Anthem BlueCross

Medi-Cal Managed Care
L.A. Care
Medicare Advantage
Cal MediConnect Plan

Provider Bulletin
January 2022

COVID-19 information updates (January 19, 2022 update)

Updated to include vaccine information

This communication applies to the Medicaid, Medicare Advantage and Medicare-Medicaid Plan (MMP) programs for Anthem Blue Cross (Anthem).

Anthem will update FAQ as more information becomes available. Providers should visit the California provider communications COVID-19 page homepage for the latest information from Anthem about COVID-19.

Anthem is closely monitoring COVID-19 developments and what it means for our customers and healthcare provider partners. Our clinical team is actively monitoring external queries and reports from the Centers for Disease Control and Prevention (CDC) to help us determine what action is necessary on our part. Providers may also visit **https://www.dhcs.ca.gov/Pages/DHCS-COVID%E2%80%9119-Response.aspx** for information from the CA Department of Health Care Services.

To help address care providers' questions, Anthem has developed the following updates and frequently asked questions.

Contents:

* LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Anthem Blue Cross.

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COVID-19 covered testing – SB510

What COVID-19 testing does the health plan cover under SB510?
Anthem covers COVID-19 diagnostic and screening tests for all fully insured members under DMHC and CDI regulated plans with no out-of-pocket costs.

Does SB510 impose specific requirements regarding type of tests covered (antigen or PCR)?
This includes antigen and PCR testing. Home testing is also covered as types of diagnostic and screening testing. To be covered, tests must be FDA approved or have FDA emergency use authorization.

How are providers reimbursed for COVID-19 testing under SB510?
In-network providers will be reimbursed at the negotiated rate. For out-of-network providers, we do not have a negotiated rate for COVID-19 diagnostic and screening tests, and SB 510 requires that reimbursement be based on a reasonable rate. Federal law also mandates reimbursement rates for out-of-network. Under federal law, out-of-network diagnostic tests are required to be reimbursed based on the out-of-network providers posted *cash price*. When federal law applies, Anthem will reimburse the provider based on federal requirements.
Out-of-network providers are prohibited from seeking reimbursement from members for COVID-19 diagnostic and screening testing services.

Is COVID-19 testing cost a delegated capitated service based on SB510?
The cost associated with COVID-19 testing under SB510 will remain with Anthem, unless a new agreement with the delegated provider is reached.

Does SB510 requirements apply retroactively?
Recent law requires health plans to cover the cost of COVID-19 tests for screening and diagnostic retroactively, beginning from the Governor's declared State of Emergency related to COVID-19 on March 4, 2020, and onward.

Anthem has and will continue to advocate for affordable access to quality health care for our members and for all Californians. As such, we support the California Association of Health Plans' (CAHP) decision to file suit against the State of California over this recent law and the retroactive components. We do not challenge the application of the law from its effective date of January 1, 2022, and forward. The retroactivity components of the law may result in an increase in healthcare premiums and for these reasons, CAHP is asking the court to halt the retroactive components of this law. Anthem is a member of CAHP and supports this effort.

Waiver of member cost shares

Will Anthem waive member cost shares related to COVID-19 including screening, testing, and treatment?

- **Screening and testing:** Yes, as of March 5, 2020, and until further notice, cost shares, inclusive of copays, coinsurance and deductibles for COVID-19, will be waived by Anthem or its delegated entities for screening and testing for COVID-19. Tests samples may be obtained in many settings including a physician's office, urgent care, ER or even drive-thru testing once available. While a test sample cannot be obtained through a telehealth visit, the telehealth provider can help a member get to a provider who can do so. The waivers apply to members who have individual, employer-sponsored, Medicare and Medicaid plans.
- **Treatment**: Yes, effective April 1, 2020, through January 31, 2021, Anthem and its delegated entities waived cost shares for members undergoing treatment related to a COVID-19 diagnosis.

Anthem will reimburse healthcare providers according to standard reimbursement rates, depending on provider participation and benefit plan. Anthem will continue to monitor and comply with state and federal guidelines.

Prior authorization

Does Anthem require a prior authorization for screening or testing for COVID-19?
No, prior authorization is not required for screening or testing related to COVID-19 testing.

Is Anthem changing its requirements for prior authorization?
Anthem recognizes the intense demands facing doctors, hospitals and all healthcare providers in the face of the COVID-19 pandemic and has put in place a temporary waiver. As of January 10, 2022, through January 31, 2022, Anthem and its delegated entities will suspend select prior authorization requirements to allow healthcare providers to focus on caring for patients diagnosed with COVID-19. These adjustments apply to members of Commercial business, including self-insured plans and Medicare business. The suspension of select prior authorization is inclusive of the following:

Inpatient and respiratory care

- To assist the removal of administrative burden on hospitals during the COVID-19 pandemic, medical reviews are suspended for all confirmed and suspected COVID-19 inpatient cases.
- **Prior authorization requirements are suspended for patient transfers from acute IP hospitals to skilled nursing facilities, acute rehabilitation, and long-term acute care**. These changes are effective January 10, 2022, through January 28, 2022. These adjustments apply for our fully-insured and self-funded employer, Individual, and Medicare plan members receiving care from in-network providers. While prior authorization is not required for facility transfers to lower levels of care, we continue to require notification of the admission via the usual channels and clinical records on day two of admission to aid in our members' care coordination and management. Anthem reserves the right to audit patient transfers. Anthem encourages providers to continue to follow normal processes and obtain prior authorization and reminds providers that patient transfers should be to in-network facilities when possible.
- **Prior authorization requirements were suspended for patient transfers through February 18, 2021** (for Medicare and MMP only; for Medicaid, there is no current end date)**. :** All hospital inpatient transfers to lower levels of care (by land only). Although prior authorization was not required, Anthem requested voluntary notification via the usual channels to aid in our members' care coordination and management.
- **The 21-day inpatient requirement** before transferring a patient to a long-term acute care hospital was suspended through February 18, 2021 (for Medicare and MMP only; for Medicaid, there is no current end date),..
- **Extended the length of time a prior authorization issued on or before May 30, 2020,** was in effect for elective inpatient and outpatient procedures an additional 180 days. This helped prevent the need for additional outreach to Anthem to adjust the date of service covered by the authorization.
- **Concurrent review for discharge planning** will continue unless required to change by federal or state directive.
- **Prior authorization requirements were suspended for COVID-19 durable medical equipment through February 18, 2021,** including oxygen supplies, respiratory devices and continuous positive airway pressure (CPAP) devices for patients diagnosed with COVID-19, along with the requirement for authorization to exceed quantity limits on gloves and masks.
- **Respiratory services** for acute treatment of COVID-19 will be covered. Prior authorization requirements were suspended where previously required through February 18, 2021.

Telehealth and telephonic services

What member cost shares will be waived by Anthem for virtual care through telehealth and telephone-only?
For COVID-19 treatments via telehealth visits, Anthem will cover telehealth and telephonic-only visits from in-network providers and will waive cost shares until further notice.

For in-network providers, effective March 17, 2020, through September 30, 2020, Anthem waived member cost share for telehealth (video + audio) and telephone-only visits for services not related to the treatment of COVID-19 from in-network providers, including visits for behavioral health, for our fully-insured employer, individual and Medicaid plans where permissible. For Medicare plans, in-network providers, effective March 17, 2020, through December 31, 2020, Anthem and its delegated entities waived member cost share for telehealth (video + audio) and telephone-only visits for services not related to the treatment of COVID-19 from in-network providers, including visits for behavioral health.

For out-of-network providers, Anthem waived cost shares for services received from March 17, 2020, through June 14, 2020. Cost sharing will be waived for members using Anthem's telemedicine service, LiveHealth Online,* as well as care received from other providers delivering virtual care through internet video + audio services. Self-insured plan sponsors may opt out of this program.

Will Anthem cover virtual care through telehealth and telephone-only?
Effective March 17, 2020, and until further notice, for COVID-19 related services, Anthem and its delegated entities will cover telehealth and telephone-only medical and behavioral health services from in-network providers and out-of-network providers.

Effective March 17, 2020, and until further notice, for services not related to the treatment of COVID-19, Anthem will cover telehealth and telephone-only medical and behavioral health services from in-network providers. For telehealth and telephonic services received from a non-contracted provider, Anthem will cover such services when there is an out-of-network benefit.

Self-insured plan sponsors may opt out of this program.

Is the option to deliver services via telehealth available for all types of services?
Yes, until further notice, so long as it is medically appropriate to render the services via telehealth.

Exceptions for Medi-Cal members include chiropractic services, physical, occupational, and speech therapies. At this time, the Department of Health Care Services (DHCS) has not authorized these services for telehealth or telephone.

Does the provider have to be physically present in their office when providing services via telehealth?
No. If the provider can effectively deliver services via telehealth from another location (for example, the provider's home), while also maintaining the patient's privacy the services are payable.

What is the reimbursement rate for telehealth and telephonic-only services?
As required by the State of California, telehealth and telephonic services must be paid at the same rate, whether a service is provided in-person or through telehealth or telephonically, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim.

Can all contracted providers provide telehealth and telephonic-only services?
Yes. All Anthem contracted providers can provide telehealth and telephonic services if clinically appropriate.

Is Anthem's vendor, LiveHealth Online, prepared for the number of visits that will increase to telehealth?
As there is a heightened awareness of COVID-19 and more cases are being diagnosed in the United States, LiveHealth Online is increasing physician availability and stands ready to have physicians available to see the increase in patients, while maintaining reasonable wait times.

What is the best way that providers can get information to Anthem's members on Anthem's alternative virtual care offerings?
Anthem.com/ca and Anthem's COVID-19 site (**https://www.anthem.com/ca/coronavirus**) are great resources for members with questions and are being updated regularly.

Anthem members have access to telehealth 24/7 through LiveHealth Online. Members can access LiveHealth Online at **https://livehealthonline.com** or download the LiveHealth Online app from the App Store or Google Play.

Anthem members also can call the Anthem 24/7 NurseLine at the number listed on their Anthem ID card to speak with a registered nurse about health questions.

For COVID-19 treatments via telehealth visits, Anthem and its delegated entities will cover telehealth and telephonic-only visits from in-network providers and will waive cost shares until further notice.

From March 17, 2020, through September 30, 2020, Anthem waived any member cost share for telehealth or telephonic visits provided by in-network provider, including visits for mental health, for our fully insured employer, individual and Medicaid plans.

For Medicare plans, in-network providers, effective March 17, 2020, and December 31, 2020, Anthem waived member cost share for telehealth (video + audio) and telephone-only visits from in-network providers, including visits for behavioral health.

Cost shares will be waived for members using Anthem's telemedicine service, LiveHealth Online, as well as care received from other telehealth providers. Self-insured plan sponsors will have the choice to participate.

Coding, billing, and claims

How should a provider bill for services delivered via telehealth or telephone during the State of Emergency, when the provider would normally deliver the services in-person?
During the COVID-19 State of Emergency, when a provider delivers a service via telehealth that the provider would normally deliver in-person, the provider should document and bill the service(s) as follows:

- Thoroughly document the visit as if the visit had occurred in person.
- Use the CPT® code(s) for in-office visit for the particular service(s) rendered. **Do not use telehealth or telephonic CPT codes.**
- Use Place of Service "02" to designate telehealth.
- Use modifier 95 or GT for synchronous rendering of services, or GQ for asynchronous.
    - **Medi-Cal exception** – use modifier 95 for synchronous rendering of services, or GQ for asynchronous.

What modifier is appropriate to waive member cost sharing for COVID-19 testing and visits related to testing?
The Centers for Medicare & Medicaid Services (CMS) has provided the Medicare guideline to use the CS modifier: **https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-10-mlnc-se**. Anthem also looks for the CS modifier to identify claims related to evaluation for COVID-19 testing. This modifier should be used for COVID-19 evaluation and testing services in any place of service.

What diagnosis codes would be appropriate to consider for a patient with known or suspected COVID-19?
The CDC has provided coding guidelines related to COVID-19:
https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

Should providers who are establishing temporary locations to provide healthcare services during the COVID-19 emergency notify Anthem of new temporary addresses?
Providers do not need to notify Anthem of temporary addresses for providing healthcare services during the COVID-19 emergency. Providers should continue to submit claims specifying the services provided using the provider's primary service address along with their current tax ID number.

How does a provider submit a telehealth visit with an existing patient that lives in a bordering state?
For providers (for example, in bordering states) who were previously seeing members in approved locations that met state and/or CMS billing requirements, effective March 17, 2020, and until further notice, a provider may submit a telehealth claim using the primary service address where they would have normally seen the member for the face-to-face visit.

How is Anthem reimbursing participating hospitals that perform COVID-19 diagnostic testing in an emergency room or inpatient setting?
Reimbursement for COVID-19 testing performed in a participating hospital emergency room or inpatient setting is based on existing contractual rates inclusive of member cost share amounts waived by Anthem.

Claims audits, retrospective review and policy changes

Anthem will adjust the way we handle and monitor claims to ease administrative demands on providers:

- **Hospital claims audits** requiring additional clinical documentation will be limited through June 24, 2020, though Anthem reserves the right to conduct retrospective reviews with expanded lookback recovery periods. To assist providers, Anthem can offer electronic submission of clinical documents through the provider portal.
- **Retrospective utilization management review** will also be limited through June 24, 2020, and Anthem reserves the right to conduct retrospective utilization management review of these claims when this period ends and adjust claims as required.
- **Our special Investigation programs** targeting provider fraud will continue, as well as other program integrity functions that ensure payment accuracy.

Anthem will continue to administer claims adjudication and payment in line with our benefit plans and state and federal regulations, including claims denials and appeals where applicable. Our timely filing requirements remain in place, but Anthem is aware of limitations and heightened demands that may hinder prompt claims submission.

Provider credentialing

Through June 24, 2020, Anthem processed provider credentialing within the standard timeframe. If we were unable to verify provider application data due to disruptions to licensing boards and other agencies we will verify this information when available.

If Anthem finds that a practitioner fails to meet our minimum criteria because of sanctions, disciplinary action etc., we will follow the normal process of sending these applications to committee review which may add to the standard timeframe. We will monitor and comply with state and federal directives regarding provider credentialing.

Vaccine administration

How is Anthem reimbursing U.S. Food and Drug Administration (FDA)-approved COVID-19 vaccines?
The cost of COVID-19 FDA-approved vaccines will initially be paid for by the government.

Anthem will reimburse for the administration of COVID-19 FDA-approved vaccines in accordance with federal and state mandates.

Recently CMS shared (**https://www.cms.gov/files/document/COVID-19-toolkit-issuers-MA-plans.pdf**) that for members of Medicare Advantage plans, the COVID-19 vaccine administration should be billed to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved. This will ensure that Medicare Advantage members will not have cost-sharing for the administration of the vaccine.

For members of our fully-insured employer and individual plans as well as self-funded plans, Anthem will cover the administration of COVID-19 vaccines with no cost share for in- and out-of-network providers, during the national public health emergency.

Department of Managed Health Care (DHMC) issued regulation directing financial risk to the health plans for delegated entities.

- Delegated Entities – Unless covered under the Division of Financial Responsibility (DOFR), Anthem will be responsible for the vaccine administration cost and will reimburse at the Prudent Buyer rate, which is the same as the Medicare national rate.
- In-Network Providers – Anthem will reimburse at the contracted rate
- Out of Network – Anthem will reimburse at the Medicare national rate

For members of Medicaid plans, Medicaid state-specific rules and other state regulations may apply.

Prescription drugs

Can members obtain an extra 30-day refill of a prescription drug?
Yes. We are also allowing members to obtain an extra 30-day supply of medication when medically appropriate and permitted by state and federal law. We are also encouraging that when member plans allow that they switch from 30-day home delivery to 90-day home delivery.

General questions

Does Anthem have recommendations for reporting, testing and specimen collection?
The CDC updates these recommendations frequently as the situation and testing capabilities evolve. See the latest information from the CDC: **https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html**

Does Anthem have recommendations for COVID-19 preventive health and clinical guidance?
Refer to the latest information found on the CDC COVID-19 website: **https://www.cdc.gov/coronavirus/2019-nCoV** as well as information found on local County Department of Public Health websites.

In case of mass pandemic, how can you ensure that your contracted providers can still provide services?
Anthem is committed to working with and supporting its contracted providers. Our benefits already state that if members do not have appropriate access to network physicians that we will authorize coverage for out-of-network physicians as medically necessary.

In addition, Anthem's telehealth provider, **LiveHealth Online**, is another safe and effective way for members to see a physician to receive health guidance related to COVID-19 from their home via mobile device or a computer with a webcam.

Are you aware of any limitations in coverage for treatment of an illness/virus/disease that is part of a pandemic?
Our standard health plan contracts do not have exclusions or limitations on coverage for services for the treatment of illnesses that result from a pandemic.

What financial assistance is available for care providers during the COVID-19 crisis?
The *CARES Act* provides financial relief to lessen the impact of the COVID-19 crisis. Included in the law are new resources to address the economic impact of COVID-19 on employers of all sizes. The *Act* expands existing federal loan programs, creates new tax credits, postpones employment tax payments, and includes additional tax relief. To help care providers navigate the resources available to them, Anthem has complied information on programs we have learned about that could provide additional financial relief during this crisis. This information can be found in the ***Federal Resources Available for Care Providers and Employers in the Federal CARES Act*** article in Anthem Provider News.

Does Anthem expect any slowdown with claim adjudication because of COVID-19?
We are not seeing any impacts to claims payment processing at this time.

Do these guidelines apply to members enrolled in the Blue Cross and Blue Shield Service Benefit Plan commonly referred to as the Federal Employee Program (FEP®)?
Where permissible, these guidelines apply to FEP members. For the most up-to-date information about the changes FEP is making, go to **https://www.fepblue.org/coronavirus**.