



In this issue of STAT, the Anthem Blue Cross Medicaid Provider e-News, you will find important policy updates and new programs or services to help you take care of our members in these plans:

- Medi-Cal Managed Care
- L. A. Care
- Healthy Families Program
- Access for Infants and Mothers
- Major Risk Medical Insurance Program

Healthy Families Transition to Medi-Cal

On January 1, 2013, children previously enrolled in the Healthy Families Program began transitioning to Medi-Cal Managed Care (Medi-Cal). This change is the result of a 2012 decision by state lawmakers to merge the health care programs for children into one program. The transition of Healthy Families Program enrollees to Medi-Cal will simplify eligibility and coverage for children and families while providing additional benefits and lowering costs for children whose families are at or below certain income levels.

Transition Phases for Healthy Families Members

The transition of children from Healthy Families to Medi-Cal is occurring in four phases:

- The Phase 1 transitions had two parts:
 - o Anthem Blue Cross members enrolled in Healthy Families who reside in Santa Clara, Alameda and San Francisco counties transitioned to Medi-Cal on January 1, 2013.
 - o Anthem Blue Cross members who are residents of Tulare, Kings, Fresno, Madera, Contra Costa and Sacramento counties, transitioned on March 1, 2013.
- Anthem Blue Cross members in Los Angeles County transitioned in Phase 2 on April 01, 2013.
- The Phase 3 transition will begin August 01, 2013. This phase will include children enrolled with a Healthy Families plan that does not participate in Medi-Cal or subcontract with a Medi-Cal managed care plan.
 - o Please note: Babies born to mothers who are enrolled in Access for Infants and Mothers (AIM) and who are under 250% of the federal poverty level (FPL) in Phase 1-3 counties will transition to a Medi-Cal plan on August 1, 2013.
- The Phase 4 transition will occur fourth quarter 2013 and will include those children residing in the rural counties that are managed exclusively by California's Department of Health Care Services Fee-for-Service program.

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Customer Care Center		Community Resource Coordinators		Additional Numbers	
Medi-Cal outside L.A. County	1-800-407-4627	Fresno/Madera	1-559-488-1380	24/7 NurseLine	1-800-224-0336
Medi-Cal inside L.A. County	1-888-285-7801	Los Angeles/San Diego	1-818-655-1255	Pharmacy Authorization	1-800-700-2533
Healthy Families Program	1-800-845-3604	Sacramento/Bay Area	1-916-325-4200	Medi-Cal Utilization Management/ Authorization	1-800-754-4708 (Fax) 1-888-831-2246 (Voice)
Access for Infants and Mothers (AIM) Program	1-877-687-0549	Stanislaus/San Joaquin	1-209-558-2762	AIM, MRMIP and CMSP Utilization Management/ Authorization	1-800-754-4708 (Fax) 1-877-273-4193 (Voice)
Major Risk Medical Insurance Program (MRMIP)	1-877-687-0549	Tulare/Kings	1-559-733-6578		
County Medical Services Program (CMSP)	1-800-670-6133				

Transition Exceptions

There are a few exceptions to who will be transitioning and when. These are as follows:

- To allow for a 60-day notification period, members who reside in Phase 1 counties but had an effective date between November 1, 2012 and December 31, 2012 transitioned to Medi-Cal on March 1, 2013 rather than January 1, 2013.
- Babies born to AIM mothers that are at or over 250% of FPL will continue to be enrolled in Healthy Families. As further information becomes available on this topic, we will certainly pass it on to all providers.
- Each phase may have members who will not transition as scheduled. The Major Risk Medical Insurance Board (MRMIB), the governing body for Medi-Cal, is allowing members to change plans on a monthly basis. If a member's plan change is or was in process during their assigned transition phase, that member may have or will transition with the next phase.

Due to the above exceptions and the type of health plan mix in each county, counties can have multiple transition dates. For example, if a county has a health plan that has members who are enrolled in both Medi-Cal and Healthy Families, those members transitioned during Phase 1. If that same county has members that are enrolled in Healthy Families alone, those members will transition in Phase 3.

Details about the Transition

Prior to and during these transitions, Anthem Blue Cross and the State of California have been working diligently to communicate the details of these changes, including the following:

- Transitioning Healthy Families members are being assigned to a network PCP. If their Healthy Families PCP is also an Anthem Blue Cross-contracted Medi-Cal PCP, their PCP assignment will not change. If the member's Healthy Families PCP is not an Anthem Blue Cross-contracted network provider, the member can continue to see their out of network PCP for up to 12-months. However, the out of network provider will have to accept the Medi-Cal rate of reimbursement and obtain authorization for services as an out of network provider.



- Families received notices from the state at 30/60 day intervals before any changes were made in their child's coverage for Phase 1. Members have been and are receiving notices at 30/60/90 day intervals for Phases 2-4.
- While the move may require some families to choose a new health plan or change their doctor or dentist, children currently in Healthy Families will continue to have comprehensive health insurance, with no gap in coverage.
- Medi-Cal coverage includes all the benefits of Healthy Families coverage, including mental health benefits.
- Most Healthy Families Program members are continuing to pay premiums after their transitions to Medi-Cal. However, the cost of premiums is not increasing, and families with incomes determined to be at or below 150 percent of the federal poverty line will no longer be charged premiums once they move to Medi-Cal.
- Post-transition, providers are no longer collecting Healthy Families copays as they are not part of the Medi-Cal plan and no longer apply.

Transition Education and Outreach

To further facilitate the transition from Healthy Families to Medi-Cal, both the state and Anthem Blue Cross developed educational materials and opportunities for members and providers alike. Here are just a couple of the steps Anthem Blue Cross has taken to ensure a smooth transition:

- Anthem Blue Cross has developed a comprehensive outreach plan that includes outreach calls, member website updates, notification flyers and FAQs.
- Members are receiving new ID cards, new member handbooks and a directory as part of a Welcome Kit after their transition from the Healthy Families Program to Medi-Cal.

For More Information

Our website has useful resources available for providers who have patients transitioning from the Healthy Families Program to Medi-Cal. As it becomes available, we post updates and new information about this transition on the Provider Resources page of our website at www.anthem.com/ca. To access those updates, please follow these websteps:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. Under **Program Information**, select **Healthy Families Program to Medi-Cal Transition**

ICD-10: Will You Be Ready?

As all providers are well aware, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets on October 1, 2014. This transition to ICD-10 is required for everyone covered by the Health Insurance Portability and Accountability Act (HIPAA). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.

Healthcare industry leaders have urged that providers, payers, and other affected stakeholders continue to move forward in preparation for ICD-10 compliance. Anthem Blue Cross and Blue Shield (Anthem) wants to remind our providers that now is the time to talk to your payer partners, practice management systems vendors and clinical information systems vendors in order to understand how your practice may be impacted by ICD-10.

As you have these conversations, it is critical to understand testing timelines and requirements to ensure a smooth transition to ICD-10 and minimize business interruption to your practice.

ICD-10: Planning Activities

The implementation plan for your practice's transition to ICD-10 is one of those long-term efforts where periodic check-ups can help to make sure you are still on target to be ready by October 1, 2014. Below is a list of some of the planning activities.

- **Processes/Workflows Changes** – You should have identified which internal processes and workflows will be affected by using the new code set, how each workflow is affected and have a plan to address the changes that need to occur to incorporate ICD-10.
- **Systems Changes** – Assessment of all systems used by your practice should be completed. You should have a comprehensive list of all necessary system changes, upgrades and/or other adjustments, the cost of these changes, the amount of time it will take to complete these changes and the timeline for implementation.
- **External Partners** – You should have a clear picture of how each of your vendors, clearinghouses and/or billing services plan to handle the transition to ICD-10 and how their plan will affect your practice.
- **Documentation Requirements** – You should have assessed a sample of your practice's patient records to determine if the clinical documentation is complete and detailed enough to properly code claims using ICD-10 diagnosis codes. With the new level of specificity of each code, having the right documentation available for your medical coders will lessen the potential for decreased productivity associated with using the new code set.
- **Training** – You should have a comprehensive list of the education and training needs for your staff members. The list should detail the type of training needed (coding, systems, etc.), who will receive the training and timeline for the training to occur. Training costs should also be determined and budgeted as appropriate in future fiscal planning.

As you move into the active phases of your implementation plan for ICD-10, having this knowledge as your foundation will be the key to a smooth transition to ICD-10.

Testing Reveals Two Key Trends

Anthem has continued to create plans for testing and we have worked with a small group of provider partners to examine critical impacts of the move from ICD-9 to ICD-10 in the institutional setting. Together with these providers, we have seen the critical importance of not only testing early but also analyzing the impacts on reimbursement.

We conducted a project with a small group of institutional providers. Together, we each coded ICD-9 claims in ICD-10 without translating or cross-walking. We then looked at the reimbursement impacts and DRG assignments. This testing revealed two key trends, and we want to make sure that our providers are aware of these results:

- 1) Do the analysis. There are reimbursement impacts to be aware of that are unique to your practice because of the change from ICD-9 to ICD-10.
- 2) Beware of coding mistakes such as including erroneous leading 0s in front of an ICD-10 code. These errors could cause a delay in processing the claim and are easily avoided.

We will be rolling out more insights from our analytical projects, so stay tuned!

For More Information

To help our providers stay informed about the ICD-10 implementation, Anthem has created an ICD-10 Update page on our website at www.anthem.com. To access the ICD-10 webpage, please use the following websteps:

1. Go to www.anthem.com/ca
2. Select **OTHER ANTHEM WEBSITES: Providers**
3. Under **Welcome to Anthem Blue Cross**, click on the orange **Enter** button
4. On the **Providers** page, scroll down to **Communications and Updates** and select **ICD-10 Updates**

Fact sheets and training materials regarding the ICD-10 implementation are available as well on the following websites:

- CMS (Centers for Medicare & Medicaid Services): <http://www.cms.gov/ICD10/>
- AHIMA (American Health Information Management Association): <http://www.ahima.org/icd10/>

- HIMSS (Healthcare Information and Management Systems): <http://www.himss.org/ASP/index.asp>
- AAPC (American Academy of Professional Coders): <http://www.aapc.com/ICD-10/>

If you have specific questions about the ICD-10 implementation, you can send us an email at ICD10-Inquiry@Anthem.com.



During Member Visits

How to Obtain Language Assistance

Our members count on you. They may have questions, but language barriers prevent them from communicating with you and your staff. Anthem Blue Cross is committed to communicating with our members about their health plan and our services, regardless of their language. Here's how your patients (our members) can receive help. Anthem Blue Cross employs a Language Line interpretation service for use by all of our Customer Service Centers. Members can simply call the Customer Care Center phone number on the back of their health plan ID card, and a representative will be able to assist them. Translation of written materials about benefits can also be requested by contacting our Customer Care Center at **1-866-407-4627** (outside L.A. County) or **1-888-285-7801** (inside L.A. County).

During Member Visits

TTY/TDD services are available during business hours by dialing **1-888-757-6034**. After-hour services are available through the California Relay Line at **1-800-735-2929** or **711** (24 hours a day), 7 days a week. A special operator will contact Anthem Blue Cross to help with member needs.

Interpreting Services Increase Patient Understanding

To ensure effective medical care, patients need to understand their doctor's recommendations. One easy way to ensure comprehension by your non-English speaking-patients is to use face-to-face or telephonic professional interpreters, including American Sign Language (ASL) interpreters. It takes only minutes to connect with an interpreter over the phone. Face-to-face interpreters/sign language interpreters can be arranged for in advance by contacting your patient's health plan.

According to members who responded to a survey conducted as part of a 2011 Los Angeles County Group Needs Assessment, 30% of non-English speakers stated their doctor does not speak their language, and 34% of those indicated they need an interpreter when talking with the doctor.

Of those 34%, "office staff" is most frequently used to interpret (46%), followed by "family member or friend" (32%). Only 9% reported using a professional interpreter. Anthem Blue Cross provides 24-hour professional interpreting services at no cost to your patients or your practice.

Using qualified interpreters in your practice improves communication with your patients and can result in better outcomes and higher levels of patient satisfaction. Although having bilingual office staff act as interpreters may seem easier, it can lead to miscommunication of important information. If you use office staff to interpret, make sure they are competent to provide medical interpretation. Not only must staff be bilingual, they must know medical terminology and understand the ethics of interpreting. At a minimum, have staff complete the appropriate Language Skills Self-Assessment Tool located under the Health Education heading on the Provider Resources webpage of our website at www.anthem.com/ca.

To locate these tools (there are separate tools for staff located inside and outside of L. A. County), please use the following websteps:

1. Go to www.anthem.com/ca
2. Select **OTHER ANTHEM WEBSITES: Providers**
3. Under **Learn More**, select **State Sponsored Plans**
4. On the **Provider Resources** webpage, scroll down to **Health Education**
5. Select the appropriate **Employee Language Skills Self-Assessment Tool**

State and federal guidelines discourage the use of friends and family members, especially minors, from interpreting for patients. The best way to protect yourself from liability is to have effective procedures in place to assess the need for language assistance in your non-English speaking patients.

Please call your Customer Care Center if you would like more information.

Immunizations: Keeping Your Patients Up-to-Date

In 2010 California declared a whooping cough epidemic and now measles cases have reached a 10 year high.¹

This rise is due in part by the highly contagious nature of these diseases. Another contributing factor is the increase in parents forgoing vaccinations because of concern over safety and the fear of autism.² You, as the primary source of health information for your patients, can allay fears and concerns about vaccine safety and urge adults and children alike to stay up-to-date with their vaccines.

Here are some tips for talking with patients:

- Reassure patients that vaccines are safe. They do not cause autism, nor can you contract the very diseases the vaccines are trying to prevent.
- Vaccines are most effective if everyone who needs them gets them. Let your patients know that they and their children are not protected simply because others are getting vaccinated.
- Remind your patients how germs quickly spread through the air when infected individuals cough or sneeze, or touch germ hands to their faces.
- Inform your patients that while some diseases are rare in the United States, if they travel outside the country they risk exposure to diseases that may be more widespread in those countries and could get sick themselves, or bring diseases back to their friends and family.

¹ Gorman, Anna, U.S. Leads in Measles Cases, Los Angeles Times, September 22, 2011.

² County of Los Angeles Public Health Department, Measles Alert A Message to Emergency Room Departments in Los Angeles County.

Are You Using an Asthma Action Plan?

Clinical practice guidelines from the National Heart, Lung and Blood Institute stress the importance of teaching patients and their families' self-management skills. The Asthma Action Plan is an excellent vehicle for accomplishing this goal.

If Asthma Action Plans provide so many benefits, why aren't more physicians using them? Some possible reasons include lack of confidence in patients self-managing their own condition and a perceived lack of time.

The asthma action plan is valuable because it:

- Reinforces what was said verbally
- Instructs parents what to do if their child gets sick
- Increases patient understanding of the difference between maintenance and rescue medications
- Improves compliance

The asthma action plan should be reviewed and updated annually as frequency and severity of symptoms often change over time.

For more information on asthma actions plans and how to obtain them, please see Create an Asthma Management Plan at the American Lung Association

website, www.lung.org. Additional resources for information on asthma, including a printable asthma action plan, can be found on the Asthma Action Plans: Help Patients Take Control page of the National Heart, Lung and Blood Institute website at www.nhlbi.nih.gov.

Health Education Supports You and Your Patients

Health education services are available to your patients through group classes, individual counseling, and patient handouts. The goal of health education is to promote health and prevent disease by improving health knowledge, attitude, skill, and voluntary behavior change.

Benefits of health education to patients include:

- Increased understanding of health
- Increased ability or self-efficacy to cope with and manage health conditions
- Better health outcomes for self-managed and/or lifestyle related conditions, such as diabetes, coronary heart disease, heart failure and rheumatoid arthritis
- Increased perceptions of social support
- Improved psychological well-being

Benefits of health education to providers include:

- Improved physician-patient relationship
- Better informed patients
- Improved patient compliance with prescribed treatment plans
- Improved efficiency through cost-effective care

Anthem Blue Cross offers several health education services and programs to meet the specific health needs of your patients. It is important that providers refer members to these resources, not only to promote healthy lifestyles and improve the health of those living with chronic diseases, but also because it is a California Department of Health



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Care Services contractual requirement. Health education classes take place at hospitals and/or community-based organizations. Classes are available at no charge to Anthem Blue Cross members and are accessible upon self-referral or referral by Anthem Blue Cross network Providers.

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

- Asthma Management
- Childbirth/Lamaze
- Diabetes Management
- Injury Prevention
- Parenting/Well Child
- Prenatal Education
- Sexually Transmitted Infections (STIs)
- Smoking Cessation/Tobacco Prevention
- Substance Abuse

For more information on health education classes, Members or providers can call the appropriate Customer Care Center.

24/7 NurseLine

Another health education resource we offer is our 24/7 NurseLine. This valuable resource is available to members and providers 24 hours a day, 7 days a week and 365 days a year. In addition to providing members with self-care information, including assistance with symptoms, medications and side-effects, and reliable self-care home treatments, the 24/7 NurseLine also has information on more than 300 health care topics through its extensive audio tape library.

To contact the 24/7 NurseLine, please call **1-800-224-0336** or **1-800-368-4424** (TTY).

Finally, we have an extensive selection of health education materials, in both English and Spanish, available on the Provider Resources webpage of our website at www.anthem.com/ca. These materials range from information on protecting your family from carbon monoxide poisoning to several educational resources on the perils of secondhand smoke and how to quit smoking.

The materials may also be translated into other languages upon request.

To find these materials, please follow these websteps:

1. Go to www.anthem.com/ca
2. Select **OTHER ANTHEM WEBSITES: Providers**
3. Under **Learn More**, select **State Sponsored Plans**
4. On the **Provider Resources** webpage, scroll down to **Health Education**
5. Select **Health Education Resources**

Got Pregnant Members? Anthem Blue Cross Can Help

Thank you for partnering with Anthem Blue Cross to ensure healthy pregnancies and babies for our Medi-Cal members. As you know, these members are at an increased risk of pregnancy-related complications due to inadequate nutrition, chronic disease, and behavioral risk factors--such as recreational drug use.

Coordination of care among physicians, health plans, and community resources is leading to more timely, adequate prenatal care for women. The earlier prenatal care is initiated, the more likely women are to receive needed education, testing, and referrals. However, recent focus groups conducted with African-American/black and Latina Medi-Cal beneficiaries revealed a number of challenges in accessing prenatal and postpartum care, including uncertainty about keeping the baby and uncertainty about the relationship with the baby's father, lack of knowledge about the importance of prenatal/postpartum care, lack of transportation, fear/distrust of the health care system, and cultural traditions.

Perinatal care also supports improved HEDIS® outcomes. Adequate prenatal care has been shown to result in increased rates for well-child visits. Timeliness and frequency of prenatal care, postpartum visits, and well-child visits are all important HEDIS measures and serve to show that you are providing preventive, quality care to your patients.

How Can You Help?

Because pregnancy and the perinatal period are critical to the health of new moms and infants, maternity and newborn health education programs, services, and materials are available at no cost to Medi-Cal members. To access these resources, simply let Anthem Blue Cross know about the pregnancy as soon as possible.

We will work with you and your patient to ensure access

During Member Visits

to linguistically-sensitive and culturally-appropriate health education services.

To notify us of a member's pregnancy, please use the Online Pregnancy Notification Form or submit a completed Pregnancy Notification Report form. Both forms are located under the Clinical and Preventive Care Tools heading in the Forms Library on the Provider Resources webpage of our website: www.anthem.com/ca. To access the forms, please use the following websteps:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. On the **Provider Resources** webpage, scroll down to **Forms and Tools** and select **Forms Library**
4. Scroll down to **Clinical and Preventive Care Tools**
5. Select either the **Pregnancy Notification Report** or the **Online Pregnancy Notification Form**

Preventing Obesity from the Start: WIC and Exclusive Breastfeeding

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), funded by the USDA, provides food, nutrition and breastfeeding education to low-income pregnant and postpartum women, and children up to age 5. In Los Angeles County, WIC serves over 500,000 participants every month. A premier public health nutrition program, WIC promotes and supports exclusive breastfeeding up to 6 months of age for all infants. Breastfeeding has long been recognized as a proven disease-prevention strategy and recently has been found to play a key role in preventing childhood obesity.

WIC administrative data analysis on 80,000 children served by WIC from birth to age four shows breastfeeding initiation is associated with a 23% reduction in childhood obesity. Breastfeeding duration to six months results in additional obesity rate reductions of almost twice that amount for some sub groups.

These results strongly support the impact of breastfeeding on reducing rates of childhood obesity among the low-income population served by the WIC Program. As more hospitals in Los Angeles County move towards becoming baby-friendly and more WIC participants initiate exclusive breastfeeding, the

WIC program, health care providers, and employers must work collaboratively to improve the duration of exclusive breastfeeding among WIC participants.

As per Medi-Cal Managed Care Division (MMCD) Policy Letter 98-10, formula samples, coupons, and materials from infant formula companies should not be routinely distributed to pregnant and postpartum Medi-Cal members as this may inadvertently be perceived by the member as an endorsement of these products by their health care provider, hospital or health plan.

Serving Seniors and People with Disabilities (SPD)

As of June 2012 there are 152,596 SPD members within the L.A. Care network and this number is expected to grow. Of this 152,596, 79% have a disability, 20% are aged, and slightly more than 1% is blind. The top languages are English (52%), Spanish (24%), and Armenian (7%).

Not surprisingly, chronic diseases such as heart disease, stroke, kidney disease, diabetes, asthma, COPD, multiple sclerosis, depression and anxiety are the top health concerns. But the SPD population has other needs that may not be as transparent.

For instance, as based on a 2011 member survey, the number one health topic SPD members report wanting to learn more about is violence prevention. They prefer to learn about health by reading a brochure, are less likely to attend a health education class, but more likely to call the 24/7 NurseLine. Almost all SPD members say they have difficulty getting information and support to stay healthy, largely due to lack of transportation and information not being available in their preferred language.

What can you and your office do to help meet these needs? Here are some suggestions:

- Offer and know how to access free interpreting services. You may find an increased need for American Sign Language (ASL) interpreting services with your SPD members.
- Make health education materials on a variety of SPD health topics available in alternative formats, such as large print, audio or Braille.

For information on how to access interpreting services,

please call our Customer Care Center or go to the Free Interpreting Services webpage of our website at www.anthem.com/ca. To locate this webpage, please use the following websteps:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. On the **Provider Resources** webpage, scroll down to **Health Education**
4. Select **Free Interpreting Services**

We Believe in Continuous Improvement

Commitment to our members' health and their satisfaction with the care and services they receive is the basis for Anthem Blue Cross' Quality Improvement Program. On an annual basis, Anthem Blue Cross prepares a quality improvement program description that outlines the plan's clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of Anthem Blue Cross' quality improvement program and most current outcomes, please go to www.anthem.com/ca and use the following websteps:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. On the **Provider Resources** webpage, scroll down to **Quality Improvement Program**
4. Select **QIP Summary**

You can also obtain further information or give feedback by calling your Community Resource Coordinators:

Fresno / Madera	1-559-488-1380
Los Angeles / San Diego	1-818-655-1255
Sacramento / Bay Area	1-916-325-4200
Stanislaus / San Joaquin	1-209-558-2762
Tulare / Kings	1-559-733-6578

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, Anthem Blue Cross has adopted nationally-recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually and updated as needed.

The current guidelines are available on our website at www.anthem.com/ca. To access them, please use the following websteps:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. Select the **Health & Wellness** tab
4. Select **Practice Guidelines**



Access to Care

Access to Care After-Hours

Anthem Blue Cross is committed to ensuring that our members have access to health care 24 hours a day, seven days a week.

We conduct annual surveys not only to measure provider compliance with after-hours access to care guidelines, but also to review provider compliance with after-hours messaging standards. Survey results have revealed that these standards are not being met.

Business Operations

Whether you use an answering machine or an answering service, please follow these guidelines for both emergency and non-emergency after-hours access to care:

Guidelines for After Hours Access to Care	
After-Hours Emergency Calls	After-Hours Non-Emergency Calls
Your answering service or answering machine must direct callers to dial 911 or go to the nearest emergency room.	<p>An answering service must be able to reach you or an on-call physician after hours to assist the member. Contact the member within 30 minutes of the initial call.</p> <p>If you use an answering machine, it must direct the caller to the appropriate person, or give the caller a number to reach you or an on-call physician. Contact the member within 30 minutes of the initial call.</p>
Suggested Answering Machine Message	
<p>“Hello, you have reached the office of [insert your name]. If this is an emergency, hang up and dial 911 or go to the nearest emergency room. If this is not an emergency and you have a medical concern or question, please call [insert contact name and phone number]. You will be contacted by the on-call physician within [timeframe].”</p>	
<p style="text-align: center;">In-Network On-Call Services</p> <p>If you are a primary care provider, (PCP), we prefer that you use a plan-contracted, in-network physician for on-call services. When that is not possible, please use your best efforts to ensure the non-contracted, on-call physician abides by the terms of your Provider Contract with Anthem Blue Cross.</p>	<p style="text-align: center;">Non-English After-Hours Messages</p> <p>Many non-English speaking members who call after-hours expect to receive a language-appropriate message. After-hours messages must be in English and Spanish.</p> <p style="text-align: center;">Interpreter Services</p> <p style="text-align: center;">7:00 a.m.-7:00 p.m., Monday through Friday</p> <p style="text-align: center;">Customer Care:</p> <p style="text-align: center;">1-800-407-4627 (outside L. A. County)</p> <p style="text-align: center;">1-888-285-7801 (Inside L. A. County)</p> <p style="text-align: center;">After Hours, call:</p> <p style="text-align: center;">24/7 NurseLine 1 800-224-0336</p> <p style="text-align: center;">TTY: 1-800-368-4424</p> <p style="text-align: center;">24 hours a day, 7 days a week</p>

Appointment Access

Anthem Blue Cross' goal is to ensure patients' have timely access to medical care and services. To achieve that goal, we conduct annual Appointment Access Surveys to evaluate providers' appointment scheduling processes and their compliance with the required standards. Both Primary Care Providers (PCPs) and Specialists must meet these standards for appointment scheduling.

Anthem Blue Cross' standards for appointment scheduling are based on guidelines published by the American College of Obstetricians and Gynecologists (ACOG), National Committee for Quality Assurance (NCQA), as well as California's Department of Health Care Services (DHCS) contractual requirements.

Business Operations

Please review the guidelines below. Make sure your policies and procedures are in compliance, as a failure to comply with these standards could result in corrective action.

Medical Appointment Standards: Outside of Los Angeles County

Medical Appointment Standards (Outside of Los Angeles County)	
General Appointment Scheduling	
Emergency Examination	Immediate access, 24 hours/7 days a week
Urgent (sick) Examination	Within 24 hours of request
Non Urgent (sick) Examination*	Within 48-72 hours of request or as clinically indicated
Routine Primary Care Examination (non urgent)	Within 10 business days of request
Non Urgent Consults/Specialty Referrals	Within 15 business days of request
Non Urgent Care with non-physician mental health providers (where applicable)	Within 10 business days of request
Non-Urgent Ancillary	Within 15 business days of request
Services for Members under the Age of 21 Years	
Initial Health Assessments	
Children under the age of 18 months	Within 60 days of enrollment (or within American Academy of Pediatrics (AAP) guidelines whichever is less)
Children aged 19 months to 20 years of age	Within 120 days of enrollment
Preventive Care Visits	Within 14 days of request
Services for Members 21 Years of Age and Older	
Initial Health Assessments	Within 120 days of enrollment
Preventive Care Visits	Within 14 days of request
Routine Physicals	Within 30 days of request
Prenatal and Post-Partum Visits	
1st and 2nd Trimester	Within 7 days of request
3rd Trimester	Within 3 days of request
High-Risk Pregnancy	Within 3 days of identification
Post-Partum	Between 21 and 56 days after delivery

*Exceptions are permitted for routine cases, other than clinical preventive services, when PCP capacity is temporarily limited.

Medical Appointment Standards: Los Angeles County Only

Medical Appointment Standards (Los Angeles County Only)	
General Appointment Scheduling	
Emergency Examination	Immediate access, 24 hours/7 days a week
Urgent (sick) Examination	Within 24 hours of request
Nonurgent (sick) Examination	Within 48 hours of request
Non-urgent Routine Examination*	Within 10 days of request
Standing Referral	Within 3 business days of request
Members Under the Age of 18 Months	
Initial Health Assessments	Within 60 days of enrollment (or within American Academy of Pediatrics (AAP) guidelines whichever is less)
Early and Periodic Screening Diagnostic and Treatment (EPSDT) Services/Child Health and Disability Prevention (CHDP) or Preventive Care Visits	Within 2 weeks of request
Services for Members 18 Months of Age or Older	
Initial Health Assessments	Within 120 days of enrollment
EPSDT/CHDP or Preventive Care Visits	Within 2 weeks of request
Routine Physicals	Within 30 days of request
Prenatal and Post-Partum Visits	
First Prenatal Visit	Within 2 weeks of request
High-risk Pregnancy	Within 3 days of identification
Post-Partum	Between 21 and 56 days after delivery

*Exceptions are permitted for routine cases, other than clinical preventive services, when PCP capacity is temporarily limited.

For more information, see the latest Provider Manual at the Provider Resources page at our website: www.anthem.com/ca. Follow these websteps to access the Provider Manual:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. Under **Provider Communications**, select **Provider Manual and Important Updates**
4. Select **Provider Manual for Medi-Cal, Healthy Families, AIM and MRMIP**
5. See the **Access Standards and Access to Care** chapter of the current **Provider Manual**

Business Operations

Community-Based Adult Services Referral Process

Anthem Blue Cross members who wish to receive Community-Based Adult Services (CBAS) benefits must be evaluated and approved for these benefits both initially and then on a regular basis. In order to evaluate prospective CBAS members for eligibility for either renewal of services or new services, (such as Seniors and Persons with Disabilities not currently receiving CBAS services) Anthem Blue Cross must collect certain information. Depending upon type of request, that information should be submitted as follows:

Authorization Request for Reassessment

Please fax to **1-855-336-4042**.

These should be faxed to us at least six weeks prior to the member's current service expiration date and should include:

- your Individual Plan of Care (IPC)
- Recommendation for # of days being requested
- Any other Medical Records necessary for Review

Authorization Request for Multi-Disciplinary Team (MDT) Evaluation (For new members)

Please fax to **1-855-336-4041**.

Please note: Urgent* CBAS evaluation requests should be faxed to **1-855-336-4043**.

*Urgent = New request from Nursing Facility or Hospital where member is currently residing on an inpatient basis.

Required Documentation for Evaluation Requests

In order to make informed decisions regarding the CBAS member, Anthem Blue Cross requires that all evaluation requests contain two items:

1. The completed Anthem Blue Cross CBAS Request Form (see below), and;
2. All comprehensive clinical information regarding the member, including:
 - Completed Individual Care Plan for Renewal Members
 - Level of Service Assessment
 - Completed CBAS Pre-Screening records for New Members (applies only if your facility does pre-screenings)

- Clear patient history and physical exam notes, including system review of the following overall significant factors:
 - o Neurological
 - o Respiratory
 - o Cardiac
 - o Gastrointestinal/ Genitourinary
 - o Endocrine
 - o Skin
 - o Musculoskeletal
- Physician notes, physician exam notes
- Any Information related to the member's Activities of Daily Living/ Instrumental Activities of Daily Living Scale

The CBAS Request Form is located on the Provider Resources page of our website at www.anthem.com/ca. To access this form, as well as other information on the CBAS program, please follow these websteps:

1. Select **OTHER ANTHEM WEBSITES: Providers**
2. Under **Learn More**, select **State Sponsored Plans**
3. On the **Provider Resources** webpage, select **CBAS Provider Toolkit**
4. Select **CBAS Service Request**

If you have multiple members needing services, please fax each request separately.

After faxing your request, it takes approximately 24-48 hours for Anthem Blue Cross' CBAS staff to receive the request. Once request has been received, the requesting provider will be sent a faxed confirmation acknowledgement of their CBAS Service request.

If you have a billing request, do not fax to any of the above fax numbers. For billing questions, please contact the appropriate Customer Service Center at the following numbers:

Outside Los Angeles County: **1-800-407-4627**

Inside Los Angeles County: **1-888-285-7801**

Monday to Friday 7 am -7 pm

Policies, Updates and Reminders

Pharmacy Information Available at [Anthem.com/ca](http://www.anthem.com/ca)

Anthem Blue Cross wants to make sure you have timely access to pharmacy policy changes and new developments. The following information is available under the Pharmacy Benefits Menu on the State Sponsored Business Pharmacy Information for Providers page of our website at www.anthem.com/ca:

- Prescription Drug Benefits
- Pharmacy and Therapeutics Process
- Where to Get Prescriptions Filled
- Preferred Drug List/Formulary
- Prior Authorization Process
- Multi-Source Brands
- Dose Optimization
- Quantity Limits
- Benefit Exclusions
- Office-Based Injectables
- Cost to Member
- Important Toll-Free Contact Numbers

To access this information:

1. Go to www.anthem.com/ca
2. Select **OTHER ANTHEM WEBSITES: Providers**
3. Under **Learn More**, select **State Sponsored Plans**
4. On the **Provider Resources** webpage, scroll down to **Additional Programs and Services**
5. Select **Pharmacy – MediCal**

If you would like more information, please call the Prescription Drug Plan at **1 800 700 2533**, or Express Scripts Prior Authorization at **1-800-338-6180**.

Member Rights and Responsibilities

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

This statement can be found on our website via the following websteps:

1. Go to www.anthem.com/ca
2. Select **OTHER ANTHEM WEBSITES: Providers**
3. Under **Learn More**, select **State Sponsored Plans**
4. Under **Provider Communications**, select **Provider Manual and Important Updates**
5. Select **Provider Manual for Medi-Cal, Healthy Families, AIM and MRMIP**
6. Go to the **Member Rights and Responsibilities** chapter of the current **Provider Manual**



Important Information About Utilization Management

Anthem Blue Cross's utilization management (UM) decisions are based on the appropriateness of care and services needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Additionally, we do not make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. Finally, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization.

Policies, Updates and Procedures

You can request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. Anthem Blue Cross' medical policies and UM criteria are available on our website. To access them, please use the following websteps:

1. Go to www.anthem.com/ca
2. Select **OTHER ANTHEM WEBSITES: Providers**
3. Under **Learn More**, select **State Sponsored Plans**
4. On the **Provider Resources** page, to the left of the screen, select **Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements**

We work with providers to answer questions about the utilization management process and the authorization of care.

Here's how the process works:

- Call us toll-free from 8:00 a.m. – 5:00 p.m. (Pacific), Monday through Friday (except on holidays).
- After business hours, you can leave a confidential voicemail message. Please leave your contact information so one of our associates can return your call the next business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the Customer Service phone number on the back of their health plan ID card.

Important Utilization Management Phone Numbers	
To discuss UM process and authorizations	1888-831-2246
To discuss peer-to-peer UM denials with physicians	1-877-496-0071
To request a copy of UM criteria	1-888-831-2246
TTY/TDD 1-888-757-6034 (during business hours) 1-800-735-2929 California Relay Line (after hours) OR 711 , (available 24/7)	

For language assistance, members can simply call the Customer Care Center phone number on the back of their health plan ID card, and a representative will be able to assist them.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.



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