to schedule face-to-face interpreter services for medical appointments during business hours. Seventy-two business hours (3 business days) are required to schedule services, and 24 business hours are required to cancel. Providers may also schedule by e-mailing [ssp.interpret@anthem.com](mailto:ssp.interpret@anthem.com). Registration with our secure e-mail is required. Please type "secure" in the subject line.

### Members with Hearing Loss or Speech Impairment

Members with hearing and/or speech impairments can use the Customer Call Center TTY number during regular business hours, and after-hours the 24-hour NurseLine TTY number can be used. In addition, members can also use the state Relay Service Line (dial 711). Customer Care Associates can also assist non-TTY users in contacting those who only utilize TTY equipment, such as provider offices needing to contact members with TTY assistive devices.

### Translation of Materials

Members can request health plan materials in alternative formats such as Braille, large print, audio CD, verbal interpretations, and non-English languages at no cost by contacting the Customer Service number on the back of their ID card.

# Professional Network Update



## New updated Health Education referral form

Anthem Blue Cross (Anthem) is committed to supporting the needs of our diverse members and helping deliver culturally and linguistically appropriate health care services. As a result, we have updated our Health Education referral form to include Cultural and Linguistic referral requests. Health education classes are available at no charge to Anthem members enrolled in Medi-Cal and are accessible upon self-referral or referral by Anthem network providers. If assistance is needed finding cultural and/or linguistic support for a member to assist with his or her health care, please complete the Cultural and Linguistic request section of the referral form with specific information identifying the members' cultural and linguistic need(s) and what services are being sought.

**Health Education Class availability varies by County. Topics include:**

- Asthma Management
- Childbirth/Lamaze/Prenatal Education
- Diabetes Management
- Injury Prevention
- Nutrition
- Parenting/Well Child
- Tobacco Cessation/Prevention
- Substance Abuse

To refer a member for cultural and linguistic services or to a health education class, please use the Health Education & Cultural and Linguistic Referral Form available at: [https://mediproviders.anthem.com/Documents/CACA\\_CAID\\_HealthEdReferralForm.pdf](https://mediproviders.anthem.com/Documents/CACA_CAID_HealthEdReferralForm.pdf)

Please fax this form to 1-818-240-1206 or email to [HealthEd\\_CA\\_Medicaid@Anthem.com](mailto:HealthEd_CA_Medicaid@Anthem.com)

Attention: Health Education

## Staying Healthy Assessment Tool (SHA)

The Staying Healthy Assessment (SHA) is the Department of Health Care Services' (DHCS's) Individual Health Education Behavior Assessment (IHEBA). Providers are required to administer the SHA to all Medi-Cal beneficiaries as part of the Initial Health Assessment (IHA) and periodically re-administer it according to the SHA periodicity chart. Annual reviews of existing SHAs and counseling are required at subsequent periodic exams.

The goals of an IHEBA, and as such the SHA, are to identify and track patient high-risk behaviors; prioritize patient health education needs; and initiate discussion and counseling on prioritized high risk behaviors related to lifestyle, behavior, environment, culture and language. Based upon a patient's behavioral risks and willingness to make lifestyle changes, Primary Care Physicians (PCPs) should provide tailored health education counseling, intervention, referral and follow-up.

**To obtain SHA Assessment Forms:**

The most current SHA assessment forms dated 12/2014 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> as well as <https://mediproviders.anthem.com/ca/pages/staying-healthy-assessment.aspx>. If your office is using outdated forms, please discard and use the most current version. To request hard copies

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of the SHA assessment forms, including electronic versions of the assessment forms in Farsi or Khmer, please contact your local Regional Health Plan.

To complete the online training please visit: <http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx>. Locate the "SHA Resources" header and click on the Provider Training to begin viewing.

### Requirements for Using the Staying Healthy Assessment Tool In an Electronic Format

If providers would like to use the SHA in *an electronic format or use another assessment tool*, they will need to notify their local Regional Health Plan prior to implementation.

Anthem Blue Cross (Anthem) staff will:

- Work with your office and review printed screen shots of the SHA electronic or other assessment tool.
- Fill out the required *SHA Electronic or Other Format Notification Form*.
- Submit the notification form along with the printed screen shots to DHCS. The state requires Anthem Blue Cross Medi-Cal Managed Care (and other Medi-Cal Managed Care health plans) to provide at least a month's notice prior to provider implementation.

### Tobacco cessation requirements

Anthem Blue Cross (Anthem) is responsible for ensuring that PCPs and their qualified staff implement the interventions outlined in MMCD Policy Letter 14-006.

1. Identify (initially and annually) all members of any age who use tobacco products or are exposed to tobacco smoke and document this information in the member's medical record. This can be accomplished through using the Staying Healthy Assessment (SHA) or equivalent approved assessment.
2. Offer Food and Drug Administration-approved tobacco cessation medications to non-pregnant adults of any age. Refer to our website for more information [here](#).
3. Refer tobacco users of any age to available individual, group and telephone counseling. Anthem members qualify for four counseling sessions of at least ten minutes for at least two separate quit attempts each year without prior authorization.

Providers can:

- a. Refer a member to the [CA Smokers Helpline](#) at 1-800-NO-BUTTS or another equivalent line. The CA Smokers Helpline is available in various languages.
- b. Use the [5A's Model](#) or other validated behavior change model when counseling members.
- c. Refer to available community programs. Please use the [Health Education Class Referral Form](#) to refer members.
4. Ask all pregnant women if they use tobacco or are exposed to tobacco smoke. If they smoke, offer at least one face-to-face counseling session per quit attempt and refer to a tobacco cessation quit line. Counseling services will be covered for 60 days after delivery. Smoking cessation medications are not recommended during pregnancy.
5. Provide education including brief counseling to children and adolescents to prevent initiation of tobacco in school-aged children and adolescents.

6. To review the following provider training information please refer to [DHCS' website](#) and view the training under SHA resources or refer to Anthem's site [here](#).

Anthem will monitor provider performance in implementing these tobacco cessation interventions through various processes comprising of medical record review, Facility Site Review process, and review of pharmacy data.

Source: Anthem Blue Cross Policy Letter and DHCS APL 14-006



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# Medicare Advantage Updates

## Additional AIM OptiNet imaging services registration webinars available

Anthem Blue Cross (Anthem) continues to offer webinars to help providers complete their *OptiNet*<sup>®</sup> surveys. These surveys collect information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of a number of outpatient diagnostic imaging services for our individual Medicare Advantage members.

AIM's online registration tool, *OptiNet*, will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

This data will be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. **All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, should complete the registration. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements.**

Providers who score less than 76 or who do not complete the survey by August 1, 2016, will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

**Anthem strongly encourages any provider who scores below 76 to improve their site score for the applicable modality before the line item denial of claims for dates of service on or after August 1, 2016. Providers who have not registered and therefore have no score also will be subject to line-item denials for claims submitted for dates of service on or after August 1, 2016.**

All facility diagnostic imaging services are excluded from line item denials at this time.

### **How to register**

Registration is available online via the AIM *ProviderPortal*<sup>SM</sup> (registration required). To access:

1. Go to [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb)
2. Select Anthem Medicare Advantage from the drop down menu
3. Log in to *ProviderPortal*
4. Select "Access My OptiNet Registration" from the *ProviderPortal* home page to begin your registration

For additional assistance you may also call AIM toll free at 1-800-714-0040, Monday through Friday, 5 a.m. to 5 p.m. Pacific Time.

### **Learn more: Attend a webinar**

Anthem continues to offer webinars to help providers complete their *OptiNet* assessments. Attend one of the webinars below to learn how to:

- Access the OptiNet Assessment
- Copy previously completed OptiNet Assessments to your Anthem Medicare Advantage account
- Complete a new AIM OptiNet registration
- Interpret and improve your site score

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Choose one of the sessions below to register for the webinar.

[April 12, 2016, 9-10 a.m. ET](#)

[April 28, 1-2 p.m. ET](#)

[May 9, 4:30-5:30 p.m. ET](#)

[May 19, 12-1 p.m. ET](#)

Check [Important Medicare Advantage Updates](#) at [www.anthem.com/ca/medicareprovider](http://www.anthem.com/ca/medicareprovider) for additional information, including a list of Frequently Asked Questions and Answers.

## Anthem Blue Cross introduces coordination plus plans

Earlier this year Anthem Blue Cross (Anthem) introduced Anthem MediBlue Coordination Plus plans in Los Angeles, Orange, Riverside, San Bernardino and San Diego counties. These plans are offered alongside Anthem's other Medicare Advantage plans. Anthem MediBlue Coordination Plus plans offer benefits consistent with Medicare statutory limits on Medicare covered services, such as medical coinsurances of 20 percent or higher, Part D member premiums and Part D deductibles. The plans offer enhanced benefit coverage at no cost to members on services not traditionally covered by Medicare, such as allowances for comprehensive dental, vision eyewear and hearing aids. These plans are open for general enrollment to all Medicare eligibles. However, members with dual eligibility may be more appropriate for this product as they may not be required to pay the cost-sharing (premium, coinsurance, copays) associated with this plan. Additional information, including billing requirements for Coordination Plus plans, can be found at [www.anthem.com/ca/medicareprovider](http://www.anthem.com/ca/medicareprovider) under [Important Medicare Advantage Updates](#) in the Anthem MediBlue Dual Coordination DSNP and Coordination Plus Plan [Fact Sheet](#).

## AIM to conduct medical necessity reviews for vascular ultrasound procedures

Anthem Blue Cross (Anthem) is collaborating with AIM Specialty Health to conduct medical necessity reviews for Vascular ultrasound management for our individual Medicare Advantage members.

Effective **August 1, 2016**, AIM will accept prior authorization requests for a number of vascular ultrasound screening and diagnostic procedures, including non-invasive diagnostic vascular studies. To submit your request, go to the AIM *ProviderPortal*<sup>SM</sup> at [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb). From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at **1-800-714-0040**, Monday through Friday, 5 a.m. to 5 p.m. Pacific Time.

Additional information also can be found at [www.aimprovider.com/cardiology](http://www.aimprovider.com/cardiology).

## AIM to review oncology and oncology supportive specialty drugs for medical necessity

Effective **May 1, 2016**, all oncology and oncology supportive specialty drugs that require prior authorization for Anthem Blue Cross (Anthem) individual Medicare Advantage members will be reviewed for medical necessity through AIM's *ProviderPortal* -- [www.providerportal.com](http://www.providerportal.com) -- or by contacting AIM at **1-800-554-0580**. Prior authorization requirements also can be reviewed online at [Availity.com](http://Availity.com).

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Providers may be familiar with and participating in the Cancer Care Quality Program administered by AIM. Effective May 1, 2016, CCQP reviews and prior authorizations will be performed by the same review team. The Medicare Advantage Specialty Pharmacy will no longer review oncology and oncology supportive drugs for medical necessity for **individual** Medicare Advantage members effective May 1, 2016.

The Medicare Advantage specialty pharmacy team will continue to conduct oncology and oncology supportive drug prior authorization reviews for Medicare Advantage group-sponsored members. Anthem Medicare Advantage member ID cards contain a CMS identifier in the lower right corner of the card. The member is in a group-sponsored plan when the CMS identifier contains eight characters and the last three digits start with an eight (8XX).

## Quality programs support patient safety, health improvement

Anthem Blue Cross (Anthem) has a number of programs in place to help measure and improve the health of our Medicare Advantage members. Check Important [Important Medicare Advantage Updates](#) at [www.anthem.com/ca/medicareprovider](http://www.anthem.com/ca/medicareprovider) for additional information.

## Keep up with Medicare Advantage news

Please continue to check [Important Medicare Advantage Updates](#) at [www.anthem.com/ca/medicareprovider](http://www.anthem.com/ca/medicareprovider) for the latest Medicare Advantage information, including:

Skilled Nursing Facilities, Home Health and Long-term Care Facilities: OrthoNet OT and PT Prior Authorization Delayed Until Further Notice (PPO only)

[Medicare Advantage reimbursement policies](#)

[Quarterly Update to the Medicare Physician Fee Schedule](#)

[Federally Qualified Health Center Billing Guidelines in Effect for Original Medicare](#)

[CMS Required CLIA Certification Number for Labs](#)

[Medicare Notices and Provider Requirements](#)

[New Prior Authorization Requirements Effective May 1, 2016](#)

[Member Incentive for Office Visit](#)

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## Additional radiation oncology prior authorizations should be directed to AIM effective August 1, 2016

Prior authorization of outpatient radiation therapy services for Anthem Blue Cross individual Medicare Advantage PPO members is administered by AIM Specialty Health® (AIM).

AIM reviews certain treatment plans against clinical appropriateness criteria to help ensure that care aligns with established medical best practices. Effective August 1, 2016, providers are required to contact AIM to request prior authorization for the radiation therapy modalities and services listed below:

- Fractions (number of treatments) for patients with breast cancer or bone metastases
- Image Guided Radiation Therapy (IGRT)
- Special consults and procedures associated with radiation therapy

Providers should continue to contact AIM to request prior authorization for the radiation therapy modalities and services listed below:

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- Intensity Modulated Radiation Therapy (IMRT)
- 3D Conformal/ External Beam Radiation Therapy (EBRT)
- Brachytherapy
- Proton Beam Therapy
- Stereotactic body radiation therapy (SBRT) and Stereotactic radiosurgery (SRS)

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through Anthem inpatient precertification process.

To submit your request, go to the AIM *ProviderPortal*<sup>sm</sup> at [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb). From the dropdown menu, select Anthem MA. For additional assistance you may also call AIM toll free at 1-800-714-0040, Monday through Friday, 5 a.m. to 5 p.m. Pacific Time.

Coverage of services will continue to be subject to all of the terms and conditions of the member's health benefit plan and applicable law. For questions regarding these changes, please contact AIM at 1-800-714-0040.

**For more information:** Go to [www.aimprovider.com/radoncology](http://www.aimprovider.com/radoncology).

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# Pharmacy

## Pharmacy information available on [anthem.com/ca](http://anthem.com/ca)

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit [anthem.com/pharmacyinformation](http://anthem.com/pharmacyinformation). The commercial drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October). To locate "Marketplace Select Formulary" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List."

Website links for the Federal Employee Program formulary Basic and Standard Options are **Basic Option:**

[https://www.caremark.com/portal/asset/z6500\\_drug\\_list807.pdf](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf); and **Standard Option:**

[https://www.caremark.com/portal/asset/z6500\\_drug\\_list.pdf](https://www.caremark.com/portal/asset/z6500_drug_list.pdf). This drug list is also reviewed and updated quarterly.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at [www.fepblue.org](http://www.fepblue.org) > Benefit Plans > Brochures and Forms > Medical Policies.



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