Anthem

SISC
Self-Insured Schools of California

The SISC Physical Medicine Review Program

Q. What are your physical medicine benefits?

A. Your benefit plan allows for in-network physical medicine services. You can enjoy chiropractic, physical and occupational therapy without any plan limits, as long as it's medically necessary. Anthem processes claims according to the medical necessity decisions made by American Specialty Health (ASH).

Q. Who is American Specialty Health (ASH)?

A. ASH is a national health services organization that specializes in the review of physical medicine services and health and wellness provider networks. Anthem contracts with ASH to ensure SISC physical medicine services are medically necessary. The ASH Clinical Staff is made up of a wide variety of experts in the field of physical medicine which includes: chiropractors, physical therapists (including those well-versed in pediatric physical therapy and in rehabilitation of cardio and neuro conditions), occupational therapists, acupuncturists, and medical physicians boarded on physical medicine and pain management. All have extensive backgrounds in utilization review, quality management, and the identification of fraud, waste, and abuse.

Q. Why does SISC want to have a physical medicine review program?

A. SISC wants to ensure you have access to all the physical medicine services you need to treat your specific condition. A review program allows SISC to offer a member as many visits or treatments as needed without pre-determined plan limits.

Reviewing for medical necessity

Q. How does the review work?

A. For in-network providers who perform physical medicine services:

- Your first five visits do not require a medical necessity review to be performed.
- Starting with your sixth visit, participating providers are responsible for obtaining medical necessity reviews through ASH.
- Anthem will deny claims where a medical necessity review is not on file.
- You and your provider will be made aware of all medical necessity review decisions and how claims are processed.
- It's important that ASH gives the OK, because the medical necessity review is needed for the provider to get paid. If ASH denies a service you are not responsible for the cost of the service if you are using an in-network provider.

Q. Do I have to have the medical necessity review done before I can get services?

A. While it is not necessary to obtain pre-service review for these services, the corresponding claim may be rejected or delayed until medical necessity review is complete. In order for such a claim to be considered for payment, the provider will need to request a retrospective review and submit the applicable medical records, if applicable.

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Q. How long does the review take?

A. If a member has not yet had the treatment, ASH will review it between 2-15 business days. If the member has already had the treatment, ASH will review it within 30 days, as long as all the paperwork has been sent. Please remember the medical necessity review does not have to be completed before services are rendered.

Q. How should information be sent to ASH for review?

A. Participating providers are responsible to work directly with ASH.

Your benefits

Q. How can I find a provider?

A. Go to **anthem.com/ca/sisc/find-care/** to find in-network providers in your area.

You also can call the Member Services number on the back of your member ID card.

If you live and work far away from in-network providers, please contact customer service for an out-of-network referral. This is on a case-by-case basis and must be approved by Anthem before you get treatment.

Q. How does medical necessity review affect coverage?

A. If ASH determines the service is medically necessary then:

- You pay your normal required amount, such as a copay or coinsurance.

If ASH determines the service is not medically necessary then:

- You may not have any additional payment responsibilities when you see an in-network provider.
- If you have used an in-network provider, you may not be responsible for services performed that do not meet ASH's guidelines for medical necessity.

Q. What if I have Medicare or another health plan as primary and my SISC plan is secondary, or if I live out of the state of California or have physical medicine services rendered in a hospital setting?

A. A medical necessity review of physical medicine services is not required.

Q. Do all providers follow this process if they offer physical medicine services?

A. Yes, all physical medicine services starting with the sixth visit must have a medical necessity review.

Handling claims

Q. Where are claims processed?

A. Anthem processes claims and will apply all medical necessity review decisions made by ASH. Members will receive an explanation of benefits from Anthem on how the claim processed.

Q. What if the claim is for a service outside of California?

A. The provider must send claims to the local Blue Cross and Blue Shield plan where you received service and the ASH review program does not apply.

Q. How do I appeal a claim or file a grievance?

A. Just follow the Anthem process on the back of your explanation of benefits or medical necessity letter.

Where to go for more information

Q. Who should I call about a claim or a medical necessity review decision?

A. Call the Member Services number on the back of your member ID card. Our Anthem Member Services representatives can help you.