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**Institutional Network Update**

June 2018
Announcements and General Updates

Anthem Blue Cross 2018 Hospital Fee Schedule and Codes

We’re pleased to announce that the Anthem Blue Cross 2018 Hospital Fee Schedule and Codes flash drives were mailed certified with request for signed receipt on April 19, 2018, with an effective date of January 1, 2018.

If you have any questions on how to use the flash drive or to request additional copies, email prov.communications@anthem.com. If you have questions regarding the Fee Schedule and Codes, email CAcontractsupports@anthem.com.

Anthem Blue Cross provider directory: Provider data updates as outlined under Senate Bill 137

Senate Bill 137 Verification Form delivery began May 25th. If your office has not yet received a verification form, you will be receiving one in the coming weeks. Your prompt response is appreciated.

Senate Bill 137 (SB 137), which went into effect on July 1, 2016, requires that Anthem Blue Cross provide our members accurate and up-to-date provider directory data. Your participation in this effort is required and failure to respond to this notification will result in suppression from the Find a Doctor tool and removal of your practice from the online directories. It is extremely important that we have accurate and up-to-date information about your practice in our directories and we appreciate your attention to this matter.

Note: 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.

Reminder: Reimbursement policy clarification – Multiple Diagnostic Imaging (Facility)

In September 2017, Anthem Blue Cross (Anthem) notified providers that we would apply multiple imaging reimbursement rules to the technical component of diagnostic imaging procedures beginning January 1, 2018. Please be aware that implementation of this policy was delayed and will now be effective for claims with dates of service on or after May 1, 2018. The following details provide additional clarification about this policy.

Multiple imaging reimbursement rules are applied to the maximum allowance for the Technical Component (TC) of the following diagnostic imaging procedures rendered on the same date of service and eligible for reimbursement: Ultrasound, Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Imaging (MRI), and Magnetic Resonance Angiography (MRA).

When two or more imaging procedures are performed in the same facility on the same patient using the same modality during the same imaging session and reported as technical component (TC) only, reimbursement is: 
Multiple imaging reimbursement rules are not limited to contiguous body areas.

### Updates to AIM Musculoskeletal Program clinical appropriateness guidelines

Beginning with dates of service on and after July 1, 2018, the following updates will apply to AIM Musculoskeletal Program Clinical Appropriateness Guidelines:

**Spine Surgery guideline:**
- Cervical decompression with or without fusion:
  - Added osteotomy and corpectomy definitions
  - Clarified implant/instrumentation failure
- Lumbar fusion and treatment of spinal deformity (including scoliosis and kyphosis):
  - Added osteotomy and corpectomy definitions
- Spinal stenosis:
  - Removed bilateral or wide decompression

**Interventional Pain Management guideline:**
- Epidural injection procedures and diagnostic selective nerve rootblocks:
  - Added prior authorization exemption for CPT codes 62320 and 62322 when used for post-procedural pain with certain ICD-10-CM diagnoses
- Repeat therapeutic epidural steroid injections, clarified initial injection as therapeutic:
  - Clarified injection sessions for procedural requirements
- Paravertebral facet injection/nerve block/neurolysis:
  - Increased procedural limitation for diagnostic medial branch blocks
  - Increased procedural limitation for therapeutic intraarticular facet joint injections and clarified requirement for conservative treatment between injections
- Sacroiliac joint injections:
  - Added HCPCS code G0260

Ordering and servicing providers may submit prior authorization requests to AIM in one of the following ways:

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

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines [here](#).
Streamline workflow with solicited medical attachments

Has your office received a request for additional information to process a claim for a commercial Anthem Blue Cross (Anthem) member? Those records can be submitted electronically using the Medical Attachments feature in your Availity claims processing portal.

The Medical Attachments feature makes submitting electronic documentation in support of a claim simple and streamlined. You can use your tax identification number (TIN) or your NPI to register and submit solicited (requested by Anthem) medical record attachments through the Availity Portal.

Anthem’s solicited Medical Attachments feature supports an unlimited number of document attachments for each submission, and can handle .tiff, .jpg and .pdf attachments. Once your office receives a letter requesting additional documentation, you can send up to 10 attachments through the portal for each claim. The maximum file size is 10MB per attachment and file sizes larger than 10MB can be split into smaller ones.

**How to Access solicited Medical Attachments for Your Office**

Availity Admin, complete these steps:

1. Select Application>choose Medical Attachments Registration
2. Provider Management>Select Organization from the drop-down. Add NPIs and/or Tax IDs Multiples can be added separated by spaces or semi-colons
3. Assign user access by checking the box in front of the user’s name. Users may be removed by unchecking their name

**Using Medical Attachments**

Availity User, complete these steps:

1. Log in to www.availity.com
2. Select Claims and Payments > Medical Attachments > Send Attachment Tab
3. Complete all required fields of the form
4. Attach supporting documentation
5. Submit

**Need Training?**

To access additional training for this Availity feature:

1. Log in to the Availity Portal at www.availity.com
2. At the top of any Availity portal page, click Help and Training > Get Trained (Make sure you do not have a pop-up blocker turned on or the next page may not open.)
3. In the new window a list of available topics will open. Locate and click Medical Attachments
4. Under the Recordings section, click View Recording

**Need More Information?**

For more information, contact your provider relations representative.
Don’t leave money on the table!
Make extra money on the Anthem members that you already care for!

Anthem Blue Cross (Anthem) is offering you up to a $100 dollar incentive for each documented health assessment performed on patients in your care who are covered by an Affordable Care Act (“ACA”) plan (see SOPA below). We also offer alternative submission formats with a $50 dollar incentive. For further details, please contact the appropriate Network Consultant below. Members impacted: Individual and small group members who purchased On-Exchange or Off-Exchange insurance plans.

We just need your “SOAP” note and the corresponding claim. Attached is information on Commercial Risk Adjustment (“CRA”) and how to easily collect this incentive offer. We also have included a simple live on-line instruction on how to submit the SOAP note on the e-PASS tool. To get a list of the target patients in your practice, simply sent an email to:

- For Medical Groups and IPAs please contact Michael Meiselman, Network Relations Consultant, Sr. at Michael.meiselman@anthem.com
- For Individual Providers please contact Gabriel Cortwright, Network Relations Consultant at: Gabriel.corwright@anthem.com

Get started today! Keep a look out for a packet mailed from our partner, INOVALON, for information on each target patient. Please see the attachments for more information.
1. Commercial Risk Adjustment overview
2. e-PASS Webinar Schedule
New PERS Select

The PERS Select (New) has been designed to provide members with comprehensive benefits that reward them for engaging in their own well-being. The plan design provides incentives for enrolling with their own personal physician, creating a relationship that fosters early detection, personal care, and avoids redundant care. Members only need to pay a $10 copayment when seeing their personal physician.

PERS Select (New) guides members and their families through the health system and encourages them to participate in positive health activities that are rewarded through lowering their deductible. Deductible credits are provided toward the annual deductible for all family members, who engage in the following activities: Biometric screening, getting a flu shot, a non-smoking certification, a second opinion for elective surgeries, and engaging with a nurse manager for if disease management is warranted.

PERS Select (New) provides opportunities for disease prevention and health promotion as well as early detection of problems and builds bridges between personal health care services and members’ families to help meet their health care needs.

### Benefit Comparison

<table>
<thead>
<tr>
<th>In-Network Coverage Common Medical Event</th>
<th>2019 PERS Select (Value Based Insurance Design)</th>
<th>2018 PERS Select</th>
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</thead>
<tbody>
<tr>
<td><strong>Coinsurance (Plan/Member)</strong></td>
<td>80/20</td>
<td>80/20</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>Individual $1000*</td>
<td>Individual $500</td>
</tr>
<tr>
<td></td>
<td>Family $2000*</td>
<td>Family $1,000</td>
</tr>
<tr>
<td></td>
<td>*Incentives to reduces deductible to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Individual $500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Family $1000</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>$10 Copay for your personal physician</td>
<td>$20 copay</td>
</tr>
<tr>
<td></td>
<td>$35 if not your personal physician</td>
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</tr>
<tr>
<td><strong>Specialist</strong></td>
<td>$35 Copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$35 Copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Laboratory Tests</strong></td>
<td>No copay for preventive 20% Coinsurance</td>
<td>No copay for preventive 20% Coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Maternity (Delivery)</strong></td>
<td>Inpatient covered in full with Future Moms enrollment</td>
<td>20% Coinsurance</td>
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<td></td>
<td>20% Coinsurance (without enrollment)</td>
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<tr>
<td>Service</td>
<td>Preferred Provider</td>
<td>Tier 1 Hospital</td>
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<tr>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td>X-Ray/ Imaging</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
</tr>
<tr>
<td>Mental Health/Behavioral Health/ Substance Abuse Physician Visit</td>
<td>$10 Copay</td>
<td>$20 copay for Preferred Provider</td>
</tr>
<tr>
<td>Inpatient Mental Health</td>
<td>80% Preferred Provider</td>
<td>80% Preferred Provider (Tier 1 Hospital)</td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% Preferred Provider</td>
<td>80% Preferred Provider (Tier 1 Hospital)</td>
</tr>
<tr>
<td>Maximum Coinsurance Out Of Pocket</td>
<td>$3,000 individual</td>
<td>$3,000 individual</td>
</tr>
<tr>
<td></td>
<td>$6,000 family</td>
<td>$6,000 family</td>
</tr>
<tr>
<td>Out of Network Coverage</td>
<td>60% Non-Preferred Provider</td>
<td>60% Non-Preferred Provider</td>
</tr>
</tbody>
</table>

*Incentives to reduce deductible by completing the following (no member cost) activities:

1. Biometric Screening: $100 Deductible Credit
2. Flu Shot: $100 Deductible Credit
3. Non-Smoking Certification: $100 Deductible Credit
4. Virtual Second Opinion: $100 Deductible Credit
5. Condition Care Certification: $100 Deductible Credit

This summary is meant only as a brief description of some of the programs for which members may be eligible. All insurance contracts and plans have limitations and exclusions that apply. Please refer to and read all plan documents for more complete descriptions.
Anthem Blue Cross streamlines member identification cards

Beginning July 1, 2018, Anthem Blue Cross (Anthem) will introduce a streamlined member identification (ID) card to help reduce confusion about member cost share. The updated member ID card will maintain the current style, but specific cost share information (such as copays or coinsurance) will be removed from the card.

Providers access Availity and the Electronic Data Interchange (EDI) to verify member benefits and obtain the most up-to-date cost share information for a member’s plan. If a member presents an older ID card with outdated benefits at the provider office, it can create confusion about member cost share.

As the streamlined ID card is adopted, it will help reduce misunderstandings around cost share. Additionally, members will be encouraged to learn more about their benefits through Anthem's digital and online tools, and can retain their card for as long as they remain in the same product plan, regardless of changes to cost share information. As a reminder, members can now view, download, email, and fax an electronic version of their member ID card using the Anthem Anywhere mobile app. Electronic ID cards will also be updated as described above.

Please note, this update does not apply to National Accounts, Federal Employee Program® (FEP®), Medicaid or Medicare plans.

For questions, please contact the provider service number on the back of the member ID card.

Availity is Anthem Blue Cross’ strategic partner

Anthem Blue Cross (Anthem) has recently moved into a strategic partnership with Availity to serve as our designated EDI Gateway and E-solutions Service Desk.

- Availity and Anthem (brand) are working together to develop new ways to simplify how you manage claims and other administrative tasks online.
- Beginning June 1, 2018, you will be able to manage all changes and new setup requests for the electronic remittance advice (835) through the Availity Portal.
- To register or manage account changes for electronic funds transfers (EFT) only, please continue to use the EnrollHub at https://solutions.caqh.org.
- If you directly submit your electronic transactions to Anthem (Brand) and have your own practice management software, Availity provides trading partner services and access to Portal tools through an easy setup experience.
- If you use a clearinghouse, they will work with Availity on your behalf.

Next Steps If you are a Direct Submitter:

<table>
<thead>
<tr>
<th>Existing Availity Account</th>
<th>New Availity Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to <a href="http://www.Availity.com">www.Availity.com</a>, click LOGIN, and log in to your account.</td>
<td>If you are not registered for Availity go to <a href="http://www.Availity.com">www.Availity.com</a> and click the REGISTER button. Refer to this Quick Guide if you need help.</td>
</tr>
<tr>
<td>Under the My Providers, click Enrollments Center.</td>
<td>Select the registration process that is appropriate to your organizational type.</td>
</tr>
</tbody>
</table>
Click ERA Enrollment and then follow the online instructions to complete and submit your enrollment. Availity will send you follow-up emails with your login credentials and guidance for your next steps.

After submitting, you will be notified by e-mail that enrollment is complete and start receiving 835’s through Availity. Please allow 5-10 business days for processing. At this point you will be able to utilize all the Availity benefits such as Claim Status, Eligibility and now EDI.

Key Factors:

- You will be able to manage changes or new registrations for the electronic remittance advice (835) through your Availity Portal account beginning June 1st 2018. We encourage you to register with Availity to initiate the change to the Availity EDI Gateway.
- Anthem and Availity are committed to transparency with this change, and will emphasize the continuity of quality service to our trading partners.

We look forward to delivering a smooth transition to Availity for our EDI services. If you have any questions or concerns please contact the E-Solutions service desk at 1-800-470-9630 or Availity at 1-800-AVAILIT Y (1-800-282-4548).

**Verifying eligibility for expanded hospice benefits**

In the April 2018 edition of the Network Update, Anthem announced an expansion of hospice benefits for local Anthem Blue Cross (Anthem) modifying treatments to continue alongside hospice services, as well as member access to hospice services with prognoses of up to 12 months.

Providers should verify whether members have the expanded hospice benefit under their Anthem policy.

For some health plans, updated benefit information will return via an electronic eligibility and benefit inquiry on the Availity Portal or using your Electronic Data Interchange (EDI) interface as early as June 1, 2018. We anticipate that all impacted plans will return the updated language by August 1, 2018. Once updated, hospice inquiries (Service Type 45) will confirm access to the expanded hospice benefit by returning: "LIFE EXPECTANCY UP TO 12 MONTHS WITH DISEASE MODIFYING TREATMENT ALLOWED.”

It may be necessary for providers to contact the Provider Service number on the back of the member ID card to confirm if a member’s plan includes the expanded hospice benefits from June 1, 2018 - August 1, 2018, before all systems are updated to report the more detailed benefit language.

As a reminder, the following plans include the expanded hospice benefits beginning June 1, 2018: Commercial fully-insured group and individual plans. The following plans do not include expanded hospice benefits: self-insured plans, HMO, Medicare, Medicaid, and FEP®.
Anthem Blue Cross Individualized Care Program to support palliative care for commercial members

Beginning June 1, 2018, Anthem Blue Cross (Anthem) will offer an Individualized Care Program to our fully insured commercial members to provide palliative care support for members with advanced illness in the last 12 months of life. This program 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
- Encouraging patients to execute advance directives
- 24/7 access to urgent clinical support from a palliative care 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 introduce Anthem's Individualized Care Program and to determine the appropriate level of palliative services in one of the following three models:

1. Telehealth services and support at routine intervals to patients by palliative trained providers
2. Home based visits by a palliative care nurse practitioner, supported by an interdisciplinary team of palliative providers for patients with a high symptom burden, increased risk of hospitalization, or other complex issues. The home based visits will be offered through an Anthem partnership with Aspire Health (available in certain geographic areas)
3. Clinic based services offered through an Anthem partnership with Aspire Health. Aspire's palliative care team will be embedded within the outpatient clinic/practice of the member's medical oncologist to provide services to targeted patients (available in certain geographic areas)

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.

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 clinical updates to your practice on a regular basis to facilitate the best possible co-management of your patient.

If you have questions regarding Anthem's Individualized Care Program, please email IndividualizedCareProgram-PalliativeCare@anthem.com
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. Scroll down and click on the box **Find Resources for California**. From the Provider Home page, select the link titled **Health Care Reform Updates and Notifications** or **Health Insurance Exchange Information**.
Billing

Reminder – miscellaneous durable medical equipment billing guidelines

Anthem Blue Cross (Anthem) continually evaluates coding and billing patterns, and recently identified trends related to the use of code E1399 — DME, miscellaneous. When an appropriate code exists for DME equipment or supply, the more specific code should be used.

Inappropriate use of code E1399 often includes, but is not limited to the following:

- Gait trainers (E8001/E8002)
- Shower chairs (E0240)
- Standing frames (E0641)
- Hospital beds (E0250-E0373)
- Stand assist lifts (E0635)

To ensure proper use of E1399, Anthem conduct post-payment reviews of code E1399. If a more appropriate code should have been used, Anthem may recoup overpayments accordingly.

Anthem continues to require prior authorization for the use of miscellaneous code E1399. If a prior authorization is approved but the claim is submitted with the incorrect code E1399, then the claim may be denied and a corrected claim will need to be resubmitted with the appropriate HCPCS code.

Receive direct deposit of patient payments with Healthcare Bill Payments

Beginning July 1, 2018, many Anthem Blue Cross (Anthem) members will be able to make payments to providers for their out-of-pocket expenses with Healthcare Bill Payments, a new feature via the member portal at www.anthem.com/ca. Now, your patients can quickly and easily pay you online as soon as their claim information is available.

Anthem has engaged with InstaMed®, a healthcare payments network, to offer Healthcare Bill Payments. InstaMed is a Payment Card Industry (PCI) Level One Service Provider and certified at the highest levels for both healthcare and payment processing.

Providers registered with InstaMed will conveniently receive patient payments by direct deposit into their bank account without ever mailing a patient bill or making a phone call. Plus, patients enjoy a simple, convenient payment option.

Registration for Healthcare Bill Payments is simple — you can get started today. Here’s what you’ll need:

- Email address
- Tax ID number for your organization
- Bank account information for direct deposit

If you are not registered, these payments are mailed to you as prepaid Mastercard® payments.

For more information about Healthcare Bill Payments:

This feature does not apply to Anthem Medicare and Medicaid plans, but may be implemented in the future.
Update claim processing for services requiring AIM prior authorization

Anthem Blue Cross (Anthem) recently discovered that some claims with services under the following programs are processing without the required prior authorization through AIM Specialty Health® (AIM), a separate company.

- Sleep Management
- Radiology Oncology
- Radiology Benefit Management
- Cardiology

Effective July 1, 2018, our claims systems will be updated to correct this issue. Claims for Sleep Management, Radiology Oncology, Radiology Benefit Management (RBM), and Cardiology services continue to require prior authorization through AIM. For a list of the codes that require precertification visit the AIM Provider Portal.

As a reminder, please submit prior authorization requests to AIM in one of the following ways:

- Access AIM ProviderPortalSM – directly a 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.

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: www.anthem.com/ca. Scroll down and click on the box Find Resources for California. From the Answers@Anthem page, select the link titled Provider Education Seminars and Webinars link.

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.
Workers' Compensation Physician Acknowledgments Required by California Code of Regulations

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.”

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.

Workers’ Compensation formulary in effect, drug formulary transition for injured workers

Physicians were required to provide a plan for replacement and weaning of previously prescribed drugs inconsistent with the MTUS and Formulary by April 1, 2018. Anthem Blue Cross (Anthem) monitors “quality” pursuant to §9767.3(d)(8)(S) of the MPN regulations for MPN clients/payors.

California Code of Regulations Section 9792.27.3. MTUS Drug Formulary Transition

(b) (1) For injuries occurring prior to January 1, 2018, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a Non-Exempt drug or unlisted drug, where that is necessary for the injured worker’s condition or necessary for safe weaning, tapering, or transition to a different drug.

The DWC Formulary Regulations are available here: http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

The Drug List is available here: http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.xls
The DWC provides an email address for questions regarding the formulary: formulary@dir.ca.gov
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 the Availity web portal, at www.Availity.com. From the Availity site, select Home > Anthem California > Education and Reference Center, 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 https://www.anthem.com/ca/provider/. From there, scroll down and click on Read Policies. This will take you to Medical Policy, Clinical UM Guidelines (for Local Plan M, and Pre-Certification Requirements. Then click on the Practice Guidelines on the Health & Wellness tab.
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, up to date 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"). In addition, your agreement with Anthem requires your office to comply with state law standards relative to 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

These surveys will begin soon, please review this information with your office staff so they are prepared and understand the importance of each providers' participation in each of the surveys.

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 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.
<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. 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 the emergency room if the caller is experiencing an emergency</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. Access to Member Service to obtain information about how to access clinical care and how to resolve problems (this is a plan responsibility and not a physician responsibility; and this also applies to our Behavioral Health members)</td>
<td>Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate &lt;5%) 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/TimelyAccessstoCare.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

Anthem Blue Cross to conduct post-payment reviews of distinct procedural services modifiers

In accordance with CMS guidelines, Anthem conducts post-payment reviews of professional claims for Medi-Cal Managed Care members billed with modifiers for distinct procedural services (modifiers 59, XE, XP, XS and XU). As part of these reviews, we may contact you with outlying billing practices to request additional documentation related to the services. If billing discrepancies are identified, we will provide you with a written report of our findings as well as your appeal rights and may initiate recoupment as appropriate. Findings may assist your office with quality improvement efforts.

For questions regarding post-payment reviews of distinct procedural services modifiers, contact our Medi-Cal Customer Care Centers at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County).

Prior authorization requirement update for Mylotarg (gemtuzumab ozogamicin)

Effective July 1, 2018, prior authorization (PA) is required for Mylotarg (gemtuzumab ozogamicin) to be covered by Anthem Blue Cross through the medical benefit. Federal and state law as well as state contract language including definitions and specific contract provisions/exclusions take precedence over these PA 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:

- Mylotarg (gemtuzumab ozogamicin) — injection, gemtuzumab ozogamicin, 0.1 mg (J9203)

To request PA, you may use one of the following methods:

- Web: Interactive Care Reviewer tool via https://www.availity.com
- Fax: 1-800-754-4708
- Phone: 1-888-831-2246 (Medi-Cal) or 1-877-273-4193 (MCAP/MRMIP)

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 may call Medi-Cal Customer Care Centers at 1-888-831-2246 (outside L.A. County) or 1-877-273-4193 (inside L.A. County) for PA requirements.
High-risk OB care management program

While most women experience uncomplicated pregnancies, others require specialized care. The Anthem Blue Cross (Anthem) High-Risk OB Care Management Program wants to identify pregnant women at high risk for pregnancy-related complications and prenatal hospitalizations. We want to reach out to our high-risk OB members as early in their pregnancy as possible.

The program utilizes a member-centric, integrated care management (CM) approach. Our care managers are experienced OB registered nurses led by an OB medical director. They work with our members to conduct an in-depth maternity assessment, use condition-specific CM tools to provide education and interventions, and will collaborate with all areas of our member’s health care team to ensure that any gaps in care or educational opportunities are addressed. Our care managers will work together with you and other health care specialists to support our members in various ways throughout their pregnancies.

If you identify a member who has a high-risk pregnancy, please refer them to Anthem Care Management using the Care Management Referral Form. The form can be accessed at https://mediproviders.anthem.com/Documents/CACA CAID CareMgmtReferralForm.pdf.

Please use the Prior Authorization Request Form or call 1-888-831-2246, option 3 to request home health services or Makena® injections. Write urgent on the form if faxing in the request or ask to speak to the urgent nurse if calling.

Thank you for helping us provide the best support for our pregnant members.

Anthem’s High-Risk OB Care Management Program...Your Health, Your Life, Your Team

Provider surveys

Each year, we may reach out to you to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers.

Thank you for participating in our network, for providing quality health care to our members and for your timely completion of any surveys you receive.

Use the Provider Maintenance Form to update your information

We continually update our provider directories to ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice — including updating your address and/or phone number, adding or deleting a physician from your practice, closing your practice to new patients, etc. — please notify us by completing the Provider Maintenance Form. Thank you for your help and continued efforts in keeping our records up to date.
**Miscellaneous durable medical equipment billing guidelines**

**Reminder:** Miscellaneous durable medical equipment (DME) procedure codes (such as E1399) cannot be used as an alternative to specific identified codes. Anthem Blue Cross (Anthem) will conduct post-payment reviews to ensure the right codes for the right services are used. This applies to all claims for Medi-Cal Managed Care members.

In an effort to improve the provider experience, we continually evaluate coding and billing patterns. Recently, we identified trends related to the use of E1399 — DME, miscellaneous. This code is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.

We continue to require prior authorization for the use of miscellaneous code E1399. To request PA, you may use one of the following methods:

- **Web:** [https://www.availity.com](https://www.availity.com)
- **Fax:** 1-800-754-4708
- **Phone:** 1-888-831-2246

As it is not our policy to inform providers of proper billing processes within prior authorization responses, authorization responses do not include code-specific details. If your service was approved but your claim was denied payment when billed using E1399, the incorrect code was used. You will need to update the authorization and the claim with the appropriate HIPAA-compliant HCPCS code.

Anthem will conduct post-payment reviews of code E1399 to ensure proper use. If it is determined a more appropriate code should have been used, we will notify you in writing and advise you of your appeal rights.

**Topical corticosteroids hot tip**

This table is to assist prescribers in identifying topical corticosteroids included on all Anthem Blue Cross formularies. It does not represent all commercially available topical corticosteroids.

When prescribing medications, always select “substitution permissible by law” (where applicable) to ensure your patients benefit from generic medications when available.

<table>
<thead>
<tr>
<th>Therapeutic class</th>
<th>Formulary product</th>
<th>Relative cost per prescription*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topical corticosteroids — low potency</td>
<td>Hydrocortisone cream</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>Hydrocortisone ointment</td>
<td></td>
</tr>
<tr>
<td>Topical corticosteroids — medium potency</td>
<td>Triamcinolone cream</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>Triamcinolone ointment</td>
<td></td>
</tr>
<tr>
<td>Topical corticosteroids — high potency</td>
<td>Fluocinonide-e cream</td>
<td>$$</td>
</tr>
<tr>
<td>Topical corticosteroids — very high potency</td>
<td>Clobetasol cream</td>
<td>$$$</td>
</tr>
<tr>
<td></td>
<td>Clobetasol-e cream</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clobetasol gel</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clobetasol ointment</td>
<td></td>
</tr>
</tbody>
</table>

* Relative cost per prescription is intended to be directional in nature. Costs may change based on market dynamics. This information is meant to be used as a guide and should not take the place of clinical decision making by a prescriber regarding treatment.

Formulary status or drug availability may change. There may be additional qualifications needed for access to some drugs, such as a prior authorization or step therapy.

This document does not guarantee benefit coverage for any medication(s) as member coverage may vary.
What matters most: Improving the patient experience

Are you looking for innovative ways to improve your patients’ experiences and earn continuing medical education credits?

Numerous studies have shown that a patient’s primary health care experience and, to some extent, their health care outcomes are largely dependent upon health care provider and patient interactions. Anthem Blue Cross (Anthem) offers a new online learning course, *What Matters Most: Improving the Patient Experience*, to offer approaches to communication with patients. This curriculum is available at no cost to providers and their clinical staff nationwide and is acceptable for up to one prescribed continuing medical education credit by the American Academy of Family Physicians.

Through the use of compelling real-life stories that convey practical strategies for implementing patient care, providers learn how to apply best practices.

**Did you know?**

Substantial evidence points to a positive association between patient experience and health outcomes.

- Patients with chronic conditions, such as diabetes, demonstrate greater self-management skills and quality of life when they report positive interactions with their health care providers.
- Patients reporting the poorest-quality relationships with their physicians were three times more likely to voluntarily leave the physician’s practice than patients with the highest-quality relationships.

**How will this benefit you and your office staff?**

You’ll learn tips and techniques to:

- Improve communication skills.
- Build patient trust and commitment.

The course can be accessed at [www.patientexptraining.com](http://www.patientexptraining.com) using your smartphone, tablet or computer, or use the QRC code below.

Like you, Anthem is committed to improving the patient experience in all interactions, and we are proud to work collaboratively with our provider network to provide support and tools to reach our goal.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
Prior authorization requirements for Darzalex (daratumumab) drug

Effective August 1, 2018, Anthem Blue Cross prior authorization (PA) requirements will change for the injectable drug Darzalex (daratumumab) for Medicaid members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines (including definitions and specific contract provisions/exclusions) take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to:
- J9145—Injection, Darzalex (daratumumab), 10 mg

To request PA, you may use one of the following methods:
- Web: [https://www.availity.com](https://www.availity.com)
- Fax: 1-800-754-4708
- Phone: 1-888-831-2246 (Medi-Cal)
  - 1-877-273-4193 (MCAP/MRMIP)

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool ([https://www.availity.com](https://www.availity.com)). Contracted and noncontracted providers who are unable to access Availity may call us at 1-888-831-2246 (outside L.A. County) or 1-877-273-4193 (inside L.A. County) for PA requirements.

Electrical stimulation device to require prior authorization

The electrical stimulation device will require prior authorization (PA) effective August 1, 2018.

Please visit [https://mediproviders.anthem.com/ca](https://mediproviders.anthem.com/ca) and select **Prior Authorization & Claims**, then select **Request Prior Authorization**.

Noncompliance with the new requirements may result in denied claims. The following code will require PA:
- E0766 – Electrical stimulation device used for cancer treatment, includes all accessories, any type

Please request PA via one of the following methods:
- Web: [https://www.availity.com](https://www.availity.com)
- Fax: 1-800-754-4708
- Phone:
  - 1-888-831-2246 (Medi-Cal Managed Care)
  - 1-877-273-4193 (Major Risk Medical Insurance Program)

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

If you have questions about this communication or need assistance with any other item, call one of our Customer Care Centers at 1-888-831-2246 (outside L.A. County) or 1-877-273-4193 (inside L.A. County).
Chimeric antigen receptor T-cell therapy requires prior authorization for all places of service

Chimeric antigen receptor T-cell (CAR T) therapy, including immunotherapy and all inpatient stays, will continue to require a prior authorization (PA) regardless of the place of service in which it is given.

CAR T codes require PA, and all requests must be reviewed by Anthem Blue Cross for PA regardless of place of service or if billed with an unlisted code.

Please refer to the Precertification Lookup Tool for detailed PA requirements by visiting https://www.availity.com, logging in with your User ID and Password, choosing Precertification from the navigation menu, and selecting Precertification Lookup Tool.

CAR T therapy is currently represented by the following codes:

- **Q2040** — Tisagenlecleucel (brand name: Kymriah™), up to 250 million CAR-positive viable T-cells, including leukapheresis and dose-preparation procedures, per infusion.
- **Q2041** — Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T-cells, including leukapheresis and dose-preparation procedures, per infusion (new code effective April 1, 2018).

CAR T therapy in any form will continue to require PA. Please use one of the following methods to submit a request:

- **Web:** https://www.availity.com
- **Fax:** 1-800-754-4708
- **Phone:**
  - 1-888-831-2246 (Medi-Cal Managed Care)
  - 1-877-273-4193 (Major Risk Medical Insurance Program)

Noncompliance with these requirements may result in denied claims. Federal and state law, as well as state contract language including definitions, and specific contract provisions and exclusions, take precedence over these PA rules and must be considered first when determining coverage.

If you have questions about this communication or need assistance with any other item, contact your local Medi-Cal Customer Care representative or call one of the Medi-Cal Customer Care Centers at 1-888-831-2246 (outside L.A. County) or 1-877-273-4193 (inside L.A. County).
New pharmacy electronic prior authorization request tool effective June 1, 2018

Anthem Blue Cross (Anthem) has partnered with CoverMyMeds to offer an electronic prior authorization (ePA) request tool that simplifies the process for requesting medications and checking the status of your submissions.

Features
These new features help simplify the prior authorization process. You will be able to:
- Submit requests for general pharmacy medications (medications dispensed directly to a member from a retail pharmacy or shipped from a specialty pharmacy).
- Check ePA status.
- Upload supporting documents and review appeal status.

Availability
The tool will be available beginning June 1, 2018.

Accessing the tool
- Locate the existing link within your electronic medical records tool if available.

Support with ePA through CoverMyMeds
- For support via chat, locate and activate the chat window in the bottom right of the webpage.
- For support via phone, call 1-866-452-5017

Anthem is focused on providing new tools to help make your job a little easier. We appreciate the compassion and dedication with which you care for your patients and our members.
Regulatory updates

The Department of Health Care Services (DHCS) periodically communicates information regarding interpretations or changes in policy or procedures, federal or State law, and regulations that impact the delivery of Medi-Cal services. The information is communicated in the form of all plan letters (APLs) and policy letters (PLs). Anthem Blue Cross has a responsibility to communicate the various changes to our contracted providers. Below are lists of the APLs and PLs that were published during the previous year.

List of new APLs

<table>
<thead>
<tr>
<th>Letter number</th>
<th>Title (subject of letter)</th>
<th>Date of issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>APL 17-001</td>
<td>2017-2018 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff And Processing Schedule</td>
<td>01/03/2017</td>
</tr>
<tr>
<td>APL 17-002</td>
<td>Health Education and Cultural and Linguistic Group Needs Assessment (Supersedes PL10-012)</td>
<td>02/03/2017</td>
</tr>
<tr>
<td>APL 17-003</td>
<td>Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers</td>
<td>03/30/2017</td>
</tr>
<tr>
<td>APL 17-004</td>
<td>Subcontractual Relationships and Delegation</td>
<td>04/18/2017</td>
</tr>
<tr>
<td>APL 17-005</td>
<td>Certification of Document and Data Submissions</td>
<td>05/02/2017</td>
</tr>
<tr>
<td>APL 17-006</td>
<td>Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments (Supersedes All Plan Letters 04-006 and 05-005 and Policy Letter 09-006)</td>
<td>05/09/2017</td>
</tr>
<tr>
<td>APL 17-007</td>
<td>Continuity of Care for New Enrollees Transitioned to Managed Care After Requesting a Medical Exemption and Implementation of Monthly Medical Exemption Review Denial Reporting (Supersedes All Plan Letter 15-001)</td>
<td>05/11/2017</td>
</tr>
<tr>
<td>APL 17-008</td>
<td>Requirement to Participate in the Medi-Cal Drug Utilization Review Program</td>
<td>05/10/2017</td>
</tr>
<tr>
<td>APL 17-009</td>
<td>Reporting Requirements Related To Provider Preventable Conditions (Supersedes All Plan Letter 16-011)</td>
<td>05/23/2017</td>
</tr>
<tr>
<td>APL 17-010</td>
<td>Non-Emergency Medical and Non-Medical Transportation Services</td>
<td>06/29/2017, revised 07/17/2017</td>
</tr>
<tr>
<td>APL 17-011</td>
<td>Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act (Supersedes APL 14-008)</td>
<td>06/30/2017</td>
</tr>
<tr>
<td>APL 17-012</td>
<td>Care Coordination Requirements for Managed Long-Term Services and Supports (Supersedes APL 14-010)</td>
<td>07/11/2017</td>
</tr>
<tr>
<td>APL 17-013</td>
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<td>APL 17-018</td>
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<td>Letter number</td>
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<td>APL 17-019</td>
<td>Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 16-012)</td>
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<td>APL 18-001</td>
<td>Voluntary Inpatient Detoxification (Supersedes APL 14-005)</td>
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<td>APL 18-002</td>
<td>2018-2019 Medi-Cal Managed Care Health Plan MEDS/834 Cutoff and Processing Schedule</td>
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<td>APL 18-003</td>
<td>Administrative and Financial Sanctions (Supersedes APL 15-014)</td>
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<td>APL 18-004</td>
<td>Immunization Requirements (Supersedes PL 96-013 and APL 07-015)</td>
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<td>APL 18-005</td>
<td>Network Certification Requirements</td>
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<td>APL 18-006</td>
<td>Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (Supersedes APL 15-025)</td>
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<tr>
<td>APL 18-007</td>
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<td>APL 18-008</td>
<td>Continuity of Care for Medi-Cal Members Who Transition into Medi-Cal Managed Care (Supersedes APL 15-019)</td>
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<td>APL 18-009</td>
<td>Memorandum of Understanding Requirements for Medi-Cal Managed Care Health Plans and Regional Centers (Supersedes APL 15-022)</td>
<td>03/02/2018</td>
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List of new PLs

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<th>Title (subject) of letter</th>
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<tr>
<td>DPL 17-001</td>
<td>Health Risk Assessment and Risk Stratification Requirements for Cal Mediconnect (Supersedes DPL 15-005)</td>
<td>07/11/2017</td>
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<tr>
<td>DPL 17-002</td>
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<td>07/21/2017</td>
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For copies of the APLs and PLs, please refer to the DHCS website at [http://www.dhcs.ca.gov/formsandpubs/pages/MgdCarePlanPolicyLtrs.aspx](http://www.dhcs.ca.gov/formsandpubs/pages/MgdCarePlanPolicyLtrs.aspx).

If you have questions about this communication or need assistance with any other item, contact your local Medi-Cal Managed Care (Medi-Cal) Customer Care representative or 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).
Complex case management program

Managing illness can be a daunting task for our members. It is not always easy to understand test results or know how to obtain essential resources for treatment or who to conduct with questions and concerns.

Anthem Blue Cross is available to offer assistance in these difficult moments with our Complex Case Management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals working to support members, families, primary care physicians and caregivers. The Complex Case Management process utilizes the experience and expertise of the Case Coordination team to educate and empower our members by increasing self-management skills. The Complex Case Management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Members Services number located on the back of their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contracting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can contact us by telephone at 1-800-407-4627. Case Management business hours are Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

Coding spotlight – pregnancy

*A provider’s guide to diagnose and code for pregnancy*

Use this guide for detailed information about pregnancy coding for risk factors, HEDIS® quality measures for prenatal and postpartum care, and ICD-10-CM general coding and documentation. To access the full pregnancy coding guide on our website use this link.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
Medical policies and clinical utilization management guidelines update

Medical Policies update

On March 7, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies which are applicable to Anthem Blue Cross (Anthem). These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the listing below. The medical policies were made publicly available on the provider website on the publish date listed below. To search for specific policies, visit https://www.anthem.com/ca/medicalpolicies/search.html. Existing precertification requirements have not changed.

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

<table>
<thead>
<tr>
<th>Publish date</th>
<th>Medical Policy number</th>
<th>Medical Policy</th>
<th>New/revised</th>
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</thead>
<tbody>
<tr>
<td>12/27/2017</td>
<td>DRUG.00112</td>
<td>Gemtuzumab Ozogamicin (Mylotarg®)</td>
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<tr>
<td>12/27/2017</td>
<td>DRUG.00118</td>
<td>Copanlisib (Aliqopa®)</td>
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<tr>
<td>11/9/2017</td>
<td>MED.00123</td>
<td>Axicabtagene ciloleucel (YescartaTM)</td>
<td>New</td>
</tr>
<tr>
<td>11/9/2017</td>
<td>DME.00040</td>
<td>Automated Insulin Delivery Devices</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>DRUG.00050</td>
<td>Eculizumab (Soliris®)</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>DRUG.00071</td>
<td>Pembrolizumab (Keytruda®)</td>
<td>Revised</td>
</tr>
<tr>
<td>12/27/2017</td>
<td>DRUG.00075</td>
<td>Nivolumab (Opdivo®)</td>
<td>Revised</td>
</tr>
<tr>
<td>11/9/2017</td>
<td>DRUG.00081</td>
<td>Eteplirsen (Exondys 51™)</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>DRUG.00109</td>
<td>Durvalumab (Imfinzi™)</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>GENE.00011</td>
<td>Gene Expression Profiling for Managing Breast Cancer Treatment</td>
<td>Revised</td>
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<tr>
<td>11/9/2017</td>
<td>SURG.00089</td>
<td>Balloon and Self-Expanding Absorptive Sinus Ostial Dilation</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>TRANS.00023</td>
<td>Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>TRANS.00024</td>
<td>Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>TRANS.00027</td>
<td>Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>TRANS.00028</td>
<td>Hematopoietic Stem Cell Transplantation for Hodgkin Disease and non-Hodgkin Lymphoma</td>
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<tr>
<td>12/27/2017</td>
<td>TRANS.00029</td>
<td>Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>TRANS.00030</td>
<td>Hematopoietic Stem Cell Transplantation for Germ Cell Tumors</td>
<td>Revised</td>
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</table>
**Clinical Utilization Management Guidelines update**

On March 7, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Clinical Utilization Management (UM) Guidelines which are applicable to Anthem. These clinical guidelines were developed or revised to support clinical coding edits. Several Guidelines were revised to provide clarification only and are not included in the listing below. The Clinical UM Guidelines on this list represent the Clinical UM Guidelines adopted by the Medical Operations Committee for the Government Business Division on March 30, 2018. To see the full utilization management guidelines on the website, visit https://www.anthem.com/ca/medicalpolicies/search.html.

On March 30, 2018, the clinical guidelines were made publicly available on the Anthem Medical Policies and Clinical UM Guidelines subsidiary website. To search for specific guidelines policies, visit https://www.anthem.com/ca/medicalpolicies/search.html. Existing precertification requirements have not changed.

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


Effective March 30, 2018, this clinical guideline will apply to Medicaid lines of business.

The clinical indication section specific to female screening of osteoporosis was revised to reflect that an initial (baseline) central (hip or spine) bone density measurement is considered medically necessary when conducted in postmenopausal individuals 65 years of age or older.

The guideline also identifies other clinical indications when initial and repeat central bone mineral density measurements are medically necessary.

<table>
<thead>
<tr>
<th>Publish date</th>
<th>Clinical UM Guideline number</th>
<th>Clinical UM Guideline title</th>
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<tbody>
<tr>
<td>12/27/2017</td>
<td>CG-DME-40</td>
<td>Electrical Bone Growth Stimulation</td>
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<td>12/27/2017</td>
<td>CG-DME-41</td>
<td>Ultraviolet Light Therapy Delivery Devices for Home Use</td>
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<td>12/27/2017</td>
<td>CG-DRUG-65</td>
<td>Tumor Necrosis Factor Antagonists</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-66</td>
<td>Panitumumab (Vectibix®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-68</td>
<td>Bevacizumab (Avastin®) for Non-Ophthalmologic Indications</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-69</td>
<td>Ustekinumab (Stelara®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-70</td>
<td>Eribulin mesylate (Halaven®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-71</td>
<td>Ziv-aflibercept (Zaltrap®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-72</td>
<td>Pertuzumab (Perjeta®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-73</td>
<td>Denosumab (Prolia®, Xgeva®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-74</td>
<td>Canakinumab (Ilaris®)</td>
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<td>12/27/2017</td>
<td>CG-DRUG-75</td>
<td>Romiplostim (Nplate®)</td>
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<td>12/27/2017</td>
<td>CG-DRUG-76</td>
<td>Plerixafor Injection (Mozobil™)</td>
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<td>12/27/2017</td>
<td>CG-DRUG-77</td>
<td>Radium Ra 223 Dichloride (Xojig®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-78</td>
<td>Antihemophilic Factors and Clotting Factors</td>
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<td>12/27/2017</td>
<td>CG-DRUG-79</td>
<td>Siltuximab (Sylvant®)</td>
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<td>12/27/2017</td>
<td>CG-DRUG-80</td>
<td>Cabazitaxel (Jevtana®)</td>
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<td>12/27/2017</td>
<td>CG-DRUG-81</td>
<td>Tocilizumab (Actemra®)</td>
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<td>Publish date</td>
<td>Clinical UM Guideline number</td>
<td>Clinical UM Guideline title</td>
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<td>12/27/2017</td>
<td>CG-GENE-01</td>
<td>Janus Kinase 2 (JAK2) V617F Gene Mutation Assay</td>
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<td>12/27/2017</td>
<td>CG-GENE-02</td>
<td>Analysis of KRAS Status</td>
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<td>12/27/2017</td>
<td>CG-GENE-03</td>
<td>BRAF Mutation Analysis</td>
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<td>12/27/2017</td>
<td>CG-GENE-04</td>
<td>Molecular Marker Evaluation of Thyroid Nodules</td>
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<td>12/27/2017</td>
<td>CG-MED-63</td>
<td>Treatment of Hyperhidrosis</td>
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<td>CG-MED-64</td>
<td>Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)</td>
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<td>CG-MED-65</td>
<td>Manipulation Under Anesthesia of the Spine and Joints other than the Knee</td>
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<td>12/27/2017</td>
<td>CG-MED-66</td>
<td>Cryopreservation of Oocytes or Ovarian Tissue</td>
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<td>12/27/2017</td>
<td>CG-MED-67</td>
<td>Melanoma Vaccines</td>
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<td>12/27/2017</td>
<td>CG-MED-68</td>
<td>Therapeutic Apheresis</td>
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<td>12/27/2017</td>
<td>CG-SURG-61</td>
<td>Cryosurgical Ablation of Solid Tumors Outside the Liver</td>
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<td>12/27/2017</td>
<td>CG-SURG-62</td>
<td>Radiofrequency Ablation to Treat Tumors Outside the Liver</td>
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<td>12/27/2017</td>
<td>CG-SURG-63</td>
<td>Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure</td>
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<td>12/27/2017</td>
<td>CG-SURG-65</td>
<td>Recombinant Human Bone Morphogenetic Protein</td>
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<tr>
<td>12/27/2017</td>
<td>CG-SURG-67</td>
<td>Treatment of Osteochondral Defects</td>
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<tr>
<td>12/27/2017</td>
<td>CG-SURG-68</td>
<td>Surgical Treatment of Femoracetabular Impingement Syndrome</td>
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<td>12/27/2017</td>
<td>CG-SURG-69</td>
<td>Meniscal Allograft Transplantation of the Knee</td>
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<td>12/27/2017</td>
<td>CG-DRUG-38</td>
<td>Pemetrexed Disodium (Alimta®)</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-50</td>
<td>Paclitaxel, protein-bound (Abraxane®)</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>CG-DRUG-61</td>
<td>Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications</td>
<td>Revised</td>
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<tr>
<td>12/27/2017</td>
<td>CG-MED-21</td>
<td>Anesthesia Services and Moderate (&quot;Conscious&quot;) Sedation</td>
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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: Mylotarg (gemtuzumab ozogamicin) and Mvasi (bevacizumab-awwb)

On July 1, 2018, prior authorization (PA) requirements will change for Part B injectable/infusible drugs Mylotarg (gemtuzumab ozogamicin) and Mvasi (bevacizumab-awwb) covered by Anthem Blue Cross. Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA 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 part B drugs:
- **Mylotarg** (gemtuzumab ozogamicin) — a humanized anti-CD33 monoclonal antibody for the treatment of acute myeloid leukemia and acute promyelocytic leukemia (J9203)
- **Mvasi** (bevacizumab-awwb) — for the treatment of metastatic colorectal cancer, nonsmall cell lung cancer, glioblastoma, metastatic renal cell carcinoma and cervical cancer as well as several eye conditions (J3590 — unlisted code, no J-code established at this time)

Please note, one of the drugs noted above is currently billed under the not otherwise classified (NOC) HCPCS J-code J3590. Since this code includes all drugs that are NOC, if the authorization is denied for medical necessity, the plan’s denial will be for the drug and not the HCPCS code.

To request PA, you may use one of the following methods:
- **Web**: Interactive Care Reviewer tool via [https://www.availity.com](https://www.availity.com)
- **Fax**: 1-866-999-1537
- **Phone**: 1-855-817-5786

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). Providers who are unable to access Availity may call our Customer Care Center at [Customer Care Centers at [1-800-407-4627] (outside L.A. county) or [1-888-285-7801] (inside L.A. county)] for PA requirements.
Prior authorization requirements for Part B drugs: ZEVALIN (ibritumomab tiuxetan) and Eptacog (recombinant factor VIIa)

On August 1, 2018, prior authorization (PA) requirements will change for Part B injectable/infusible drugs ZEVALIN® (ibritumomab tiuxetan) and Eptacog (recombinant factor VIIa) to be covered by Anthem Blue Cross (Anthem) for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. **Non-compliance with new requirements may result in denied claims.**

PA requirements will be added to the following:

- ZEVALIN (ibritumomab tiuxetan) — for treatment of relapsed or refractory low-grade or follicular B-cell non-Hodgkin's lymphoma (NHL) or previously untreated follicular NHL (J9999)

Please note, the drug listed below is currently billed under the not otherwise classified (NOC) HCPCS J-code J3490 or J3590. 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.

- Eptacog Beta (recombinant factor VIIa) — for treatment of hemophilia A and B patients who have developed antibodies to factor VIII and IX (J3490, J3590)

To request PA, you may use one of the following methods:

- Web: [https://www.availity.com](https://www.availity.com)
- Fax: 1-866-959-1537
- Phone: 1-855-817-5786

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool ([https://www.availity.com](https://www.availity.com)). Contracted and non-contracted providers who are unable to access Availity may call our Customer Care Centers at **1-800-407-4627** (outside L.A. County) or **1-888-285-7801** (inside L.A. County) for PA requirements.

Prior authorization required for Part B drug: Trelstar (triptorelin)

Effective August 1, 2018, prior authorization (PA) requirement will change for Part B injectable/infusible drug Trelstar (triptorelin) to be covered by Anthem Blue Cross for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) 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 PA 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 Part B drug:

- Trelstar (triptorelin) — for the palliative treatment of advanced prostate cancer and the treatment of central precocious puberty (J3315)

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 Availity Portal at https://mediproviders.anthem.com/ca > Login. Contracted and noncontracted providers who are unable to access Availity may call our Customer Care Centers at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County) for PA requirements.

Chimeric antigen receptor T-cell therapy requires prior authorization for all places of service

Chimeric antigen receptor T-cell (CAR T) therapy, including immunotherapy and all inpatient stays, will continue to require a prior authorization (PA) regardless of the place of service in which it is given.

CAR T codes require PA, and all requests must be reviewed by Anthem Blue Cross for PA regardless of place of service or if billed with an unlisted code.

Please refer to the Precertification Lookup Tool for detailed PA requirements by visiting https://www.availity.com, logging in with your User ID and Password, choosing Precertification from the navigation menu, and selecting Precertification Lookup Tool.

CAR T therapy is currently represented by the following codes:

- **Q2040** — Tisagenlecleucel (brand name: Kymriah™), up to 250 million CAR-positive viable T-cells, including leukapheresis and dose-preparation procedures, per infusion.
- **Q2041** — Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T-cells, including leukapheresis and dose-preparation procedures, per infusion (new code effective April 1, 2018).

CAR T therapy in any form will continue to require PA. Please use one of the following methods to submit a request:

- **Web:** https://www.availity.com
- **Fax:** 1-866-959-1537
- **Phone:** 1-855-817-5786

Noncompliance with the new requirements may result in denied claims. Federal and state law, as well as state contract language including definitions, and specific contract provisions and exclusions, take precedence over these PA rules and must be considered first when determining coverage.

If you have questions about this communication or need assistance with any other item, contact your local Customer Care Center representative or call Customer Care Centers at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County).
Electrical stimulation device to require prior authorization

An electrical stimulation device will require prior authorization (PA) effective August 1, 2018. Please use the Precertification Lookup Tool for authorization requirements.

Noncompliance with the new requirements may result in denied claims. The following code will require PA:

- E0766 – Electrical stimulation device used for cancer treatment, includes all accessories, any type

Please request PA via one of the following methods:

- Availity Portal: https://www.availity.com
- Fax: 1-866-959-1537
- Phone: 1-855-817-5786

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

If you have questions about this communication or need assistance with any other item, call our Customer Care Centers at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County).

Miscellaneous durable medical equipment billing guidelines

Miscellaneous durable medical equipment (DME) procedure codes (such as E1399) cannot be used as an alternative to specific identified codes. Anthem Blue Cross (Anthem) will conduct postpayment reviews to ensure the right codes for the right services are used. This applies to all claims for Anthem Blue Cross Cal MediConnect Plan (Medicare-Medicaid Plan) members.

In an effort to improve the provider experience, we continually evaluate coding and billing patterns. Recently, we identified trends related to the use of E1399 — DME, miscellaneous. This code is only intended for use when a more appropriate code is not available. When an appropriate code does exist, that code must be used regardless of your contracted rate. It is not appropriate to use E1399 for payment increases.

We continue to require prior authorization for the use of miscellaneous code E1399. To request PA, you may use one of the following methods:

- Web: https://www.availity.com
- Fax: 1-866-959-1537
- Phone: 1-855-817-5786

As it is not our policy to inform providers of proper billing processes within prior authorization responses, authorization responses do not include code-specific details. If your service was approved but your claim was denied payment when billed using E1399, the incorrect code was used. You will need to update the authorization and the claim with the appropriate HIPAA-compliant HCPCS code.

Anthem will conduct postpayment reviews of code E1399 to ensure proper use. If it is determined a more appropriate code should have been used, we will notify you in writing and advise you of your appeal rights.
Prior authorization requirements for cardiovascular services

Effective August 1, 2018, prior authorization (PA) requirements for cardiovascular services for Anthem Blue Cross members will change. Federal law, state law and state contract language (including definitions and specific contract provisions/exclusions) take precedence over these PA 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 CPT codes:

- 93285: Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values
- 33282: Implantation of patient-activated cardiac event global recorder

To request PA, you may use one of the following methods:

- Web: https://www.availity.com
- Fax: 1-866-959-1537
- Phone: 1-855-817-5786

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Availity Portal. Contracted and noncontracted providers who are unable to access Availity may call our Customer Care Centers at 1-800-407-4627 (outside L.A. County) or 1-888-285-7801 (inside L.A. County) for PA requirements.
Medicare Advantage Updates

Cologuard covered for Medicare Advantage

*Please note, this notice is only applicable to Medicare Advantage members:* Cologuard, an at-home colorectal cancer screening, is covered at 100 percent for Anthem Medicare Advantage individual and group-sponsored members. Members will not incur an out-of-pocket cost for the screening and no prior authorization is required.

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Peer-to-peer process can help clarify clinical record

The Medicare peer-to-peer process facilitates a conversation between a provider and an Anthem medical director. The peer-to-peer process should be used to explain or clarify something that a clinical record cannot convey. To learn how to initiate a peer-to-peer conversation, please see [Important Medicare Advantage Updates](https://www.anthem.com/ca/medicareprovider).

Motion Picture Industry Pension and Health Plans Offers Medicare Advantage Option

Effective July 1, 2018, Anthem will be a Medicare Advantage (MA) plan option for Motion Picture Industry Health and Pension Plans (MPI). Anthem will provide medical benefits for MPI retirees through Anthem’s Local Preferred Provider Organization (LPPO) product. The MA plan offers the same hospital and medical benefits that Medicare covers. In addition, MPI retirees will pay the same cost share for both in-network and out-of-network services. The MA plan also covers additional benefits that Medicare does not such as hearing, acupuncture, LiveHealth Online and SilverSneakers.

MPI retirees will have a customized identification card that includes the MPI logo. The prefix on their cards will be MBL. Providers will follow their normal claim filing procedures for MPI member claims. Additional information is available at [Important Medicare Advantage Updates](https://www.anthem.com/ca/medicareprovider).

MA home health network to be delegated to myNEXUS

We want to thank our PCPs and hospitals for their coordination of home health care for our members. We want to alert you to important changes to our Home Health provider network for most of our Medicare Advantage members. Anthem will delegate its provider network for Home Health Care Services for most of our Medicare Advantage members to myNEXUS August 1, 2018. Additional information will be available at [Important Medicare Advantage Updates](https://www.anthem.com/ca/medicareprovider).
Medication adherence incentive offered to EPHC providers

Medication non-adherence increases mortality and costs the healthcare system billions of dollars per year. Anthem is collaborating with physicians engaged in our Enhanced Personal Health Care (EPHC) programs to promote adherence by increasing 90-day supply prescriptions. Patients who receive 90-day supplies are more likely to be adherent, and Anthem's Medicare Advantage plans allow 90-day supplies to be filled for chronic medications at any retail pharmacy. Beginning in July, EPHC providers program will receive a monthly report that identifies Medicare members eligible for a 90-day supply. Please evaluate that member list and discuss the benefits of a 90-day supply with your patients.

Keep up with Medicare news

Please continue to check Important Medicare Advantage Updates at www.anthem.com/ca/medicareprovider, including:
- Updated: Prior authorizations required for new group-sponsored MA membership
- Anthem adopts MCG care guidelines 22nd Edition
- Improve Medicare Advantage members’ medication adherence with 90-day prescriptions
- Prior authorization requirements for cardiovascular services
- CMS selects Anthem for 2016 National RADV audit
- Medicare Advantage reimbursement policy provider bulletin
- Medicare risk adjustment and documentation training
- Dual Eligible Special Needs Plans – provider training required
- Prior authorization requirement for Electrical Stimulation Device
- Prior authorization requirements for Part B drugs: Zevalin and Eptacog
- Prior authorization requirements for Part B drug: Trelstar

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Pharmacy

Reminder: Anthem Blue Cross accepts prior authorization requests for prescription medications online

As a reminder, Anthem Blue Cross (Anthem) accepts electronic medication prior authorization requests for commercial health plans. This feature reduces processing time and helps determine coverage quicker. Some prescriptions are even approved in real time so that your patients can fill a prescription without delay.

Electronic prior authorization (ePA) offers many benefits to providers:
- More efficient review process
- Ability to identify if a prior authorization is required
- Able to see consolidated view of ePA submissions in real time
- Faster turnaround times
- A renewal program that allows for improved continuity of care for members with maintenance medications. Prior authorizations are preloaded for the provider before the expiration date.

Providers can submit ePA requests by logging in at covermymeds.com. Creating an account is FREE.

For questions, please contact the provider service number on the back of the member ID card.

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 https://www11.anthem.com/ca/pharmacyinformation/. The commercial and marketplace drug lists 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. This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

Effective January 1, 2018, AllianceRX Walgreens Prime is the new specialty pharmacy program for the Federal Employee Program. You can view the 2018 Specialty Drug List or call us at 1-888-346-3731 for more information.