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anthem.com/ca

Network Relations:
CAContractSupport@Anthem.com
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Health Care Reform Updates (including Health Insurance Exchange)

PCP assignment for California Individual plans

Commencing with the 2017 benefit year, Covered California is requiring Anthem Blue Cross (Anthem) to ensure that all PPO/EPO members have a Primary Care Physician (“PCP”)*. If you subscribe to the Anthem’s professional newsletter, Network Update, you may have seen an article regarding this requirement in the December 2016 edition. To comply with this Covered California requirement, Anthem will be assigning Anthem PPO/EPO Individual members a PCP, whether they purchased their Individual coverage on or off the Exchange, with the exclusion of Individual members with grandfathered plans.

While assigning PCPs to PPO/EPO members is a mandate from Covered California that is designed to support improved health by promoting the establishment of a Physician/Patient relationship for all those enrolled with PPO or EPO benefits, this assignment does NOT create a gatekeeper model like an HMO benefit plan.

To conform with the Covered California requirement that all PPO/EPO members have a Primary Care Physician, Anthem is taking steps to assign all PPO/EPO members to a Primary Care Physician.

Members are not obligated to seek care from this assigned PCP and may continue their existing physician relationships without interruption. Members may also contact Anthem to change this PCP assignment at any time. Similarly, the assigned PCP has no obligation to reach out to any assigned members. Physician roles and responsibilities for PPO/EPO members have not changed.

*Please note that from the member’s perspective, when the member accesses Anthem’s Provider Finder tool to select their personal physician, the Anthem Provider Finder terminology references the Member Preferred Provider (“MPP ID”) and does not use the term “PCP” – this is consistent with Covered California terminology.

If your identified primary specialty is one of those listed below, members may receive a letter, such as the sample member letter enclosed, which has your name as their PCP.

- Family practice
- General practice
- Internal medicine
- Pediatrician

Note: Members may also choose a PCP with a primary specialty identified as either a geriatrician or OB/GYN, but a physician with that primary specialty will not be automatically assigned to a member.

Anthem is hopeful that the assignment of PCPs will help PPO/EPO members who do not see a physician regularly reach out to Anthem’s participating physicians in the Pathway PPO/EPO network for medical services and establish a relationship with the physician, so that they will return to that physician, or another physician to whom the PCP refers, when additional medical services are needed.
If your primary specialty is on the preceding page, we hope you will see the advantages of potentially being assigned as a PCP and having members reaching out to your office to arrange an appointment.

Some key points you should be aware of:

- This is NOT a gatekeeper relationship – no authorizations are needed for referrals or specialty care like an HMO arrangement. 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 use a Member Preferred Provider (MPP ID) as the code for the PCP designation.

- PCP information WILL NOT be included on member ID cards. Members will be notified of their assignment by letter starting in February.

- As an in-network physician, you can continue to schedule appointments with patients enrolled in on/off exchange plans whether or not your practice is assigned as the patients’ Member Preferred Provider (PCP).

- If you access the Anthem Blue Cross provider portal, Availity, the Member Preferred Provider may be listed. Once again, if the member is enrolled in a Covered CA or off-exchange PPO or EPO plan, there is no gatekeeper arrangement and you can continue to schedule appointments as usual.

- A copy of this letter will also be in the February newsletter. If you do not already subscribe to the newsletter, please contact our Network Relations team to sign up. Our newsletters are posted online and an email is sent out to registrants bi-monthly.

If you have any questions, please contact our Network Relations team at CAContractSupport@anthem.com.

Preventive care services covered with no member cost-share (updated December 2016)

The Affordable Care Act (ACA, or health care reform law) requires Anthem Blue Cross (Anthem) to cover certain preventive care services with no member cost-sharing (copayments, deductibles, or coinsurance).\(^1\) Cost-sharing requirements may still apply to preventive care services received from out-of-network providers.

The list shares an overview of services, drugs, and pharmacy items covered by Anthem under preventive care benefits.\(^1\) Services listed may not be appropriate for all members, as some may be covered based on member age and health condition(s). These benefits may not apply to grandfathered health plans. Providers should continue to verify eligibility and benefits for all members prior to providing services or receiving member copayments, deductibles, or coinsurance.

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

Sleep studies, related services, and supplies and frequency editing

Sleep Studies and Related Services & Supplies and Frequency Editing – professional
In our June 29, 2016 provider notice, we advised physicians and other providers that we would be implementing a one (1) per 60 days frequency limit to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783 for dates of service effective October 1, 2016). We have reconsidered this limit and removed this edit for dates of service on or after October 1, 2016.

Clinical guideline/medical policy update

Below are new Clinical Guidelines for the requirement of a clinically equivalent treatment effective May 1, 2017.

For more information on Anthem Medical Policy and Clinical UM guidelines and dosing guidelines refer to the complete list of our Medical Policies and Clinical UM Guidelines that are accessed on Anthem Blue Cross’ provider web site at www.anthem.com/ca.

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Impacted Products</th>
<th>Clinically Equivalent Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-Approved Biosimilar Products; CG-DRUG-64</td>
<td>Inflectra®</td>
<td>Remicade®</td>
</tr>
<tr>
<td>Hyaluronic Injections in the Knee; CG-DRUG-29</td>
<td>Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®</td>
<td>Monovisc®, Orthovisc®, Synvisc®, Synvisc One®</td>
</tr>
</tbody>
</table>

Anthem Blue Cross will expand the Specialty Pharmacy program to include level of care review for hemophilia drug indications beginning May 1, 2017

Listed below are details about upcoming changes to the current coverage guideline, Specialty Pharmaceuticals CG-DRUG-47.

<table>
<thead>
<tr>
<th>Clinical Guideline Number</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DRUG-47</td>
<td>This coverage guideline will apply to hemophilia drug indications beginning with dates of service on and after May 1, 2017.</td>
</tr>
<tr>
<td></td>
<td>Added DRUG.00066 (Antihemophilic Factors and Clotting Factors)</td>
</tr>
<tr>
<td></td>
<td>CG-DRUG-55 – Vimizim (J1322)</td>
</tr>
<tr>
<td></td>
<td>CG-DRUG-57 – Elaprase (J1743)</td>
</tr>
</tbody>
</table>

The level of care pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health, (AIM), a separate company administering the program on behalf of Anthem Blue Cross (Anthem).
Ordering and servicing physicians may submit to AIM a precertification request for these services in one of several ways:

- Access AIM ProviderPortal℠ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-877-291-0360

The expanded program applies to local Anthem members who have specialty pharmacy services medically managed by AIM Specialty Health. The expanded program does not apply to the following plans: HMO, BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, and Federal Employee Program® (FEP®).

AIM sleep disorder update

For dates of service on or after May 12, 2017, the following enhancement to AIM Sleep Disorder Management Diagnostic and Treatment Guidelines will become effective: An exclusion of patients with LV ejection fraction of <45% is being added to the appropriateness criteria for use of BPAP (with back-up rate feature) in established central sleep apnea. This change is based on safety concerns brought to light by the SERVE-HF study, and is aligned with recommendations from AASM.

New specialty pharmacy program for utilization review of drug dosage and frequency

Beginning with dates of service on and after May 1, 2017, Anthem Blue Cross (Anthem) will implement a new clinical guideline, Drug Dosage, Frequency, and Route of Administration CG-DRUG-53. This will apply to the review process for Specialty Pharmacy. The program will be administered by AIM Specialty Health® (AIM), a separate company. Based on the information you provide, AIM will review the drug for clinical appropriateness, and drug dosage and frequency against health plan clinical criteria.

What’s new beginning with dates of service on and after May 1, 2017?

Description: CG-DRUG-53 contains clinical criteria for review of the medical necessity of dosage and frequency

- As part of pre cert process the following will be required:
  1. Weight, Height, Age, Gender
  2. Dose per treatment and Directions per treatment (frequency), and duration (length of therapy)

To ensure accurate and timely payment, it is important that you provide the above requested information effective May 1, 2017.

Providers may continue to request authorization for specialty drugs in one of several ways:

- Access AIM ProviderPortal℠ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-877-291-0360, Monday–Friday, 7:00 a.m.–5:00 p.m. PT.

For more information on Anthem Med Policy and dosing guidelines refer to the complete list of our Medical Policies and Clinical UM Guidelines that are accessed on Anthem’s provider web site at www.anthem.com/ca.

Reminder – Drug wastage should be reported with modifier “JW”:
Providers may be reimbursed for single dose vial drug wastage beyond the approved dosage that is authorized per the Utilization Review process outlined above. The Provider is expected to utilize the most economical combination of vial sizes for the drug administered and must report the drug wastage as a separate line item on the claim form with modifier “JW” appended. Anthem reimbursement limits will apply and will take into consideration applicable wastage based on the most economical combination of vial sizes.

**Effective May 1st, Anthem Blue Cross will expand the Specialty Pharmacy prior authorization list**

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

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

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Code</th>
<th>Drug</th>
<th>Comments</th>
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<tbody>
<tr>
<td>CG-DRUG-09</td>
<td>J3490</td>
<td>Cuvitru</td>
<td>New drug to existing Clinical UM Guideline</td>
</tr>
<tr>
<td>CG-DRUG-54</td>
<td>J0180</td>
<td>Agalsidase beta (Fabrazyme)</td>
<td>New Clinical UM Guideline</td>
</tr>
<tr>
<td>CG-DRUG-55</td>
<td>J1322</td>
<td>Elosulfase alfa (Vimizim)</td>
<td>New Clinical UM Guideline</td>
</tr>
<tr>
<td>CG-DRUG-56</td>
<td>J1458</td>
<td>Galsulfase (Naglazyme)</td>
<td>New Clinical UM Guideline</td>
</tr>
<tr>
<td>CG-DRUG-57</td>
<td>J1743</td>
<td>Idursulfase (Elaprase)</td>
<td>New Clinical UM Guideline</td>
</tr>
<tr>
<td>CG-DRUG-58</td>
<td>J1931</td>
<td>Laronidase (Aldurazyme)</td>
<td>New Clinical UM Guideline</td>
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<td>CG-DRUG-62</td>
<td>J9395</td>
<td>Fulvestrant (FASLODEX)</td>
<td>New Clinical UM Guideline</td>
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<tr>
<td>CG-DRUG-63</td>
<td>J0641</td>
<td>Levoleucovorin Calcium (Fusilev)</td>
<td>New Clinical UM Guideline</td>
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<tr>
<td>DRUG.00002</td>
<td>J3590</td>
<td>Adalimumum-abto (Amjevita)</td>
<td>New Drug to existing Medical Policy</td>
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<tr>
<td>DRUG.00090</td>
<td>J3490, J3590</td>
<td>Bezlotoxumab (ZINPLAVA)</td>
<td>New Medical Policy</td>
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<tr>
<td>DRUG.00097</td>
<td>J9999</td>
<td>Olaratumab (Lartruvo)</td>
<td>New Medical Policy</td>
</tr>
<tr>
<td>DRUG.00102</td>
<td>J9043</td>
<td>Cabazitaxel (Jevtana)</td>
<td>New Medical Policy</td>
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</tbody>
</table>
Anthem Blue Cross will be expanding the Specialty Pharmacy level of care medication list

Listed below are specialty pharmacy codes from new or current Medical Policies and Clinical UM Guidelines that will be added to our existing Level of Care review process using CG-DRUG-47, effective May 1, 2017.

Level of care pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health (AIM), a separate company administering the program on behalf of Anthem Blue Cross.

Level of Care drug list
FAQ link
http://www.aimprovider.com/specialtyrx/FAQ.html

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<th>Drug Code(s)</th>
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<td>Vimizim</td>
<td>J1322</td>
</tr>
<tr>
<td>CG-DRUG-57</td>
<td>Elaprase</td>
<td>J1743</td>
</tr>
</tbody>
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Reminder – eligible providers can register as a specialty drug infusion/injection provider using OptiNet

As previously communicated, Anthem Blue Cross (Anthem) expanded the Specialty Pharmacy program to include level of care clinical review for specialty pharmacy infusions and injections for dates of service on and after July 18, 2016.

Ambulatory Infusion Suites, Home Infusion Providers, and physician offices can register to be included as an alternative location for the administration of specialty drugs using the OptiNet registration tool. Providers that complete the registration process are available as an alternative provider the subsequent business day. Please note, providers must be contracted as an Ambulatory Infusion Suite, Home Infusion Provider, or physician office to be eligible as an alternative specialty drug infusion/injection provider. Claim payment issues (e.g. delay in payment or denial of reimbursement) can result if hospital/facility providers incorrectly register as alternative providers.

Providers already registered as an alternative location can review or edit the list of drugs provided at their site by logging in here.

If providers have questions about their network contract status, please contact our Network Relations Team by email at CAContractSupport@anthem.com prior to registration.
Servicing out-of-area members, domestic and international

Out of Area or BlueCard members are members who have insurance from Blue Plans other than Anthem Blue Cross (California). The BlueCard program enables members to obtain healthcare services while traveling or living in another Blue Plan's service area. Thus, the BlueCard Program ensures a member’s health benefits travel with the member.

It is important to ask members at each visit for their current membership ID card, as new cards may be issued throughout the year. Most Blue identification cards have a three-character alpha prefix. The alpha prefix is the first three characters of the member’s identification number. A BlueCard member can be identified through the suitcase logo that appears on the ID card. This suitcase logo can appear either as an empty suitcase or with “PPO” in the logo. The suitcase logo identifies the reimbursement level to the provider, not the member benefits.

While most patients are US based, international members may also carry the Blue Cross and/or Blue Shield logos on an ID card through an International Licensee, specifically GeoBlue. These ID cards include the three-character alpha prefix and may also include a benefit product logo, such as the suitcase logo.

Shown here is a sample ID card from GeoBlue for a BlueStudent product.

Anthem Blue Cross contracted providers should accept BlueCard® members with these types of ID cards.

Misrouted protected health information (PHI)

Providers and facilities are required to review all member information received from Anthem Blue Cross (“Anthem”) to help ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Anthem’s provider services area to report receipt of misrouted PHI.
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

Practitioners’ rights during the credentialing process

The credentialing process must be completed before a practitioner begins seeing Anthem Blue Cross (Anthem) enrollees and enters into a contractual relationship with a health plan or HMO. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application
- Correct erroneous information regarding a credentialing application
- Be notified of the status of credentialing or re-credentialing applications

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a group practice. Doing so will help minimize any disruptions to the practice and members’ claims.

ProviderAccess Web Portal retirement delayed

The decision has been made to postpone the ProviderAccess web portal retirement until second quarter 2017. We previously announced that Anthem Blue Cross (Anthem) was targeting January 2017 to retire ProviderAccess and transition all functionality to a single website, the Availity Web Portal.

Soon, Anthem will be introducing our new secure self-service tool on the Availity Web Portal where you can access all the important proprietary information and educational materials found on ProviderAccess today. After that tool is in place and you have had some time to get familiar with locating what you need, we will move forward with retiring ProviderAccess. More communication will follow as soon as we have determined the dates for these exciting changes.

Many tools on ProviderAccess have already been moved. If you are still going to ProviderAccess for Remittance Inquiry or the Professional Fee Schedule Inquiry tool (Contracted Pricing Tool), please start using these tools through Availity today. Currently, these tools are available in both systems, but after the retirement date, they will only be available through Availity.

Use the Interactive Care Reviewer to submit your requests for behavioral health services today!

Now with Interactive Care Reviewer (ICR), your practice can initiate precertification and prior authorization requests online more efficiently and conveniently for many Anthem Blue Cross (Anthem) members. Access ICR via the Availity Web Portal to experience a streamlined process to request inpatient and outpatient medical and behavioral health procedures for many of your patients covered by Anthem.

How does a provider gain access to our Interactive Care Reviewer (ICR)?

Access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select Register in the upper right hand corner of the page. If your organization already has access to Availity, your Availity Administrator can grant you access to Authorization and Referral Request for submission capability and Authorization and Referral Inquiry for inquiry capability. You can then find our tool under Patient Registration|Authorizations & Referrals then choose the Authorizations or Auth/Referral Inquiry option as appropriate.
**Are there any specific services Behavioral Health practices can precertify using ICR?**

ICR can be used to submit or inquire on a precertification or prior authorization for many behavioral health services, including: Intensive Outpatient Program, Partial Hospital Program, Inpatient, Residential, Adaptive Behavioral Treatment (also known as Applied Behavior Analysis), and Transcranial Magnetic Stimulation.

**Are there any services where an immediate decision can be obtained?**

Yes! Starting mid-January 2017, requests for Transcranial Magnetic Stimulation (TMS), will be eligible for an immediate decision when the completed provider tool within ICR is part of the submitted request.

**Who can providers contact with questions?**

For questions regarding our ICR, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Availity Client Services is available Monday-Friday, 5 am to 4 pm PT (excluding holidays) to answer your registration questions.

Here are a just a few of the many benefits and efficiencies:

- **Automated routing to ICR:** From the Availity Web Portal, you will automatically be routed to ICR to begin your precertification or prior authorization request once the migration has occurred and you go to Patient Registration | Authorizations & Referrals, then Authorizations. There is no need for you to remember the prefixes or migration dates.
- **Determine if a precertification or prior authorization is needed:** For most requests, when you enter patient, service an provider details, you receive a message indicating whether or not review is required.
- **Inquiry capability:** Ordering and servicing physicians and facilities can inquire to find information on any precertification or prior authorization they are affiliated with and the request was previously submitted via phone, fax, ICR, or other online tool, (i.e., AIM Specialty Health®, OrthoNet LLC, eReview, etc.).
- **Easy to use:** Submit both outpatient and inpatient requests online for medical and behavioral health services, using the same, easy to use functionality.
- **Reduce the need to fax:** Submit online requests without the need to fax medical records. Our ICR allows both text detail and photo and image attachments to be submitted along with the request.
- **No additional cost:** You get access to a no-cost solution that's easy to learn and even easier to use.
- **Access almost anywhere:** Submit your requests from any computer with internet access. Use browser Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.
- **Comprehensive view of all precertification requests:** You have a complete view of your UM requests submitted online, including status of your requests with views of case updates. Cases now include an imaged copy of the associated letters.

**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 CAContratSupport@anthem.com.

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

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 CACONTRACTSUPPORT@Anthem.com.
Guidelines and Quality Programs

Clinical practice and preventive healthy guidelines available online

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

Commercial HEDIS 2017 starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax.

The fax will contain 1) a cover letter with contact information your office can use to contact us if there are any questions; 2) a member list, which includes the member and HEDIS measure(s) the member was selected for; and 3) an instruction sheet listing the details for each HEDIS measure. As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c) (4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within five business days. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in the 3rd quarter provider newsletter.

To return the medical record documentation back to us in the recommended 5-day turnaround time, simply choose one of these options:

1. Upload to our secure portal. This is quick and easy. Logon to www.submitrecords.com, enter the password: wphedis57 and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.
   OR

2. Send a secure fax to 1-888-251-2985
   OR

3. Mail to us via the US Postal Service to:
   Anthem, Inc., 66 E. Wadsworth Park Drive, Suite 110H, Draper, UT 84020

Thank you in advance for your support of HEDIS.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Timely access regulations and language assistance program

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

There are many activities that are conducted to support compliance with the regulations and we need you, as well as covered individuals, to help us attain the information that is needed. Some of these studies are sponsored by the Industry Collaborative Effort (ICE), allowing for consistency across Health Plans. These studies allow our Plan to determine compliance with the regulations.

The activities include, but are not limited to the following:

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

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

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

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

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

We hope this clarifies Anthem’s expectations and your obligations regarding compliance with the Timely Access Regulations. Our goal is to work with our providers to successfully meet the expectations for the requirements with the least amount of difficulty and member abrasion.
## Access Standards for Medical Professionals

<table>
<thead>
<tr>
<th>Access to</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent appointments for Primary Care (PCP)</td>
<td>Must offer the appointment within 10 business days of the request</td>
</tr>
<tr>
<td>Urgent Care appointments not requiring prior authorization</td>
<td>Must offer the appointment within 48 hours of request</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist Physicians</td>
<td>Must offer the appointment within 15 business days of the request</td>
</tr>
<tr>
<td>Urgent Care (that requires prior authorization)</td>
<td>Must offer the appointment within 96 hours of request</td>
</tr>
<tr>
<td>Non-urgent appointment for ancillary services (for diagnosis or treatment of inquiry, illness, or other health condition)</td>
<td>Must offer the appointment within 15 business days of the request</td>
</tr>
<tr>
<td>In-office waiting room time</td>
<td>Usually members do not wait longer than 15 minutes to see a physician or his/her designee</td>
</tr>
<tr>
<td>After Hours Care</td>
<td>Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back</td>
</tr>
<tr>
<td>Emergency Care (California law requires health plans to follow the “prudent layperson” standard in providing direction for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any “prudent layperson” would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go the emergency room if the caller believes they are experiencing an emergency)</td>
<td>Immediate Access to Emergency Care. Members are directed to 911 or the nearest emergency room</td>
</tr>
</tbody>
</table>
Members also have access to Anthem’s 24/7 NurseLine. The phone number is located on the back of the member ID card. In addition, Members and Providers have access to Anthem’s Customer Service team at the telephone number listed on the back of the member ID card. A representative may be reached within 10 minutes during normal business hours.

Please contact the Anthem Member Services team at the telephone number listed on the back of the member ID card to obtain assistance if a patient is unable to obtain a timely referral to an appropriate provider.

If you have further questions, please contact Network Relations at CAContractSupport@anthem.com.

For Patients with Department of Managed Health Care Regulated Healthplans:
If you or your patients are unable to obtain a timely referral to an appropriate provider or for additional information about the regulations, visit the Department of Managed Health Care’s website at www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessstoCare.aspx or call 1-888-466-2219 for assistance.

For Patients with California Department of Insurance Regulated Healthplans:
If you or your patients are unable to obtain a timely referral to an appropriate provider or for additional information about the regulations, visit the Department of Insurance’s website at www.insurance.ca.gov or call 1-800-927-4357 for assistance.

Language Assistance Program
For members whose primary language isn’t English, Anthem offers free language assistance services through interpreters and other written languages. If you or the member are interested in these services, please call the Anthem Member Services number on the member’s ID card for help (TTY/TDD: 711).
Survey says... Patients see room for improvement with physician care

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

The following tables compare our results from 2015 with those in 2016. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th percentile.

When you’re reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Physician 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>81%</td>
<td>80%</td>
<td>↓</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>78%</td>
<td>80%</td>
<td>↑</td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>69%</td>
<td>76%</td>
<td>↑</td>
</tr>
<tr>
<td>Getting Care Quickly 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>83%</td>
<td>87%</td>
<td>↑</td>
</tr>
<tr>
<td>Got appointment for check-up or routine care as soon as needed</td>
<td>77%</td>
<td>72%</td>
<td>↓</td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>77%</td>
<td>NA</td>
<td>--</td>
</tr>
<tr>
<td>Doctor’s Communication with Patients 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>94%</td>
<td>92%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>93%</td>
<td>94%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>92%</td>
<td>97%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>87%</td>
<td>91%</td>
<td>↑</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons to take a medicine? 3</td>
<td>87%</td>
<td>93%</td>
<td>↑</td>
</tr>
<tr>
<td>Doctor discussed reasons you may not want to take a medicine? 3</td>
<td>73%</td>
<td>71%</td>
<td>↓</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you? 3</td>
<td>74%</td>
<td>72%</td>
<td>↓</td>
</tr>
</tbody>
</table>
Continuity of Care & Health Promotion

| How often did your personal doctor seem informed about care you received from other health providers? ² | 78% | 82% | ↑ |
| Did you and your doctor discuss ways to prevent illness? ³ | 64% | 74% | ↑ |

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding “Usually” or “Always.”
3 = % responding “Yes”
4 = Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

*The source of data contained in this report is Quality Compass® 2016 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

Improving your patients’ health care experience

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

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

“This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California.”
Medi-Cal Managed Care Updates

Medical Policies and Clinical Utilization management guidelines update

On August 4, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies applicable to Anthem Blue Cross (Anthem). These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The Medical Policies were made publicly available on the Anthem provider website on the effective date listed below. Visit [www.anthem.com/cptsearch_shared.html](http://www.anthem.com/cptsearch_shared.html) to search for specific policies. Existing precertification requirements have not changed.

The Medical Operations Committee also adopted the Interqual Coronary Bypass Procedures Criteria for use in review of the 1-2 vessel coronary artery bypass grafting (CABG) procedures on September 11, 2016.

Please share this notice with other members of your practice and office staff.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Medical Policy number</th>
<th>Medical Policy title</th>
<th>New or revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/18/2016</td>
<td>DRUG.00087</td>
<td>Asfotase Alfa (Strensiq®)</td>
<td>New</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>DRUG.00088</td>
<td>Atezolizumab (Tecentriq®)</td>
<td>New</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>DRUG.00089</td>
<td>Daclizumab (Zinbryta®)</td>
<td>New</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>DRUG.00093</td>
<td>Sebelipase alfa (KANUMA™)</td>
<td>New</td>
</tr>
<tr>
<td>10/6/2016</td>
<td>DRUG.00081</td>
<td>Eteplirsen (Exondys 51™ )</td>
<td>New</td>
</tr>
<tr>
<td>10/4/2016</td>
<td>GENE.00046</td>
<td>Prothrombin G20210A (Factor II) Mutation Testing</td>
<td>New</td>
</tr>
<tr>
<td>10/4/2016</td>
<td>GENE.00047</td>
<td>Methylene tetrahydrofolate Reductase Mutation Testing</td>
<td>New</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>LAB.00032</td>
<td>Zika Virus Testing</td>
<td>New</td>
</tr>
<tr>
<td>8/1/2016</td>
<td>RAD.00066</td>
<td>Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy</td>
<td>New</td>
</tr>
<tr>
<td>10/4/2016</td>
<td>SURG.00144</td>
<td>Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia</td>
<td>New</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>BEH.00002</td>
<td>Transcranial Magnetic Stimulation</td>
<td>Revised</td>
</tr>
<tr>
<td>10/4/2016</td>
<td>DRUG.00002</td>
<td>Tumor Necrosis Factor Antagonists</td>
<td>Revised</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>DRUG.00024</td>
<td>Omalizumab (Xolair®)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/18/2016</td>
<td>DRUG.00058</td>
<td>Pharmacotherapy for Hereditary Angioedema (HAE)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/1/2016</td>
<td>GENE.00006</td>
<td>Epidermal Growth Factor Receptor (EGFR) Testing</td>
<td>Revised</td>
</tr>
</tbody>
</table>
Effective March 20, 2017, the following Reimbursement Policies will transition to the Anthem Blue Cross (Anthem) Medi-Cal Managed Care (Medi-Cal) website. Reimbursement Policy language may have changed. For policy-specific information, go to https://mediproviders.anthem.com/ca > Prior Authorizations & Claims > Reimbursement Policies.

These policies will serve as a guide to assist you in accurate claim submission and to outline the basis for reimbursement if the service is covered by the Medi-Cal benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required, along with the use of industry-standard compliant codes on all claim submissions.

**Code and Clinical Editing**
Anthem applies code and clinical editing guidelines (CCEG) to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. Anthem utilizes sophisticated software products to ensure compliance with standard code edits and rules. These products increase consistency of payment for providers by ensuring correct coding and billing practices. Editing sources include but are not limited to CMS National Correct Coding Initiative, *Clinical Utilization Management Guidelines* and medical policies. Anthem is committed to working with you to ensure timely processing and payment of claims.

Medi-Cal does not apply CCEG to state-defined local procedure codes.

**Provider Updates**

**Diagnosis-Related Group (DRG) Inpatient Facility Transfers**
*(Policy 13-002, effective 03/20/2017)*

Anthem allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for the same episode of care in compliance with provider contracts and federal and/or state guidelines regarding facility transfer payment. In the absence of such guidelines, Anthem will use the following criteria:

- Transferring facility will receive a calculated per diem rate based on length of stay, not to exceed the amount that would have been paid if the patient had been discharged to another setting.
Receiving facility will receive full DRG payment.

Inpatient Readmissions
(Policy 13-001, effective 05/15/2017)

Anthem will implement Inpatient Readmission rules effective May 15, 2017 following state and CMS guidelines.

Claims identified as a readmission are subject to the following:

- Readmissions occurring on the same day from discharge for symptoms related to or for evaluation and management of the prior stay’s medical condition are considered part of the original admission and should be combined.
- Readmissions occurring within two to thirty days will be subject to clinical reviews. If the clinical review indicates that the second admission is for the same, similar or related condition, it may be considered a continuation of the initial treatment for the purposes of reimbursement.

Inpatient Readmission rules only affect facilities reimbursed for inpatient services by a DRG methodology.

Anthem reserves the right to recoup and/or recover monies previously paid on a claim that falls within the guidelines of a readmission.

For additional information, please reference your provider manual and/or your Provider Agreement as a guide for reimbursement criteria.

Your continued feedback is critical to our success. For more information on this topic or questions about this provider bulletin, please call one of our Medi-Cal Customer Care Centers at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County).

Behavioral Health medication management program

The Anthem Blue Cross (Anthem) Behavioral Health (BH) Medication Management program targets the specific needs of [health plan name] members using BH medications. Our goals are to specifically improve the quality of care provided to our members and promote member adherence to prescribed medication treatments.

Anthem conducts proactive outreach and education programs that focus on:

- Reducing polypharmacy
- Promoting age appropriate use of BH medications
- Providing new start and adherence education

The outreach and education programs also support BH-related HEDIS®* measures such as:

- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

To learn more about the BH Medication Management program, call Pharmacy Operations at 1-800-719-4871 Monday through Friday between 5:30 a.m. and 1 p.m. PT.

* HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5®) updates

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from DSM-5®.

When transitioning from DSM-IV-TR to DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial 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 DSM-5 diagnostic system. DSM-5 combines DSM-IV-TR axes I-III diagnoses into one list, as shown in Table 1.

Table 1: DSM-5 diagnosis

<table>
<thead>
<tr>
<th>DSM-IV multiaxial system</th>
<th>DSM-5 nonaxial system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I: clinical disorder (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>Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.</td>
</tr>
<tr>
<td>Axis III: general medical conditions</td>
<td>Disability included in notation.</td>
</tr>
<tr>
<td>Axis IV: psychosocial and environmental stressors</td>
<td>World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.</td>
</tr>
<tr>
<td>Axis V: Global Assessment of Functioning (GAF)</td>
<td></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 GAF was removed from DSM-5. Alternatively, 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 DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

Revisions to 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 [http://psychiatryonline.org](http://psychiatryonline.org). Select View the DSM-5® Update (September 2016).

Table 2

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Codes effective October 1, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant/Restrictive Food Intake Disorder</td>
<td>F50.89</td>
</tr>
<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>
</tbody>
</table>
Other Specified Obsessive-Compulsive and Related Disorder F42.8
Pica, in adults F50.89
Premenstrual Dysphoric Disorder F32.81
Social (Pragmatic) Communication Disorder F80.82
Unspecified Obsessive-Compulsive and Related Disorder F42.9

Some resources that may best help you include:


Medi-Cal Providers - HEDIS 2017 is coming

Each year as part of the Healthcare Effectiveness Data and Information Set (HEDIS®) Quality Study, Anthem Blue Cross (Anthem) reviews a sample of our members’ medical records to measure the quality of care they receive. We are pleased to participate in this study as a means of pursuing continuous improvement in the services provided to our members.

The HEDIS® project will begin February 2017. During this time, Anthem staff may be contacting your office requesting medical records. Anthem staff will provide a list of members, which will include the measure for each member. Anthem will be requesting a quick response from your office. If needed, Anthem staff will make an appointment with your office to review the requested medical records onsite. Your assistance is crucial to ensure that our data is statistically valid, auditable and accurately reflects quality performance.

Special authorization is not required to share member medical record information with Anthem. The form you obtain from the patient permitting you to bill for care is sufficient under HIPAA regulations.

- Section §164.506 of HIPAA indicates the routine form you have the member sign is sufficient for disclosures to carry out health care operations.
- Section §164.501 defines health care operations to include quality assessment and improvement activities.

HEDIS® is part of a nationally recognized quality improvement initiative. HEDIS® is used by the Centers for Medicare and Medicaid Services, the National Committee for Quality Assurance and several states to monitor the performance of managed care organizations.

If you have any questions, please contact:

Northern region: 1-916-589-3030
Central region: 1-559-353-3500
Southern region: 1-866-465-2272
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.

FX modifier and tetanus vaccine

Payment reduction for X-rays taken using film
Effective for dates of service on or after January 1, 2017, Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) follows the CMS requirement in which providers must use the FX bill modifier when billing for X-rays using film. A payment reduction of 20% will apply to the technical component (and the technical component of the global fee) for X-ray services provided using film for which payment is made under the Medicare Physician Fee Schedule.

Claims for tetanus vaccinations
Effective January 1, 2016, tetanus vaccine 90703 is no longer accepted by Medicare. Effective for dates of service on and after January 1, 2016, providers administering a tetanus vaccine for an open wound or laceration should bill using 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to a 90471 and/or 90472 administration code and the appropriate diagnosis code to indicate an open wound or laceration. Claims should be submitted to Anthem Blue Cross Cal MediConnect Plan.

If a tetanus vaccine is administered for a reason other than a puncture wound or laceration and the member has pharmacy benefits, bill the member’s Medicare Part D plan. This applies to the vaccine and the administration charges. To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse via their website (www.transactrx.com) or call Customer Service at 1-866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no cost to providers who use electronic funds deposit to receive payment; however, there is a service fee of $2.50 for check payments on claims.

Prior authorization requirements for new injectable/infusible drugs: Erelzi (etanercept), Amjevita (adalimumab), Voretigene neparvovec, Nanacog (recombinant factor IX) and Lartruvo (olaratumab)

On April 1, 2017, prior authorization (PA) requirements will change for five new, Part B injectable/infusible drugs covered by Anthem Blue Cross for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members. These drugs include Erelzi (etanercept), Amjevita (adalimumab), Voretigene neparvovec, Nanacog (recombinant factor IX) and Lartruvo (olaratumab). Federal and state law, as well as state contract language and CMS 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. PA requirements will be added to the following drugs billed with not otherwise classified (NOC) HCPCS J codes (J3590 and J9999):
- Erelzi (etanercept): for treatment of rheumatoid arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis and plaque psoriasis (unlisted, no J code established at this time) (J3590)
- Amjevita (adalimumab): for treatment of Crohn's disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis, plaque psoriasis, noninfective uveitis and hidradenitis suppurativa (unlisted, no J code established at this time) (J3590)
- Voretigene neparvovec: for treatment of inherited retinal disease for which there is no current treatment; the disease is caused by mutations in the RPE65 gene (unlisted, no J code established at this time) (J3590)
- Nanacog (recombinant factor IX): for the treatment of hemophilia B (unlisted, no J code established at this time) (J3590)
- Lartruvo (olaratumab): a platelet-derived growth factor antagonist, in combination with doxorubicin, for the treatment of soft tissue sarcoma not amenable to curative treatment with radiotherapy or surgery (unlisted, no J code established at this time) (J9999)
Please note, these drugs are currently billed under the NOC J codes J3590 and J9999. Since this code includes 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. Detailed PA requirements are available to contracted providers by logging in to ProviderAccess using your Availity credentials. On the left-side navigation, select Services Requiring Prior Authorization. Noncontracted providers may call Provider Services at 1-855-817-5786 for PA requirements.

**Update to the ClaimsCheck® upgrade to ClaimsXten™**

Earlier this year, Anthem Blue Cross announced plans for an upgrade from ClaimsCheck to McKesson’s next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

With the new software functionality, edits will be applied with greater accuracy. The new software functionality will also allow for greater flexibility with rule development and configuration.

For additional details regarding this software update, please refer to the original communication posted at [https://mediproviders.anthem.com/ca > Provider Support > Communications and Updates > Network Updates & Newsletters > 2016 > Current Network Update > Archive > Professional > June 2016 Professional Edition](https://mediproviders.anthem.com/ca).

**Prior authorization required for continuous Interstitial Glucose monitoring**

Effective **March 1, 2017**, Anthem Blue Cross will require prior authorization (PA) for Continuous Interstitial Glucose Monitoring. This applies to the following procedure codes:

- 95250: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.
- 95251: Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report.

Noncompliance with new requirements may result in denied claims.

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

Not all PA 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 required for Epidermal Growth Factor Receptor (EGFR) Testing

Effective May 1, 2017, prior authorization (PA) will be required for Epidermal Growth Factor Receptor (EGFR) Testing for members enrolled in Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan).

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

- 81235 – EGFR (epidermal growth factor receptor) (e.g. non-small cell lung cancer) gene analysis, common variants (e.g. exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)

Detailed PA requirements are available by logging into [https://mediproviders.anthem.com/ca](https://mediproviders.anthem.com/ca) using your Availity credentials and selecting Services Requiring Prior Authorization. You may also call Provider Services at 1-855-817-5786.

Prior authorization change for new injectable/infusible drugs: Cuvitru, Ocrevus and Lutathera

On March 1, 2017, Anthem Blue Cross prior authorization (PA) requirements will change for three new Part B injectable/infusible drugs covered by Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). These drugs include: Cuvitru (immune globulin), Ocrevus (ocrelizumab) and Lutathera (octreotate Lu-177 DOTA Tyr-3). Federal and state law, as well as state contract language and Centers for Medicare and 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 which are drugs billed with not otherwise classified (NOC) HCPCS J codes (J3490, J3590 and J9999):

- **Ocrevus (ocrelizumab)** – For treatment of primary progressive multiple sclerosis and relapsing-remitting multiple sclerosis. (Unlisted, no J code established at this time) (J3490)
- **Cuvitru (immune globulin)** – For treatment of primary immunodeficiency in adults and children aged 2 years and older, primarily administered via pump. (Unlisted, no J code established at this time) (J3590)
- **Lutathera (octreotate Lu-177 DOTA Tyr-3)** – For treatment of neuroendocrine tumors in patients who have progressed on traditional somatostatin analogues. (Unlisted, no J code established at this time) (J9999)

Please note, these drugs are currently billed under the NOC J-codes [J3490, J3590 and J9999]. Since this code includes 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 who are unable to access Availity may call our Anthem Blue Cross Cal MediConnect Plan Provider Services at 1-855-817-5786.

Transitional care management services eligibility

A beneficiary is not eligible to receive Transitional Care Management (TCM) services until 30 days after 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 Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) 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.

Medicare Advantage Updates

New CMS requirement – hospitals must use Medicare Outpatient Observation Notice (MOON) form

CMS requires that all hospitals and critical access hospitals (CAHs) provide written notification and an oral explanation to individuals receiving observation services as outpatients for more than 24 hours. Hospitals should use the OMB-approved standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611.

All hospitals and CAHs are required to provide this statutorily required notification no later than March 8, 2017. The notice and accompanying instructions are available at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

The MOON was developed to inform all Medicare beneficiaries, including Anthem Blue Cross Medicare Advantage members, when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.

AIM OptiNet imaging services registration, scores no longer tied to reimbursement

Recent issues of Network Update have included information about an initiative administered by AIM Specialty Health® to collect information about imaging capabilities of our Medicare Advantage providers. At this time, California providers in our Medicare Advantage network will not be included in this initiative. California providers will not be subject to the requirement to have a specific OptiNet score to be reimbursed for outpatient diagnostic imaging services. Although there is no reimbursement impact at this time, Anthem continues to encourage network providers to submit imaging services data for the AIM Specialty Health initiative. The provider registration is available online at www.providerportal.com.

Claim adjustments may change member cost share

Anthem Blue Cross (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.

Payment reduction for X-rays taken using film

Effective for services furnished beginning January 1, 2017, we will follow the Centers for Medicare & Medicaid Services’ requirement for providers to bill modifier FX when billing for X-rays using film. A payment reduction of 20 percent will apply to the technical component (and the technical component of the global fee) for X-ray services furnished using film for which payment is made under the Medicare Physician Fee Schedule.
Claims for tetanus vaccinations

Effective January 1, 2016, tetanus vaccine (90703) was deleted by Medicare. Effective for dates of service January 1, 2016 and after, providers who have administered a tetanus vaccine for an open wound or laceration should bill 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to the administration 90471 and/or 90472; with the appropriate diagnosis to indicate open wound or laceration. Please submit the claim to the member’s Medicare Advantage or Medicare Medicaid Plan.

If a tetanus vaccine is administered for a reason other than puncture wound or laceration and the member has pharmacy benefits, please bill their Medicare Part D plan. This applies to the vaccine and the administration charges.

To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse at the website (http://www.transactrx.com) or call Customer Service at 1-866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

The Centers for Medicare & Medicaid Services provides more information on Part D vaccines here.

Individual MA members should use Hearing Care Solutions

As a reminder, members enrolled in individual Medicare Advantage plans that provide routine hearing exam and/or hearing aid benefits must use Hearing Care Solutions for their hearing benefits. When the member contacts Hearing Care Solutions to use hearing benefits, Hearing Care Solutions staff helps the member find a provider in their area that will best meet their needs. Providers interested in joining the Hearing Care Solutions network should call 1-855-312-2545.

If a member sees a provider who is not contracted with Hearing Care Solutions, those hearing claims would deny. If you have questions, please call provider services on the number on the back of the member’s ID card.

Include NPI in surgical procedure bills

When billing a surgical procedure for a Medicare Advantage member, bill the surgical operator’s NPI in box 77 on the facility UB claim form, also known as the CMS 1450 claim form.

Transitional Care Management (TCM) services

This is a correction to the related article in the December 2016 Network Update.

A beneficiary is eligible to receive TCM services beginning on the date they are discharged from the inpatient hospital setting and continues for the next 29 days. 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.

Retrospective medical record review program launches

Our retrospective medical record review initiative is a risk adjustment program intended to identify and capture previously undocumented or new diagnosis data that might have been missed due to coding and/or technical limitations.

We contract with Verscend Health, formerly Verisk, to conduct provider outreach requesting medical records with dates of service for the target year (2016) thru present day, then review and code the record.

What you need to know

Jaime Marcotte, Retrospective Risk Program Lead, is managing this initiative. Should you have any questions regarding this program please do not hesitate to contact Jaime at Jaime.Marcotte@anthem.com or 314-925-6094.

Additional information, including FAQs, is available at Important Medicare Advantage Updates found at anthem.com/ca/medicareprovider

Keep up with Medicare news

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

2017 Medicare Advantage Plan Changes
Medicare risk adjustment and documentation guidance training offered
Prior authorization requirements for intracardiac electrophysiological studies and catheter ablation

December Reimbursement Policy Provider Bulletin
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 for the Federal Employee Program formulary Basic and Standard Options are:

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

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.