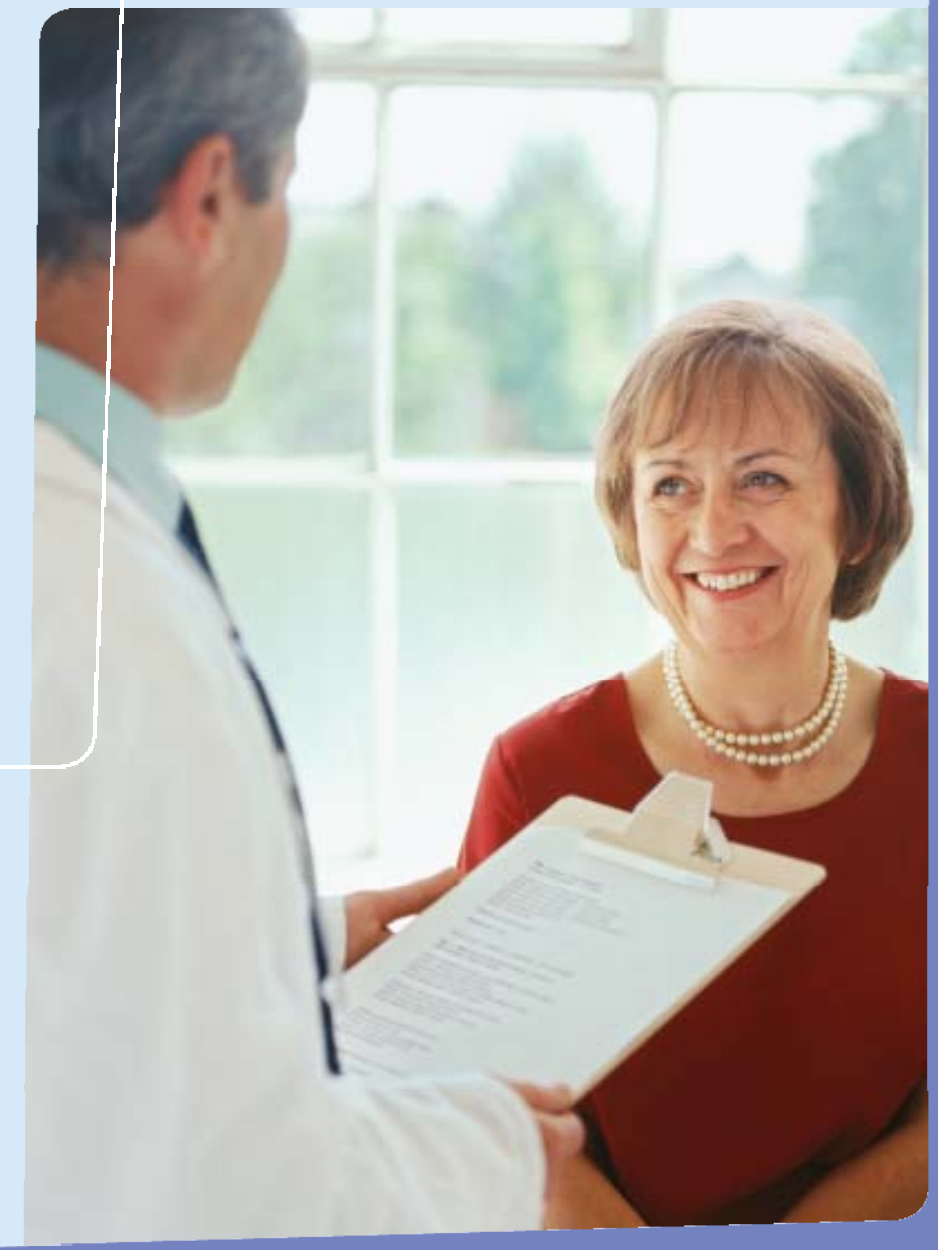
Anthem Blue Cross

Medi-Cal Managed Care Program for Community-Based Adult Services (CBAS)

Provider Orientation *for*

Adult Day Health Care (ADHC) Providers

October 2012



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Welcome to Anthem Blue Cross
New Provider Orientation

Program Introduction

- Provider Resources at Anthem Blue Cross
- Member Eligibility Verification
- Member Benefits and Services
- Claims and Billing Overview
- CBAS Enrollment
- The Care Management Difference
- Provider Grievance & Appeals
- Provider Responsibilities
- Member Rights and Responsibilities
- Contracting Support

New Medi-Cal CBAS Benefit . . .

"...upholds the state's commitment to provide essential medical and social services to those with the greatest need efficiently and economically."

Toby Douglas, Director of California Department of Health Care Services (DHCS)

Beginning October 1, 2012, Community-Based Adult Services (CBAS) will become a Medi-Cal Managed Care Benefit in the Two-Plan and Geographic Managed Care (GMC) counties. As Adult Day Health Care (ADHC) providers we wanted you to have the facts about what will change and the new benefits available to Anthem Blue Cross members.

-Announced August 28, 2012 by CBAS Branch of the California Department of Aging (CDA)

A new extension period has been added for those who have chosen to remain in Fee-For-Service Medi-Cal. ***November 1, 2012*** is the new "Confirmation Period", allowing those eligible for CBAS benefits more time and opportunity to understand the facts they need to make the best decision about choosing Managed Care with CBAS benefits.

Managed Care Partnership

At Anthem Blue Cross our goal is to help you continue—without interruption—the multidisciplinary services and support that helps Seniors and Persons with Disabilities to remain in their own communities; promoting independence, choice and dignity while minimizing the risk of institutionalization.

Our Mission at Anthem Blue Cross is to improve the lives of the people we serve and the health of our communities.

In our partnership with ADHC providers and members participating in CBAS services, we will strive to make the right connections to:

- ✓ Promote better health for your participants through Care Management and coordination, particularly for complex cases
- ✓ Develop strong collaborative relationships with you and your operations staff
- ✓ Ease you through the enrollment, claims and billing guidelines and other procedures now in effect for ADHC Providers
- ✓ Partner with the community resources to provide outreach to our members

75 Years in California

2012 marks the 75th Anniversary of Anthem Blue Cross providing healthcare plans to the people of California.

We have a long-standing history of providing Medi-Cal services to Californians.

In fact, we were the original Medi-Cal Managed Care Organization …and we continue to the be the largest health plan provider that Medi-Cal works with.

Our role as a Managed Care Plan is to provide an integrated system that manages health services for each of our members, rather than simply providing or paying for them.

Through our processes or techniques we deliver, administer and/or assume risk for health services in order to influence:

- **Quality**
- **Utilization**
- **Accessibility**
- **Cost and prices**
- **Accessibility**
- **Outcomes**

Provider Resources at Anthem Blue Cross

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Customer Care Centers

Committed to providing excellent service to both members and providers

Provider Telephone Support:

Customer Care Center

Outside Los Angeles County	**800-407-4627**
Inside Los Angeles County	**888-285-7801**
Monday to Friday	**7 am - 7 pm**

Web support: www.anthem.com/ca

24/7 NurseLine: **800-224-0336**

Inquiries	Web Portal	Customer Care Center
Eligibility Verification	√	√
Claims Inquiries	√	√
Benefit Verification	√	√
Primary Care Physician Assistance	√	√
Interpreter/Hearing Impaired Services	√	√

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24/7 NurseLine

Members

24/7 NurseLine provides access to registered nurses for answers to general health questions and guidance with health concerns.

- 800-224-0336
- 7 days a week
- 24 hours a day

Providers

Can contact 24/7 NurseLine after regular business hours for:

- After-hours member eligibility and verification
- Schedule interpreters for medical visits or telephone conversations

Interpreter Services and Cultural Competency

Members

- Interpreter services at all points of contact
- Interactive Voice Recognition System (IVR) to quickly identify member language and access an interpreter for the call
- Bilingual documents (English/Spanish) required for all member materials; additional languages as needed

Providers

- Web-based information regarding cultural differences and access to interpreter services at www.anthem.com/ca
  - ❑ Cultural Competency Toolkit that covers many topics such as communication styles, health care traditions, cultural beliefs
  - ❑ Employee Language Skills Self-Assessment Tool
  - ❑ Interpreter Services
  - ❑ Interpreter Services Desktop Reference

Additional Resources

Provider Relations

- ✓ Access to the appropriate contacts
- ✓ Community Resource Coordinators
- ✓ Operations Manual
- ✓ Newsletters
- ✓ Bulletins and program updates
- ✓ www.anthem.com/ca - 24/7 Provider access

Provider Training

- ✓ Regular, on-going training regarding the Medi-Cal Managed Care program and services to members
- ✓ On-going training on specific plan guidelines

Member Eligibility Verification

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Eligibility Verification

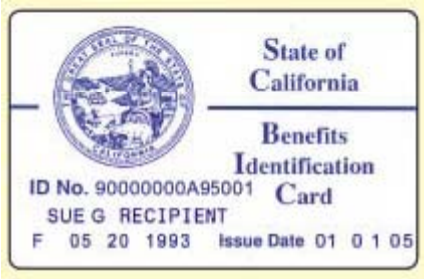
Our Managed Care Plan enrollees have received Anthem Blue Cross new Member Kits, which include:

- ✓Member identification card
- ✓Member Handbook
- ✓Letter with Managed Care Physician choice or assignment
- ✓Other information about health care services

Verify Member I.D. Before Rendering Service

The Department of Health Care Services (DHCS) determines beneficiary eligibility for the Medi-Cal program.

Once a member has been enrolled, they receive a state Beneficiary Identification Card (BIC). The BIC contains eligibility information that is accessible when providers swipe the card in their Point-Of-Service (POS) device before each visit.



California Medi-Cal Managed Care Plan

In addition to the State-issued BIC card, Anthem Blue Cross provides each member with an identification card.

Member Eligibility Verification

Providers should verify eligibility before rendering services.

Ways to verify member eligibility

With the State

- 24/7 Automated Eligibility Voice System (AEVS) **800-456-2387**
- www.medi-cal.ca.gov/Eligibility/Login.asp
- Swipe the BIC card with a Point of Service (POS) device
- Using the Certified Eligibility Real Time Systems (CERTS)

With Anthem Blue Cross

- Accessing our ProviderAccess website
- Calling our 24/7 Interactive Voice Response (IVR)
  - LA County: **888-285-7801**
  - Outside LA County: **800-407-4627**

For **After Hours** eligibility verification, call the 24/7 NurseLine: **800-224-0336**.

Submitted claims do not guarantee payments. Payment is subject to patient eligibility.
Be sure the patient's eligibility is current before rendering service.

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Member Benefits and Services

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Medi-Cal Covered Benefits

Some of the benefits to new members include:

- Coordination of Managed Care Plan
- Initial Health Assessments (IHA), within first 90 days
- Physician office visits, inpatient and outpatient services
- Durable medical equipment and supplies
- Pharmacy benefits by Express Script
- Emergency Services
- Behavioral Health
- Mental Health Services
- Vision Service Plan (VSP)
- Denti-Cal dental services

Managed Care Services

Additional services provided by Anthem Blue Cross for members:

- **Health Education**
- **Case Management –** *coordination of health care needs*
- **Non-emergency transportation** - *transport to physician when State's medical Transportation program is not available*
- **Chronic Disease coordination-of-care and support**
  - Diabetes
  - Asthma
  - Heart Disease
  - Health education classes

Claims and Billing Overview

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The Importance of a Correct Claim

We have a reputation with our network of Providers for *rapid* and *efficient* claims payments.

There are two ways to submit your claims to Anthem Blue Cross:

Electronically

Electronic Data Interchange (EDI):
800-227-3983
E-mail: edi.bccenrollment@wellpoint.com

Manually

Mail Paper or "hard copy" of Claim to:
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Type of Billed Services

CMS-1450 (UB-04) Institutional Services

- Hospitals
- Home Health (and Home Based Therapies)
- Hospitals Based ASCs

Types of Billed Services

The following billing codes and rates are used for CBAS services

HCPCS Code	Description	Rate
H2000	Comprehensive multidisciplinary evaluation	$80.08
S5102	Day care services, adult; per diem	76.27
T1023	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	64.83

PLEASE NOTE : All codes are to be billed with revenue code 560 (Medical Social Services-General Classification)

Submitting Electronic Claims

Timely filing limit is *180 days* from the date of service
(or as stated in your provider contract)

Electronic Submission

- Electronic Data Interchange (EDI)
- Web submission through Availity
- National Provider Identifier (NPI) - used in all HIPAA transactions

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

- EFT allows claims payments to be deposited directly into a previously selected bank account
- Enroll in EDI Services or ERA by calling **800-227-3983**

Additional EDI information can be obtained at www.anthem.com/edi and choose "California". Further support can be obtained by emailing EDI.ENT.SUPPORT@Anthem.com

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CBAS Enrollment Process

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Existing Participants

1. **CBAS Center Re-Assesses participant and sends Prior Authorization request, including Individual Plan of Care (IPC) with Level of Service (LOS) recommendation is created and sent to Anthem Blue Cross Utilization Management via fax at 800-754-4708.**

2. **Anthem receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Anthem will handle recommendation through existing prior authorization process which includes:**
   - ✓ Anthem will approve, modify or deny prior authorization request within **5 business days**, in accordance with Health and Safety Code 1367.01
   - ✓ If Anthem cannot make a decision within **5 business days** a **14-day** delay letter will be sent to the member and center.
   - ✓ Anthem notifies Center within **24 hours** of decision. Anthem notifies member within **48 hours** of decision.

Existing Participants

To deny or decrease the Prior Authorization request, Anthem must conduct a Face-to-Face (F2F) assessment with the member.

- *Process must be completed in accordance with Health and Safety Code 1367.01 and ensure timelines are met.*
- *F2F may be conducted at either the ADHC center or the member's home, at the member's convenience*
- *F2F will be conducted by Anthem Blue Cross associates who are Registered Nurses and Certified Case Managers*

New CBAS Candidates

1. **Providers identifies a potential need for CBAS services and submits a request for inquiry to begin the CBAS assessment process.**
2. **Anthem schedules Face to Face (F2F) with member using the following process:**
   - ✓ Anthem acknowledges, in writing, to requestor and member, the inquiry and makes first attempt to schedule F2F within **5 business days**.
   - ✓ Anthem makes two additional attempts via telephone to schedule **between 5 and 8 business days** of request.
   - ✓ Anthem makes final attempt in writing giving the member until **14th** calendar day to schedule F2F. If member does not schedule within **14 days** from inquiry, plan will send a follow-up letter to member and requestor that if services are still needed a new inquiry must be submitted to begin the process again.

Anthem conducts F2F with member using the following Guidelines:

- o Anthem must schedule F2F within **14 calendar days**.
- o F2F must be completed, using CBAS Evaluation Determination Tool (CEDT), within **30 days** from initial inquiry. Approval or denial of eligibility for CBAS to conduct IPC will be sent to the Center within **1 business day** of decision.
- o Member has the right to choose a center**.**

New CBAS Candidates Continued

3. CBAS Center Completes & Submits Prior Authorization Request

- ✓ Receives authorization from Anthem to conduct IPC/LOS assessment
- ✓ CBAS center multi-disciplinary team performs assessment
- ✓ Prior authorization request, including IPC with Level of Service recommendation is created and sent to Anthem.

4. Anthem receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Anthem will handle recommendation through existing prior authorization process which includes:

- ✓ Anthem will approve, modify or deny prior authorization request within **5 business days**, in accordance with Health and Safety Code 1367.01
- ✓ If Anthem cannot make a decision within 5 business days a **14-day** delay letter will be sent to the member and center.
- ✓ Anthem notifies Center within **24 hours** of decision. Anthem notifies member within **48 hours** of decision.

New Expedited Candidates

Nursing Facility or Hospital identifies a potential need for *expedited* CBAS services in the discharge plan and provider submits a request for inquiry to begin the CBAS assessment process. Expedited process will be conducted with 5 business days.

1. **Anthem, schedules Face to Face at the Nursing Facility or Hospital with member/facility immediately, using the following guidelines**
   - ✓ **Anthem must complete F2F within *5 business* days.**
   - ✓ **F2F must be completed, using CEDT tool, within *5 business* days from initial inquiry. Approval or denial of CBAS eligibility to conduct IPC will be sent to the Center within 1 business day of decision.**
   - ✓ **Member has the right to choose a center.**
2. **CBAS Center**
   1. **Receives approval from Anthem to conduct IPC assessment**
   2. **CBAS center multi-disciplinary team performs IPC assessment**
   3. **Prior authorization request, including IPC with Level of Service recommendation is created, sent to Anthem.**
3. **Anthem receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Authorization process includes:**
   - ✓ **Anthem will approve, modify or deny prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)**
   - ✓ **Anthem notifies Center within 24 hours of decision. Anthem notifies member within 48 hours of decision.**

New Expedited Candidates

Nursing Facility or Hospital identifies a potential need for *expedited* CBAS services in the discharge plan and provider submits a request for inquiry to begin the CBAS assessment process. Expedited process will be conducted with 5 business days.

1. **Anthem, schedules Face to Face at the Nursing Facility or Hospital with member/facility immediately, using the following guidelines**
   - ✓ **Anthem must complete F2F within *5 business* days.**
   - ✓ **F2F must be completed, using CEDT tool, within *5 business* days from initial inquiry. Approval or denial of CBAS eligibility to conduct IPC will be sent to the Center within 1 business day of decision.**
   - ✓ **Member has the right to choose a center.**
2. **CBAS Center**
   1. **Receives approval from Anthem to conduct IPC assessment**
   2. **CBAS center multi-disciplinary team performs IPC assessment**
   3. **Prior authorization request, including IPC with Level of Service recommendation is created, sent to Anthem.**
3. **Anthem receives Prior Authorization request from CBAS center, which includes a completed IPC and Level of Service recommendation. Authorization process includes:**
   - ✓ **Anthem will approve, modify or deny prior authorization request within 72 hours, in accordance with Health and Safety Code 1367.01(h)(2)**
   - ✓ **Anthem notifies Center within 24 hours of decision. Anthem notifies member within 48 hours of decision.**

Submitting CBAS Assessment Requests

Assessment requests should be submitted appropriately by type. All information should be via secure email.

Reassessment

- For current CBAS members for continued eligibility
- Should be emailed at least 6 weeks prior to the 6 month anniversary of the previous eligibility assessment determination
- Send to: CBAS-Renewal-SM@wellpoint.com

New Authorization Requests

- For member not currently receiving CBAS benefit
- Request to conduct MDT should be emailed to: new_cbas@wellpoint.com

Expedited CBAS Assessment

- Can be requested only by Nursing Facility, Hospital or attending Physician
- Member must be currently in Hospital or SNF
- Send to: urgentcbas@wellpoint.com

Once the MDT is Completed, the LOS, IPC and Prior Authorization Request should be sent to the mailbox you originally submitted your request.

Submitting CBAS Assessment Requests Continued

When submitting requests, Anthem Blue Cross requires the following information in order to make the most informed determination.

1. The completed Anthem Blue Cross CBAS medical necessity request form.
2. All Supporting Clinical Information regarding the member.

Supporting Clinical Information includes information that may have previously been submitted to the state for review, such as:

- ✓ IPC
- ✓ Interventions
- ✓ Documentation on major clinical issues
- ✓ Team Discussions & Notes

These items can and should include such things as:

- Completed Care Plans and LOS assessment
- Any information related to the member's ability to perform ADL/IADLS
- Physician Notes, History, Physical Exam Notes
  (system review of Neurological, Respiratory, Cardiac, GI/GU, Endocrine, Skin, Musuloskeletal and other significant factors)

The Care Management Difference

Minimizes fragmentation in the health care delivery system

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Care Management

Care Management is a collaborative process that assesses, develops, implements, coordinates, monitors and evaluates care plans designed to optimize member's health care benefits and promote quality outcomes.

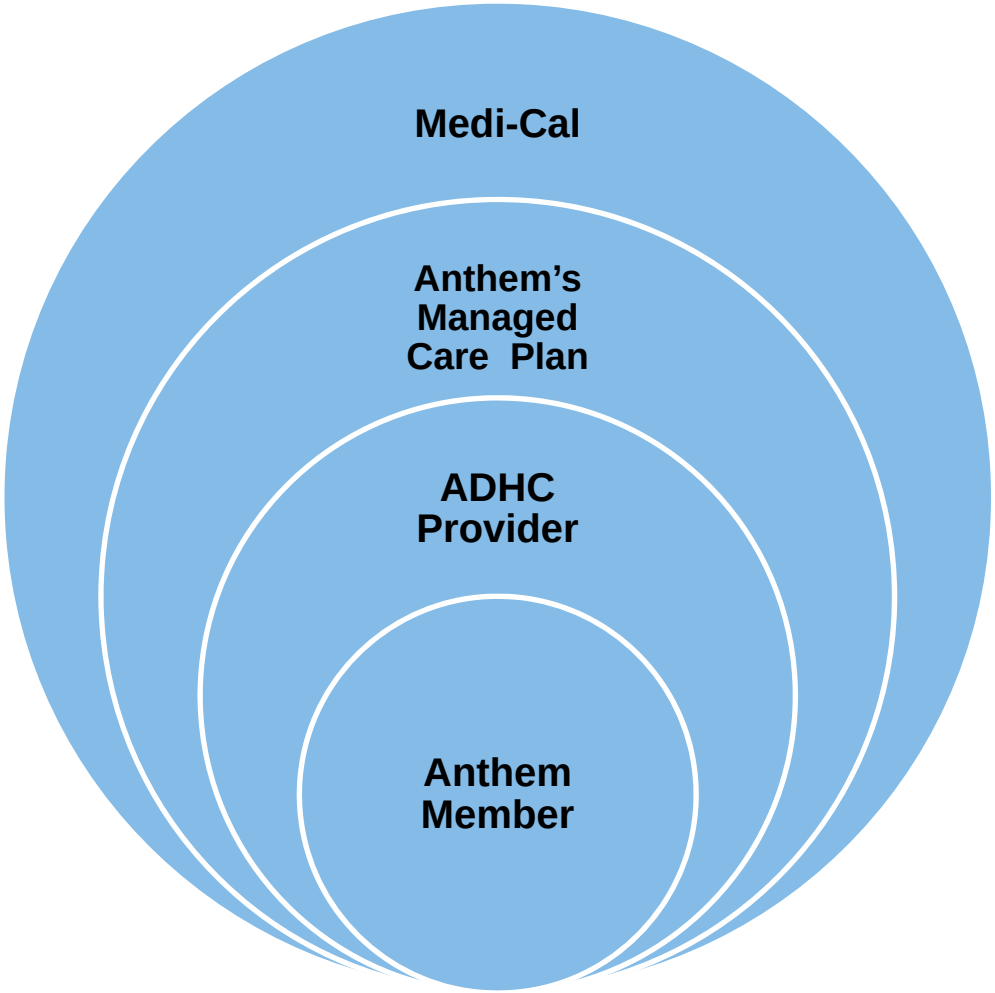
The Care Management team includes:

- Credentialed, experienced registered nurses who are Certified Case Managers as well as Case Manager Social Workers
- Teams with oversight of not only the member's medical needs, but also their psychological, social and referral issues

Cases appropriate for Case Management:

- Medically complex patients with special health care needs
- Chronic long-term conditions
- Patients with frequent emergency room visits or hospital admissions

Anthem's Care Management Coordination of Services



Case Manager: Benefits of Managed Care

Case Managers:

- Develop a care plan
- Facilitate communication and coordination between all members of the health care team
- Involve the member and family in the decision-making process
- Minimize fragmentation in the health care delivery system
- Coordinate with members and providers of the established health care delivery team about care management, community resources, benefits, cost factors

Managed Care Case Management encourages appropriate use of medical facilities and services, improves the quality of care and maintains cost-effective services on a case-by-case basis.

Referrals to Case Management

Providers, nurses, social workers and members or their representatives may refer members to Case Management in one of two ways:

By Phone

Call the Care Management Department at **866-595-0145**

By Fax

Submit a completed Care Management Referral Form to **866-333-4827**

Utilization Management

Our Utilization Management (UM) program is a collaboration with providers to promote and document the appropriate use of health care resources, and which reflect the most current UM standards from the National Committee for Quality Assurance (NCQA).

In conjunction with providers, UM assists in providing access to the right care to the right members at the right time in an appropriate setting.

The UM Department provides preservice, concurrent and post-service reviews using clinical criteria based on sound clinical evidence. These criteria are available upon request by contacting the UM Department.

By Phone: **888-831-2246**

By Fax: **800-754-4708**

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Utilization Management Pre-Service Review

All services provided by out-of-network providers, except emergency care, are rendered by in-network providers and require prior authorization.

A preservice review is required before rendering some services.

Pre-service requests are reviewed for:

- ✓ Member Eligibility
- ✓ Appropriate level of care
- ✓ Benefit Coverage
- ✓ Medical Necessity

Examples of services requiring pre-service review include, but are not limited to:

- ✓ Selected durable medical equipment
- ✓ Speech therapy
- ✓ Sensory Integration Therapy

For a more detailed list (by CPT and HCPCS codes) of services requiring preservice review, go to **www.anthem.com/ca** and select State Sponsored Plans. Select **Prior Authorization Toolkit**, then select specific program.

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Provider Grievances and Appeals

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Provider Complaints

Providers may submit complaints relating to the operations of the plan

- Providers may file written complaints involving dissatisfaction or concerns about other Providers, the Plan or a member
- Provider can also request an appeal on behalf of a member for denial, deferral, or modification of a prior authorization or request or concurrent review (see Provider Manual, Chapter 9 Member Grievance and Appeals)

Complaints are required to include

- Provider's name
- Date of the incident
- Description of the incident

Requests for additional information

- Anthem Blue Cross may request additional information or medical records related to the complaint, and providers are expected to comply with the request within **10 calendar days**

Timeframes

- Provider grievance may be filed up to **180 days** after date of incident
- An acknowledgement letter is sent within **5 business days** of receipt of the complaint
- A resolution letter is sent within **30 calendar days** of receipt of the complaint

Submitting A Provider Complaint

Providers may file a grievance, in writing, to the Grievance and Appeals (G&A) Department.

By Mail

Attn: Grievance & Appeals Department
Anthem Blue Cross
PO Box 60007
Los Angeles, CA 90060-0007

By FAX

Attn: Grievance & Appeals Department
866-387-2968

To download the Physician/Provider Grievance Form, go to **www.anthem.com/ca** and select **Forms and Tools**

Provider Appeals

Providers can appeal Anthem Blue Cross' denial of a service or denial of payment.

Submit an appeal in writing using the Provider Dispute Resolution (PDR) Form

- Submit within **356 calendar days** from receipt of the Remittance Advice (RA) or notice of action letter
- The Provider Dispute Resolution Form is located at www.anthem.com/ca under Forms and Tools
- Anthem Blue Cross sends an acknowledgement of receipt to providers within **15 business days**

When will the appeal be resolved?

- If the Provider Dispute results in reimbursement, we will send an Overturn letter within **45 business days**. If no reimbursement is made, provider will receive an Uphold letter within **45 business days**.

External Review

If a provider is still dissatisfied with Anthem Blue Cross' decision to not pay a claim after the initial appeal process, the provider may request an external review from a non-network provider of the same or related specialty.

Requests for external reviews must be submitted in writing to:

Attn: Grievance & Appeals Department
Anthem Blue Cross
PO Box 60007
Los Angeles, CA 90060-0007

Provider Responsibilities

Provider Responsibilities

Providers maintain a responsibility for understanding and adhering to policies and guidelines, some of which are:

- Eligibility Verification
- Collaboration
- Continuity of Care
- Medical Records/Documentation: Standards
- Mandatory Reporting of Abuse
- Updating Provider Information
- Provider Contract Termination
- Disenrollees
- Prohibited Activities

****Explanations for all of the above Provider Responsibilities can be found in Chapter 8, of the California Provider Operations Manual.***

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Provider Responsibilities Continued

We are committed to protecting the integrity of the programs we offer and the efficiency of our operations by preventing, detecting and investigating fraud, abuse and waste.

Combating fraud, abuse, and waste begins with knowledge and awareness. For specific information about how to identify, avoid and report Fraud and Abuse, please refer to the **Anthem Blue Cross Medicaid Provider Operations Manual**: Chapter 20, Fraud and Abuse.

If you suspect Fraud and Abuse, you may report it in one of two ways:

By Phone

Contact our Customer Care Center at **800-407-4627**

By Fax

Complete the Fraud Referral Form and Fax to:

Attn: **Fraud and Abuse Unit at 866-454-3990**

Member Rights & Responsibilities

Members are also granted Rights and Responsibilities which are included on the state Medi-Cal website and also included in the Anthem Blue Cross member handbook. These include:

- Tell your doctors what they need to know to treat you.
- Learn as much as you can about your health.
- Follow the treatment plans agreed upon by you and your doctors.
- Follow your doctor's advice about taking good care of yourself.
- Use the right sources of care.
- Bring your health plan ID card with you when you visit your doctor.
- Treat your doctors and other caregivers with respect.
- Understand this health plan.
- Know and follow the rules of this health plan.
- Know that laws govern this health plan and the types of service you get.
- Know that we cannot discriminate against you because of your age, sex, race, national origin, culture, language needs, sexual orientation or health.

Contracting Support

Our official partnership begins with the signing and submission of your CBAS Provider Contract to Anthem's Provider Contracting Department.

If you have questions about completing your CBAS provider contract, please contact:

Cora Ross, Regional Manager of Contracting for Government Products

Phone: **805 -234-5959**

E-mail: **cora.ross@wellpoint.com**

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Community Resource Coordinators

Anthem Blue Cross Providers have a direct line of communication with Community Resource Coordinators (CRCs).

CRCs work within your community. The CRC staff provide localized customer service to our members and providers. You may contact your local CRC at one of the numbers below.

Covered Region	Phone
Southern California	818-655-1255
Central California	559-623-0480
Northern California	916-325-4200

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Contact Reference

As a convenient reference, the following list offers contact points found elsewhere in this presentation.

Customer Care Center
Outside Los Angeles County: 800-407-4627
Inside Los Angeles County: 888-285-7801

Community Resource Coordinators
Southern California: 818-655-1255
Central California: 559-488-0480
Northern California: 916-325-4200

CBAS Care Management Process
Liza Warren Liza.Warren@wellpoint.com 408-824-0873
Shalon Irby Shalon.Irby@wellpoint.com 314-413-9511

Contracting Support
Cora Ross cora.ross@wellpoint.com 805 -234-5959

Eligibility Verification
State AEVS: 800-456-2387
Anthem Blue Cross
Inside LA County: 888-285-7801
Outside LA County: 800-407-4627
NurseLine 24/7 *(after hours)*: 800-224-0336

Grievance & Appeals 866-387-2968

Electronic Data Interchange 800-227-3983

In Closing

Thank You.

We appreciate your time today…as well as all you do everyday in the pursuit of quality care for our members.