# Network Update

## In this issue

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Reform Updates (Including Health Insurance Exchange)</td>
<td>Important information available online</td>
<td>3</td>
</tr>
<tr>
<td>Announcements and General Updates</td>
<td>URGENT OrthoNet Update: Contact information change</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Important information about coverage for Digital Breast Tomosynthesis (DBT) or 3-D mammography</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Registration for prescribing of controlled substances: Required by December 31, 2015</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Specialty pharmacy updates</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Changes to AIM Specialty Health’s sleep disorder management diagnostic and treatment guidelines</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Reference based benefits for CVT members</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Family-Based treatment for adolescents with Anorexia Nervosa</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Introducing Anthem Togetherworks</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Anthem Blue Cross Partners with Vital Decisions to provide services to members with advanced illness</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Mobile App to manage cancer symptoms updated to address Psychosocial distress</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Survey says...Patients see room for improvement with physician care</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Improving your patients’ health care experience</td>
<td>11</td>
</tr>
<tr>
<td>Billing</td>
<td>Anthem Blue Cross has implemented ICD-10</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>ICD-10: Splitting bills could cause overpayments</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Workers’ compensation referrals to participating providers</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Contracted provider claim escalation process</td>
<td>13</td>
</tr>
<tr>
<td>Network</td>
<td>Anthem Blue Cross “Find a Doctor” tool</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Providers update your Anthem Blue Cross provider demographic information via the Availity Web Portal</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Anthem Blue Cross cost transparency</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Provider Network Education 2015 seminars and e-solutions</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Sign-up for our Network eUPDATE today – it’s free!</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Network leasing arrangements</td>
<td>16</td>
</tr>
</tbody>
</table>
In this issue Continued

**Guidelines and Quality Programs**
- Clinical practice and preventive health guidelines available on the web
- Timely Access Regulations
- Take a look at our Behavioral Health Case Management (BCHM) program
- Coordination of care has an big impact

<table>
<thead>
<tr>
<th>Medi-Cal Managed Care Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>October is National Breast Cancer Awareness month is more important than ever</td>
</tr>
<tr>
<td>Provider self-service tools make it easy to do business</td>
</tr>
<tr>
<td>ICD-10 documentation and diagnosis coding tips</td>
</tr>
<tr>
<td>Update: Hemophilia drugs medical necessity reviews</td>
</tr>
<tr>
<td>Behavioral health authorization requirement changes</td>
</tr>
<tr>
<td>Medical Policies and Clinical Utilization Management guidelines update</td>
</tr>
<tr>
<td>CDC predicts another moderately severe flu season dominated by Influenza A (H3N2)</td>
</tr>
<tr>
<td>Synagis guidelines for Respiratory Syncytial Virus season</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anthem Blue Cross Cal Mediconnect Plan Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality improvement program announced</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Advantage Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep up with Medicare Advantage at Important Medicare Advantage updates</td>
</tr>
<tr>
<td>Routine physical exams are covered in 2016</td>
</tr>
<tr>
<td>Administrative denials may be appealed</td>
</tr>
<tr>
<td>HRM program designed to reduce risk to Medicare Advantage members</td>
</tr>
<tr>
<td>Precertification requirements updated for 2016</td>
</tr>
<tr>
<td>Correction: CMS colorectal cancer screening guidelines</td>
</tr>
<tr>
<td>Imaging site scores for outpatient diagnostic imaging could impact reimbursement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy information available on Anthem.com/ca</td>
</tr>
</tbody>
</table>

Professional Network Update

October 2015
Health Care Reform Updates (including Health Insurance Exchange)

Important information available online

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

Announcements and General Updates

URGENT OrthoNet Update: Contact information change

Effective November 1, 2015, Anthem Blue Cross (Anthem) will implement a physical therapy and occupational therapy utilization management program for outpatient and office service. In order to help us effectively administer this program, we have contracted with an external vendor, OrthoNet LLC, to work with us. OrthoNet is a leading musculoskeletal management company, with significant experience working with physical and occupational therapists. Providers were sent an initial 90 day notification in July 2015.

Utilization Review: Pre-certification will be required for outpatient and office physical and occupational therapy services for Anthem members except for the following health benefit plans:

- Medicare Advantage
- Medicare Supplement
- Medicare Part D
- Medi-Cal/Medicaid
- Anthem National Accounts (ANA)
- ASO – Self Funded Groups
- Federal Employee Program (FEP)
- Blue Card
- HMO
- POS

What has changed since the July 2015 notice?
1. Beginning October 19, 2015: OrthoNet will be prepared to accept precertification requests for service dates on or after November 1, 2015. (Formerly communicated beginning October 6, 2015.)
2. OrthoNet call center: 1-844-691-4062 (old number – 1-844-282-6994)
3. OrthoNet Fax: 1-844-349-7496 (old fax - 1-844-216-1599)
Important information about coverage for Digital Breast Tomosynthesis (DBT) or 3-D mammography

In 2015, the USPSTF reviewed screening recommendations for breast cancer and concluded in a draft recommendation statement that Digital Breast Tomosynthesis (DBT) or 3-D mammography does not meet evidence level A or B and should not be recommended in place of digital mammography for routine breast cancer screening. The draft statement also notes that DBT may expose women to approximately twice the radiation of 2-D digital mammography.

Based on the USPSTF conclusion and Anthem Blue Cross’ independent review of the available evidence, Anthem Blue Cross considers Digital Breast Tomosynthesis investigational and not medically necessary for all indications.

Please note that two imaging vendors currently have FDA approval for DBT and actively promote their services to academic centers and private hospitals or imaging centers. As marketing and adoption of DBT increases, we expect an increase in interest and use of this service, which is why it is important for providers to be aware that DBT is a non-covered service.

Anthem Blue Cross has extensively reviewed the available evidence addressing the use of Digital Breast Tomosynthesis and presented this data to the Medical Policy and Technology Assessment Committee (MPTAC) for discussion and evaluation. The MPTAC agrees with the USPSTF concerns and recommendations.

To read more about the USPSTF’s conclusion, please see the USPSTF Breast Cancer Screening Draft Recommendation Statement. Providers can also review Anthem Blue Cross’ medical policy for Digital Breast Tomosynthesis.

Registration for prescribing of controlled substances: Required by December 31, 2015

CURES 2.0, the updated version of the “Controlled Substance Utilization Review and Evaluation System”, is now active. There is a rollout to present users of Version 1.0 and the California Department of Justice has mandated that all prescribers and pharmacists apply for CURES access by January 1, 2016. The CURES system is designed to identify and deter drug abuse and diversion through accurate and rapid tracking of Schedule II through IV controlled substances. It is a valuable investigative, preventive and educational tool for law enforcement, regulatory boards, educational researchers, and the healthcare community.

The CUREs Database is available to those who “prescribe, order, administer, furnish, or dispense Schedule II-IV Controlled Substances. CURES contains the following information: patient name, patient date of birth, patient address, prescriber name, prescriber DEA number, pharmacy name, pharmacy license number, date prescription was dispensed, prescription number, drug name, drug quantity and strength, and number of refills remaining.”
Specialty pharmacy updates

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

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

The changes listed below will become effective on October 15, 2015.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
</table>
| DRUG.00078       | Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors | J3490- Unclassified drug [when specified as alirocumab]  
|                  |                                               | J3590 - Unclassified biologics [when specified as alirocumab] |

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

<table>
<thead>
<tr>
<th>Medical Policy ur UM Clinical Guideline</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
</table>
| DRUG.00077                             | Secukinumab (Cosentyx™)                        | J3490 – Unclassified drug [when specified as secukinumab]  
|                                        |                                               | J3590 – Unclassified biologics [when specified as secukinumab] |
| CG-DRUG-45                             | Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot) | J2353 – Injection, octreotide, depot form for intramuscular injection, 1 mg  
|                                        |                                               | J2354 – Injection, octreotide, nondepot form for subcutaneous or intravenous injection, 25 mcg |

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

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

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

Online Requests – Pre-service clinical review will be available online via AIM through their web-based application which is available twenty-four hours a day, seven days a week. It is fully interactive, processing requests in real-time using clinical criteria. The AIM web-based application may be accessed online through the Availity Web Portal at www.availity.com.
Changes to AIM Specialty Health’s sleep disorder management diagnostic and treatment guidelines

An important component of AIM Specialty Health’s (AIM) Sleep Disorder Management program focuses on the management of Obstructive Sleep Apnea (OSA) through the use of custom made oral appliances. These appliances include, mandibular repositioning that are billed using HCPCS E0486.*

Effective January 1, 2016, AIM will be revising this guideline to ensure that oral appliances used in the treatment of OSA meet the criteria established by CMS for mandibular repositioning appliances. The CMS specifies that to be coded as E0486, custom fabricated mandibular advancement devices must:

- Have a fixed mechanical hinge at the sides, front or palate, and,
- Have a mechanism that allows the mandible to be advanced in increments of one millimeter or less, and,
- Be able to protrude the mandible beyond the front teeth at maximum protrusion, and,
- Be adjustable by the beneficiary in increments of one millimeter or less, and,
- Retain the adjustment setting when removed, and
- Maintain mouth position during SLEEP so as to prevent dislodging the device.

In addition to the preamble section of the Guideline, a question will be added to the pre-authorization request. The questions will read: Does the mandibular repositioning device requested comply with CMS criteria?

Cases in which the provider responds “No” or “I don’t know” will be routed for review.

*Prefabricated oral appliances (HCPCS code E0485) are not considered appropriate therapy for OSA in any clinical situation.

Reference based benefits for CVT members

Effective October 1, 2015, California’s Valued Trust (CVT) will be implementing a Reference Based Benefit design on all their PPO, HDHP, and Wellness plans for Hip Replacement, Knee Replacement, Hysterectomy and Laminectomy surgeries.

These four procedures will have a reference price point (benefit maximum) based on the member’s geographic region. Members are responsible for obtaining their reference price point (through Anthem Blue Cross’ Customer Service) prior to the surgery and are encouraged to have the surgery performed at a facility whose charges won’t exceed the benefit allowed amount. Amounts over the benefit maximum may not be payable under regular plan benefits and may be applied as member responsibility.

Reference Based Benefits do not apply to Retiree or Medicare Supplement plans.

Family-Based treatment for adolescents with Anorexia Nervosa

Anorexia Nervosa continues to be one of the most impairing and difficult to treat conditions amongst psychiatric disorders. Approximately 50% of individuals develop a chronic and relapsing illness course characterized by significant physical and psychological impairment. Current research efforts are focused on ways to better understand the neurobiology of the illness, as well as to establish evidenced based biological and psychosocial interventions aimed at successfully treating the illness. With a typical onset during adolescence and poor treatment outcomes by adulthood, it has become increasingly evident that successful early intervention during childhood and adolescence is essential.
Current research suggests that family-based treatment is an effective intervention for adolescents with anorexia nervosa. In recent years, family-based treatment (FBT), also known as Maudsley Family Therapy, or the “Maudsley approach”, has emerged as one such specialized evidenced based treatment intervention for adolescents with Anorexia Nervosa. There is a growing body of literature supporting the FBT approach. In 2014, the Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders indicated that FBT is a first line treatment for Anorexia Nervosa in adolescents less than age 19 and with duration of illness less than three years. (Australian & New Zealand Journal of Psychiatry 2014, Vol. 48 (11) 977-1008).

FBT is a form of family therapy that consists of 10-20 family sessions over a period of 6-12 months. When applied early in the course of the illness, the need for inpatient or residential treatment stays may be avoided. The premise is simple. With therapeutic guidance, parents are supported and empowered to take control of their child’s eating patterns and activity levels. Amidst a background of love and empathy, parents set limits to achieve healthy weight restoration. Once normal weight is achieved and the adolescent is able to eat independently, control is returned to the adolescent. The final phase of treatment focuses on the developmental issues and psychosocial stressors faced by adolescents, and may underlie the propensity toward food restriction and unhealthy weight loss.

In May, 2015, a revised version of the “Practice Parameter for the Assessment and Treatment of Children and Adolescents with Eating Disorders” was published in the Journal of the American Academy of Child and Adolescent Psychiatry (AACAP). This treatment guideline provides a concise and comprehensive summary of the DSM-5 Eating Disorders including Anorexia Nervosa. The authors point out that there is little evidence to support that treatment for patients with Anorexia Nervosa in inpatient, residential or even partial hospital settings are more effective than that provided with outpatient treatment. Despite their disadvantages for patients and families, treatment at such higher levels of care is often unavoidable, due to a lack of locally available outpatient treatment providers trained in specialized interventions for eating disorders or the result of a poor response to outpatient treatment. (J Am Acad Child Adolesc Psychiatry 2015; 54(5):412–425).

Family Based Therapy for adolescents with Anorexia Nervosa shows great promise and has been endorsed as a viable treatment approach for childhood and adolescent eating disorders by the American Psychological Association (APA), the AACAP, and the National Association for Clinical Excellence (NICE). It might be worthwhile to consider learning more about this valuable treatment option for your patients. Efforts are underway to improve the dissemination of this first-line treatment as there continues to be a shortage of providers trained in the FBT approach. Nevertheless, a number of short-term family-based programs exist throughout the country that allow family members to access and receive training in this type of approach. Websites for FBT workshops, trainings and certifications are easily found on the Internet. Educational materials and resources for parents can also be found, including local listings of providers and treatment centers specializing in FBT interventions. Here are some resources that you may find useful.

Clinician Training Institute for Child and Adolescent Eating Disorders
Maudsley Parent Resource website
Family-based therapies can treat anorexia in teens
Intensive Family Based Therapy for Eating Disorders
Introducing Anthem Togetherworks

At Anthem Blue Cross, we look for ways to get results and achieve goals together. Every day we bring our tools, information, and expertise to the table in ways that benefit our members and providers. With this effort, we introduce Anthem Togetherworks – a new name for our provider collaboration strategy. Anthem Togetherworks refers to a broad spectrum of partnership options already in place at Anthem Blue Cross, and includes programs like Enhanced Personal Health Care (EPHC) and the Quality-In-Sights®: Hospital Incentive Program (Q-HIP®).

Anthem Togetherworks also includes tools we offer, such as our web-based Provider Care Management Solutions and Care Delivery Transformation support. Through Anthem Togetherworks, we'll continue to offer a wide range of provider collaboration programs and offerings based on your needs, to help us work together to meet the challenges of a new era in health care.

Anthem Blue Cross Partners with Vital Decisions to provide services to members with advanced illness

Anthem Blue Cross (Anthem) is pleased to announce that it has entered into an agreement with Vital Decisions, a company specializing in providing healthcare counseling services to individuals and their families who are experiencing advanced illness. Vital Decisions currently works with multiple national, regional and local health plans across the country. Their Living Well counseling program has been recognized as a Best Practice in Consumer Protection and Empowerment by URAC.

Beginning this quarter, selected Anthem PPO members will have access to Vital Decisions’ specially trained counselors that will help educate, discuss, and work through important topics of advance care and life planning. The counselor’s role is to help individuals identify their quality of life preferences and values and help them to actively and effectively communicate their priorities to family and physicians.

Vital Decisions counselors will at no time interfere with the physician-patient relationship, provide medical advice, or provide an opinion regarding the care plan or team in place. If you are treating an Anthem member who has elected to work with a Vital Decisions counselor, your office will be contacted in writing by Vital Decisions.

Anthem appreciates the care you provide our members, your patients. If you have any questions about the program, please go to the Vital Decisions web site.

Mobile App to manage cancer symptoms updated to address psychosocial distress

A free mobile app that aims to help people with cancer manage the physical symptoms of the disease has been updated to address the emotional and social stressors of cancer as well.

Originally launched in October 2014, the Self-Care During Cancer Treatment app provides strategies for managing the symptoms related to cancer and its treatment. It was developed by Empowerment and Action for Cancer Care, an alliance between Anthem, Inc. and Genentech.

The app, available in the iTunes App Store and Google Play, will now include the Cancer Support Community’s CancerSupportSource®, the organization’s evidence-based distress screening tool.

“The ability for people with cancer to access tools that can help them manage their emotional wellbeing is another innovative step in helping to close gaps in care for so many individuals who are living with cancer,” said Jennifer Hausman, community health initiatives director at Anthem, Inc. “Self-Care During Cancer Treatment continues to be a tool that empowers individuals to more actively engage in their own health and wellbeing foster a dialogue with their physician.”
“Screening people for cancer-related distress, defines quality cancer care and yet countless patients are never asked about their distress or given resources for support. This self-care app will provide patients with a tool at their fingertips to identify their worries and concerns and get information. Patients can use their results to talk to their healthcare provider or to reach out to advocacy organizations to find the information and support they need to reduce distress and improve their quality of life,” said Vicki Kennedy, LCSW, CSC vice president of program development and delivery.

Survey says....Patients see room for improvement with physician care

Every year, Anthem Blue Cross sends out the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to our HMO/POS members. The survey provides Anthem members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. The CAHPS survey is used by all HMO/POS plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

The following tables compare our results from 2014 with those in 2015. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem Blue Cross. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

When you’re reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.
## 2015 Anthem Blue Cross HMO/POS
### CAHPS Adult Member Satisfaction Survey Results
And NCQA Quality Compass Percentile Achieved

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2014</th>
<th>2015</th>
<th>Trend 2014 vs. 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>86%</td>
<td>81%</td>
<td>↓</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>75%</td>
<td>78%</td>
<td>↑</td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>74%</td>
<td>69%</td>
<td>↓</td>
</tr>
<tr>
<td>Getting Care Quickly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>84%</td>
<td>83.3%</td>
<td>↓</td>
</tr>
<tr>
<td>Got appointment for check-up or routine care as soon as needed</td>
<td>DNA</td>
<td>77%</td>
<td>---</td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>DNA</td>
<td>77%</td>
<td></td>
</tr>
<tr>
<td>Doctor's Communication with Patients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>95%</td>
<td>94%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>94%</td>
<td>93%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>96%</td>
<td>92%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>92%</td>
<td>87%</td>
<td>↓</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons to take a medicine?</td>
<td>DNA</td>
<td>87%</td>
<td>---</td>
</tr>
<tr>
<td>Doctor discussed reasons you may not want to take a medicine?</td>
<td>DNA</td>
<td>73%</td>
<td>---</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you?</td>
<td>DNA</td>
<td>74%</td>
<td>---</td>
</tr>
<tr>
<td>Continuity of Care &amp; Health Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did your personal doctor seem informed about care you received from other health providers?</td>
<td>75%</td>
<td>78%</td>
<td>↑</td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness?</td>
<td>78%</td>
<td>64%</td>
<td>↓</td>
</tr>
</tbody>
</table>

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding “Usually” or “Always.”
3 =% responding “A lot” or “Some”
4 = % responding “Yes”
5 = Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
DNA = Data Not Available
NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
*The source of data contained in this report is Quality Compass © 2015 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.
Improving your patients’ health care experience

Anthem Blue Cross is committed to working with our network physicians to make our members' health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Simply log onto our website at www.anthem.com/ca and follow this path: Providers>Enter>Communications>Guide to Improving the Patient Experience.

“This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California.”
Anthem Blue Cross has implemented ICD-10

The U.S. Department of Health and Human Services (HHS) mandated October 1, 2015, as the compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

Effective October 1, 2015, Anthem Blue Cross began accepting and processing ICD-10 diagnosis and inpatient procedure codes for claims with dates of service/discharge on or after the October 1, 2015, compliance date. Our systems, supporting business processes, policies and procedures are now compliant with ICD-10.

The ICD-10 Updates webpage contains reference materials and other information for your use:

- Coding Guidelines for Preauthorization and Claims Submission Reference Chart
- Claims Billing by Service Type Reference Chart
- Link to EDI Edits for ICD-10
- Guidance on paper claims containing ICD-10 codes
- Our Response to the CMS/AMA Announcement on ICD-10 in July 2015
- FAQs with Anthem Blue Cross-specific Information
- Our medical policies and clinical UM guidelines have been updated to include ICD-10 coding.

Please note once ICD-10 goes live on October 1, 2015, and providers are ready, these preparation tools and resources will no longer be available on our webpage:

- TIBCO Validator claims file acceptance testing
- Coding Practice Tool for Professional Providers
- e-Cast on Preparing for ICD-10: A Provider’s Perspective
- Dedicated email box for ICD-10 inquiries and surveys

Effective October 1, 2015, all questions and claims inquiries regarding ICD-10 should be handled as any other questions and claims inquiries are handled today. Contact the PROVIDER SERVICES UNITS first. The Provider Services units have been trained to handle questions on ICD-10 and resolve ICD-10 claims issues.

ICD-10: Splitting bills could cause overpayments

Anthem Blue Cross is requiring that outpatient services with dates of service that span from September 30, 2015 to October 1, 2015, are required to be split so services rendered up to September 30, 2015, are filed with ICD-9 codes on one claim and services rendered on/after October 1, 2015, are filed on a separate claim with ICD-10 codes.

However, some provider reimbursement agreements limit the reimbursement amounts for certain outpatient services, such as when combined services are negotiated as a case rate. Splitting the claim could cause these episodes of care to be overpaid. Should you receive any overpayments, here is how you can help resolved these claims quickly.

Be Proactive – Should you discover an overpayment for services due to splitting the claim into ICD-9 and ICD-10 coded claims, notify Anthem Blue Cross immediately and refund the overpaid amount back to us.
Be Responsive – Anthem Blue Cross will request a refund of any overpayment amounts discovered. Please remit refunds promptly once notified.

Working together, we can resolve these overpayments in a timely manner as we partner for a smooth transition to ICD-10.

Workers’ compensation referrals to participating providers

Anthem Workers’ Compensation has recently noticed a high volume of referrals to non-participating workers’ compensation providers. This note is a reminder that as required by your Anthem Agreement, referrals to a specialist or other contracted Providers, hospitals, ambulatory surgery centers, ancillary and Behavioral Health providers must be within the Anthem Workers’ Compensation Network or for clients that have an MPN, within the client’s MPN. To ensure that you utilize the correct online directory please refer to the list of Other Payors for Workers’ Compensation Network Leasing, which is available on the Anthem secure portal for ProviderAccess site. Click on link for “Network Leasing Arrangements” to download the list and search for Payors that have a specific directory web address. The Workers’ Compensation online Provider directory is available by visiting www.anthemwc.com/find_a_doctor.asp and selecting “California.” Assistance is also available by calling 1-866-700-2168. This online Provider directory will identify Providers who treat work-related illness or injuries.

Refer within the MPN. For employers and carriers accessing the Anthem Blue Cross Prudent Buyer Network for Workers’ Compensation, this means referrals must be made to Providers participating in the Anthem Workers’ Compensation Network that are included in the MPN. Contact our MPN Services department at 1-866-700-2168 for assistance or refer to the “Other Payor” listing, which may include MPN Program Contact and/or the online Provider search websites for clients that utilize the Anthem network for their MPN.

Please note that referrals to non-participating providers could result in non-payment of that workers’ compensation bill. We value your participation in our network and want to work with you to make your daily operations smooth. If you have any questions regarding who is contracted for workers’ compensation contact workers’ compensation customer service at 1-866-700-2168. Please be aware that workers’ compensation resources are also available at www.bclhwcmcs.com.

Contracted provider claim escalation process

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

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

Anthem Blue Cross: “Find a doctor tool”

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

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

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

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

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

Anthem Blue Cross cost transparency

As an Anthem Blue Cross (Anthem) participating provider you may have received our November 2014 or May 2015 correspondence, or read the articles in our June, August, or September Provider Network Update newsletters, regarding Anthem Cost Transparency. We informed you in those letters and articles that in response to consumer demand for transparency in health care costs, Anthem released its first cost transparency tool, Anthem Care Comparison, and later its successor, Estimate Your Costs, a tool available to members on our anthem.com/ca website, which includes functionality allowing members to estimate their out-of-pocket impact and view the estimated costs for many procedures.

Enclosed with the correspondence was also a summary of the methodology used to generate the cost information housed in the National Consumer Cost Tool (NCCT), the source data used to display costs in Estimate Your Costs. The treatment categories for which costs are displayed and the methodology in determining such costs, are defined by the Blue Cross Blue Shield Association. As indicated in the correspondence, NCCT cost data is updated twice annually; the most recent update completed in May of 2015, and the next update scheduled for November 2015. Please look for further information on this in our calendar year 2015 Provider Network Update Newsletters posted to anthem.com/ca.

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

Should you wish to review the methodology, you may request a copy by sending an email request to the Anthem California contract support team at CAContractSupport@anthem.com.

To obtain the date of any future biannual updates (2016 or thereafter) to the cost transparency data on Estimate Your Costs, please review our Provider Network Update Newsletters. You will then know the dates to go into AVAILITY to review your cost information, just as you are able to do so this year. If you do not currently receive our Provider Network Update Newsletters, please sign up, it’s free and it only takes a moment.

Thank you for your service to our members.

**Provider Network Education 2015 seminars and e-solutions**

The Provider Network Education team develops and delivers quality educational programs and materials for the staff of physicians, hospitals, medical groups, ancillary, behavioral health and other health care professionals. Our education programs offer ‘blended learning’, combining face-to-face and web-based opportunities. Our ‘complimentary’ education programs are offered to all contracted providers throughout California.

**Seminars**

Our Fall ‘Contracted Provider Information Exchange’ seminars are interactive and offer tips, process improvements and best practices. Many relevant Anthem Blue Cross business topics are presented. These seminars will be offered in [16] sixteen locations throughout California in October and November.

In the [Spotlight](http://www.anthem.com/ca) section of [www.anthem.com/ca](http://www.anthem.com/ca), click on the ‘2015 Provider Education Seminars and Webinars’ link, which takes you to the Provider Network Education landing page. A collection of provider education tools are available to view and print.

**e-Solutions**

The following web-based learning opportunities are available 24/7/365 from your office and personal computer:

- **SEMs – Supplemental Education Materials** are available on a variety of Anthem Blue Cross business subjects. These documents will display in pdf format and can be viewed, saved or printed.

- **On-Demand e-Courses** offer a self-paced instruction environment. Currently there are [3] three e-Courses available for you to take. To register for an e-Course, select the ‘click here’ link on the Provider Network Education landing page.


**Questions?**

E-mail: network.education@anthem.com
Phone: 818-234-1016
Fax: 818-234-8959
Sign-up now for our Network eUPDATE today – it’s free!

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

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

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

Registration is fast and easy. There is no limit to the number of subscribers who can register for Network eUPDATEs, so you can submit as many e-mail addresses as you like.

Network leasing arrangements

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

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

Clinical practice and preventive health guidelines available online

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

Timely Access Regulations

Anthem Blue Cross is committed to keeping you, our network partners, updated on our activities related to our compliance with the Department of Managed Health Care (DMHC) Timely Access to Non-Emergency Health Care Services Regulations (the “Timely Access Regulations”). Anthem Blue Cross maintains policies, procedures, and systems necessary to ensure compliance with the Timely Access Regulations, including access to non-emergency health care services within prescribed timeframes (also referred to as the “time elapsed standards” or “appointment wait times”). Anthem can only achieve this compliance with the help of our provider network partners, you!

There are many activities that are conducted to support compliance with the regulations and we need you, as well as members, to help us attain the information that is needed. Some of these studies are sponsored by the Industry Collaborative Effort (ICE), allowing for consistency across Health Plans. These studies allow our Plan to determine compliance with the regulations. The activities include, but are not limited to the following:

- ICE Provider Appointment Availability Survey
- ICE Provider Satisfaction Survey
- ICE Provider After - Hours Survey

These surveys are currently in process. Please make note of this with your office staff to ensure that they are prepared and that they understand the importance of each provider's participation in each of the surveys.

We appreciate that in certain circumstances the time-elapsed requirements may not be met. The Timely Access Regulations have provided a few exceptions to the time-elapsed standards to address these situations:

Extending Appointment Wait Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

Preventive Care Services and Periodic Follow Up Care: Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Advanced Access: The primary care appointment availability standard may be met if the primary care physician office provides “advanced access.” “Advanced access” means offering an appointment to a patient with a primary care physician (or nurse practitioner or...
physician’s assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

We hope this clarifies Anthem’s expectations and your obligations regarding compliance with the Timely Access Regulations. Our goal is to partner with our providers to successfully meet the expectations for the requirements with the least amount of difficulty and member abrasion. See below for a chart that outlines the Accessibility Standards for providers.

**Access Standards for Medical Professionals**

<table>
<thead>
<tr>
<th>Access to</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent appointments with Specialist Physicians</td>
<td>Must offer the appointment within 10 business days of the request</td>
</tr>
<tr>
<td>Urgent Care appointments not requiring prior authorization</td>
<td>Must offer the appointment within 48 hours of request</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist Physicians</td>
<td>Must offer the appointment within 15 business days of the request</td>
</tr>
<tr>
<td>Urgent Care (that requires prior authorization)</td>
<td>Must offer the appointment within 96 hours of request</td>
</tr>
<tr>
<td>Non-urgent appointment for ancillary services (for diagnosis or treatment of inquiry, illness, or other health condition)</td>
<td>Must offer the appointment within 15 business days of the request</td>
</tr>
<tr>
<td>In-office waiting room time</td>
<td>Usually members do not wait longer than 15 minutes to see a physician or his/her designee</td>
</tr>
<tr>
<td>After hours care</td>
<td>Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back</td>
</tr>
<tr>
<td>Emergency Care (California law requires health plans to follow the “prudent layperson” standard in providing direction for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any “prudent layperson” would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go the emergency room if the caller believes they are experiencing an emergency)</td>
<td>Immediate access to Emergency Care</td>
</tr>
<tr>
<td>Member Services by Telephone. Access to Member Service to obtain information about how to access clinical care and how to resolve problems (this is a plan responsibility and not a physician responsibility; and this also applies to our Behavioral Health members)</td>
<td>Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate &lt;5%) Member Nurse line available 24/7</td>
</tr>
</tbody>
</table>
Access Standards for Behavioral Health and EAP Practitioners

<table>
<thead>
<tr>
<th>Access to</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care Instructions (California law requires health plans to follow the “prudent layperson” standard in providing direction for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any “prudent layperson” would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller believes they are experiencing an emergency).</td>
<td>Members are directed to 911 or the nearest emergency room</td>
</tr>
<tr>
<td>Non-Life Threatening Emergency Care</td>
<td>6 hours</td>
</tr>
<tr>
<td>Urgent Care (that does not require prior authorization)</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Care (that requires prior authorization)</td>
<td>96 hours</td>
</tr>
<tr>
<td>Routine Office Visit/Non-urgent Appointment</td>
<td>15 Business days (Psychiatrists)</td>
</tr>
<tr>
<td>Access to After-hours Care</td>
<td>Available 24 hours / 7 days. Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Behavioral Health/EAP provider, and be informed when the call will be returned.</td>
</tr>
<tr>
<td>In office waiting room time</td>
<td>Usuually members do not have to wait longer than fifteen (15) minutes after their scheduled appointment to see a Behavioral Health/EAP provider.</td>
</tr>
</tbody>
</table>

Members also have access to Anthem Blue Cross’ 24/7 NurseLine. The phone number is located on the back of the member’s health insurance ID card. In addition, Members and Providers have access to Anthem Blue Cross' Customer Service team at the telephone number listed on the back of the members' ID card. A representative may be reached within 10 minutes during normal business hours. 

*If you have further questions, please contact Network Relations at 1-855 238-0095 or CAContractSupport@anthem.com.*
Take a look at our Behavioral Health Case Management (BHCM) program

A central premise to Anthem’s Behavioral Health Case Management (BHCM) Program is to promote collaboration between all treating providers, ensuring coordination between medical care and behavioral health care. Once members are identified, Behavioral Health Care Managers outreach/consult with our community partners in medical and behavioral health practice settings. Our program supports the treatment planning needs of providers with respect to behavioral health services and often provides consultation/suggestions for modifications in current care. This coordination is performed through various avenues including: notification letters to physicians informing them that their patients are engaged with the program, telephonic outreach calls, and physician peer-to-peer discussion when needed. Anthem’s BHCM program focuses on the most appropriate level and timely application of evidence-based interventions necessary for the successful and cost-effective management of the condition.

Our clinicians work with the member and their family to:

- Understand the options available for BH treatment, utilize Anthem benefits for lowest possible out of pocket cost, and decrease unnecessary healthcare expenditures
- Advocate for the coordination of all care, both medical and behavioral health
- Educate on symptoms and condition management to prevent future inpatient hospitalization stays
- Discuss and identify barriers to treatment compliance and offer resources and support to overcome them
- Improve overall health outcomes for improved quality of life

Coordination of Care has big impact

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross would like to take this opportunity to stress the importance of communicating with your patient’s other health care providers. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health providers.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care provider. We urge you to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care providers at the time treatment begins.

We expect all health care providers to:

- Discuss with the patient the importance of communicating with other treating providers.
- Obtain a signed release from the patient and file a copy in the medical record.
- Document in the medical record if the patient refuses to sign a release.
- Document in the medical record if you request a consultation.
- If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring provider.
- Document evidence of clinical feedback (i.e., consultation report) to include, but not limited to:
  - Diagnosis
  - Treatment plan
  - Referrals
  - Psychopharmacological medication (as applicable)

To facilitate coordination of care, we have tools available to you on our website including a Coordination of Care Form and Letter Templates. Start using them today! Got to anthem.com/ca > Providers > Enter > Answers@Anthem > Coordination of Care Form and Letter Templates.
October is National Breast Cancer awareness month is more important than ever

According to the American Cancer Society, every year over 200,000 American women are diagnosed with breast cancer. Although there is a significant amount of community outreach on the subject, 29% of insured women are still not getting their mammograms. This fact makes National Breast Cancer Awareness Month as important as ever.

Although coverage for screenings may not conform to the American Cancer Society’s recommended guidelines, Anthem Blue Cross Medi-Cal Managed Care (Medi-Cal), along with other California providers, cover mammogram screenings. Prior approval may be necessary; visit the Medi-Cal provider web portal for more information about services requiring prior authorization.

For more information about Breast Cancer Awareness Month, or to take advantage of the many online tools available to share with your patients, visit the National Breast Cancer Awareness Month website for free downloads.

Provider self-service tools make it easy to do business

The provider self-service web portal offers 24/7 access to simple to use tools - making it easier than ever to get information. Read more for benefits and access.

ICD-10 documentation and diagnosis coding tips

This handy reference sheet puts ICD-10 formatting, structure, official outpatient services guidelines, documentation concepts and more, right at your fingertips. Get the coding tips reference sheet here.

Update: Hemophilia drugs medical necessity reviews

Effective November 1, 2015, certain hemophilia drugs requests must be reviewed by Anthem Blue Cross for prior authorization. Use this link to access new prior authorization requirements.

Behavioral health authorization requirement changes

Anthem Blue Cross has recently updated our Precertification Lookup Tool (PLUTO) to more accurately reflect the current behavioral health authorization process for our Medicaid products. As a result of this update, effective November 1, 2015, PLUTO has been updated to show that authorization is required for psychological and neuropsychological testing for both medical and behavioral health purposes. Use this link to access the code changes and service descriptions.
Medical Policies and Clinical Utilization Management guidelines update

The Medical Policy and Technology Assessment Committee (MPTAC) approved Anthem Blue Cross medical policies and Clinical Utilization Management (UM) Guidelines, developed or revised to support clinical coding edits for Medi-Cal Managed Care members. These approved medical policies and Clinical UM Guidelines are publicly available on the MediCal provider website.

CDC predicts another moderately severe flu season predominated by Influenza A (H3N2)

Anthem Blue Cross is launching an annual member outreach campaign to encourage high-risk Medi-Cal Managed Care (Medi-Cal) members to visit their providers for a flu vaccine. Outreach includes automated outbound telephone calls, text messages and newsletter articles. Providers may experience an increase in phone calls and early appointments for the flu vaccine as a result of this outreach campaign. Read more about the impacts of flu season on your practice.

Synagis guidelines for Respiratory Syncytial Virus season

Respiratory syncytial virus (RSV) season begins as early as September with occurrences through April. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. All requests for Synagis require prior authorization to ensure patients meet medical necessity criteria based on the American Academy of Pediatrics recommended guidelines. Read more about dosage, preferred specialty pharmacy and prior authorization.

Anthem Blue Cross Cal MediConnect Plan Update

This section of the newsletter addresses information about the Medicare-Medicaid Plan or MMP. Members are enrolled in both Medicare and Medicaid under the Anthem Blue Cross Cal MediConnect Plan.

Quality Improvement program announcement

Our focus at Anthem Blue Cross Cal MediConnect Plan is helping our members stay healthy through quality medical care. Each year we look closely at the medical care programs we use to measure our quality. The results tell us what is working best to help improve our members' health and what we should change. This process is called the Quality Improvement program. The QI program and its goals help us support our provider network in delivering quality care to our members.

Use this link to read about the Quality Improvement program and expectations.
Medicare Advantage Updates

Keep up with Medicare Advantage news at Important Medicare Advantage Updates

Please continue to check Important Medicare Advantage Updates at www.anthem.com/ca/medicareprovider for the latest Medicare Advantage information.

Routine physical exams are covered in 2016

Anthem Blue Cross Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2016 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding. When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay as applicable by the member’s plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider.

Additional details can be found at Important Medicare Advantage Updates at www.anthem.com/ca/medicareprovider.

Administrative denials may be appealed

For the member to receive maximum benefits, the health plan must authorize or precertify the covered services prior to being rendered. As previously communicated, please notify Anthem Blue Cross as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

If you do not notify us within the required timeframe, you may file an appeal. As part of the appeal, providers must demonstrate that they did notify Anthem Blue Cross or attempted to notify Anthem Blue Cross AND that the service is medically necessary. Anthem Blue Cross also reminds all providers – network physicians and facilities -- that they cannot bill the member if the services are denied for the failure to obtain a required precertification.

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the provider home page at www.anthem.com/ca.com for further information on existing precertification requirements and provider appeals.

HRM program designed to reduce risk for Medicare Advantage members

Anthem Blue Cross is working to decrease the amount of High Risk Medications (HRM) prescribed by primary care providers. A HRM contains a heightened risk for causing significant harm when Medicare Advantage members use them in error. Examples of commonly prescribed HRMs include zolpidem (Ambien®) and zaleplon (Lunesta®). Falls and fractures may occur when these HRMs are used.
Anthem Blue Cross identifies providers who have prescribed HRMs and will contact the prescriber’s office to validate the prescriber/patient relationship. Anthem Blue Cross then will schedule an appointment for an Anthem Blue Cross pharmacist to speak with the provider about HRMs.

Precertification requirements updated for 2016

Please refer to your provider agreement, Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem Blue Cross provider home page at www.anthem.com/ca for further information on existing precertification requirements and new precertification requirements for 2016. Non-contracted providers should contact the Health Plan.

Anthem Blue Cross Cal MediConnect Plan providers, please see related information in your provider manual. To access your provider manual: www.anthem.com/ca>Providers>Plans & Benefits>Cal MediConnect Plan>Anthem Blue Cross Cal MediConnect Plan>Provider Manual.

Correction: CMS colorectal cancer screening guidelines

In August, we published incorrect information regarding CMS guidelines for colorectal cancer screening. Here is the correct information:

- For members ages 50 to 75, colorectal cancer screenings include Fecal Occult Blood Test (FOBT) during the year, flexible sigmoidoscopy during the year or the four years prior to and/or colonoscopy during the year or the prior nine years.

55290WPPENMUB 08/11/2015

Imaging site scores for outpatient diagnostic imaging could impact reimbursement

The following information does not apply to California delegated providers

Anthem Blue Cross is dedicated to meeting the evolving needs of our members and ensuring that they receive the most appropriate care possible. We are pleased to introduce a new program for imaging services administered by AIM Specialty Health® (AIM).

What Does This Mean to You?

Effective November 1, 2015, Anthem Blue Cross Medicare Advantage plans begin collecting information about the imaging capabilities of all Anthem Blue Cross Medicare Advantage contracted providers who provide the technical component of the following outpatient diagnostic imaging services for our individual Medicare Advantage members:

- Computed Tomography (CT)
- Magnetic Resonance (MR)
- Positron Emission Tomography (PET)
- Nuclear Medicine (NUC)
- Ultrasound
X-Ray
Echocardiograph

Emergency room outpatient diagnostic imaging services are excluded.

AIM’s online registration tool, OptiNet®, will continue to collect modality-specific data from providers who render imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment, and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

That data will continue to be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. Each modality or piece of equipment will receive its own score. Providers with an imaging site score of 76 or higher will see no change in reimbursement.

- **Effective March 1, 2016 for providers who have not completed the online registration:** Claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

- **Effective March 1, 2016 for providers with an imaging site score below 76 for the applicable modality for any of the outpatient diagnostic imaging services listed above:** Claims with dates of service on or after March 1, 2016 for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

Members cannot be balance billed if a line-item denial occurs.

Please note that any decision to deny reimbursement and/or approval of an imaging service is separate and apart from the determination of the medical necessity of the same service.

Please note that the line-item denial for a site score below 76 for the applicable modality applies only to individual Medicare Advantage claims at this time.

Additional detail can be found [here](#).
Pharmacy

Pharmacy information available on anthem.com/ca

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The commercial drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate “Marketplace Select Formulary” and pharmacy information, go to Customer Support, select your state, Download Forms and choose “Select Drug List.”