In this issue

<table>
<thead>
<tr>
<th>Announcement and General Updates</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reminder: Anthem Blue Cross’ provider website will have improved look and feel</td>
<td>3</td>
</tr>
<tr>
<td>Anthem Blue Cross in-network laboratory update</td>
<td>3</td>
</tr>
<tr>
<td>Anthem Blue Cross’ clinically equivalent immune globulin agents</td>
<td>3</td>
</tr>
<tr>
<td>Update regarding clinical data sharing requirements</td>
<td>4</td>
</tr>
<tr>
<td>National Urban League, team up with Anthem to help prevent opioid misuse and addiction</td>
<td>4</td>
</tr>
<tr>
<td>Anthem Blue Cross expands partnership with Aspire Health to support palliative care for commercial members</td>
<td>5</td>
</tr>
<tr>
<td>California updated MTUS for Workers’ Compensation treatment</td>
<td>6</td>
</tr>
<tr>
<td>Use Interactive Care Reviewer to submit your online authorization request</td>
<td>6</td>
</tr>
<tr>
<td>University of Southern California Trojan Care EPO plan utilizing Anthem Prudent Buyer PPO network</td>
<td>7</td>
</tr>
<tr>
<td>Misrouted protected health information (PHI)</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Reform Updates (including Health Insurance Exchange)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important information available online</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important information about filing Home Infusion Therapy claims</td>
<td>9</td>
</tr>
<tr>
<td>Reimbursement policies in a new location</td>
<td>9</td>
</tr>
<tr>
<td>Reimbursement policy update: Evaluation and management services and related modifiers 25 and 57</td>
<td>9</td>
</tr>
<tr>
<td>Updates to reimbursement policies</td>
<td>10</td>
</tr>
<tr>
<td>Contracted provider claim escalation process</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Network</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Education seminars, webinars, workshops and more!</td>
<td>12</td>
</tr>
<tr>
<td>Anthem Blue Cross Directory: Provider data updates</td>
<td>12</td>
</tr>
<tr>
<td>New! Easily update provider demographics with the online Provider Maintenance Form</td>
<td>12</td>
</tr>
<tr>
<td>Extended! SOPA Notes for 2017 calendar year submission deadline extended to February 10, 2018</td>
<td>13</td>
</tr>
<tr>
<td>Qualified Autism service professional requirements</td>
<td>14</td>
</tr>
<tr>
<td>Workers’ Compensation Physician Acknowledgments required by California Code of Regulations</td>
<td>14</td>
</tr>
<tr>
<td>Sign-up now for our Network UPDATE today – it’s free!</td>
<td>15</td>
</tr>
<tr>
<td>Network leasing arrangements</td>
<td>15</td>
</tr>
</tbody>
</table>
In this issue Continued

Guidelines and Quality Programs
- Clinical practice and preventive healthy guidelines available online 16
- HEDIS 2018 starts early February 16
- Timely access regulations and language assistance program 17

Medi-Cal Managed Care Updates
- Medical policies update 20
- Levoleucovorin calcium, elosulfase alfa, histrelin acetate, idursulfase and fulvestrant to require prior authorization 21
- Elotuzumab to require prior authorization 22

Cal MediConnect Plan Updates
- Prior authorization requirements for Part B drugs: Aliqopa (Copanlisib injection), Cinvanti (aprepitant injection) and Opsiria (sirolimus injection) 23
- Imaging program expands to include level of care reviews 24
- Prior authorization requirements for Part B drugs: Besponsa (inotuzumab ozogamicin) and Vyxeos (daunorubicin and cytarabine) 25

Medicare Advantage and Medicare Supplement Updates
- Medical policies and clinical guidelines updated 26
- Improve member medication regimen 26
- Keep up with Medicare news 27

Pharmacy Updates
- Update regarding Shingrix shingles vaccine 28
- Important update to Anthem Blue Cross' commercial drug lists 28
- Pharmacy information available on anthem.com/ca 28
Announcements and General Updates

Reminder: Anthem Blue Cross’ provider web site will have improved look and feel

The Anthem Blue Cross (Anthem) Provider public website has launched a new landing page to help you find important information you need. As of January 20, 2018, the Provider public landing page now has a new look and feel and more intuitive access to key provider resources, allowing you to more easily find what you are looking for. Watch for additional announcements about our continued improvements to the public Provider site in future Network Update newsletters.

Anthem Blue Cross in-network laboratory update

Effective January 1, 2018, Exact Sciences Laboratories, LLC will no longer be an in-network laboratory for Anthem Blue Cross. Providers should use in-network laboratory providers, such as LabCorp and Quest Diagnostics, for non-invasive colon cancer screening testing for their Anthem patients beginning January 1, 2018. Using an in-network laboratory helps patients maximize their laboratory benefits and minimize their out-of-pocket expenses.

If you have specific questions regarding non-invasive colon cancer screening testing performed by in-network labs, please see the below contact information. For a complete listing of in-network laboratory providers, please use the Find A Doctor application on our website www.anthem.com.

- LabCorp: 1-888-LABCORP (522-2677) or www.LabCorp.com.
- Quest Diagnostics: 1-866-MY-QUEST (866-697-8378) or http://www.questdiagnostics.com

Anthem Blue Cross’ clinically equivalent immune globulin agents

Effective for dates of service on or after May 1, 2018, Gamunex-C® and Octagam® will be the immune globulin agents of choice over Bivigam®, Carimune NF®, Flebogamma®, Gammagard®, Gammagard S/D®, Gammaplex®, and Privigen®.

Some health plans require the use of clinically equivalent agents. When prescribing a therapy in these categories, please consider using a preferred clinically equivalent agent. Anthem Blue Cross (Anthem) has a process in place to consider requests for continuing members on existing agents. To inquire about this process, please call Anthem Provider Service Department at 1-855-854-1438.

The following clinical guidelines have been updated to include the requirement of a clinically equivalent agent effective May 1, 2018.

<table>
<thead>
<tr>
<th>Clinical Guideline</th>
<th>Impacted Agent</th>
<th>Clinically Equivalent Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DRUG-09 Immune Globulin (IG) Therapy</td>
<td>Bivigam®, Carimune NF®, Flebogamma®, Gammagard®, Gammagard S/D®, Gammaplex®, Privigen®</td>
<td>Gamunex-C®, Octagam®</td>
</tr>
</tbody>
</table>
Update regarding clinical data sharing requirements

Providers and Anthem Blue Cross (Anthem) have a shared goal to improve the quality of health care for Anthem members. To support this goal, it is critical that both providers and Anthem have access to up-to-date clinical and administrative data. Anthem will update its clinical data sharing requirements effective April 1, 2018.

Examples of clinical data sharing include using Electronic Medical Record (EMR) data to provide a more complete clinical picture of a member's condition (for more targeted and comprehensive treatment plans), to facilitate the collection of risk data, improve HEDIS scores and other quality improvement initiatives.

When clinical data is required, Anthem will request this information in a specific format from the provider. For more information about clinical data sharing, review the Provider Administrative policy.

National Urban League, team up with Anthem to help prevent Opioid misuse and addiction

In response to the opioid addiction crisis devastating communities across the country, the National Urban League and Anthem Blue Cross' (Anthem) and with the support of Anthem's parent company, are teaming to help create awareness and prevent opioid misuse and addiction with a free online toolkit, What's Up With Opioids?

The online toolkit was designed specifically to help non-profits, faith-based groups, parents and others keep their communities safe by preventing opioid misuse and addiction -- especially among young adults. The website includes a workshop kit with ready-to-use materials and a step-by-step guide for hosting a local discussion or town hall meeting.

Presented in an easy to understand format, the kit features a video and slideshow to help people learn about opioids, risk factors, warning signs and prevention strategies. The workshop kit also provides tips for inviting key community experts such as pharmacists, doctors and first responders who bring expertise and local insights that are impactful to the conversation, as well as customizable postcards and social media posts to help organizers promote their event. And, for individuals who need help for substance abuse disorders, the site also provides links to helpful community resources.

"Young people are among the most vulnerable to this deadly epidemic," National Urban League President and CEO Marc H. Morial said. "Drug overdoses killed more Americans than even guns last year, and are the leading cause of death for Americans under 50. Urban League affiliates who work closely with this vulnerable population are in a unique position to effectively intervene to prevent misuse and addiction."

Opioid addiction among Americans under the age of 25 is skyrocketing, climbing nearly six-fold between 2001 and 2014. Researchers predict that, without serious intervention, the annual death toll from opioid overdose will increase by at least 35 percent by 2027. In fact, the White House recently directed the Department of Health and Human Services to declare the opioid crisis a public health emergency.

"Today all our communities are at risk of being touched by the opioid crisis," said Craig Samitt, MD, chief clinical officer at Anthem, Inc. "This free online resource is another way parents, local churches, service organizations and others in our community can become better informed and help raise awareness on this important issue facing so many."
To showcase the ease of using What's Up With Opioids?, the National Urban League together with Anthem affiliated health plans will host town hall meetings at Urban League affiliates across the country. "We are committed to breaking down barriers to economic and civic participation," Morial said. "In addition to the devastating health consequences of the epidemic, opioid misuse and addiction are robbing young people of their futures." Morial noted that opioid addiction is linked to other social challenges at the heart of the Urban League mission, such as homelessness and unemployment.

For more information, visit "What's Up With Opioids".

Anthem Blue Cross expands partnership with Aspire Health to support palliative care for commercial members

Beginning April 2, 2018, Anthem Blue Cross (Anthem) will partner with Aspire Health to supply palliative care support services to our fully insured commercial members with advanced illness. Aspire Health already provides services for members with advanced illness enrolled in our Medicare and Medicaid health plans and has demonstrated improvement in quality and cost of care savings.

Aspire does not replace the care of PCPs and specialists, but provides an extra layer of support with an interdisciplinary team that includes Palliative care physicians, Palliative care nurse practitioners, registered nurses, social workers, chaplains and patient care coordinators.

Specific palliative care services include:

- Comprehensive assessments including symptoms, spiritual and psychosocial needs
- Expert symptom management
- Supporting patients in defining their goals, values and preferences and in advance care planning
- Empowering patients to execute advance directives
- 24/7 access to urgent clinical support from an Aspire interdisciplinary team member
- Securing needed resources
- Education on palliative services and hospice care services

An initial telephonic outreach to identified members will be made by a palliative care professional to determine the appropriate level of palliative services in one of the following three models:

1. Home based visits by Aspire's interdisciplinary team for patients with a high symptom burden, increased risk of hospitalization or other complex issues (available in certain geographic areas)
2. An Aspire palliative care team embedded within an outpatient medical oncology clinic to provide services to targeted patients (available in certain geographic areas)
3. Provision of telephonic/telehealth services and support at routine intervals to patients by palliative trained providers

If you are an Anthem contracted network provider, an Aspire Health palliative physician may reach out to your practice to introduce themselves in order to establish a physician to physician relationship. They may also discuss developing an individualized mechanism by which to share information regarding patients that have been identified for palliative care services. Aspire will provide updates to your practice on a regular basis to facilitate the best possible co-management of your patient.

If you have questions regarding Aspire Health or palliative care, please email palliativecareaspirehospice@anthem.com
California updated MTUS for Workers’ Compensation treatment

The Division of Workers’ Compensation (DWC), per Labor Code, has updated the CA MTUS to the most recent American College of Occupational and Environmental Medicine Medical Treatment Guidelines (ACOEM). The updates will make treatment more contemporary, and changes some of the Titles of the Sections. “Hip and Groin”, “Work Related Asthma”, and “Occupational Lung Disease”, is being added, and “Acupuncture Medical Treatment”, and “Post-Surgical Treatment” Guidelines are being deleted as these subjects are addressed in other Guidelines. The ACOEM Guidelines are available from the ReedGroup, the publisher of the ACOEM Guidelines. All physicians working with Workers’ Compensation patients should be aware that changes have been made and that the revised ACOEM Based MTUS will apply for procedures and treatment after December 1, 2017. In addition, the CA W.C. Formulary is in effect beginning January 1, 2018. There is a transitional period for patients on medications prior to that date.

Use Interactive Care Reviewer to submit your online authorization request

Improve the efficiency of your preauthorization process by submitting your Anthem Blue Cross inpatient and outpatient medical and behavioral health requests using our online authorization tool, the Interactive Care Reviewer (ICR). Access to ICR is available exclusively on the Availity Portal.

Begin using ICR today and discover all the great benefits your organization will gain by submitting your authorizations online.

Time Savings
- Reduce and practically eliminate the need to fax or phone in your requests
- No time spent waiting on hold
- Save an average of 15 minutes per case compared to fax or phone
- Precertifications are accessible in one place, at any time by designated staff

Ease of Use and Improved Efficiency
- No need to fax! Reduced paperwork!
- The ICR dashboard lists current status of your organization’s cases
- Track status on cases submitted via phone or fax
- Attach and submit clinical notes and supporting images
- Proactive contact via email updates
- View and print case determination letters

Automated Responses
- ICR is able to provide a decision on whether an authorization is required
- For some procedures, ICR is able to deliver immediate decisions

Is it your first time using ICR on the Availity Portal?
Contact your Availity Administrator and request to be assigned the Authorization and Referral Request role. Once you have the role assignment you can immediately access ICR, just log onto Availity and select the Patient Registration | Authorizations & Referrals. Then choose Authorizations.
Need training?  
We’ve got it covered. Check out our ICR Help Page, and on Availity select Payer Spaces | Education and Reference Center for educational resources.

University of Southern California Trojan Care EPO plan utilizing Anthem Prudent Buyer PPO Network

Effective January 1, 2018, the University of Southern California has implemented a new EPO Plan for their employees. The USC Trojan EPO is a plan especially designed for USC employees, and utilizes the Anthem Blue Cross Prudent Buyer PPO Network for services. The USC EPO Plan network does not include Cedars Sinai or UCLA Medical Center facilities or providers. Members enrolled on the plan must use network providers; there is no out-of-network coverage (except in an emergency).

The USC Trojan Care EPO Plan is administered by HealthComp. Call 1-855-727-5267 with questions about plan benefits, eligibility or claims. Anthem Blue Cross Prudent Buyer providers may call Anthem Blue Cross for questions regarding claim pricing or to obtain prior authorization for services.

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.
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.
Billing

**Important information about filing Home Infusion Therapy claims**

To assist in the accurate and timely processing of Home Infusion Therapy (HIT) claims, it is important for HIT Providers to file professional HIT claims to the correct Blue Plan. The following information applies to professional HIT claims for all Blue-branded health plans.

Professional claims from a HIT Provider should be filed to the Blue Plan where the service was rendered (which may be the member's home or equivalent setting). Even if a HIT Provider employs traveling health care professionals or renders services in multiple states, professional HIT claims should submitted to the state Blue Plan where the service was rendered.

The following example illustrates appropriate filing of a professional HIT claim:

- **HIT Provider A** regularly renders services in multiple states and service areas.
- **Provider A** renders services to a member using a traveling home health nurse in the member's home.
- The member's home is located in the service area for *Blue Plan XYZ*.
- **Provider A** submits the professional HIT claim to *Blue Plan XYZ*, even though **Provider A** may be located in a different service area than the member's residence.

Please note, professional HIT claims that are not submitted to the Blue Plan where the service was rendered may be denied and require the provider to resubmit the claim to the correct Blue Plan.

**Reimbursement policies in a new location**

We are making it easier for you to find the information you need. The reimbursement policies, previously on ProviderAccess, the secure provider portal, have now moved to the Availity Portal at [www.availity.com](http://www.availity.com).

If you wish to navigate to them, you can go to Payer Spaces | Education and Reference Center | Administrative Support to find the link "Reimbursement Policies and McKesson Claims Xten™ Rules" that will take you to a downloadable pdf of the policies.

**Reimbursement policy update: Evaluation and management services and related modifiers 25 and 57**

On September 30, 2017, Anthem Blue Cross (Anthem) mailed to its professional provider network upcoming changes to the Evaluation and Management Services and Related Modifiers 25 and 57 Professional Reimbursement Policy. The notice indicated that evaluation and management services that are eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery would be reduced by 50% beginning January 1, 2018. Please note, the following information replaces the previously mailed policy information.
Instead, beginning with dates of service on or after March 1, 2018, Evaluation and Management Services (CPT codes 99201-99215) that are eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery will be reduced by 25%. Minor surgeries have a global period of 0 or 10 days and impacted CPT codes are 10000-69999, excluding CPT codes 36415, 36416, and 69210. As a reminder please review the guidelines on reporting Modifier 25 in Anthem's reimbursement policy.

To access the complete policy online, go to [www.Availity.com](http://www.Availity.com). Once logged in, follow the quick steps below:

1. Under the Payers Spaces tab, select Anthem Blue Cross
2. Select Education and Reference Center
3. Select Administrative Support
4. Scroll to the document, Reimbursement Policies and McKesson Claims Xten™ Rules, and select the policy you would like to view

Thank you for your attention to this update. If you have any questions, please contact our Network Relations staff via email at [CAContractSupport@Anthem.com](mailto:CAContractSupport@Anthem.com).

### Updates to reimbursement policies

<table>
<thead>
<tr>
<th>Name</th>
<th>Description of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency Editing</td>
<td>Beginning with dates of service on or after January 1, 2018, Anthem Blue Cross (Anthem) will be removing the frequency limits for definitive drug testing HCPCS codes G0482 and G0483.</td>
</tr>
<tr>
<td>Policy Reviews</td>
<td>The following professional reimbursement policies received an annual review and include minor language revisions; however, there were no changes to the policy position or criteria: <em>Place of Service</em></td>
</tr>
<tr>
<td>Reminder - Global billing for the Professional and Technical Component-Professional</td>
<td>When the professional and the technical components of a global diagnostic procedure are performed separately by the same provider or associate providers in the same practice for the same patient for the same date of service, the services must be reported as a global procedure. When reporting the global service, the Health Plan considers the day the professional component (the reading) was rendered to be the date of service even if the technical component was performed on the same date or performed on a date that is prior to the professional component. Additionally, when the professional component is performed in a location separate from the location where the technical component was rendered, the service location for the global service should be reported as the location where the professional component was rendered.</td>
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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

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. Scroll down to the Providers / Spotlight section and click on the Provider Education Seminars and Webinars link.

Anthem Blue Cross Directory: 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 ongoing 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.

Easily update provider demographics with the online Provider Maintenance Form

Anthem Blue Cross (Anthem) providers should now submit changes to their practice profile using our online Provider Maintenance Form.

Online update options include: add an address location, name change, tax ID changes, provider leaving a group or a single location, phone/fax numbers, closing a practice location, etc. Visit the Anthem.com/ca form page to review more. The new online form can be found on www. Anthem.com/ca> Menu-Providers>Provider Home Page> Answers@Anthem tab>Provider Forms bullet>Provider Change Forms> Provider Maintenance Form. In addition, the Provider Maintenance Form can be found on the Availity Web Portal by selecting California> Payer Spaces-Anthem Blue Cross> Resources tab >Provider Maintenance Form.

Important information about updating your practice profile:
- Change request should be submitted using the online Provider Maintenance Form
- Submit the change request online. No need to print, complete and mail, fax or email demographic updates
- You will receive an auto-reply e-mail acknowledging receipt of your request and another email when your submission has been processed
- For change(s) that require submission of an updated IRS Form w-9 or other documentation, attach them to the form online prior to submitting
- Change request should be submitted with advance notice
- Contractual agreement guidelines may supersede effective date of request

You can check your directory listing on the Anthem Blue Cross: “Find a Doctor tool”. The Find a Doctor tool at 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 Find A Doctor tool (www.anthem.com/ca) and review how you and your practice are being displayed.

To report discrepancies please make correction by completing this Provider Maintenance Form online.

**Extended! SOAP Notes for 2017 calendar year submission deadline extended to February 10, 2018**

In compliance with the Affordable Care Act (ACA) Risk Adjustment Program, Anthem Blue Cross is required to submit diagnosis code information for the purpose of risk adjustment scoring. We are asking for your assistance by requesting that you conduct health assessments of selected members – your patients. The documentation that you provide will help us ensure that all potential conditions are documented annually. We have engaged Inovalon – an independent company that provides secure clinical documentation services – to process your patients’ assessments.

To accomplish this goal, Anthem network providers – usually primary care physicians – may receive letters from Inovalon, requesting that physicians perform patient assessments, followed by submission of a Subjective, Objective, Assessment and Plan (also called SOAP Note or Encounter Facilitation Form). Providers will receive $100.00 for each properly submitted electronic SOAP Note, or $50.00 for each properly completed and submitted paper SOAP Note.

Our deadline has now been extended! While the date of service must be from a comprehensive visit in the 2017 calendar year, you now have until February 10, 2018 to submit the SOAP note/Health Assessments.

Also be on alert for Commercial Risk Adjustment SOAP note packets from Inovalon for 2018 that will start being sent out in the end of February. The same incentive will stand for 2018 SOAP note assessments. If you would like to work out an alternative process please contact Michael Meiselman (email provided below)

Webinars offered by Inovalon on a weekly basis to assist eligible providers in completing a SOAP Note and utilizing the ePASS® electronic tool and increasing your incentive opportunities. If you have not already done so, we encourage you to attend an upcoming session. All webinars take place on Wednesdays at 12 pm PT. There is still an opportunity to attend one before the submission deadline, and others establish a process for the upcoming year:

- **Wednesday, February 7, 2018, 12:00 PM – 1:00 PM PT (before the February 10, 2018 deadline)**
- **Wednesday, February 14, 2018, 12:00 PM – 1:00 PM PT**
- **Wednesday, February 21, 2018, 12:00 PM – 1:00 PM PT**
- **Wednesday, February 28, 2018, 12:00 PM – 1:00 PM PT**

- **Wednesday, March 7, 2018, 12:00 PM – 1:00 PM PT**
- **Wednesday, March 14, 2018, 12:00 PM – 1:00 PM PT**
- **Wednesday, March 21, 2018, 12:00 PM – 1:00 PM PT**
- **Wednesday, March 28, 2018, 12:00 PM – 1:00 PM PT**
Registration

We encourage you to register in advance by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

How to join the webinars

The following information can be used to join all webinars scheduled:

- **Teleconference:** Dial 1-415-655-0002 (USToll) and enter access code: 736 436 872
- **WebEx:** Visit https://inovalonmeet.webex.com and enter meeting number: 736 436 872
- **Once you join the call, live support is available at any time by dialing *0**

For more information on the outreach process or the ePASS tool or any other questions on commercial risk adjust, please contact Michael Meiselman at michael.meiselman@anthem.com.

Qualified Autism service professional requirements

Effective January 1, 2018, Assembly Bill (AB) 1074 amends current law. This bill authorizes a qualified autism service professional to supervise a qualified autism service paraprofessional. The bill also allows the behavioral health treatment provided by a qualified autism service professional to include clinical case management and case supervision under the direction and supervision of a qualified autism service provider. Qualified autism service professionals and qualified autism service paraprofessionals may now be employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Workers’ Compensation Physician Acknowledgments Required by California Code of Regulations

As a reminder, the Medical Provider Networks (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 www.Availity.com 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.”

Please also be advised the Provider Affirmation Portal will also notify participating medical providers when an MPN is terminating its relationship with Anthem and/or the Division of Workers Compensation.
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 2018 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 included with your HEDIS Member List 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

Please contact your Provider Network Representative to let them know if you have a specific person in your organization that we should contact for HEDIS medical records.

Thank you in advance for your support of HEDIS.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Professional Network Update

February 2018
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

Professional Network Update

February 2018
<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</td>
<td>Immediate Access to Emergency Care. Members are directed to 911 or the nearest emergency room</td>
</tr>
<tr>
<td>Member Services by Telephone</td>
<td>Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate &lt;5%) The Member NurseLine is available 24/7 and the wait time is not to exceed 30 minutes.</td>
</tr>
</tbody>
</table>

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).
Medi-Cal Managed Care Updates

Medical policies update

On December 6, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies for 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. We made these Medical Policies publicly available on our website on the effective date listed below.

Visit https://www.anthem.com/ca/medicalpolicies/search.html to search for specific policies. Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

<table>
<thead>
<tr>
<th>Medical Policy effective date</th>
<th>Medical Policy number</th>
<th>Medical Policy title</th>
<th>Revised or new?</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/17</td>
<td>DRUG.00110</td>
<td>Inotuzumab ozogamicin (Besponsa®)</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>MED.00124</td>
<td>Tisagenlecleucel (Kymriah™)</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>DRUG.00043</td>
<td>Tocilizumab (Actemra®)</td>
<td>Revised</td>
</tr>
</tbody>
</table>

Clinical Utilization Management Guidelines update

On December 6, 2017, the MPTAC approved the following Clinical Utilization Management (UM) Guidelines for Anthem. These guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing.

The Clinical UM Guidelines on this list represent those adopted by the Medical Operations Committee for the Government Business Division on October 19, 2017. We made these guidelines publicly available on the Medical Policies and Clinical UM Guidelines page on the effective date listed below.

Visit https://www.anthem.com/ca/medicalpolicies/search.html to search for specific guidelines. Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Clinical UM Guideline number</th>
<th>Clinical UM Guideline title</th>
<th>Revised or new?</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/17</td>
<td>CG-LAB-11</td>
<td>Screening for Vitamin D Deficiency in Average Risk Individuals</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>CG-MED-59</td>
<td>Upper Gastrointestinal Endoscopy for Diagnosis, Screening or Surveillance</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>CG-SURG-59</td>
<td>Vena Cava Filter</td>
<td>New</td>
</tr>
</tbody>
</table>
Levoleucovorin calcium, elosulfase alfa, histrelin acetate, idursulfase and fulvestrant to require prior authorization

Effective April 1, 2018, levoleucovorin calcium, elosulfase alfa, histrelin acetate, idursulfase and fulvestrant will require prior authorization (PA).

Levoleucovorin calcium, elosulfase alfa, histrelin acetate, idursulfase and fulvestrant will require PA, and all requests must be reviewed by Anthem Blue Cross for PA dates of service beginning on or after April 1, 2018. Please refer to the provider website additional prior authorization information at https://mediproviders.anthem.com/CA/Pages/request-prior-authorization.aspx.

Please note: These drugs may not be covered in all states. Providers must review their specific state for coverage because not all drugs in this update will apply to the state in which you participate.

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

- J0641 — Injection, levoleucovorin calcium, 0.5 mg
- J1322 — Injection, elosulfase alfa, 1mg
- J1675 — Injection, histrelin acetate, 10 mcg
- J1743 — Injection, idursulfase, 1 mg
- J9395 — Injection, fulvestrant, 25 mg

Please use one of the following methods to request PA:

- Phone: 1-800-450-8753
- Fax: 1-800-754-4708
- Web: https://www.Availity.com

Federal and state law, as well as state contract language (this includes definitions and specific contract provisions/exclusions) take precedence over these PA rules and must be considered first when determining coverage.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, 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).
Elotuzumab to require prior authorization

Effective May 1, 2018, Anthem Blue Cross requires prior authorization (PA) for elotuzumab for Medi-Cal Managed Care members. 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 code:
- J9176 — injection, elotuzumab, 1 mg

To request PA, you may use one of the following methods:
- Web: https://www.availity.com
- Phone: 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County)
- Fax: 1-800-754-4708

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at https://www.availity.com. Providers who are unable to access Availity can 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) for PA requirements.
Cal MediConnect Plan Update

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

Prior authorization requirements for Part B drugs: Aliqopa (Copanlisib injection), Cinvanti (aprepitant injection) and Opsiria (sirolimus injection)

On March 1, 2018, Anthem Blue Cross prior authorization (PA) requirements will change for Part B injectable/infusible drugs covered by Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). The drugs are Aliqopa (copanlisib injection), Cinvanti (aprepitant injection) and Opsiria (sirolimus injection). 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. Non-compliance with new requirements may result in denied claims.

Prior authorization requirements will be added to the following part B drugs:
- Aliqopa (copanlisib injection): for the treatment of adults with relapsed follicular lymphoma who have received at least two prior treatments (J9999)
- Cinvanti (aprepitant injection): for the treatment of chemotherapy-induced nausea and vomiting (J3490, J3590)
- Opsiria (sirolimus injection): for the treatment of uveitis and works by blocking an enzyme called “mammalian target of rapamycin” (J3490, J3590)

Please note: The above drugs are currently billed under the Not Otherwise Classified (NOC) HCPCS codes J3490, J3590 and J9999; they are unlisted because no J code has been established at this time. Since these codes include Part B 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.

To request PA, you may use one of the following methods:
- Phone: 1-855-817-5786
- Fax: 1-866-959-1537
- Interactive Care Reviewer via www.Availity.com

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at www.Availity.com. Contracted and non-contracted providers who are unable to access Availity may call one of our Customer Care Centers at 1-800-407-4627 (outside L.A. county) or 1-888-285-7801 (inside L.A. county) for assistance with PA requirements.
Imaging program expands to include level of care reviews

Effective with dates of service on or after March 1, 2018, Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) will require a medical necessity review of the requested level of care for computed tomography (CT) imaging and magnetic resonance imaging (MRI) for some Anthem Blue Cross Cal MediConnect Plan members. AIM Specialty Health® will administer the review.

Beginning March 1, 2018, submit prior authorization requests to AIM through one of the following methods:

- Access the AIM Provider Portal directly at https://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.
- Call the AIM Contact Center at 1-800-714-0040, Monday to Friday, 5:30 a.m. to 4 p.m. PT.

For additional questions about prior authorization requirements, contact the Anthem Blue Cross Cal MediConnect Plan Customer Care Center at 1-855-817-5786.

AIM will evaluate the clinical criteria to determine if the imaging service requires a hospital-based outpatient setting, which offers a higher intensity of service resources, or if a free-standing imaging center is a clinically appropriate and available alternative. For additional information on AIM's review process, visit http://aimproviders.com/radiology.

There may be circumstances where a member's clinical situation requires that he or she receive an MRI or CT scan in a hospital facility. Based on the information you provide, AIM will review both the requested advanced imaging scan for clinical appropriateness and the level of care against health plan clinical criteria. The level of care review does not apply to requests for review of imaging as part of an inpatient stay or when Anthem Blue Cross Cal MediConnect Plan is the secondary payer.

What's new beginning with dates of service on and after March 1, 2018

When providers select a hospital-based outpatient facility as the level of care, a list of alternate free-standing imaging centers will be made available. If providers still select the hospital-based outpatient facility, they will be prompted to indicate the reason this location is medically necessary.

If a request for a hospital-based level of care does not meet medical necessity criteria upon review by a physician, the request will not be approved. We encourage providers to discuss alternate sites with the member.

Special considerations for advanced imaging providers

The OptiNet® solution at https://providerportal.com is a proprietary, multifaceted program designed to provide health plans with information on outpatient imaging providers. For providers who bill with place of service codes 11, 49 or 81, AIM has prepopulated the Provider Type selection with Freestanding Imaging Facility/Physician Groups. For providers who bill with place of service codes 19 or 22, AIM has prepopulated the Provider Type selection with Outpatient Hospital Department.

Prior to the start date of March 1, 2018, advanced imaging providers should review their OptiNet registration to ensure:

- All information is current.
- The prepopulated Place of Service code is correct.
- The Provider Type accurately reflects the site's status as a free-standing imaging center, physician group or hospital.

If you do not find the Provider Type field populated, you may edit the assessment. After selecting the applicable provider type, you will need to submit a Statement of Attestation to ensure all information submitted is accurate. Provider
assessments that are already complete will remain in a *Completed* status until an update has been applied to the assessment.

*OptiNet* provider registration is available online at [https://providerportal.com](https://providerportal.com) (make sure you select Medicare Advantage/Medicaid from the drop-down menu). Providers must complete the registration to view their information online.

If you already completed an *OptiNet* assessment, make sure you keep your registration up to date.

If you have questions or need help completing the registration, call AIM Customer Service at 1-800-252-2021, Monday to Friday, 5 a.m. to 4 p.m. PT or send an email to Assessment@AIMSpecialtyHealth.com.

**Prior authorization requirements for Part B drugs: Besponsa (inotuzumab ozogamicin) and Vyxeos (daunorubicin and cytarabine)**

On April 1, 2018, Anthem Blue Cross prior authorization (PA) requirements will change for Part B injectable/infusible drugs covered by Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan). The drugs are Besponsa® (inotuzumab ozogamicin) and Vyxeos™ (daunorubicin and cytarabine). 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.

Prior authorization requirements will be added to the following part B drugs:
- Besponsa (inotuzumab ozogamicin): for the treatment of adults with relapsed or refractory B-cell precursor acute lymphocytic leukemia (J3590, J9999)
- Vyxeos (daunorubicin and cytarabine): for treatment of adults with newly diagnosed therapy-related acute myeloid leukemia or acute myeloid leukemia with myelodysplasia-related changes (J9999)

Please note: The above drugs are currently billed under the not otherwise classified (NOC) HCPCS codes J3590 and J9999; they are unlisted because no J code has been established at this time. Since these codes include all drugs that are NOC, if the authorization is denied for medical necessity, the plan’s denial will be for the drug and not the HCPCS code.

To request PA, you may use one of the following methods:
- Phone: 1-855-817-5786
- Fax: 1-866-959-1537
- Interactive Care Reviewer: [https://www.availity.com](https://www.availity.com)

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at [https://www.availity.com](https://www.availity.com). Contracted and noncontracted providers who are unable to access Availity may call our Customer Care Center at 1-855-817-5786 for assistance with PA requirements.
Medicare Advantage and Medicare Supplement Updates

Medical policies and clinical guidelines updated

The Anthem Medical Policy and Technology Assessment Committee (MPTAC) approved additional medical policies. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only.

Visit Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements at anthem.com/ca/medicareprovider to review specific policies.

Improve member medication regimen

Anthem and the Centers for Medicare & Medicaid Services consider medication review and reconciliation a top priority to help ensure members take their medications safely. Our pharmacists use medication review and reconciliation to help members understand what medications they are taking, why they are taking them, how they should be taking their medication and to answer any questions or concerns they have about their medication regimen.

Anthem may contact you to discuss members’ medications as part of either the Medication Therapy Management (MTM) or the Medication Reconciliation Post Discharge (MRPD) programs:

- The MTM program starts with a letter welcoming members to participate in a private medication review with one of our pharmacists over the phone. This free service gives members the opportunity to ask questions about the medicines they are taking and to review prescription and over-the-counter drugs to prevent drug reactions, and helps members get the most benefit from their medications at the lowest cost. At the end of the discussion, your patient is encouraged to share a written summary of their medication list and any medication-related concerns with you.

- Medication Reconciliation Post Discharge is a HEDIS and Centers for Medicare & Medicaid star ratings measure for 2018. The MRPD program helps members with their medications after they have been discharged from an inpatient hospital stay. Anthem pharmacists will work with you and the member to identify and correct any medication-related problems to reduce the risk of readmission. To complete this measure per HEDIS specifications, it is necessary to include the appropriate documentation in the member’s chart. The medication reconciliation post-discharge HEDIS measure medical record documentation must include the following:
  1. Date medication reconciliation was performed
  2. Notation stating that current medication and discharge medication lists were reviewed
  3. Signature of prescribing care provider, clinical pharmacist or registered nurse who performed medication reconciliation
  4. If medications were provided at discharge, please include the member’s next steps such as:
     a. Take new medications as prescribed.
     b. Discontinue all discharge medications.
  5. Notation if no medications were prescribed at discharge
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:

- 2018 annual visit guidelines
- Prior authorization requirements for injectable drugs: Brineura, Tremfya and Zinplava
- Prior authorization requirements for Part B drugs: Rebinyn, Fibryna and Hemlibra
- Prior authorization requirements for part B drugs Varubi and Fasenra
Pharmacy

Update regarding Shingrix shingles vaccine

Anthem Blue Cross (Anthem) updated its Affordable Care Act (ACA) preventive care coverage to include Shingrix, the new zoster (shingles) vaccine, based on a new recommendation by the Advisory Committee on Immunization Practices (ACIP).

This coverage update is effective for all ACA-compliant commercial health plans for dates of service on and after January 1, 2018. Shingrix will pay at 100% with no member cost share for members who use an in-network provider. Providers should continue to verify eligibility and benefits for all health plans prior to rendering services.

Shingrix is recommended for the prevention of herpes zoster and related complications for immunocompetent adults age 50 years and older as well as those who may have previously received Zoster Vaccine Live (Zostavax).

Important update to Anthem Blue Cross’ commercial drug lists

Effective with dates of service on and after April 1, 2018, and in accordance with Anthem Blue Cross’ (Anthem) Pharmacy and Therapeutic (P&T) process, Anthem will update its commercial drug lists. Updates may include changes to drug tiers or the removal of a drug. Anthem members filling prescriptions for these medications for the first time will be impacted by these changes. Anthem members currently using a medication that is moving to a higher tier or being removed from the drug list may remain on the existing therapy with no changes to benefits. However, providers should consider if a lower tier drug, or other drug from the updated list may be appropriate for their patients.

Please note, this update does not apply to the Select Drug List and does not impact Medicare and Medicaid plans. To view a summary of changes, click here

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](http://www.fepblue.org) > Benefit Plans > Brochures and Forms > Medical Policies.