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Health Care Reform Updates (including Health Insurance Exchange)

Update on Anthem Blue Cross Individual PPO/EPO plans and network for 2017

Statewide we will offer individual PPO or EPO benefit products, depending on the region, which include on and off exchange plans. These are supported by our Pathway X PPO/EPO network (on exchange plans) and our Pathway PPO/EPO network (off exchange plans). The Pathway X PPO/EPO network and the Pathway PPO/EPO network consist of the same providers.

The Regions where we currently offer a Tiered Pathway PPO plan and Tiered Pathway X PPO plan in 2016, we will instead offer a Pathway EPO Plan and Pathway X EPO Plan with no tiering. Specifically, the Regions are San Francisco county (Region 4), Los Angeles county (Regions 15 and 16 – Los Angeles East and Los Angeles West, respectively), Orange county (Region 18) and San Diego county (Region 19). The elimination of tiered benefit plans is the result of Covered California's instruction to Qualified Health Plans, such as Anthem, that tiered benefit plans can no longer be offered on the Exchange. For those Regions, the result of the loss of tiering means that most Anthem hospitals which are currently Tier 2 hospitals in 2016 in these Regions, will be out-of-network for 2017.

For Regions moving to an EPO Plan, please note that as a general rule, the EPO plan will not provide coverage for services provided by out-of-network providers, except for urgent/emergent services.

There will be additional correspondence sent to you on the PPO to EPO transition and the Individual Pathway network. If you have questions on your Pathway network status, becoming a provider in the Pathway network or any other questions related to the Individual changes from 2016 to 2017, please email us at CAContractSupport@Anthem.com.

PCP assignment for California Individual plans

For the 2017 benefit year, as part of our contractual mandated requirements with Covered CA, Anthem Blue Cross will assign all PPO/EPO members to a Primary Care Physician (PCP). Anthem will be assigning enrolled members, whether they purchased coverage ON or OFF the Exchange. Please note that grandfathered plan members will NOT be affected.

This mandate from Covered California is designed to support improved health by promoting the establishment of a Physician/Patient relationship for all those enrolled with PPO or EPO benefits.

Key Points

- This is NOT a gatekeeper relationship – no authorizations are needed for referrals or specialty care. Members may choose to establish a relationship with their assigned doctor but are under no obligation to do so.
- Doctors do NOT need to reach out to any assigned members. Your roles and responsibilities for PPO/EPO members have not changed.
- Anthem will be using a Member Preferred Physician (MPP ID) as the code for the PCP designation.
- PCP information will NOT be included on ID cards. Members will be notified of their assignment by letter starting in February.
- More information will be forthcoming as part of the February newsletter.

If you should have any questions, please contact our Network Relations team by email at CAContractSupport@anthem.com.
Exchange provider toolkits

To support the Affordable Care Act initiative, Anthem Blue Cross (Anthem) has developed the Exchange Provider Toolkit. This toolkit provides valuable links, tools and resources to assist you in your interaction with our Exchange members.

Learn how to:
- Determine if you are participating in the Exchange
- What plans are offered through the Exchange
- Identify an Exchange Member ID Card
- Access the Network Update newsletter for Professional, Institutional and Behavioral Health providers
- Formally notify Anthem of any practice changes
- ....and more!


Medical chart reviews for members with plans on or off the exchange

Each year, Anthem Blue Cross (“Anthem”) requests your assistance in our retrospective medical chart review programs. We continue to request members’ medical records to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS).

We will continue our chart review program for those members who have purchased our individual and small group health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the exchange). This particular effort is part of Anthem’s compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual or small group health plans on or off the exchange. The members’ medical record documentation helps support this data requirement.

Anthem engages Inovalon to conduct medical chart reviews for our exchange members

To assist with our ongoing medical chart review program for members enrolled in our individual and small group exchange plans, Anthem is again collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon’s Web-based workflows help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. Anthem is working with Inovalon in retrieving and reviewing our members’ medical records.

Inovalon is using the following methods of collecting medical record information:
- Scanned or faxed medical records that providers’ offices send to Inovalon

Institutional Network Update
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider’s EHR system

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the providers’ offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within 30 days.

In cases where Inovalon is requesting more than six medical records to review, an Inovalon reviewer calls the provider’s office and arranges a time convenient to visit the office onsite to collect the appropriate information. Before the onsite visit, Inovalon mails or faxes the provider’s office a letter to confirm the upcoming visit. The Inovalon medical record review personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, an automated, medical record data retrieval occurs through the provider’s EHR system. Upon receiving the provider group’s one-time authorization, Inovalon’s systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this partnership is to both improve the medical record data extraction experience for Anthem’s network-participating hospitals, clinics and physician offices. Anthem and Inovalon are working together to identify facilities and providers’ offices for engagement.

Appropriate coding helps provide comprehensive picture of patients’ health and services provided

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. When members visit your practice or office, we encourage you to document ALL of the members’ health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.

By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping Anthem meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.

Reminder about ICD-10 CM coding

As you are aware, the ICD-10 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, Anthem uses ICD-10 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.

- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider’s overall management or treatment of that patient in the remaining positions.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Inovalon continues outreach efforts on Anthem Blue Cross’ behalf to help identify members needing care

At Anthem Blue Cross (“Anthem”), we are working to update health documentation for our members in the individual and small group markets who have purchased our health insurance plans on and off the exchange. Working with our providers, we engaged Inovalon to contact our members and encourage in-office visits with their physicians. Therefore, as a physician, you may receive letters throughout the year from Inovalon on our behalf. In 2017, we are continuing these efforts and want to help ensure you and your office staff are aware of these ongoing outreach efforts Inovalon is conducting on our behalf. The goal is to identify or help close gaps in care. We appreciate your cooperation should Inovalon contact your office or facility.

In the event our members do not visit their physicians, Inovalon also offers the option of a personal health visit that a medical professional from Inovalon conducts in members’ homes. The member may also opt to visit a retail clinic or other Inovalon location. We’ll continue to provide updates about the Inovalon engagement in upcoming editions of the Network Update.

If you have questions about the Inovalon effort and this ongoing outreach effort, we’ve compiled a list of questions and responses for your reference on our website.

Reminder about completing SOAP Notes

The SOAP Note – the standardized documentation format of a medical record – stands for Subjective, Objective, Assessment, and Plan. SOAP Notes are used with the Inovalon outreach efforts and are meant to be a supplement to providers’ usual documentation process. When submitting information to Inovalon, providers have the option of completing SOAP Notes electronically using Inovalon’s ePASS® Web-based tool or using a paper format. Here are some tips for completing SOAP Notes that we hope you find helpful.

✓ The exam date for the patient must match the exam date on the completed SOAP Note
✓ A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note
✓ The provider signature date should be the actual date the SOAP Note is signed
✓ All “mandatory” fields on the paper SOAP Note must be completed
✓ All “mandatory” fields on the paper SOAP Note must be completed to be eligible for incentive payment
✓ Incentives are only paid once for each patient for whom a health assessment was requested
✓ The exam date must always be in the current benefit year of when the member was targeted
  For example: A member targeted in 2016 must have an exam date in 2016. Also, all SOAP notes for 2016 must be submitted no later than February 15, 2017.

For additional information about SOAP notes, incentives, the medical record review process or the outreach effort, please refer to the frequently asked questions document available on our website.

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

Anthem Blue Cross launches new design changes to our public website – anthem.com/ca

Anthem Blue Cross launched the redesign of a simpler anthem.com/ca home page. The link to the provider home page is now located at the bottom right side of the anthem.com/ca home page under “Partners in health.” Select “Tools for providers”, you will be navigated to the provider home page, and you can create a bookmark to access this page more directly in the future.

Important update: Delay of the transition of NOC oncology and biologic drugs to pre-service clinical review

Anthem Blue Cross (“Anthem”) in partnership with AIM Specialty Health (“AIM”) planned an expansion of Pre-service Review to the medical necessity of coverage requests for all not otherwise classified “NOC” oncology and biologic drugs starting November 1, 2016. Anthem is delaying this transition to pre-service review by AIM until further notice. Any medical necessity review of NOC oncolytic and biologic drugs will continue to be reviewed by Anthem as they are today.

Specialty pharmacy drug program updates

Listed below are specialty pharmacy codes from new or current Clinical UM Guidelines that will be added to our existing pre-service review process effective March 1, 2017.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Code</th>
<th>Drug Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>J3590</td>
<td>Erelzi (etanercept-szzs)</td>
<td>New drug to existing Medical Policy</td>
</tr>
<tr>
<td>DRUG.00081</td>
<td>J3490, J3590</td>
<td>Exondys 51 (eteplirsen)</td>
<td>New Medical Policy</td>
</tr>
</tbody>
</table>

Effective April 24, 2017, the specialty pharmacy codes from new and current Medical Policies and Clinical UM Guidelines listed below will be added to the existing review process using CG-DRUG-47 Level of Care: Specialty Pharmaceuticals.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>Inflectra (inflixamab-dyyb)</td>
<td>Q5102</td>
</tr>
<tr>
<td>DRUG.00084</td>
<td>Actimmune (interferon gamma-1b)</td>
<td>J9216</td>
</tr>
<tr>
<td>DRUG.00086</td>
<td>Increlex (mecasermin)</td>
<td>J2170</td>
</tr>
<tr>
<td>CG-DRUG-43</td>
<td>Tysabri (natalizumab)</td>
<td>J2323</td>
</tr>
</tbody>
</table>

These changes do not apply to Federal Employee Plan® (FEP®), or Medicaid/Medi-Cal members. Please contact 1-800-676-BLUE (2583) to verify pre-certification requirements for BlueCard® business.

Pre-service and level of care clinical review of these specialty pharmacy drugs may be managed by AIM Specialty Health® (AIM), a separate company administering the program on behalf of Anthem.

If you have any questions about these changes, please feel free to contact our Network Relations department at CAContractSupport@anthem.com. Thank you for your participation in our network and for the care you provide your patients, and our members.
**Changes to the CalPERS outpatient prescription drug program**

**Effective January 1, 2017,** the Pharmacy Benefit Manager will change to OptumRx for the following CalPERS health plans administered by Anthem Blue Cross (“Anthem”):

- PERS Select/Choice/Care PPOs
- Anthem Blue Cross Traditional and Select HMOs
- Anthem Blue Cross Del Norte and Monterey County EPOs

If members have a question about their 2017 pharmacy benefits they can contact OptumRx Customer Care at **1-855-505-8110** for commercial members or **1-855-505-8106** for Medicare supplemental members. Members may also visit the dedicated website at [www.optumrx.com/calpers](http://www.optumrx.com/calpers). Additional information is also available in the CalPERS Evidence of Coverage booklet.

**2017 FEP Benefit information available online**

To view the 2017 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to [www.fepblue.org](http://www.fepblue.org)>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2017. For questions please contact FEP Customer Service toll-free at **1-800-284-9093**.

**Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5®) updates**

In an effort to keep our provider community abreast of changes occurring in the behavioral health community, we wanted to share a couple of new changes from the DSM-5.

When transitioning from the DSM IV-TR to the DSM-5, the provider community moved from using a multiaxial system to the current use of a non-axial system upon diagnosis. While the information included in the diagnosis remains much the same, the “axes” are not included in DSM-5. Although formatted differently, the same information is found within the DSM-5 diagnostic system. DSM-5 combines DSM- IV-TR Axes I-III diagnoses into one list, as shown in Table 1.

**Table 1: The DSM-5 Diagnosis**

<table>
<thead>
<tr>
<th>DSM-IV Multiaxial System</th>
<th>DSM-5 Non-axial System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I: Clinical d/o and other conditions that are focus of treatment</td>
<td>Combined attention to clinical disorders, including personality disorders and intellectual disability; other conditions that are the focus of treatment; and medical conditions.</td>
</tr>
<tr>
<td>Axis II: Personality d/o and mental retardation</td>
<td></td>
</tr>
<tr>
<td>Axis III: General medical conditions</td>
<td></td>
</tr>
<tr>
<td>Axis IV: Psychosocial and environmental stressors</td>
<td>Reason for visit, psychosocial, and contextual factors via expanded list of V Codes and Z Codes.</td>
</tr>
<tr>
<td>Axis V: Global Assessment of Functioning</td>
<td>Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.</td>
</tr>
</tbody>
</table>

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled “Other Conditions That May Be a Focus of Clinical Attention”. In addition, Axis V, Global Assessment of Functioning (GAF), was removed from DSM-5. Alternatively, the World Health Organization Disability Assessment Schedule (WHODAS 2.0) is included in Section III of DSM-5.
We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at: dsm.psychiatryonline.org. Select the link, View the DSM-5® Update (September 2016).

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Codes effective October 1, 2016</th>
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<tr>
<td>Avoidant/Restrictive Food Intake Disorder</td>
<td>F50.89</td>
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<tr>
<td>Binge-Eating Disorder</td>
<td>F50.81</td>
</tr>
<tr>
<td>Disruptive Mood Dysregulation Disorder</td>
<td>F34.81</td>
</tr>
<tr>
<td>Excoriation (Skin-Picking) Disorder</td>
<td>F42.4</td>
</tr>
<tr>
<td>Gender Dysphoria in Adolescents and Adults</td>
<td>F64.0</td>
</tr>
<tr>
<td>Hoarding Disorder</td>
<td>F42.3</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>F42.2</td>
</tr>
<tr>
<td>Other Specified Depressive Disorder</td>
<td>F32.89</td>
</tr>
<tr>
<td>Other Specified Feeding or Eating Disorder</td>
<td>F50.89</td>
</tr>
<tr>
<td>Other Specified Obsessive-Compulsive and Related Disorder</td>
<td>F42.8</td>
</tr>
<tr>
<td>Pica, in adults</td>
<td>F50.89</td>
</tr>
<tr>
<td>Premenstrual Dysphoric Disorder</td>
<td>F32.81</td>
</tr>
<tr>
<td>Social (Pragmatic) Communication Disorder</td>
<td>F80.82</td>
</tr>
<tr>
<td>Unspecified Obsessive-Compulsive and Related Disorder</td>
<td>F42.9</td>
</tr>
</tbody>
</table>

Table 2

Some resources that may best help you include:

- American Medical Association, 2016 Professional Edition CPT (current procedural terminology)
Save time using the Interactive Care Reviewer

The Interactive Care Reviewer (ICR) now offers an immediate authorization decision for some inpatient and outpatient precertification requests.* See below for the current list of services that may result in an immediate authorization decision.

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>CG-DME-01  External (Portable) Continuous Insulin Infusion Pumps</td>
</tr>
<tr>
<td>CG-DME-06  Pneumatic Compression Devices for Lymphedema</td>
</tr>
<tr>
<td>DME.00004  Electrical Bone Growth Stimulation</td>
</tr>
<tr>
<td>DME.00009  Wound Vacuum Assisted Wound Therapy in OP Setting – DME provider</td>
</tr>
<tr>
<td>DME.00027  Ultrasound Bone Growth Stimulation</td>
</tr>
<tr>
<td>CG-DME-15  Hospital Beds and Accessories</td>
</tr>
<tr>
<td>CG-DME-34  Wheeled Mobility Devices: Wheelchair Accessories</td>
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</tbody>
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<th>SURGICAL</th>
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<td>CG-SURG-18  Septoplasty</td>
</tr>
<tr>
<td>CG-SURG-24  Functional Sinus Surgery</td>
</tr>
<tr>
<td>CG-SURG-30  Tonsillectomy</td>
</tr>
<tr>
<td>SURG.00074  Nasal Surgery for the Treatment of Obstructive Sleep Apnea (OSA) and Snoring</td>
</tr>
<tr>
<td>SURG.00096  Surgical and Ablative Treatments for Chronic Headaches</td>
</tr>
<tr>
<td>SURG.00046  NEW Gastric Electrical Stimulation</td>
</tr>
<tr>
<td>SURG.00007  NEW Vagus Nerve Stimulation</td>
</tr>
<tr>
<td>SURG.00117  NEW Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Stimulation (PTNS) for Urinary and Fecal Incontinence; Urinary Retention</td>
</tr>
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<thead>
<tr>
<th>ANESTHESIA, PAIN MANAGEMENT OR SPINE PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-MED-34  Monitored Anesthesia for Endoscopic Procedures</td>
</tr>
<tr>
<td>CG-SURG-39  Pain Management: Epidural Injections for Pain Relief</td>
</tr>
<tr>
<td>SURG.00060  Implanted (Epidural and Subcutaneous Spinal cord Stimulators (SCS)</td>
</tr>
<tr>
<td>SURG.00067  Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty</td>
</tr>
</tbody>
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<thead>
<tr>
<th>RECONSTRUCTIVE PROCEDURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURG.00023  Breast Reconstruction</td>
</tr>
<tr>
<td>ANC.00007  Cosmetic and Reconstructive Services: Skin Related</td>
</tr>
<tr>
<td>SURG.00011  Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENETIC TESTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENE.00011  Monitored Anesthesia for Endoscopic Procedures</td>
</tr>
<tr>
<td>GENE.00029  Gene Expression Profiling for Managing Breast Cancer Treatment</td>
</tr>
<tr>
<td>GENE.00028  Genetic Testing for Breast and/or Ovarian Cancer Syndrome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL/RADIOLOGY-OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAD.00030  Wireless Capsule Endoscopy for Gastrointestinal Imaging</td>
</tr>
<tr>
<td>MED.00013  Parenteral Antibiotics for the Treatment of Lyme Disease</td>
</tr>
<tr>
<td>MED.00064  NEW Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)</td>
</tr>
<tr>
<td>MED.00100  NEW Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems</td>
</tr>
</tbody>
</table>

**Note:** ICR continues to periodically add services eligible for an immediate authorization decision.
As a reminder, to submit your precertification requests via ICR, go to the Availity Web Portal at www.availity.com and select **Authorizations & Referrals** under **Patient Registration** from the top menu bar on the Availity Web Portal home page. (If you don’t have access, contact your organization’s Availity administrator.)

During the process of submitting your request via ICR, if the service is available for immediate authorization determination, you will see a message asking you to complete the provider form by checking all clinical that applies to the request. If the requested service is not available for immediate authorization, you will be asked to enter clinical information in the clinical notes section.

To learn more about ICR’s time-saving features, including immediate authorization determination, attend one of our upcoming webinars. Register now by clicking [here](#).

*Excludes: some Medicare Advantage, some Medicaid, Federal Employee Program® (FEP®), BlueCard® and some National Account members

Requests involving transplant services
Services administered by AIM Specialty Health
Services administered by OrthoNet LLC (Indiana, Kentucky, Missouri, Ohio, Wisconsin, California, Colorado and Nevada)

For the above requests, follow the same precertification process that you use today.

**Anthem Blue Cross 2016 Facility Manual**

We are pleased to announce the Anthem Blue Cross 2016 Facility Manual [CD] mailed on November 22, 2016, and will become effective on **March 1, 2017**. This effective date allows a 90 day notification.

In this Manual, you will find important updates; including but not limited to mobile health care identification cards, the Availity Web Portal (Availity) and risk adjustments, to name a few. This year a few sections were added, BlueCard® Program, Cultural Diversity and Linguistic Services, Health Insurance Marketplace (Exchanges), Federal Employees Health Benefits Program and Fraud, Waste and Abuse Detection.

For a summary of the material changes, refer to the “**Summary of Material Changes**” section within the Manual CD. While the summary will help you locate the 2016 changes, it does not contain all of the details that you need to know. Refer to the appropriate section of this Manual to become familiar with any new requirements that are effective on March 1, 2017.

- Need help using the CD or to request additional copies, email [prov.communications@anthem.com](mailto:prov.communications@anthem.com) or fax to **1-818-234-8959**.

The Manual is also available online through Anthem Blue Cross’ ProviderAccess® for contracted hospitals, facilities and health care providers that serve Anthem Blue Cross members. Enter your log-in information to view this information in [ProviderAccess](#). For technical issues and support, email [provideraccess.pins@anthem.com](mailto:provideraccess.pins@anthem.com) or call toll-free **1-866-755-2680**.

**Mental health services highly utilized on University of California campuses**

As you may be aware, Anthem Blue Cross contracts to provide medical and behavioral health services to many of the University of California’s students. Recently, Anthem has expanded our footprint and we are now offering benefits to the student health plans for nearly all University of California (UC) campuses, including UC Berkeley, UC Davis, UC Hastings, UC Irvine, UC Los Angeles, UC Merced, UC Riverside, UC Santa Cruz, UC San Francisco, and UC San Diego. Based on utilization reporting, behavioral health services are the most highly used benefits that UC students access, and providers for this important population are in high demand.

Your expertise in treating student mental health issues like depression, eating disorders, gender identity and substance abuse is valued and much-needed. Please help us in meeting the demand for this important benefit.
Billing

Tips for billing CPT Modifier 33

The modifier 33 was created to aid compliance with the Affordable Care Act (ACA) which prohibits member cost sharing for defined preventive services for non-grandfathered health plans. The appropriate use of modifier 33 reduces claim adjustments related to preventive services and your corresponding refunds to members.

Modifier 33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier 33 will process under the member’s medical or preventive benefits, based on the diagnosis and CPT codes submitted.

Modifier 33 should be appended to codes represented for services described in the US Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) Guidelines.

The CPT® 2016 Professional Edition manual shares the following information regarding the billing of modifier 33, “When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.”

Report HCPCS code C9257 for Avastin Intravitreal Injection

Anthem Blue Cross (“Anthem”) will now accept HCPCS code C9257 for physician reporting of Avastin for intravitreal injection. Physicians should no longer report codes J3490, J3590, J9035, or J9999 for Avastin used in intravitreal injections.

Anthem has established a reimbursement allowance for code C9257, and will allow a maximum of 5 units per injection. Use of code C9257 will ensure that the appropriate reimbursement for this specific treatment is made.

This reporting and reimbursement change impacts commercial Anthem members only.

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 email at CAContractSupport@anthem.com to answer questions you have about the process.
Network

ProviderAccess Retirement Coming Soon: Transition to the Availity Web Portal Now

Prepare Now for This Upcoming 2017 Change!

Anthem continues to improve your web portal experience by transitioning all functionality to a single website, the Availity Web Portal. We are targeting January 20, 2017 to retire ProviderAccess and your electronic access to Eligibility, Benefits, Claim Status Inquiry, Remittance Inquiry, Professional Fee Schedule and important proprietary information will be available exclusively through Availity, our multi-payer portal solution. Note: This change does not affect the anthem.com public website or electronic transactions submitted via our Enterprise EDI Gateway; you may continue to submit all X12 transactions through your current EDI transmission channels.

Contact your organization’s administrator to obtain access to everything you need on Availity. To determine who your organization's administrator is, select “Who controls my access” from your account drop down box located in the upper right corner of the Availity Web Portal’s top menu bar.

Want Quick and Easy Access to the Tools You Use Most?
On the Availity Web Portal, you can now save your frequently used tools by selecting the heart icon next to the tool. This action will save it to your personal favorites. To access your favorites quickly and easily going forward, select My Favorites from the top menu bar.

Do You Have All of Your Tax IDs Registered on the Availity Web Portal?
If not, now is the time to register. Your organization’s administrator can add additional tax ids by selecting Maintain Organization from the Admin Dashboard.

If Your Organization Is Not Registered for Availity:
- Have your organization’s designated administrator go to www.availity.com and select Register.
- Complete the online registration wizard.
- The administrator will receive an email from Availity with a temporary password and next steps.

Free Training
Once you log into the secure portal, you’ll have access to many resources to help jumpstart your learning, including free live training, on-demand training, frequently asked questions, and comprehensive help topics. To view the current training resources, access the Help menu on the Availity Web Portal.

Anthem Blue Cross Cost Transparency

As an Anthem Blue Cross (“Anthem”) participating provider, you may have received our prior correspondence, or read the articles in our Network Updates on Anthem Cost Transparency. Specifically, Anthem’s Estimate Your Costs tool is available to members on anthem.com that allows members to estimate their out-of-pocket impact and view the estimated costs for many procedures.

In our prior correspondence, we also enclosed 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 are defined by the Blue Cross Blue Shield Association. As indicated in the correspondence, BCBS Axis (formerly NCCT) cost data is updated twice annually; the most recent update completed in November 2016, and the next update scheduled for May 2017. Please look for more information in our 2016 provider newsletters posted to anthem.com/ca.
As a reminder, participating Anthem provider costs are now available 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, and register to view the costs for their facility or practice. 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 e-mail request to the Anthem California contract support team at

**Provider data updates**

It is extremely important that we have accurate and up-to-date information about your practice in our directories. Senate Bill 137 (SB 137), which went into effect on July 1, 2016, requires that Anthem Blue Cross (“Anthem”) provide our members accurate and up-to-date provider directory data. As a result, Anthem will be conducting semi-annual outreaches to all practices to confirm the information we have on file is accurate. Without verification from you that our provider directory information is accurate, we will be required to remove your practice from the directories we make available to our members. We appreciate your attention to this matter.

**How to check and update your Demographic Information**

**Anthem Blue Cross: “Find a doctor tool”**
The Find a Doctor tool at Anthem Blue Cross (“Anthem”) 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.

**Availity**

In addition to your participating in Anthem’s outreach efforts, we ask that you still provide us with updates promptly when there is a change in your practice per your Anthem Provider Agreement by using the Availity Web Portal. You can 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:**
- Contractual agreement guidelines may supersede effective date of request
- You will receive an auto-reply e-mail acknowledging receipt of your request
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 (“Anthem”) has network leasing arrangements with a variety of organizations, which we call Other Payors. Other payors and affiliates use the Anthem network.

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem members. As such, they’re entitled to the same Anthem 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 website at www.anthem.com/ca, or email us at CACContractSupport@Anthem.com.
Quality Programs and Guidelines

Case management program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem is available to offer assistance in these difficult moments with our Case Management Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 1- 888-613-1130</td>
<td><a href="mailto:Case.management@anthem.com">Case.management@anthem.com</a></td>
<td>Monday –Thursday, 8:00am to 9:00pm</td>
</tr>
<tr>
<td>Fax: 1- 800-947-4074</td>
<td></td>
<td>Friday, 8:00am to 8:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saturday, 8:00am to 4:30pm</td>
</tr>
<tr>
<td>For Federal Employee Program (FEP). Case Management is administered by Blue Shield of California: 1-800-995-2800</td>
<td><a href="mailto:FEP_PPO_Case_Mgmt@blueshielddca.com">FEP_PPO_Case_Mgmt@blueshielddca.com</a></td>
<td>Monday – Friday 8am-4:30pm EST</td>
</tr>
<tr>
<td>National: 1-877-783-2756</td>
<td><a href="mailto:NationalWest-CM@anthem.com">NationalWest-CM@anthem.com</a></td>
<td>Monday – Friday 8am-8pm PST</td>
</tr>
</tbody>
</table>

Anthem Blue Cross Quality improvement programs

“Together, we are transforming health care with trusted and caring solutions.” We believe health care is local, and Anthem Blue Cross (“Anthem”) has the strong local presence required to understand and meet customer needs. Our plans are well positioned to deliver what customers want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information to assist them in seeking quality care. Our local plan presence and broad expertise create opportunities for collaborative programs that reward providers and facilities for clinical quality and excellence. Providers and facilities must cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to customers and health care professionals – helping improve both health and health care costs for those Anthem serves. Anthem takes a leadership role to improve the health of our communities and is helping to address some of health care’s most pressing issues. The Quality Improvement (“QI”) Program Description defines the quality infrastructure that supports Anthem’s improvement strategies.

Information on Anthem’s Quality Improvement programs can be found on anthem.com/ca. Select the Providers link at the top of the landing page (under the “Other Anthem Websites” section), then Enter. On the Provider Home Web page, under the “Health & Wellness” tab (on the blue toolbar) select the link, Quality Improvement and Standards.
Member's rights and responsibilities

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

It can be found on our web site. To access, go to https://www11.anthem.com/ca/home-providers.html, from there, click on “Enter” then Health & Wellness> Quality > Member Rights & Responsibilities. Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

Clinical practice and preventive health guidelines available the web

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 https://www11.anthem.com/ca/home-providers.html. From there, click on “Enter” then Health & Wellness > Practice Guidelines.

We believe in continuous improvement

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

Coordination of care

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

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 practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:

- Diagnosis
- Treatment plan
- Referrals
- Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available on the Provider website including a Coordination of Care template and cover letters for both Behavioral Health and other Healthcare Practitioners.* In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.**

*Access to the forms and cover letters are available at anthem.com>Providers>Provider Home>Answers@Anthem
**Access to the Toolkit is available at anthem.com>Providers>Provider Home>Health and Wellness

An overview of our medical necessity review process

A medical necessity review may be called many things - including utilization review (UR), utilization management (UM) or medical management - within the Explanation of Coverage agreement. Requirements for medical necessity review vary based on the member’s benefit plan. Reviews of a medical service may occur:

- when it is requested or planned (prospective or pre-service review)
- during the course of care (inpatient or outpatient ongoing care review)
- after services have been delivered (retrospective or post-service review)

With so many variables, it may help to get a clear picture of what to expect and how the process works.

Timing is Important
We are committed to deciding cases quickly and professionally. Here are several time frames you can expect:

<table>
<thead>
<tr>
<th>Type of review</th>
<th>The maximum amount of time from receipt of the information in which a health plan must decide medical necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent pre-service</td>
<td>5 business days for fully insured and HMO/POS members&lt;br&gt;72 hours for non-urgent prescription drug requests for fully-insured and HMO/POS plan members&lt;br&gt;15 calendar days for self-funded members</td>
</tr>
<tr>
<td>Urgent pre-service</td>
<td>72 hours&lt;br&gt;24 hours for urgent prescription drug requests for fully-insured and HMO/POS plan members</td>
</tr>
<tr>
<td>Urgent inpatient or outpatient ongoing care</td>
<td>24 hours (in specific instances, no later than within 72 hours of receiving a request)</td>
</tr>
<tr>
<td>Retrospective/post-service</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>

Notification of Delay in Review Determination
If we do not have the information we need to make our decision, we will try to get it from the physician or other health care provider who is requesting the service, medical procedure or equipment. If a delay is anticipated because the information is not readily available, we will notify the member as well as the requesting physician or other health care provider in writing. Delay letters include a description of the information we need to make a decision and also specify when the decision can be expected once the information is received. If we do not receive the necessary information, we will send a final letter explaining that we are unable to approve access to benefits due to lack of the information requested.
We Use Professional, Qualified Reviewers
Experienced clinicians review requests for services using medical criteria, established guidelines and Anthem Blue Cross Medical Policy. Requests for covered benefits meeting those standards are certified as medically necessary.

Only a Peer Clinical Reviewer May Determine That a Service is Not Medically Necessary
Peer Clinical Reviewers (PCRs) are California licensed health care professionals qualified and clinically competent to evaluate the specific clinical aspects of the request and/or treatment under review. PCRs are licensed in California in the same license category as the requesting physician or other health care provider. If you need to discuss a Medical Policy or a medical necessity review decision, an Anthem Blue Cross medical director or physician reviewer is available at 1-800-794-0838. If the PCR is unable to approve a service, the requesting physician, another health care provider or the member has the right to request an appeal.

Decisions Not to Approve Are in Writing
Written notice is sent to the member and the requesting physician or other health care provider within two business days of the decision. This written notice includes:
- a clear and concise explanation of the reason for the decision
- the name of the criteria and/or guidelines used to make the decision
- the name and phone number of the Peer Clinical Reviewer who made the decision, for peer-to-peer discussion
- instructions for how to appeal a decision
- specific provisions of the contract that excludes coverage if the denial is based upon benefit coverage

Access to Criteria is Open
Anthem Blue Cross medical necessity guidelines and criteria for specific services are available to members, member representatives, health care providers and the public. Members may call the number on the back of their ID card for a copy of the guidelines used to determine their case. Anthem Blue Cross Medical Policy is also available at www.anthem.com/ca. Providers can access UM criteria by selecting “Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider Home page; or call 1-800-794-0838 to request that a paper copy be sent to you. The requested criteria is provided free of charge.

A Determination of Medical Necessity Does Not Guarantee Payment or Coverage
The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of a member's coverage at the time of service. These terms include certain exclusions, limitations and other conditions, as outlined in the member's Evidence of Coverage. Payment of benefits could be limited for a number of reasons, for example:
- the information submitted with the claim differs from that given at time of review
- the service performed is excluded from coverage
- the member is not eligible for coverage when the service is actually provided

Decisions about Coverage of Service
Our utilization management decisions are based on the appropriateness of care and services, as well as the member’s coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization.

We Are Available for Questions
If you need to request precertification, need information about our UM process, or have questions or issues, call our toll-free number: 1-800-274-7767. Our associates are available Monday through Friday (except holidays), 7:30 a.m. to 5:00 p.m., Pacific Time. If you call after hours or do not reach someone during business hours, you may leave a confidential voice mail message. Please leave your name and phone number; we will return your call no later than the next business day during the hours listed above, unless other arrangements are made. Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls.
Language Assistance
For those who request language services, Anthem Blue Cross provides service in the requested language through bilingual staff or an interpreter, to help members with their UM issues. Language assistance is provided to members free of charge. Oral interpretation is available at all points of member contact regarding UM issues.

TDD/TTY Services
TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. If you have a hearing or speech loss, call 711 to use the National Relay Service or the number below for the California Relay Service. A special operator will contact Anthem to help with member needs. (English TTY/ English Voice): 1-800-855-7100

For Federal Employee Program, call the number on the member ID card. Utilization management is administered by Blue Shield of California.
HEDIS 2016 commercial results are in

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) commercial data collection project for 2016. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate commercial HEDIS process improvement by:

- Responding to our requests for medical records within five days if at all possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient’s medical record

Further information regarding documentation guidelines can be found on the HEDIS page of our Provider Portal. The Provider Portal can be accessed by signing in to www.anthem.com and clicking on “Provider”, followed by “Health and Wellness”, “Quality”, and finally “HEDIS”. You will find reference documents entitled “HEDIS 101 for Providers” and “HEDIS Documentation Guidelines”.

The following table shows some of our key measure rates across California.

- Yellow boxes indicate rates that are above the national average.
- **Bold** indicates improvement in rate over the previous year.
- **Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good**

### HEDIS 2016 Commercial California HMO/POS

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of Care - Prevention and Screening</strong></td>
<td></td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>86.46</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Total</td>
<td><strong>65.83</strong></td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition Total</td>
<td>62.06</td>
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<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity Total</td>
<td>56.03</td>
</tr>
<tr>
<td>Childhood Immunization Status - Combo 2</td>
<td>77.37</td>
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<tr>
<td>Childhood Immunization Status - Combo 3</td>
<td>75.18</td>
</tr>
<tr>
<td>Immunizations for Adolescents - Combo 1</td>
<td>71.64</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine for Female Adolescents</td>
<td><strong>23.60</strong></td>
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<tr>
<td>Breast Cancer Screening Ages Total</td>
<td>77.29</td>
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<tr>
<td>Cervical Cancer Screening</td>
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</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>70.49</td>
</tr>
<tr>
<td>Chlamydia Screening in Women - Total</td>
<td>55.25</td>
</tr>
</tbody>
</table>
California Commercial HMO/POS plans had strong results in 2016 (measuring care delivered in 2015), with many of the key measures both improving from last year and exceeding the national average. There is a notable upward trend in the number of well child visits in the first 15 months of life (W15) as the number of members with 6 or more visits continues to increase each year. There was also a significant increase in the number of medical records recording the BMI percentile at office visits for children 3-17 (WCC–BMI).

This year the PPO plans reflected a greater number of measures with improved results from last year as well as an increase in measures exceeding the national average. The most improvements were seen in the recording of BMI for adults (ABA) and in the postpartum care of members receiving care for pregnancy (PPC-POST).

There are, of course, opportunities for improvement, especially for the measures with the most significant decreases in rates. For HMO/POS plans, this includes immunizations for children before age 2 (CIS), where one or more of the required immunizations were either missing or administered after the second birthday. In PPO Plans, improvement opportunities are notable in the influenza vaccination component for children before age 2 (CIS), as well as in physical activity counseling of children ages 12-17, an element of the Weight Assessment/Nutritional and Physical Counseling measure (WCC-Activity).

Again, we thank you and your staff for demonstrating teamwork as we work together to improve the health of our members and your patients. We look forward to working with you again next HEDIS season.

**HEDIS®** is a registered trademark of the National Committee for Quality Assurance (NCQA)
HEDIS spotlight: Respiratory conditions

Asthma and Chronic Obstructive Pulmonary Disease (COPD) are major causes of morbidity, mortality, lower quality of life, and lost productivity including missed days from school or work. According to the Centers for Disease Control and Prevention (CDC), one in 14 people have asthma or about 24 million Americans (roughly 7.4% of adults and 8.6% of children). Asthma causes almost 2 million emergency room visits each year; more than 14 million doctor visits; and 439,000 hospital stays. More than half of children and one-third of adults missed school or work due to their asthma. Each day, 10 Americans die from asthma. Many of these deaths are avoidable with proper treatment and care.

Since medication is vital to controlling asthma exacerbations, the National Commission for Quality Assurance (NCQA) requires health plans to review claims for medication management among members with persistent asthma, and contributes to health plan Accreditation levels and the Quality Rating System (QRS) measurement weight for plans purchased on the Health Insurance Marketplace or the exchange. The three measures are:

- **Use of Appropriate Medications for People with Asthma (ASM):** The percentage of members 5 to 85 years of age who were identified as having persistent asthma and who were appropriately prescribed medication.

- **Medication Management for People with Asthma (MMA):** The percentage of members 5 to 85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:
  - The percentage of members who remained on asthma controller medication for at least 50% of their treatment period.
  - The percentage of members who remained on asthma controller medication for at least 75% of their treatment period.

- **Asthma Medication Ratio (AMR):** The percentage of members 5 to 85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of .50 or greater.

COPD can also be managed by medication. However, it is important to distinguish diagnosis between asthma and COPD because of the differences in treatment, disease progression, and outcomes. According to the American Lung Association, COPD cost the U.S. $49.9 billion in 2010. Of that, $29.5 billion was spent on direct health care costs, $8 billion from indirect morbidity costs, and $12.4 were indirect mortality costs. COPD is often misdiagnosed or undiagnosed until later in the disease. Almost 15.7 million Americans (6.4%) reported that they have been diagnosed with COPD. More than 50% of adults with low pulmonary function were not aware that they had COPD. In 2014, COPD was the third leading cause of death in the U.S. Establishing a diagnosis of COPD requires spirometry testing, interpreted in the context of the patient's symptoms, smoking status, age, and comorbidities.

The HEDIS measures related to COPD are:

- **Use of Spirometry testing in the Assessment and diagnosis of COPD (SPR):** The percentage of members 40 years of age and older with a new diagnosis of COPD, or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

- **Pharmacotherapy Management of COPD Exacerbation (PCE):** The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and who were dispensed appropriate medications. Two rates are reported:
  - Dispensed a systemic corticosteroid (or evidence of an active prescription) within 14 days of the event.
Dispensed a bronchodilator (or evidence of an active prescription) within 30 days of the event.

**Anthem is helping**

A consolidated Medication Review note may be sent to members and their providers when the following criteria are met:
- Member is less than 80% compliant on their asthma controller medication
- Member shows high utilization of short-acting beta agonist medication and not on an asthma controller (inhaled corticosteroid)
- Member has claim(s) for COPD medications including Atrovent, instead of more effective therapy (Spiriva)

**What can you do?**

- Use spirometry to diagnose and monitor treatment efficacy.
- Adopt a Patient Centered Planned Visit Model. Provide ongoing follow-up and care plans for patients throughout the year. Use every patient engagement/acute appointment to discuss concerns, compliance, and closing gaps in care.
- Educate your patients about their disease, possible consequences to their health and quality of life.
- Remind patients to take and refill controller medications. Discuss patient concerns that might interfere with adherence. Provide simple written instructions that are appropriate both culturally and in literacy level.
- Review proper inhaler use at each visit, encouraging patients to demonstrate. Work with your patients who have asthma to have a current written action plan and to use a peak flow meter to monitor control. Discuss patient’s triggers and ways to avoid exposure to triggers.
- Code and document visits accurately.

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Medi-Cal Managed Care Updates

California Medi-Cal in-network laboratory update

Effective January 1, 2017, Myriad Genetic Laboratories will no longer be an in-network laboratory for the Medi-Cal Managed Care Program of Blue Cross of California doing business as Anthem Blue Cross and its affiliates (Anthem). Providers should start using, Ambry Genetics, Counsyl, LabCorp, Medical Diagnostic Laboratories (MDL) or Quest Diagnostics for BRCA testing and other services ordered from Myriad Genetic Laboratories on or before January 1, 2017. Using an in-network laboratory helps patients maximize their laboratory benefits and minimize their out-of-pocket expenses.

If you have specific questions regarding BRCA testing or other genetic testing performed by in-network labs, please see the below contact information.

- Ambry Genetics: 1-866-262-7943 or http://www.ambrygen.com/contact-us
- Counsyl: 1-888-268-6795 or https://www.counsyl.com/contact/
- LabCorp: 1-888-LABCORP (522-2677) or www.LabCorp.com.
- Medical Diagnostic Laboratories (MDL): 1-877-269-0090 or https://mdlab.com/company/contact/
- Quest Diagnostics: 1-866-MY-QUEST (866-697-8378) or https://questdiagnostics.com/

Non-capitated, institutional Medi-Cal claims must have individual attending provider NPI – effective January 1, 2017

In an effort to more closely align with guidelines from the Centers for Medicare & Medicaid Services (CMS), effective January 1, 2017, Anthem Blue Cross will require that all non-capitated claims have an individual attending provider National Provider Identifier or NPI (Type 1) on institutional Medicaid claims. Claims submitted without the required NPI information in the attending field will be denied, with the exception of emergency claims.

To comply with the Health Insurance Portability and Accountability Act (HIPAA), the attending provider name and identifiers (including NPI) are required on institutional claims for all services other than nonscheduled transportation. The attending provider is the individual who has overall responsibility for the patient’s medical care and treatment.

Please refer to ANSI X12 837 – 5010 Technical Report Type 3 (TR3) for required electronic data interchange (EDI) transaction standards. If you have additional questions, please call our Medi-Cal Customer Care Center at 1-800 407-4627 (TTY 711) – outside L.A. County, Monday through Friday from 8 a.m. until 6 p.m., Pacific Time. Inside L.A. County, dial 1-888-285-7801.
Prior authorization required for elective one-and two-vessel Coronary Artery Bypass Graft

On January 1, 2017, Anthem Blue Cross precertification requirements will change for elective one- and two-vessel Coronary Artery Bypass Graft (CABG). Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage.

In review of these services, physicians should reference the MCG Care Guidelines criteria for CABG.

To find precertification and code-specific requirements:

2. Select Login from the upper right-hand corner of the screen.
3. In ProviderAccess, enter your credentials to log in.

Please share this notice with other members of your practice and office staff. If you have questions, call our Medi-Cal Customer Care Centers at 1-800-407-4627 (outside Los Angeles County) or 1-888-285-7801 (inside Los Angeles County).

Prior authorization requirements for injectable/infusible drugs: Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin) Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb)

On February 1, 2017, Anthem Blue Cross will require prior authorization (PA) for injectable/infusible drugs: Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb). Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

To find precertification and code-specific requirements:

2. Select Login from the upper right-hand corner of the screen.
3. In ProviderAccess, enter your credentials to log in.

Please share this notice with other members of your practice and office staff. If you have questions, call our Medi-Cal Customer Care Centers at 1-800-407-4627 (outside Los Angeles County) or 1-888-285-7801 (inside Los Angeles County).

Provider website survey

Anthem Blue Cross relies on your feedback to improve and strengthen our processes and operations. Our Provider Website Survey is a new tool to evaluate the effectiveness of our Medi-Cal Managed Care provider website. Input about your experience with our website is essential to our goal of efficient and effective provider resources. We will use your survey responses to better understand your experiences and continue to improve our site. Providing exceptional service to providers who serve our members is one of our strongest commitments.

Thank you in advance for taking the time to complete this brief survey. To access the survey, go to https://www.surveymonkey.com/r/7PHY5BL.
New provider webinar worth three CMEs

A new webinar is available for providers worth three CMEs. The three-part webinar series covers the basics of HEDIS® * and keys for success to earn higher HEDIS scores. At the completion of this program, you will be able to obtain a comprehensive understanding of HEDIS measures and positive learning outcomes by way of virtual self-study.

This self-paced webinar series is located within our Provider Website. Locate the Provider Support tab, select Quality Assurance and then select Quality Improvement.

At the conclusion of the activity, participants will be able to:

- Define the purpose for why HEDIS data is rendered.
- List two practical approaches to improve HEDIS scores in their own practices.
- State three best practices to improve record collection positively impacting HEDIS scores

To obtain CE credit:

- View all three virtual self-study webinars as follows: HEDIS 101 Webinar, Adult HEDIS Measures Webinar and Child HEDIS Measures Webinar.
- Complete the HEDIS Webinar CME Evaluation form (following the webinar links) and fax it to Health Education at 1-818-240-1206 or email it to healthed_ca_medicaid@anthem.com.

Please email any questions to healthed_ca_medicaid@anthem.com

NOTE: This CE opportunity is offered to providers; however, it may be useful to other health practitioners and staff. Please confirm with the appropriate party if credit will be accepted for your business need.

This Enduring Materials series activity, HEDIS provider webinar, will be available June 13, 2016 – June 13, 2017. It has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Coding guide for tobacco use brochure for providers

Anthem Blue Cross has created a guide for providers to utilize when identifying patients as tobacco users. According to California’s tobacco cessation policy letter, managed care plans are advised to promote tobacco cessation services to Medi-Cal members by developing a process to identify tobacco users and record utilization data of tobacco cessation activities. The complete guide includes options on how to document the patient as a tobacco user in addition to a thorough list of ICD-10 tobacco use codes to log in the patient’s medical record.

The guide entitled, “Coding Guide for Tobacco Use,” can be accessed through the following link: https://mediproviders.anthem.com/ca/pages/tobacco-cessation.aspx
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.

Prior authorization for elective one-and two-vessel Coronary Artery Bypass Graft

Effective January 1, 2017, prior authorization (PA) requirements will change for members enrolled in Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members for certain elective one- and two-vessel Coronary Artery Bypass Graft (CABG). Non-compliance with new requirements may result in denied claims. This applies to the following procedure codes:

- 33510 - Coronary artery bypass, vein only; single coronary venous graft
- 33511 - Coronary artery bypass, vein only; 2 coronary venous grafts
- 33517 - Coronary artery bypass, using venous graft(s) and arterial graft(s); single vein graft (List separately in addition to code for primary procedure)
- 33518 - Coronary artery bypass, using venous graft(s) and arterial graft(s); 2 venous grafts (List separately in addition to code for primary procedure)
- 33530 - Reoperation, coronary artery bypass procedure or valve procedure, more than 1 month after original operation (List separately in addition to code for primary procedure)
- 33533 - Coronary artery bypass, using arterial graft(s); single arterial graft
- 33534 - Coronary artery bypass, using arterial graft(s); 2 coronary arterial grafts

Federal law, state law, state contract language and Centers for Medicare & Medicaid Services (CMS) guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage.

In review of these services, physicians should reference the MCG Care Guidelines criteria for CABG.

In absence of an existing National Coverage Determination or Local Coverage Determination, physicians should reference the MCG criteria for CABG.

Not all prior authorization requirements are listed here. For more information, please log in at [https://mediproviders.anthem.com/ca](https://mediproviders.anthem.com/ca) using your Availity credentials and select Services Requiring Prior Authorization. You may also call Provider Services at 1-855-817-5786.

Prior authorization for injectable/infusible drugs: Doxil (doxorubicin) and Sustol (granisetron)

On January 1, 2017, Anthem Blue Cross will change prior authorization (PA) requirements for two Part B injectable/infusible drugs for members enrolled in Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). These drugs include: Doxil (doxorubicin) and Sustol (granisetron). Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage.

Non-compliance with new requirements may result in denied claims. PA requirements will be added to the following codes:

- **Doxil (doxorubicin):** for treatment of ovarian cancer after failure of platinum-based chemotherapy, AIDS related Kapoli Sarcoma after failure of prior systemic chemotherapy or intolerance to such therapy, Multiple Myeloma when used in combination with bortezomib and have received on prior therapy. Doxil may also be used for breast cancer, Hodgkin's Lymphoma, Non-Hodgkin's lymphoma, sarcomas of soft tissue and uterine neoplasms (Q2049 and Q2050).
Drugs billed with not otherwise classified (NOC) HCPCS J codes (J3490 and J3590):

- **Sustol (granisetron):** indicated in combination with other antiemtics in adults for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy (MEC) or anthracycline and cyclophosphamide (AC) combination chemotherapy (unlisted, no J code established at this time).

Please note, this drug is currently billed under the NOC J-codes [J3490 and J3590]. Since this code includes all drugs that are NOC, if the authorization is denied for medical necessity, the plan's denial will be for the drug and not the HCPCS.

Not all PA requirements are listed here; however, detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at [www.Availity.com](http://www.Availity.com) Contracted and non-contracted providers unable to access Availity may call Provider Services at 1-855-817-5786.

**Prior authorization for new injectable/infusible drugs: Inflectra (infliximab-dyyb) and Cinqair (reslizumab)**

On **January 1, 2017**, Anthem Blue Cross will change prior authorization (PA) requirements for two Part B injectable/infusible drugs covered by the Plan: Inflectra (infliximab-dyyb) and Cinqair (reslizumab ). This change impacts members enrolled in the Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan).

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage.

**Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following codes:

- **Inflectra (infliximab-dyyb):** for treatment of moderate to severely active Crohn's disease, Ulcerative colitis, Rheumatoid arthritis, Ankylosing spondylitis and Psoriatic arthritis. (Q5102)

Drugs billed with not otherwise classified (NOC) HCPCS J code (J3490/J3590)

- **Cinqair (reslizumab):** for add-on maintenance treatment of patients with severe asthma with an eosinophilic phenotype (unlisted, no J code established at this time)

Please note, two of these drugs are currently billed under the NOC J code (J3490/J3590). Since this code includes all drugs NOC, if the authorization is denied for medical necessity, the Plan's denial will be for the drug and not the HCPCS.

Not all PA requirements are listed here; however, detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at [www.Availity.com](http://www.Availity.com). Contracted and non-contracted providers unable to access Availity may call Provider Services at 1-855-817-5786.
Prior authorization change to three drugs: Interferon gamma-1b (Actimmune), Mecasermin (Increlex) and Azacitidine (Vidaza)

On January 1, 2017, Anthem Blue Cross will change prior authorization (PA) requirements for three drugs covered for members enrolled in the Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). These drugs include: Interferon gamma-1b (Actimmune®), Mecasermin (Increlex®) and Azacitidine (Vidaza®). Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage.

Non-compliance with new requirements may result in denied claims. PA requirements will be added to the following codes:

- J9216 – Injection, Interferon gamma-1b (Actimmune®), 3 million units.
- J2170 – Injection, Mecasermin (Increlex®), 1 mg.
- J9025 – Injection, Azacitidine (Vidaza®), 1 mg.

Not all PA requirements are listed here; however, detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at www.Availity.com. Contracted and non-contracted providers who are unable to access Availity may also call Provider Services at 1-855-817-5786.

Prior authorization requirement change to Torisel (Temsirolimus)

On February 1, 2017, Anthem Blue Cross prior authorization (PA) requirements will change for the drug Torisel (Temsirolimus) covered by Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over this precertification rule and must be considered first when determining coverage.

Noncompliance with new requirement may result in denied claims. PA requirement will be added to the following code:

- J9330 – Torisel (Temsirolimus)

Not all PA requirements are listed here; however, detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at www.Availity.com. Contracted and non-contracted providers who are unable to access Availity may call our Anthem Blue Cross Cal MediConnect Plan Provider Services at 1-855-817-5786.
Medicare Advantage Updates

Medicare Supplement members should be using new ID cards

Anthem Medicare Supplement individual members recently received new member ID cards. Please obtain a copy of the new member ID cards to file claims for dates of service December 1, 2016 and beyond. Additional information, including alpha prefixes, is available at the Answers @ Anthem tab at the top of the Anthem provider home page.

Cardioverter Defibrillators -- confirm if authorization required for implants

When obtaining an authorization for a surgery that involves an implant, you must check the associated implant codes to determine if an authorization is also needed for the implant.

2017 Medicare Advantage individual benefits and formularies available

Summary of benefits, evidence of coverage and formularies for 2017 Individual Medicare Advantage plans can be found at anthem.com/ca/medicareprovider. An overview of notable 2017 benefit changes also is available at anthem.com/ca/medicareprovider.

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

Application of Copayments: When member cost share is a copayment amount, members will be responsible for a copayment for each type of service rendered. If a member receives more than one type of service, the applicable copayment for each service will apply. Only one copayment will apply for each type of service rendered.

As an example, if a member receives three X-rays in a Specialist Office on the same date of service, the member would be responsible for the one X-Ray copayment and one Specialist Office copayment.

Please note: Certain places of service; including but not limited to, Inpatient Hospital, Outpatient Hospital, Emergency Room and Urgent care will only assess one member copayment for each visit.

No copay benefit for diabetes retinal exam and HbA1c testing effective 1/1/2017: Effective January 1, 2017, no copay will be required for HbA1c testing for individual and group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual retinal exam at no out-of-pocket cost.
**Routine physical exams are covered in 2017**

The majority of Anthem Medicare Advantage (MA) plans will continue to supplement Medicare covered preventive services and offer coverage for routine physicals in 2017 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 or coinsurance 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. Please call the number of the back of the member’s ID card for specific coverage information.

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

**Dual Eligible Special Needs Plans – provider training required**

In 2017, Anthem is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors’ appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items. Centers for Medicare & Medicaid Services regulations protect D-SNP members from balance billing.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans will receive notices in Q4 2016 that contain information for online training. Every provider contracted for our D-SNP plans is required to complete this annual training and click the attestation within the training site stating that they have completed the training. These attestations can be completed by individual providers or at the group level with one signature.

Additional information will be available at anthem.com/ca/medicareprovider under Important Medicare Advantage Updates.

**Claim adjustments may change member cost share**

Anthem reminds providers to please check the explanation of payments on claims. There are situations in which a claim may be adjusted and this may change a member’s cost-share. If you receive a claim adjustment from Anthem, please ensure the member cost-share is still accurate. Basic member cost-share information is located on the front right-side of the member ID card but please note that not all cost shares are listed. If you have any questions about a member’s cost share, please call the number on the back of the member ID card.
Verify injectable, infusion billable units approved via AIM

Providers are to submit claims for medical injectable and infusion drugs in billable units for the Healthcare Common Procedure Coding System (HCPCS) code authorized. Providers can verify the amount of billable units approved for a case by using the member ID and authorization number provided. All claims submitted for more units than approved are subject to denial. To adjust the dose of an approved AIM authorization, please contact AIM for a new drug authorization request.

Claims are submitted in billable units per the HCPCS code. The billable units are calculated based on the HCPCS code administered and the dose associated with the code.

For example:

One (1) HCPCS unit of Rituxan represents 100mg of drug per HCPCS code

J9310 (Rituxan) is administered at 1000mg for two doses

1000mg = 10 units (HCPCS code is 100mg)

Each dose of 1000mg is 10 billable units

Two doses = 20 billable units

AIM authorization details can be obtained via phone or the provider portal.

AIM phone number: 1-800-714-0040

AIM provider portal: [www.providerportal.com](http://www.providerportal.com)

For AIM Provider portal support please contact AIM at [1-800-252-2021](tel:1-800-252-2021) option 2.

Note: An email address and the TIN for the facility/provider are needed to register for the site. Once registered, providers can view all AIM oncology drug approvals/denials by using the member information (name, ID#, Date of Birth).

For all other Part B injectable and infusion approvals/denials, inquiries will be answered via email at [www.MASpecialtyPharm@Anthem.com](mailto:www.MASpecialtyPharm@Anthem.com) or via phone at [1-866-797-9884](tel:1-866-797-9884) option 5.

HCPCS codes required for Rural Health Clinic claims

All claims from Rural Health Clinics (RHC) with dates of service April 1, 2016, and after must contain an appropriate HCPCS code for each service line along with a revenue code on their Medicare Advantage claims. This pertains to Contracted and Non-Contracted Providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans, including Dual Special Needs Plans and Medicare-Medicaid Plans.
Transitional Care Management Services eligibility

A beneficiary is not eligible to receive TCM services until 30 days have passed since the beneficiary was discharged from an inpatient hospital setting. Anthem Blue Cross (“Anthem”) determines the date of discharge based on the date the beneficiary received their discharge evaluation and management (E&M) visit. TCM services will be denied by Anthem if the discharge E&M visit is not received before the TCM service.

These billing instructions apply to all individual Medicare Advantage plans, including Dual Special Needs Plans and Medicare-Medicaid Plans.


Avoid needless claims denials

Anthem Blue Cross (“Anthem”) has compiled tips for avoiding unnecessary claims denials, including:

- Services disallowed by utilization management
- Valid Clinical Laboratory Improvement Amendments number must be submitted
- Procedure not covered by diagnosis
- Inappropriate or missing modifier
- Duplicate claim

To view go to anthem.com/ca/medicareprovider under Important Medicare Advantage Updates.

Clarification – Requesting Authorization for certain Arterial Duplex Imaging Procedures

As communicated in the April 2016 Network Update and Important Medicare Advantage Updates, Anthem Blue Cross is collaborating with AIM Specialty Health® to conduct medical necessity reviews for Vascular ultrasound management for our individual Medicare Advantage members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days from the day the procedure is performed and before you submit a claim.

Please note failure to contact AIM within the 10 day post service window for review will result in a denial of payment.

Impact codes are as follows:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Brief Description</th>
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<tr>
<td>93925</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS COMPL BI STUDY</td>
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</tr>
<tr>
<td>93931</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS UNILMTD STUDY</td>
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</tbody>
</table>

To submit your request, go to the AIM Provider Portal www.aimspecialtyhealth.com. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at 1-800-714-0040, Monday through Friday, 7 a.m. to 7 p.m. Central Time.
AIM clinical appropriateness guidelines for advanced imaging

Effective February 18, 2017, the following changes to AIM Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

**Oncologic imaging (CT, MRI and PET)**
- Enhanced criteria around surveillance following completion of therapy for colorectal cancer
- Updated criteria for appropriate use of imaging studies in the management of prostate cancer and breast cancer
- New guidelines for appropriate use of multiparametric MRI in the diagnosis of prostate cancer

**Breast MRI**
- Enhanced criteria for appropriateness of MRI in DCIS, atypical ductal hyperplasia, and follow-up imaging of BIRADS 3 studies

**Abdominal and pelvic imaging (CT and MRI)**
- Updated criteria for appropriateness of imaging in inflammatory bowel disease
- Guidelines for follow-up of incidental liver lesions utilizing advanced imaging
- Enhanced criteria for imaging in chronic abdominal pain and nephrolithiasis

**Keep up with Medicare news**

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

- September reimbursement policy provider bulletin
- Medicare Advantage reimbursement policies
- Medicare notices and provider requirements
- Clinical Cumulative Morphine Equivalent Dosing Point of Sale Edit effective January 1, 2017
- Prior authorization requirement for Torisel
- Prior authorization changes to Interferon gamma-1b, Mecasermin, and Azacitidine
- Prior authorization requirements for Doxil and Sustol
Pharmacy

Anthem Blue Cross preferred products

Immunoglobulin Preferred Products

Anthem Blue Cross (“Anthem”) has reviewed the immunoglobulin products through the P&T process and has selected two preferred drugs: Gamunex-C® and Octagam®. When prescribing these products, please consider the preferred drugs for initial therapy.

<table>
<thead>
<tr>
<th>Preferred Product</th>
<th>Non Preferred Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamunex C®</td>
<td>Gammagard®</td>
</tr>
<tr>
<td>Octagam®</td>
<td>Privigen®</td>
</tr>
</tbody>
</table>

Botulinum Toxin Agents Preferred Products

Anthem has reviewed the botulinum toxin agents and has selected Xeomin® as the preferred agent. When prescribing a botulinum toxin, please consider Xeomin® for initial therapy.

<table>
<thead>
<tr>
<th>Product</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xeomin®*</td>
<td>Preferred</td>
</tr>
<tr>
<td>Botox®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Myobloc®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Dysport®</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

*Preferred product for the following medical indications: upper limb spasticity, cervical dystonia and blepharospasm.

Hyaluronic Acid Preferred Products

Anthem has reviewed the hyaluronic acid agents through the P&T process and has selected four preferred drugs: Synvisc-One®, Synvisc®, Monovisc® and Orthovisc®. Beginning September 1, 2016, an edit was put in place requiring one of the preferred drugs below to be tried before a non-preferred drug. When prescribing these products, please consider the preferred agents below for patients needing hyaluronic acid therapy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Weekly Injections</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synvisc-One®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Synvisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Monovisc®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Orthovisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Euflexxa®</td>
<td>3</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Gel-One®</td>
<td>1</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Hyalgan®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Supartz®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>
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.”

Website links are listed below for the Federal Employee Program® (FEP®) formulary.

**Basic Option:** [https://www.caremark.com/portal/asset/z6500_drug_list807.pdf](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf)

**Standard Option:** [https://www.caremark.com/portal/asset/z6500_drug_list.pdf](https://www.caremark.com/portal/asset/z6500_drug_list.pdf)  This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at [www.fepblue.org](http://www.fepblue.org) > Benefit Plans > Brochures and Forms > Medical Policies.