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Health Care Reform Updates (including Health Insurance Exchange)

Important information available online

We invite you to go to our website to learn about the many ways health care reform and health insurance exchange may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance exchange, and all archived articles, go to anthem.com/ca > Menu > Support > Providers. Click on 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

Benefit changes for Butte area School District members effective July 1st

Effective July 1, 2017, the members of the Butte Self-Funded Program will join the Self-Insured Schools of California (SISC). This will mean some benefit changes for this group including, but not limited to; the requirement to use a Blue Distinction+ facility for Hip, Knee and Spine inpatient procedures and a Blue Distinction or Blue Distinction+ facility for Bariatric surgery and no out of network coverage for Medical Equipment or Supplies, Diagnostic X-ray or Lab services, and Physical Medicine. As a result of this transition members are encouraged to contact their prescriber if a new prescription is needed due to a change in pharmacy benefit managers. You can identify a SISC plan member with the Anthem Blue Cross ID card.

2017 Risk Adjustment data validation audit

The Centers for Medicare & Medicaid Services (CMS) is conducting a Risk Adjustment Data Validation (RADV) Audit beginning June 2017 through January 2018. This audit is in accordance with provisions of the Affordable Care Act (ACA) and its risk adjustment data validation standards.

For this audit, CMS will select a statistically valid sample of Anthem Blue Cross’ (Anthem) members enrolled in an ACA plan members purchased on or off the Health Insurance Marketplace (also referred to as the exchange). Provider(s) whose patients during the benefit year (BY) 2016 selected for this audit will receive request(s) and must provide copies of medical record(s)/chart(s) within the specified timeframe on the request letter. This audit is to verify that diagnosis codes reported to CMS are accurate, properly documented, and coded with accurate levels of specificity.

In the event your patient(s) are selected for this RADV audit, Anthem is working with Altegra Health – an independent company that provides secure, clinical documentation services – to assist us in requesting and collecting the needed medical records and signature attestations (if applicable) on our behalf. We appreciate your assistance and patience during this process. Altegra is a business partner of Anthem and can provide a copy of the business associate agreement upon request.

Representatives from Anthem may also reach out to your site for more information and/or clarification as necessary in addition to Altegra’s efforts. In addition, you may also receive medical record requests from the Blue Cross Blue Shield Association (BCBSA) contracted vendor Verscend for services rendered outside of the Control/Home Plan’s service area.

Be advised that Anthem is not requesting copies of “psychotherapy notes” as defined by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, psychotherapy notes are defined as “notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical record. However, any data excluded from the definition of psychotherapy notes must be provided where applicable and pursuant to this request.

As to disclosure of information related to outpatient psychotherapy records of California residents, such disclosures of outpatient psychotherapy records for this CMS audit purpose is permitted under exceptions for regulatory activities set out in sections 56.10 & 56.104 of the CA Civil Code.

If you have any questions/concerns, please send them via email to RiskAudit@anthem.com.
Reminder: Prior authorization for Genetic Testing

As previously communicated, Anthem Blue Cross (Anthem) will transition the medical necessity review of all genetic testing services for local fully insured members to AIM Specialty Health® (AIM), a separate company effective with dates of service on or after July 1, 2017. Additionally, this review will now take place as a prior authorization.

Beginning July 1, 2017, please submit genetic testing prior authorization requests to AIM through one of the following 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.
- To find more information about genetic testing prior authorization at AIM please go to the following website:

The program applies to local Anthem fully insured members only.
This program excludes the following: Medicare, Medicaid, CA HMO, FEP, Labor & Trust, National Accounts and Local ASO.

For further questions regarding prior authorization requirements please contact the provider service number on the back of your patient’s ID card.

Anthem Blue Cross will be expanding the Specialty Pharmacy prior authorization drug list

Listed below are specialty pharmacy codes from Medical Policies that will be added to our existing pre-service review process effective September 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</th>
<th>Code</th>
<th>Drug</th>
<th>Comments</th>
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<tr>
<td>DRUG.00077</td>
<td>J3490,3590</td>
<td>Siliq</td>
<td>New Drug to Existing Policy</td>
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<td>DRUG.00094</td>
<td>J3490,3590</td>
<td>Dupixent</td>
<td>New Drug Policy</td>
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<tr>
<td>DRUG.00095</td>
<td>J3490,3590</td>
<td>Ocrevus</td>
<td>New Drug Policy</td>
</tr>
</tbody>
</table>
Update to AIM diagnostic imaging clinical appropriateness guidelines

On September 5, 2017, the following changes to AIM Diagnostic Imaging Clinical Appropriateness Guidelines will become effective:

1. **Focal liver lesions (CT abdomen, MRI abdomen)**
   - Enhanced criteria for initial evaluation and follow up imaging of incidental liver lesions based on size or underlying risk factors

2. **Established malignancy (CT chest, CT abdomen, CT pelvis, CT abdomen & pelvis, MRI abdomen, MRI pelvis)**
   - Criteria added which limit the use of CT or MRI for routine surveillance following completion of therapy for colorectal cancer, prostate cancer and breast cancer.
   - Criteria added to limit the use of CT or MRI for staging of low risk breast cancer in the absence of signs or symptoms of metastatic disease
   - Criteria to restrict the use of MRI as a replacement for CT in staging or follow up of established tumor to situations where CT is contraindicated, or where MRI has been shown to be superior for evaluation (e.g., rectal cancer)

3. **Recurrent lower urinary tract infection (CT abdomen, CT pelvis, CT abdomen & pelvis)**
   - Indication is being removed, as the literature does not support the use of advanced imaging in this scenario.

4. **Venous thrombosis or occlusion (MRA abdomen, CTA abdomen, CTA abdomen & pelvis)**
   - Added requirement that ultrasound be performed prior to any advanced imaging to evaluate suspected hepatic, portal, splenic and renal vein thrombosis.

These changes will be effective for dates of service on or after September 5, 2017.

Ordering and servicing providers may submit pre-certification requests to AIM in one of several ways:

- Access AIM’s ProviderPortalSM directly at www.providerportal.com, available 24/7 to process orders in real time.
- Call the AIM Specialty Health Call Center

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click here to access and download a copy of the current guidelines.
Training opportunities to learn more about Interactive Care Reviewer

Are you aware of the training opportunities available to you and your staff for Interactive Care Reviewer (ICR), Anthem Blue Cross’ (Anthem) online preauthorization tool?

Physicians and facilities can use the ICR to submit online Medical and Behavioral Health outpatient and inpatient precertification and prior authorization requests for many members* covered by Anthem. Also, ordering and servicing physicians and facilities can use the inquiry feature to find information on their organization’s requests.

If you are a new user attend one of our FREE upcoming monthly webinars, and get a jump start on navigating the ICR tool.

After you attend the webinar you will be able to:
- Describe the benefits of using ICR
- Be familiar with the products and services available for authorization via ICR
- Access ICR through the Availity Web Portal
- Create a precertification or prior authorization request
- Inquire on a previously submitted authorization

Select the following link to register for an ICR webinar today:
Interactive Care Reviewer Webinar Registration

*Note: ICR may not be available for Federal Employee Program® (FEP®), BlueCard®, and some National Account members; requests involving transplant services; or services administered by AIM Specialty Health®, for these requests, follow the same precertification process that you use today.

Medical treatment utilization schedule - formulary

The DWC is in the process of promulgating regulations in the form of guidelines that will dictate when it is appropriate to prescribe certain medications. A public hearing has been scheduled to permit all interested persons the opportunity to present statements, arguments, either orally or in writing, with respect to the proposed Formulary. The first hearing will be held May 1, 2017, in Oakland. For more information go to http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

CURES 2.0: All California licensed prescribers for scheduled drugs must be registered!

The CURES 2.0 database addresses the prescribing and dispensing of Schedule II through IV controlled medications. Prescribers (anyone with a DEA Certificate and CA Licensure) had to have been registered by July 1, 2016, or upon issuance of a DEA Certificate. This includes Medical Physicians, N.P.s, P.A.s, Podiatrists, Dentists, Naturopathic Physicians, and others. Licensed pharmacists, dispensing pharmacies, clinics or any other dispensers of controlled medication are also required to use the CURES system. It is notable that tamper-resistant prescription forms must be utilized, and these can be ordered from State-approved printers.

Reports concerning CURES information on specific patients is available to prescribers for patient care purposes. Other state, local and public agencies may access the information under certain regulated circumstances.

The potential of curtailing the morbidity and mortality due to excessive and inappropriate prescribing should be greatly reduced by the program. Registration is easily accomplished on the State website where more information is available: https://oag.ca.gov/cures.
Myriad Genetic Laboratories, Inc.: Out-of-Network Laboratory, effective May 15, 2017

A friendly reminder, effective May 15, 2017, Myriad Genetic Laboratories, Inc. is no longer an in-network laboratory provider for Blue Cross of California dba Anthem Blue Cross (BLUE CROSS).

Other laboratories that continue to be in-network for BRCA testing and other genetic testing services include: Ambry Genetics, Counsyl, Inc., Invitae Corp., LabCorp, Medical Diagnostics Laboratories (MDL) and Quest Diagnostics. Please use one of these labs for Anthem members requiring this testing. As a reminder, your Anthem agreement requires referrals to in-network providers and using an in-network laboratory helps your 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 the following in-network labs, please contact them directly:

<table>
<thead>
<tr>
<th>Lab</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambry Genetics</td>
<td>866-262-7943</td>
<td><a href="http://www.ambrygen.com/contact-us">http://www.ambrygen.com/contact-us</a></td>
</tr>
<tr>
<td>Counsyl, Inc</td>
<td>888-268-6795</td>
<td><a href="https://www.counsyl.com/contact/">https://www.counsyl.com/contact/</a></td>
</tr>
<tr>
<td>LabCorp</td>
<td>888-522-2677</td>
<td><a href="http://www.labcorp.com">http://www.labcorp.com</a></td>
</tr>
<tr>
<td>Medical Diagnostic Laboratories</td>
<td>877-269-0090</td>
<td><a href="https://mdlab.com/company/contact/">https://mdlab.com/company/contact/</a></td>
</tr>
<tr>
<td>(MDL)</td>
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A complete up-to-date list of in-network participating laboratories may be obtained online at www.anthem.com/ca > Menu > Support > Provider > Find a Doctor.

It is important to check benefit plan details for coverage terms and conditions, including preauthorization requirements and coverage limits. If you or an Anthem member you are treating have questions regarding coverage for genetic testing under the member’s benefit plan please contact the Member Services telephone number on the back of the member ID card.

Workers’ Compensation physician acknowledgements required by California Code of Regulations §9767.5.1

As a reminder, the “MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN.”

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem’s Provider Affirmation Portal, go to Availity and login. Once in, click on the Payer Spaces drop down menu in the top right hand corner, and select Anthem Blue Cross from the options available to you. On the next page click on “Resources” in the middle of the page and look for “MPN Provider Affirmation Portal.”

If you cannot go online, call Anthem Workers’ Compensation at 1-866-700-2168 and we can take action on your behalf in the Provider Affirmation Portal. Please also keep an eye out for email notifications from “Anthem MPN Admin.”
Updated Provider Guidance for Uniform Coding for Habilitative services

Providers should use the available Healthcare Common Procedure Coding System (HCPCS) modifier SZ (Habilitative Services) when billing habilitative services on claims for Anthem Blue Cross (Anthem) members.

This billing requirement applies to both professional (CMS-1500) and outpatient facility (UB-04) claims. For electronic professional claims, the modifier is coded in the SV1 segment and for electronic facility claims, the modifier is coded in the SV2 segment. Without the (SZ) modifier, the service will be considered rehabilitative. Providers’ use of the code modifier allows Anthem Plans to be able to track habilitative and rehabilitative services separately, in order to comply with EHB requirement of the ACA regulations.

Current Procedural Terminology (CPT®) codes and CMS’ Healthcare Common Procedure Coding System (HCPCS) Level II codes are defined for rehabilitative services (see Appendix). Many of the procedure codes used for rehabilitative services are also used for habilitative services, which do not have a separate set of procedure codes. In 2014, the HCPCS modifier SZ (Habiltative Services) was created for providers to accurately specify when habilitative services are billed. Use of the (SZ) modifier is supported by the situational rule for HIPAA-adopted claim transactions which requires modifiers for procedure codes when they clarify or improve the reporting accuracy of the associated procedure code.
835 Electronic remittance advices for cashless payments versus zero paid

Anthem Blue Cross (Anthem) subscribers may seek services from a health care provider that is also their employer. The employer is a self-funded, administrative services only (ASO) group contracted by Anthem. For this type of arrangement, cashless payments apply as these self-funded employer groups pay themselves for the claim services incurred by their employees with no exchange of monies from the payer, Anthem.

On the 835 ERA, cashless payment is further defined by the Claim Adjustment Reason Code (CARC) of 139; Contracted funding agreement – Subscriber is employer by the provider of services. Review of the entire 835 ERA must be done to also account for when claims are zero paid due to uncovered services, exhaustion of benefits, or member liability.

<table>
<thead>
<tr>
<th>835 Example – Subscriber paid $20 copayment</th>
<th>835 Example – $59.12 towards coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLP<em>999999999</em>1<em>246</em>0<em>20</em>12<em>CLAIMNO1</em>111*</td>
<td>CLP<em>999999999</em>1<em>1075</em>5<em>59.12</em>15<em>CLAIMNO2</em>13</td>
</tr>
<tr>
<td>SVC<em>HC:99214</em>246<em>0</em></td>
<td>AMT<em>AU:591.25</em></td>
</tr>
<tr>
<td>DTM<em>472</em>20160531~</td>
<td>SVC<em>N:0921</em>1075<em>0</em>1*</td>
</tr>
<tr>
<td>CAS<em>PR:3</em>20~</td>
<td>DTM<em>472</em>20170119~</td>
</tr>
<tr>
<td>CAS<em>CO:45</em>126.65**139*99.35~</td>
<td>CAS<em>PR:2</em>59.12~</td>
</tr>
<tr>
<td>REF*6R:1234567~</td>
<td>AMT<em>B6</em>591.25~</td>
</tr>
<tr>
<td>AMT<em>B6</em>119.35~</td>
<td></td>
</tr>
</tbody>
</table>

Claims Paid Amount $0 | CLP04 $0
Total Charged Amount $246 | $1075
Copayment $20 | CAS PR 3
Coinsurance | $59.12 | CAS PR 2
Contractual write Amount $126.55 | $483.75 | CO 45
Amount we would have paid $99.35 | $532.13 | CO 139
Total $246.00 | $1075

<table>
<thead>
<tr>
<th>835 Example – $242.96 towards coinsurance</th>
<th>835 Example – $110 towards deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLP<em>999123000</em>1<em>2429.58</em>0<em>242.96</em>15<em>CLAIMNO3</em>111*</td>
<td>CLP<em>999123000</em>1<em>200</em>0<em>110</em>15<em>CLAIMNO4</em>13</td>
</tr>
<tr>
<td>CAS<em>CO:139</em>2186.62~</td>
<td>CAS<em>CO:45</em>90~</td>
</tr>
<tr>
<td>CAS<em>PR:2</em>242.96~</td>
<td>CAS<em>PR:1</em>110</td>
</tr>
<tr>
<td>AMT*AU:2429.58~</td>
<td>AMT<em>B6</em>110~</td>
</tr>
</tbody>
</table>

Claims Paid Amount $0 | CLP04 $0 | CLP04 $0
Total Charged Amount $2429.58 | $200
Copayment |
Coinsurance $242.96 | CAS PR 2
Deductible $110 | CAS PR 1
Contractual write Amount $2186.62 | $90
Amount we would have paid $0 | CO 139
Total $2429.58 | $200

Changes for Mid-June 2017
Currently, employee claim payments are combined with non-employee claims in a single 835 from Application Sender’s Code NASCO (GS02). Changes are scheduled for mid-June to report cashless payments into a separate B835 identified by the BPR01, BPR02, BPR04 and TRN02:

<table>
<thead>
<tr>
<th>Transaction Handling Code (BPR01)</th>
<th>Monetary (Check) Amount (BPR02)</th>
<th>Payment Method Code (BPR04)</th>
<th>Check/EFT Number TRN02</th>
</tr>
</thead>
<tbody>
<tr>
<td>must = H</td>
<td>must = 0 (zero)</td>
<td>must = NON</td>
<td>Begins with ‘V’ or ‘F’</td>
</tr>
</tbody>
</table>

If you have questions specific to 835s, please contact your local E-Solutions Help Desk at 1-800-470-9630 or via email at e-solutions.support@anthem.com.
Beginning next year the Blue Cross and Blue Shield Association prefixes will contain letters and numbers

Beginning April 15, 2018, all new prefixes issued by the Blue Cross and Blue Shield Association will contain a combination of letters and numbers. This change will apply to all Blue Cross and Blue Shield Plans - Anthem Plans as well as non-Anthem Plans. The Blue Cross and Blue Shield Association assigns prefixes to all Blue-branded Plans, and is mandating this change because there are a limited number of unused three-character, alpha-only prefixes remaining.

What does this mean to you?
- It will be even more important to ask your patients for their most recent identification (ID) card.
- When submitting claims, enter the identification number exactly as it appears on the member’s ID card.
- In certain states, member IDs contain a suffix. Ensure you are not submitting a member suffix at the end of the identification number which will result in a rejected claim in the future.
- Check your EDI Software to make sure it can accept alpha-numeric prefixes.
- Check any internal documents you may have and update any references of “alpha prefix” to “prefix”.
- Note: Current three-character, alpha-only prefixes will not be affected by this change. Current prefixes will still be valid after April 15, 2018, unless there is another need to change or remove a prefix currently in use.

We’ll send you reminders of this upcoming change in future issues of Network Update.

Anthem e-Solutions service desk supports EDI direct submitters

At Anthem Blue Cross (Anthem), our knowledgeable and experienced E-Solutions Service Desk associates are available to assist if you directly submit and receive electronic data interchange (EDI) transactions. Note: If you use a clearinghouse, please use existing procedures in place for EDI questions and/or concerns.

<table>
<thead>
<tr>
<th>E - Solutions EDI Website</th>
<th><a href="http://www.anthem.com/edi">www.anthem.com/edi</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>E - Solutions EDI Service Desk Hours</td>
<td>Service Desk is open in all time zones 8-4:30</td>
</tr>
</tbody>
</table>

You can call 1-800-470-9630 or submit to our mailbox E-solutions.support@anthem.com

For us to assist you as quickly as possible, please provide the following:
- ERA Inquiries/ Follow-up - Trading Partner/Submitter ID, REQ number if available
- Electronic Remittance Advice (ERA) only requests - Link under the register tab on EDI webpage - ERA registration E-Form
- Submitted claim information - Trading Partner/Submitter ID, Member ID and Date of Service
- Submitted file information - Trading Partner/Submitter ID, Control number and File Submission Date
- Requested research follow-up - Trading Partner/Submitter, the File Control number or ticket number provided by service desk if available
- Claim receipt verification - Trading Partner/Submitter ID, Tax ID and Check Information
- Batch claim status and benefit inquiry - Trading Partner/Submitter ID and File Submission Date
- To register for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) or Electronic Funds Transfer (EFT) only - Please visit www.caqh.org/solutions/enrollhub
- For established Electronic Funds Transactions (EFT) - Please contact EDI at the toll free number or support mailbox
We also offer a Live Chat option located on the EDI web page. Please be prepared to provide the following required components for Live Chat:

- Trading Partner/Submitter ID
- Region
- Name
- Email address
- Phone number
- TAX ID/NPI Number
- Clear Description of Question

**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](mailto:CAContractSupport@anthem.com) to answer questions you have about the process.
Network

Contracted providers credentialing update

As previously advised, Anthem Blue Cross (Anthem) will be credentialing additional practitioner and health delivery organization (HDO) provider types who are currently contracted with Anthem. It is important that you respond with the information requested when you are contacted by Anthem’s credentialing department.

Upcoming re-credentialing event? Re-attest to your CAQH ProView profile today

Anthem Blue Cross (Anthem) uses the CAQH ProView® system to gather and coordinate the information needed for credentialing. If you are due for an upcoming re-credentialing event and have not accessed CAQH ProView recently, please take a moment to login to CAQH ProView, update your data profile and re-attest to your information.

Re-attestation is due every 120 days, and it is very important to keep your data profile accurate and current so that Anthem can complete the credentialing process without requiring additional outreach to you.

Below are frequently asked questions regarding the CAQH ProView system.

What is CAQH ProView?

CAQH ProView is an online provider data-collection solution. It streamlines provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital and other healthcare organization.

CAQH ProView enables physicians and other healthcare professionals in all 50 states and the District of Columbia to enter information free-of-charge into a secure central database and authorize healthcare organizations to access that information. CAQH ProView eliminates redundant paperwork and reduces administrative burden.

Does it cost anything to use CAQH ProView?

There is no cost for physicians and other health care providers to use CAQH ProView.

How do providers access CAQH ProView?

Providers can register online at https://proview.caqh.org/, or will receive registration instructions once Anthem notifies CAQH that the provider needs to access the database. Once registered, use the CAQH Provider ID and password to access CAQH ProView.

How do physicians and other healthcare professionals complete the CAQH ProView data collection process?

Completing the online form requires five steps:

1. Register with CAQH ProView.
2. Complete the online application and review the data.
3. Authorize access to the information.
4. Verify the data and/or attest to it.
5. Upload and submit supporting documents.
Why should providers respond to CAQH re-attestation notices?

After providers complete their CAQH ProView applications, CAQH will notify them every four months to re-attest that all information is still correct and complete. This enables a provider’s contracted participating organizations to access CAQH ProView profile information based on their different re-credentialing cycles.

Who can I contact for help or if I have any questions about CAQH ProView?

Contact the CAQH Help Desk:

**Providers:** [Log in to CAQH ProView](#) and click the chat icon at the top of any page or call: **1-888-599-1771**.

Help Desk hours are:

- Monday – Thursday: 7 AM – 9 PM (ET)
- Friday: 7 AM – 7 PM (ET)

Provider Education seminars, webinars, workshops and more!

Our Provider Network Education team offers quality complimentary educational programs and materials specially designed for our providers. For a complete listing of our workshops, seminars, webinars and job aids, log on to the Anthem Blue Cross website: [http://www.anthem.com/ca/home-providers.html](http://www.anthem.com/ca/home-providers.html). Scroll down to the Providers / Spotlight section and click on the Provider Education Seminars and Webinars link.

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](http://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 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

Workers’ Compensation CME Educational Program by the Division of Workers’ Compensation

Physicians treating in the California workers’ compensation system are required to follow the evidence-based recommendations in the DWC medical treatment utilization schedule (MTUS). The online course below provides helpful instruction.

Available now online and for mobile app! Free CME credit: [http://www.dir.ca.gov/dwc/CaliforniaDWCCME.htm](http://www.dir.ca.gov/dwc/CaliforniaDWCCME.htm)

Causation: An important issue in Workers’ Compensation

Causation is a part of all Claims in Workers’ Compensation (WC). A WC injury or illness must arise out of and during the course of employment. The threshold for stating the connection between the injury or illness may be in question depending on the injury and state jurisdiction.

The AMA Guides to the Evaluation of Disease and Injury Causation*, Second Edition (2014) can be very informative and of great aid in rendering an opinion concerning causality. The Thirty-Three Chapters, covering various body “parts”, have variable degrees of epidemiologic studies to support or refute the relationship of injuries or illnesses to specific employment. “The Guides” is available from the AMA, as well as online from book sellers such as amazon.com

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 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. From there, select “Provider” and your state> then Health & Wellness> Practice Guidelines.

HEDIS® 2017: What’s new?

Here are some highlights of the HEDIS measure revisions that went in to place 2017.

Human Papilloma Virus (HPV)
This measure was retired in 2017 but the vaccine requirement was added to the IMA (Immunization for Adolescents) measure.

Immunization for Adolescents (IMA)
The HPV vaccine was added to this measure. It is now required for both male and female members. There are two combination requirements.

- **Combination 1** (Meningococcal, Tdap)
  - Adolescents who are compliant for both the meningococcal conjugate and Tdap vaccines

- **Combination 2** (Meningococcal, Tdap, HPV)
  - Adolescents who are compliant for all three vaccines (meningococcal, Tdap, HPV).

In addition, the tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines were removed from this measure.

Colorectal Cancer Screening (COL)

These two tests were added as acceptable proof of colorectal screening
- CT Colonography within the last 5 years
- FIT-DNA test within the last 3 years

For more information on HEDIS go to the “Provider” home page at Anthem.com. Click on the “Providers” link at the bottom of the landing page. Select your state and click enter. On the Provider home page, look on the blue toolbar for the Health and Wellness tab. Click it and then select the Quality Improvement and Standards link, then scroll down to “HEDIS Information”. Thank you for your continued cooperation and 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. These studies allow our Plan to determine compliance with the regulations.

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

- Provider Appointment Availability Survey
- Provider Satisfaction Survey
- 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>
</tbody>
</table>

**After Hours Care**

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

**Emergency Care**

Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller is experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller is experiencing an emergency.

Immediate Access to Emergency Care. Members are directed to 911 or the nearest emergency room.

**Member Services by Telephone.** Access to Member Service to obtain information about how to access clinical care and how to resolve problems (this is a plan responsibility and not a physician responsibility; and this also applies to our Behavioral Health members)

Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate <5%) The Member NurseLine is available 24/7 and the wait time is not to exceed 30 minutes.
Members also have access to Anthem’s 24/7 NurseLine. The NurseLine wait time is not to exceed 30 minutes. 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 (Members) with Department of Managed Health Care Regulated Health plans:
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/TimelyAccesstoCare.aspx or call toll-free 1-888-466-2219 for assistance.

For Patients (Members) with California Department of Insurance Regulated Health plans:
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 toll-free 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 is interested in these services, please call the Anthem Member Services number on the member’s ID card for help (TTY/TDD: 711).
Diabetic retinal eye exam

National guidelines and the National Committee of Quality Assurance (NCQA) recognize the importance of screening people with diabetes annually for diabetic retinopathy through its inclusion in one of the Comprehensive Diabetes Care (CDC) measures. Similarly, Anthem has included retinal eye exams (either by dilation or photograph) for people with diabetes as one of the measures on the Enhanced Personal Health Care scorecard.

What can you do to improve compliance rates?

- Talk to your patients with diabetes about the importance of getting an annual comprehensive eye exam including dilation. Since the retinal eye exam (DRE) is recommended by evidenced based clinical guidelines as a medically necessary part of a diabetic care plan, a member’s medical benefits will cover the exam, subject to his or her share of the cost including co-pays and deductibles. A diabetic eye exam does NOT require vision benefits, as it is part of the medical benefit package. Patients should call Member Services on the back of their identification card for clarification around benefits.
- If you are a primary care doctor or endocrinologist, refer your patients with diabetes to an in-network ophthalmologist or optometrist, if they aren’t already connected with an eye doctor. Follow-up with their eye doctor, as you would any other specialist.
- If you are an eye doctor, follow-up and provide the patient’s test results to their primary care doctor and/or endocrinologist.
- Keep clear documentation in the patient’s medical record:
  - Clearly document referrals and eye exam and lab results.
  - Document the date of the most recent diabetic eye exam with results and name of vision provider.
  - Obtain and include a copy of diabetic eye exams performed by an optometrist or ophthalmologist.
- Use the following medical procedure codes to document diabetic eye exams.

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Submission Method</th>
<th>CPT codes</th>
<th>HCPCS Codes</th>
<th>CPT Category II Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Procedures</td>
<td>Anthem Medical</td>
<td>67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67115, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228</td>
<td>S0620, S0621, S3000 – Diabetic indicator; retinal eye exam, dilated, bi-lateral</td>
<td>2022F, 2024F, 2026F, 3072F - Low Risk for Retinopathy (no evidence of retinopathy in the prior year)</td>
</tr>
<tr>
<td>Evaluation and Management Codes (by an Optometrist or Ophthalmologist Only)</td>
<td>Anthem Medical</td>
<td>92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 92213-99215, 99242-99245</td>
<td></td>
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</tr>
</tbody>
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Medi-Cal Managed Care Updates

CMS emergency preparedness rule

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Anthem Blue Cross (Anthem) seeing Medi-Cal Managed Care members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following common and well-known industry best practice standards:

1. **Emergency plan:** Based on a risk assessment, develop an emergency plan using an all-hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
2. **Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.
3. **Communication plan:** Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
4. **Training and testing program:** Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

Important dates:
The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

Impacted providers:
The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

*Note,* while all 17 providers/suppliers are impacted, requirements may differ between types.
Additional information:
Anthem does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (https://www.cms.gov > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

What if I need assistance?
If you have questions about this communication, contact your local Provider Relations representative.

New pregnancy notification form for Medi-Cal providers

Effective February 1, 2017, an enhanced Pregnancy Notification Form replaces all prior versions. Anthem will no longer accept old forms after June 30, 2017. For your convenience, multiple entry lines and high-risk obstetric criteria have been added. Additionally, the new fax number is 1-855-410-4451. The revised Pregnancy Notification Form can be found on the Anthem Provider website in the Prenatal Toolkit at: https://mediproviders.anthem.com/ca/pages/prenatal-resources.aspx

Providers play an important role in assisting Anthem Blue Cross (Anthem) to serve our members. The pregnancy notification process identifies Anthem members who are covered by Medi-Cal Managed Care (Medi-Cal) early in their pregnancy. Our goal is to identify women who may need additional health education, transportation assistance, case management (including high-risk obstetrics), care coordination and any other needs related to women’s health.

We recommend faxing the Pregnancy Notification Form frequently to share with Anthem any pregnant members as soon as they are identified. This form provides important information to Anthem in an effort to ensure pregnant members access prenatal care timely, within their first trimester or within 42 days of enrollment, as recommended by NCQA.

Beginning in April: Access Patient360 directly through the Availity Web Portal

In mid-April 2017, Anthem Blue Cross (Anthem) is making it easier for you to access Patient360 by giving you two navigation options within the Availity Web Portal. You’ll still be able to access Patient360 through our secure self-service website; however, we will also offer you the opportunity to easily access records for your Medi-Cal Managed Care (Medi-Cal) members when you are checking member eligibility and benefits in the Availity Web Portal.

About Patient360
Patient360 is a real-time dashboard that gives you a robust picture of your Medi-Cal patients’ health and treatment history as well as helps you facilitate care coordination. You can drill down to specific items in a patient’s medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information and care management-related activities.

Accessing Patient360 within the Availity Web Portal
You must first be assigned the Patient360 role in the Availity Web Portal; administrators can make this assignment within the Clinical Roles options. Then, navigate to Patient360 using one of the methods outlined below:

- Method one:
Select **Patient Registration** from the top menu bar in the Availity Web Portal.

- Choose **Eligibility and Benefits**.
- Complete the required fields on the **Eligibility and Benefits** screen.
- Select the **Patient360** link on the member's benefit screen.
- Enter the member's information in the required fields.

**Method two:**
- Select **Payer Spaces** from the top menu bar in the Availity Web Portal.
- Choose the Anthem tile.
- Select **Patient360** located on the **Applications** page.
- Enter the member's information in the required fields.

**Registering for the Availity Web Portal**

To gain access to the Availity Web Portal:
- Select **Register**.
- Select **Get Started**.
- Complete the online registration form.

**For assistance**

If you have questions about Patient360, contact your local Provider Relations representative. If you have questions about registering for the Availity Web Portal, contact Availity Client Services at 1-800-282-4548.

**Update regarding Digital Breast Tomosynthesis**

Beginning February 20, 2017, Anthem Blue Cross (Anthem) will no longer apply medical policy to digital breast tomosynthesis (DBT or 3-D mammography) services provided to members in its individual, small group, group and employer-sponsored plans, and its Medicaid plans when the State Medicaid programs provide coverage for this service. Dates of service before February 20, 2017, may still be reviewed using the medical policy. Under an existing rule by The Centers for Medicare & Medicaid Services (CMS), Medicare plans provide benefits for DBT. **Providers should verify eligibility and benefits (including appropriate copays or coinsurance amounts) for all members prior to rendering services.**

Anthem previously reviewed DBT under medical policy RAD.00060, which has been archived and is no longer in effect as of February 20, 2017. When a medical policy no longer exists, coverage is guided by members' plan benefits.
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.

CMS emergency preparedness rule impacts MMP members

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Anthem Blue Cross (Anthem) seeing Medi-Cal Managed Care members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters. See page 22 in this edition of the Network Update for more information.

New place of service code 02 for telehealth services

Effective January 1, 2017, Anthem Blue Cross is following The Centers for Medicare and Medicaid Services (CMS) in implementing new Place of Service (POS) code 02. The POS code 02 is for use by physicians or practitioners furnishing telehealth services from a distant site.

When billing telehealth services, providers must bill with POS code 02 and continue to bill modifier GT (via interactive audio and video telecommunication systems) or GQ (via asynchronous telecommunications system). Telehealth services not billed with the new POS code 02 will be denied back to the provider.

See https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html for the list of Medicare telehealth services.

High-risk medications report

In an effort to enhance patient safety, reviewing high-risk medication reports is required to monitor prescriptions activity for high-risk medications as defined by The Centers for Medicare and Medicaid Services (CMS).

To ensure providers are aware of any high-risk medications prescribed for members enrolled in Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan), we fax a list of high-risk medication claims to providers each week. In addition, Anthem Blue Cross distributes a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication report, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed on www.anthem.com/maprovidertoolkit.
 Billing changes for 2017 home health agencies

For dates of service on and after January 1, 2017, Anthem Blue Cross will provide separate payment to home health agencies (HHAs) for disposable negative pressure wound therapy (NPWT) device claims for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members who receive home health services for which payment is made under the Medicare-Medicaid Plan home health benefit. In addition to billing a claim with type of bill 32X, HHAs must enter a claim with type of bill 34X, HCPCS code 97607 or 97608, and the appropriate revenue code (042X, 043X or 0559) in order to receive separate payment for NPWT.

For dates of service on or after January 1, 2017, G0163 and G0164 will be retired and replaced with the following new G codes:

- G0493: skilled services of a registered nurse (RN) for the observation and assessment of a patient's condition — each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
- G0494: skilled services of a licensed practical nurse (LPN) for the observation and assessment of a patient's condition — each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
- G0495: skilled services of an RN to train and/or educate a patient or family member in the home health or hospice setting — each 15 minutes
- G0496: skilled services of an LPN to train and/or educate a patient or family member in the home health or hospice setting — each 15 minutes

For more information, contact Provider Services at 1-855-817-5786.

Beginning in April: Access Patient360 directly through the Availity Web Portal impacts MMP members

In mid-April 2017, Anthem Blue Cross is making it even easier for you to access Patient360 by giving you two navigation options within the Availity Web Portal. You’ll still be able to access Patient360 through our secure self-service website; however, we will also offer you the opportunity to easily access records for your Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members when you are checking member eligibility and benefits in the Availity Web Portal. See page 23 in this edition of the Network Update for more information.

New CMS requirement: Hospitals must use the Medicare Outpatient Observation notice

Summary

CMS requires that all hospitals and critical access hospitals (CAHs) provide written and verbal notification to inform Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members that they are receiving observation services on an outpatient basis for more than 24 hours.

All hospitals and CAHs are required to provide this statutory notification no later than March 8, 2017. Hospitals should use the standardized Medicare Outpatient Observation Notice (MOON) (CMS-10611) approved by the Office of Management and Budget. The MOON and accompanying instructions are available on the CMS website at https://www.CMS.gov > Medicare > Medicare - General Information > Beneficiary Notices Initiative (BNI).
What if I need assistance?
If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call 1-855-817-5786.

Inpatient readmissions update

In an effort to identify clinically related readmissions to the same facility, licensed clinical staff will review at the time of an inpatient authorization the clinical information submitted regarding the medical treatment and management of an admission that occurred within 2 to 30 days from a previous admission to the same facility. If an admission is believed to be related, a medical director will contact the admitting physician to confirm that the clinical information is accurate. If the second admission is determined to be clinically related, we will not reimburse for an additional admission as this is considered a continuation of the episode of care. This process will be implemented June 2017.

Policy Update
(Policy 13-001)
Based on the information above, the Inpatient Readmissions Reimbursement Policy has been updated. Anthem Blue Cross will utilize information indicating clinically related readmissions, clinical criteria and/or licensed clinical medical review for readmissions from day 2 to day 30 for the second admission determination. For additional information, please refer to the Inpatient Readmissions Reimbursement Policy at https://mediproviders.anthem.com/ca.

Reimbursement policy bulletin

Effective October 1, 2017, the following Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) Reimbursement Policies will become effective and will be located on the Anthem Blue Cross provider website.


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 Anthem Blue Cross Cal MediConnect Plan benefit plans. 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 Blue Cross Cal MediConnect Plan applies code and clinical editing guidelines to evaluate claims for accuracy and adherence to accepted national industry standards and plan benefits. We utilize 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 the CMS National Correct Coding Initiative, medical policies and Clinical Utilization Management Guidelines. Anthem Blue Cross Cal MediConnect Plan is committed to working with you to ensure timely processing and payment of claims.

Anthem Blue Cross Cal MediConnect Plan does not apply code and clinical editing guidelines to state-defined local procedure codes.
HCPCS codes allow for payment for coordinating behavioral health services

Anthem Blue Cross would like to remind providers seeing Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members of the collaborative care, case management (CM) and cognitive assessment HCPCS codes that went into effect on January 1, 2017. CMS approved these codes for services provided under the psychiatric collaborative care model, which supports integration of behavioral health (BH) care into primary care treatment. The codes allow payment for efforts to coordinate and integrate BH services, including key services of CM, for patients receiving BH treatment and psychiatric consultation by primary care treatment teams. The collaborative care codes introduced in 2017 include the following:

<table>
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<tr>
<th>HCPCS code</th>
<th>Description:</th>
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| G0502      | Initial psychiatric collaborative CM (first 70 minutes in the first calendar month of BH care manager activities) in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional (QHCP) with the following required elements:  
  • Outreach to and engagement in treatment of a patient directed by the treating physician or other QHCP  
  • Initial assessment of the patient including administration of validated rating scales with the development of an individualized treatment plan  
  • Review by the psychiatric consultant with modifications of the plan if recommended  
  • Entering patient in a registry and tracking patient follow-up and progress using the registry with appropriate documentation and participation in weekly caseload consultation with the psychiatric consultant  
  • Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies |
| G0503      | Subsequent psychiatric collaborative CM (first 60 minutes in a subsequent month of BH care manager activities) in consultation with a psychiatric consultant and directed by the treating physician or other QHCP with the following required elements:  
  • Tracking patient follow-up and progress using the registry with appropriate documentation  
  • Participation in weekly caseload consultation with the psychiatric consultant  
  • Ongoing collaboration with and coordination of the patient’s mental health (MH) care with the treating physician or other QHCP and any other treating MH providers  
  • Additional review of progress and recommendations for changes in treatment as indicated including medications based on recommendations provided by the psychiatric consultant  
  • Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies  
  • Monitoring of patient outcomes using validated rating scales  
  • Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment |
| G0504      | Initial or subsequent psychiatric collaborative CM (each additional 30 minutes in a calendar month of BH care manager activities) in consultation with a psychiatric consultant and directed by the treating physician or other QHCP (list separately in addition to code for primary procedure)  
(Note, G0504 should be used in conjunction with G0502 or G0503.) |
| G0507      | CM services for BH conditions (at least 20 minutes of clinical staff time per calendar month) directed by a physician or other QHCP with the following required elements:  
  • Initial assessment or follow-up monitoring including the use of applicable validated rating scales  
  • BH care planning in relation to BH/psychiatric health problems including revision for patients who are not progressing or whose status changes  
  • Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or |

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<thead>
<tr>
<th>HCPCS code</th>
<th>Description</th>
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<tr>
<td></td>
<td>psychiatric consultation</td>
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<td></td>
<td>• Continuity of care with a designated member of the care team</td>
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<tr>
<td>G0505</td>
<td>Cognitive/functional assessment and care planning</td>
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</tbody>
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For more information, visit the CMS website at [https://www.CMS.gov](https://www.CMS.gov) > Newsroom > search for “Medicare finalizes substantial improvements that focus on primary care, mental health, and diabetes prevention” from November 2016.

**Modifier FX and reimbursement policy update**

CMS has added a new Modifier FX, used to indicate X-rays that are taken using film. Reimbursement will be subject to a 20% reduction of the applicable fee schedule and/or contracted/negotiate rate. Anthem Blue Cross (Anthem) will begin following CMS Modifier FX reimbursement guidelines effective September 15, 2017.

Modifier FX (X-ray taken using film) has been added to our reimbursement modifiers list. This modifier is applicable to Anthem only. Refer to Modifier Usage Reimbursement Policy (Exhibit A) at [https://mediproviders.anthem.com/ca](https://mediproviders.anthem.com/ca) for more information.
Medicare Advantage and Medicare Supplement Updates

Tips for submitting Medicare Advantage corrected claims

When submitting a corrected claim, clearly identify the claim as a correction to an original bill. Additional details for submitting corrected medical electronic CMS-1500 claims, paper CMS-1500 claims and facility UB-04 electronic or paper claims can be found at anthem.com/ca/medicareprovider at Important Medicare Advantage Updates.

Bill CLIA certification for individual Medicare Advantage claims

Effective July 1, 2015, Anthem began denying claims for individual Medicare Advantage members billed without the CMS-required CLIA certification number and claims billed with an invalid CLIA certification number. The CLIA number must be included on each claim billed on the ASC X12 837 professional format or Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. The CLIA number is not required on the ASC X12 institutional claim data set or its related paper Form CMS-1450. Please bill the CLIA certification in the following fields:

- ASC X12 837 professional claim format REF segment as REF02, with qualifier of “X4” in REF01,
- Field 23 of the paper CMS-1500

HCPC codes allow for payment for coordinating behavioral health services

Anthem would like to remind Medicare Advantage providers of the collaborative care, case management and cognitive assessment HCPC codes that became effective January 1, 2017. The Centers for Medicare & Medicaid Services (CMS) approved these codes for services provided under the Psychiatric Collaborative Care Model, which supports integration of behavioral health care into primary care treatment. These codes allow payment for the efforts to coordinate and integrate behavioral health care services by primary care providers, including key services of care management for patients receiving behavioral health treatment and psychiatric consultation to primary care treatment teams. For a list of the collaborative care codes introduced in 2017, please see Important Medicare Advantage Updates at anthem.com/ca/medicareprovider.

Tetanus vaccine billing guidelines

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. Tetanus administered in the Emergency Room should be billed with the appropriate revenue codes (0250 or 0636 for vaccine and 0771 for the administration). 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 web site (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.

**Use code 1111F to receive reimbursement for post-discharge medication reconciliation**

Medication Reconciliation once the patient is discharged plays an important role in preventing adverse drug events. This should be done within 30 days of discharge from an acute or non-acute inpatient stay. Later this year, Anthem will reimburse providers who conduct medication reconciliation within 30 days of an inpatient hospital discharge for individual and group-sponsored Medicare Advantage members and submit the claim using the CPT Category II code 1111F. Medication reconciliation must be completed by the prescribing practitioner, registered nurse or clinical pharmacist and noted by one of these professionals on the outpatient medical record. The effective date of this additional reimbursement will be announced at anthem.com/ca/medicareprovider under Important Medicare Advantage Updates as soon as it is available.

**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:

- Prior authorization requirement change for Part B drug: Herceptin
- Prior authorization requirement change for Part B drug: Bavencio
- Prior authorization requirement change for Part B drug: Spinraza
- Prior authorization requirements for continuous interstitial glucose monitoring
- Risk adjustment and documentation guidance training offered
- Retrospective medical record review program launches

**No copay benefit for diabetes retinal exam and HbA1c testing effective January 1, 2017**

Effective January 1, 2017, no copay is required for HbA1c testing for individual and some group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual dilated retinal exam at no out-of-pocket cost.

The annual retinal exam claim must include a line for measurement code 2022F to report the use of dilation during the exam for no copay to apply.

This is not applicable to Anthem Blue Cross Special Needs Plans or Anthem Blue Cross MediBlue Coordination Plus plans. Some group-sponsored plans may require a member copayment or coinsurance for these services.
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; and Standard Option: 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 > Benefit Plans > Brochures and Forms > Medical Policies.