Changes to Affordable Care Act compliant plans offered in 2017

Anthem will continue to offer Affordable Care Act (ACA) compliant health plans for the 2017 plan year. This year we are still offering 5 different network options for our members between Individual and Small group business offered both on and off the exchange. Please reference the chart below to see which options are available on or off exchange for both Individuals and Small Group members.

<table>
<thead>
<tr>
<th>Networks</th>
<th>Plans on the exchange</th>
<th>Plans off the exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individual</td>
<td>Small Group</td>
</tr>
<tr>
<td>Pathway</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Mountain Enhanced</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Anthem PPO</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Blue Priority HMO</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Blue Priority PPO</td>
<td>●</td>
<td>●</td>
</tr>
</tbody>
</table>

*Changes for 2017*: Anthem PPO plans will not be sold in 2017 for Individual on exchange members as it was in 2016. *Instead, Anthem will only offer a catastrophic PPO plan to off exchange Individual members in 2017. This DOES NOT mean that our PPO network is going away, as it is still one of our largest networks for Large Group and National Account business. These changes for 2017 are specific to ACA membership.

ACA members with PPO plans offered in 2016 (identified by an HWT alpha prefix) will need to select a different plan option in 2017. While there are more than one plan options available in 2017, most of the plans for Individuals in the Front Range area will be aligned with our Pathway Network. We are not anticipating the need for further additions to the Pathway network, but we will review the following information in evaluating the need to add non-ancillary providers along the Front Range:

- Geographic area
- Provider specialty
- Do you serve a special member demographic
- Hospital affiliation or admitting privileges [must be affiliated with a HealthONE or other participating facility]
- Reason for your request to be part of the Pathway network
Once a month, a panel will review these requests to determine if we need a particular provider in the Pathway network. The Contract Manager will follow up with the provider after the meeting to let them know the final outcome. If you are not sure who your Contract Manager is, please reference the Escalation Contact List, under the Provider Solutions Team on page 2.

Networks at a Glance

Not sure which networks you are participating with Anthem? We’ve created a document called our Networks at a Glance. This shows all of our Networks available in Colorado. If you’d like a customized version, please email your Provider Relations Representative with your Tax ID number, and we can create a customized version for your organization to confirm with which networks you participate. If you are not sure who your Provider Relations Representative is, please reference the Escalation Contact List, under the Provider Solutions Team on page 2.

Access more information online:

- Affordable Care Act – Quick Reference Guide (Colorado)
- Plans offered in 2017 - Colorado – All plans actively offered in 2017, not just ACA compliant plans, including Individual on and off exchange, Small Group on and off exchange, and Large Group plans.

ProviderAccess Retirement Coming: Transition to the Availity Web Portal Now

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

All tools on ProviderAccess have already been moved over to Availity with the exception of Professional Reimbursement Policies, which will be moving soon. If you are still accessing ProviderAccess for Remittance Inquiry, Fee Schedules, of Clear Claim Connection, please start utilizing these tools through Availity today to ensure you know how to access before the targeted January 20, 2017 ProviderAccess retirement date. Today, these tools are available in both systems, but after the retirement date, they will only be available through Availity.

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

Do you have all of your tax IDs registered on the Availity Web Portal? If not, now is the time to register. Your organization’s administrator can add additional tax ids by selecting Maintain Organization from the Admin Dashboard.

If your organization is not registered for Availity: Have your organization’s designated administrator go to www.availity.com and select Register. Complete the online registration wizard. The administrator will receive an e-mail from Availity with a temporary password and next steps.

Free Training: Once you log into the secure portal, you'll have access to many resources to help jumpstart your learning, including free live training, on-demand training, frequently asked questions, and comprehensive help topics. To view the current training resources, access the Help menu on the Availity Web Portal.
As new groups may be opting for Blue Priority plans in 2017, know your organizations participation level

Anthem’s Blue Priority plans are intended to better support the Patient Centered Primary Care concepts and put primary care physicians back at the center of the health care delivery system. Anthem recently expanded our existing Blue Priority HMO network to Larimer and Weld counties in July. Large group business became available in Larimer and Weld counties starting in July, and small group business will be available in these counties starting January 1, 2017.

The Blue Priority products:

- include both HMO and PPO plans and are available to Local Colorado large group and small group clients only.
- require the selection of a primary care physician (PCP) for both the HMO and PPO options.
- require referral management for the HMO products that may improve the coordination of and quality of care as well as ensure the efficient use of services.
- allow the PCP to manage the whole patient throughout the continuum of care; preventive care through chronic care; and makes referrals as appropriate to other network physicians.

HMO – This network option:

- includes a subset of PCPs and Specialists from Anthem’s standard HMO network.
- provides coverage only when using selected PCP groups and selected specialists; (For a complete list of PCPs and Specialists, please reference the Find a Doctor tool, our online provider directory. See navigation instructions below)
- includes all facilities, ancillary providers, and behavioral health providers in the current HMO network;
- requires member selection of a PCP;
- requires referrals for most specialty care;
- no out-of-network benefits or access to most specialists without a referral
  - The exceptions are emergent and urgent care and specific types of specialty care as required by state law.

PPO – This three tier PPO option:

- requires member selection of a PCP;
- allows access to the Anthem PPO network without a referral;
- provides for the highest level of benefits when using the first tier of providers (Designated Providers); which are those PCPs and specialists in the HMO Blue Priority network;
- allows access to the second tier of providers (Participating Providers), which includes all Anthem PPO contracted providers (not already considered a Designated Provider), at a reduced benefit.
- allows access to non-network providers at a significantly reduced benefit level.

Identifying Blue Priority Members

<table>
<thead>
<tr>
<th>Alpha Prefix</th>
<th>Product Type</th>
<th>Network Name (On Member ID cards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>XFA</td>
<td>HMO</td>
<td>Blue Priority</td>
</tr>
<tr>
<td>XFD</td>
<td>HMO</td>
<td>Blue Priority</td>
</tr>
<tr>
<td>XFI</td>
<td>HMO</td>
<td>Blue Priority</td>
</tr>
<tr>
<td>XFH</td>
<td>PPO</td>
<td>Blue Priority PPO</td>
</tr>
<tr>
<td>XFM</td>
<td>PPO</td>
<td>Blue Priority PPO</td>
</tr>
<tr>
<td>XFS</td>
<td>PPO</td>
<td>Blue Priority PPO</td>
</tr>
</tbody>
</table>
Health Plan ID Cards

Samples of our Member Health Plan ID Cards (including Blue Priority HMO and PPO) are available in our Provider Toolkit online. Go to anthem.com, select the Provider link at the bottom of the page. Select Colorado from drop down list and enter. From the Provider Home tab, select the link titled Provider Communications and Education, then Provider Toolkit, and “Membership Health Plan ID Card Samples”.

Navigation instructions for Anthem’s “Find a Doctor” tool

Go to anthem.com, select the Provider link at the bottom of the page. Select Colorado from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Find a Doctor”.

Important Note: Searching without selecting a plan/network displays information specific to the provider. The most accurate way to search for a provider within a specific member’s plan is by the member’s alpha prefix search option (first 3 characters in member’s ID number).

Referrals for Blue Priority HMO members

Referrals can be obtained through two options: 1. through our secure portal, providers can submit referral request through Interactive Care Reviewer tool on the Availity Web Portal at availity.com, or 2. through our public website, go to anthem.com, select Provider, then Colorado and enter, from the Provider Home page, select Download Commonly Requested Forms, then the “Blue Priority Referral Form” link.

Networks at a Glance

Not sure which networks you are participating with Anthem? We’ve created a document call our Networks at a Glance. This shows all of our Networks available in Colorado. If you’d like a customized version, please email your Provider Relations Representative with your Tax ID number, and we can create a customized version for your organization to confirm with which networks you participate. If you are not sure who your Provider Relations Representative is, please reference the Escalation Contact List, under the Provider Solutions Team on page 2.

Members managed by OrthoNet available online through Availity Web Portal

In November of 2015, Anthem selected OrthoNet, LLC, a leading musculoskeletal management company, to administer a physical and occupational therapy utilization management program.

The program requires that all outpatient and office based physical and occupational therapy services following the initial evaluation be authorized by OrthoNet. As indicated in previous communications, OrthoNet handles pre-certification requests for all Anthem members except: Medicaid, Medicare supplement, Medicare Part D, Federal Employee Program® (FEP®), BlueCard, National Accounts, and certain self-funded and alternatively-funded groups. Members ages 6 and under are also excluded from participation in this program.

Providers are able to view members online through the Availity Web Portal to determine which members are administered under through OrthoNet.

- Log into Availity.com.
- From the Patient Registration tab, select Eligibility and Benefits (E&B) Inquiry
- Enter all required fields
– Under Benefit / Service Type, select Physical Therapy. [Special Note: Currently available for Physical Therapy benefit type inquiries, and coming in early 2017 for Occupational Therapy inquiries]

Note: Members managed by OrthoNet is available on Availity for all Anthem affiliated plans which include: Anthem plans in CA, CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI, and Blue Cross and Blue Shield of Georgia, and Empire Blue Cross and Blue Shield.

Sample screen shot below is utilizing Physical Therapy as the Benefit/Service Type. Note the OrthoNet message below including the phone number. If you see this message during your E&B inquiry, then please contact OrthoNet for authorization requests for this member. This message will not be displayed for members that are not administered by OrthoNet, saving you time to verify this information prior to submitting an authorization request through OrthoNet.

OrthoNet Quick Reference Guide

Based on provider feedback, we’ve created a document called the OrthoNet Quick Reference Guide to outline the OrthoNet program overview and summarize important details such as:

- Program overview
- services included and not included in program
- Online verification of Eligibility and Benefits, and members managed by OrthoNet
- Pre-authorizations request options
- Checking status of Pre-authorization Requests
- Timeline for OrthoNet decisions
- Other sources, which includes newly defined escalation process

Access this document online. Go to anthem.com, select Provider, then Colorado and enter, from the Provider Home page, under the Communications and Updates heading select Provider Toolkit, then OrthoNet Quick Reference Guide – Colorado.
Fall 2016 Provider Webinars – recorded version now available online

Even if you missed one of our “in-person” meetings or one of our “webinars”, you still have the opportunity to listen to a recorded version. The sessions included important updates and information to make it easier to do business with us. We split our seminar content into two portions; Part 1 (general content), and Part 2 (Provider Connectivity/Availity specific content). Because of the proprietary nature of the information covered in the Part 2 content with Availity, we are not able to post a recording on Anthem’s website. To access a recorded version of our Part 1 (general content), go to anthem.com and select the Tools for Provider link (bottom of the page). Next, select Colorado from the drop down list and enter. On the Provider Home page, under the Communications and Updates heading select the Provider Seminars link. From the Provider Seminars landing page, under the Fall 2016 Provider Seminars heading, select Fall 2016 Provider Seminar – Part 1 (General Content), recorded version. Several people have asked for a full version of the power point presentation which you can now access from this page as well; just select the link titled Fall 2016 Provider Seminar Power Point (full presentation).

Additional Availability Training

For additional information regarding Availity, once logged into Availity.com, click Help | Get Trained for additional live and on-demand training.

Reminder: Surveys for the 2016 Anthem Quality-In-Sights® Primary Care Incentive Program due no later than February 28, 2016

This is a reminder for all Primary Care Providers (PCP) participating in Anthem’s Quality-In-Sights Primary Care Incentive Program that a survey is required upon completion of the reporting period for 2016 which ends December 31, 2016. This is a required survey for the External Physician recognition, Clinical Improvement, and Care Systems components and may satisfy certain requirements that will assist you in achieving established goals, and therefore may result in higher reimbursement for PCP. The survey should be completed once for all practice locations under a single Tax ID.

Surveys that need to be completed and returned are available online. The easiest way to submit this information is through Provider Online Interactive Tool (POIT) available through our secure provider portal, Provider Access. Just log on to POIT no later than February 28, 2017, enter your information and you’re done!

You can also submit your survey to Anthem via email prprogramscow@wellpoint.com or mail to the following address: Anthem Blue Cross and Blue Shield, Quality-In-Sights Program, 700 Broadway, Mail No: CO0105-0527, Denver, CO 80273.

Accessing the survey online:

Access to POIT is through Anthem’s secure provider portal at www.anthem.com. Select Provider link at the bottom of the page. Select Colorado from drop down list and enter. From the Provider Home page, go to the “ProviderAccess Login” tout (blue box on left side of page), and select “Medical” from the drop down, and select “Login”. Enter your ProviderAccess user name and password to login. Next, click on the Rewards and Recognition box, and select Programs. Then select Quality-In-Sights, and click start survey to access the POIT tool and complete the survey. Please note: your ProviderAccess Account Administrator will need to grant access to individual Users to be able to view this tool.

If you have any questions regarding this information, please call 1-888-650-5743, or contact your Provider Solutions Contract Manager directly.

Please note, that the AQS program will not be offered in 2017.
2017 FEP Benefit information available online

To view the 2017 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2017. For questions please contact FEP Customer Service at: 800-852-5957.

Attention OB/GYN Providers: Prenatal/Postpartum Related HEDIS Measure Information

Recently, Anthem Federal Employee Program mailed out a Quick Reference Guide to our OB/GYN provider community, in an effort to help provide important information about prenatal and postpartum claim submission. The mailer included guidance for providers to submit the Category II CPT codes for Prenatal services: 0050F (Initial prenatal care visit), 0501F (Prenatal flow sheet documented in medical record by first prenatal visit) and Postpartum services: 0503F (indicating a postpartum visit) and ICD-10 code Z39.2 (routine postpartum follow-up). Submitting these codes helps alleviate the need for medical record submission and less time and disruption to your office by the health plan to review patient charts. We value the relationship we have with our providers, and appreciate any and all effort put forth on this request.

If your office did not receive a Quick Reference Guide to post in your office billing department, please contact FEP Customer Service at 800-852-5957.

Tips for Billing CPT Modifier 33

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

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

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

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

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

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

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

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

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled “Other Conditions That May Be a Focus of Clinical Attention”. In addition, Axis V, Global Assessment of Functioning (GAF), was removed from DSM-5. Alternatively, the World Health Organization Disability Assessment Schedule (WHODAS 2.0) is included in Section III of DSM-5.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2.

Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at: dsm.psychiatryonline.org. Select the link, View the DSM-5® Update (September 2016).

Table 2

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

The content of this update is for informational purposes only and should not be construed as treatment protocols or required practice guidelines, nor should anything herein be construed as legal advice. Readers are strongly advised to consult their own legal counsel as necessary. Diagnoses, treatment recommendations and the provision of health care services for Anthem Blue Cross and Blue Shield members are the responsibility of physicians and providers.
Some resources that may best help you include:

- American Medical Association, 2016 Professional Edition CPT (current procedural terminology)

Survey says... Patients see room for improvement with physician care

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

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

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

<p>| 2016 Anthem Colorado HMO/POS CAHPS® Adult Member Satisfaction Survey Results and NCQA Quality Compass Percentile Achieved |
|-----------------------------------------------|-----------|-----------|---------|---------|
| Rating of Physician                           |           |           |         |
| Rating of Personal Doctor                     | 85%       | 86%       | ↑        |
| Rating of Specialist Seen Most Often          | 83%       | 85%       | =        |
| Rating of All Health Care Provided in Past 12 Months | 75%       | 79%       | ↓        |
| Getting Care Quickly                         |           |           |         |
| Got appointment for urgent care as soon as needed | 85%       | 86%       | --       |
| Got appointment for check-up or routine care as soon as needed | 80%       | 79%       | ↓        |</p>
<table>
<thead>
<tr>
<th>Doctor's Communication with Patients²</th>
<th>64%</th>
<th>83%</th>
<th>--</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>96%</td>
<td>98%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>95%</td>
<td>97%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>95%</td>
<td>97%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>92%</td>
<td>96%</td>
<td>↓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Shared Decision Making</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor discussed reasons to take a medicine? ³</td>
<td>96%</td>
<td>97%</td>
<td>--</td>
</tr>
<tr>
<td>Doctor discussed reasons you may not want to take a medicine? ³</td>
<td>81%</td>
<td>77%</td>
<td>--</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you? ³</td>
<td>82%</td>
<td>84%</td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continuity of Care &amp; Health Promotion</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did your personal doctor seem informed about care you received from other health providers?</td>
<td>82%</td>
<td>78%</td>
<td>↓</td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness?³</td>
<td>81%</td>
<td>74%</td>
<td>↑</td>
</tr>
</tbody>
</table>

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

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

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

Improving Your Patients’ Health Care Experience

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


*This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California.*
**Anthem Preferred Products**

**Immunoglobulin Preferred Products**

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

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

**Botulinum Toxin Agents Preferred Products**

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

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

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

**Hyaluronic Acid Preferred Products**

Anthem has reviewed the hyaluronic acid agents through the P&T process and has selected four preferred drugs: Synvisc-One®, Synvisc®, Monovisc® and Orthovisc®. When prescribing these products, please consider the preferred agents below for patients needing hyaluronic acid therapy.

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

**HEDIS Spotlight: Respiratory Conditions**

Asthma and Chronic Obstructive Pulmonary Disease (COPD) are major causes of morbidity, mortality, lower quality of life, and lost productivity including missed days from school or work. According to the Centers for Disease Control, 1 in 14 people have asthma or about 24 million Americans (roughly 7.4% of adults and 8.6% of children). Asthma causes almost 2 million emergency room visits each
year; more than 14 million doctor visits; and 439,000 hospital stays. More than half of children and one-third of adults missed school or work due to their asthma. Each day, ten Americans die from asthma. Many of these deaths are avoidable with proper treatment and care.

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

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

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

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

COPD can also be managed by medication. However, it is important to distinguish diagnosis between asthma and COPD because of the differences in treatment, disease progression, and outcomes. According to the American Lung Association, COPD cost the U.S. $49.9 billion in 2010. Of that, $29.5 billion was spent on direct healthcare costs, $8 billion from indirect morbidity costs, and $12.4 were indirect mortality costs. COPD is often misdiagnosed or undiagnosed until later in the disease. Almost 15.7 million Americans (6.4%) reported that they have been diagnosed with COPD. More than 50% of adults with low pulmonary function were not aware that they had COPD.

In 2014, COPD was the third leading cause of death in the U.S. Establishing a diagnosis of COPD requires spirometry testing, interpreted in the context of the patient’s symptoms, smoking status, age, and comorbidities.

The HEDIS measures related to COPD are:

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

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

**Anthem is helping**

A consolidated Medication Review note may be sent to members and their providers when the following criteria are met:

- Member is less than 80% compliant on their asthma controller medication
- Member shows high utilization of short-acting beta agonist medication and not on an asthma controller (inhaled corticosteroid)
- Member has claim(s) for COPD medications including Atrovent, instead of more effective therapy (Spiriva)
What can you do?

☑️ Use spirometry to diagnose and monitor treatment efficacy.

☑️ Adopt a Patient Centered Planned Visit Model. Provide ongoing follow-up and care plans for patients throughout the year. Use every patient engagement/acute appointment to discuss concerns, compliance, and closing gaps in care.

☑️ Educate your patients about their disease, possible consequences to their health and quality of life.

☑️ Remind patients to take and refill controller medications. Discuss patient concerns that might interfere with adherence. Provide simple written instructions that are appropriate both culturally and in literacy level.

☑️ Review proper inhaler use at each visit, encouraging patients to demonstrate. Work with your patients who have asthma to have a current written action plan and to use a peak flow meter to monitor control. Discuss patient’s triggers and ways to avoid exposure to triggers.

☑️ Code and document visits accurately.


Webinars still available regarding ePASS® and SOAP Notes overview giving you opportunities to increase your reimbursement before the end of the year

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

We have engaged Inovalon – an independent company that provides secure clinical documentation services – to process your patients’ assessments.

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

Overview of Webinar to earn incentives offered

Inovalon is conducting webinars that provide a practical overview of how eligible providers can use the Electronic Patient Assessment Solution Suite (ePASS®) to access a supplemental clinical profile and complete a compliant medical SOAP Note for patients identified by Anthem.

The webinar typically takes 30 minutes followed by time for questions.
Registration

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

December Webinar Dates

- Wednesday, December 7, 2016: 1:00 PM – 2:00 PM MT
- Wednesday, December 14, 2016: 1:00 PM – 2:00 PM MT
- Wednesday, December 21, 2016: 1:00 PM – 2:00 PM MT
- Wednesday, December 28, 2016: 1:00 PM – 2:00 PM MT

How to join the webinars

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

- Teleconference: Dial 1-888-850-4523 and enter access code: 108 607
- WebEx: Visit https://inovalon.webex.com and enter meeting number: 746 707 227
- Once you join the call, live support is available at any time by dialing *0

For more information on the outreach process or the ePASS tool, please reference our FAQs. Go to anthem.com; select the Provider link at the bottom of the page. Select Colorado from the drop down list, and click Enter. From the Provider Home page, select the link titled "Anthem engages Inovalon to conduct outreach efforts for our Exchange business: Frequently Asked Questions (Revised June 2015)". You may also contact Inovalon toll free at 1-877-448-8125.

To help easily identify members with Affordable Care Act plans, and the aligned networks, please see our Affordable Care Act – Quick Reference Guide.

Clinical Practice and Preventive Health Guidelines Available on the Web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to www.anthem.com and follow this path: Tools for Providers > Colorado > Enter > Health & Wellness > Practice Guidelines.

Update to Claims Processing Edits and Professional Reimbursement Policies

Multiple Diagnostic Cardiovascular Procedures – professional

We are adding information to section B of our policy that our multiple diagnostic cardiovascular reimbursement rules are not applicable to procedures for which there are no RVUs assigned to the technical component of a code.
Prolonged Services – professional
We have updated our Prolonged Services Diagnosis Coding list dated October 1, 2016, to include additional ICD-10-CM diagnosis codes that were effective October 1, 2016, and for which prolonged services are allowed – E083211-E083213, E083219, E083311-E083313, E083319, E083411-E083413, E083419, I16, I160, I161, I169, O115, O165. In addition, we have removed the ICD-9-CM diagnosis codes which are no longer valid for dates of service on or after October 1, 2015.

Sleep Studies and Related Services & Supplies and Frequency Editing – professional
In our June 2016 issue of Network Update, we advised we would be implementing a one (1) per 60 days frequency limit to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783 for dates of service on or after September 1, 2016. Upon further review, we have reconsidered our position and have removed this edit for dates of service on or after September 1, 2016.

Unit Frequency Maximums for Drugs and Biologic Substances – professional
We are adding information to our policy to document that modifiers do not override our unit frequency maximums for drugs and biologic substances.

Review of reimbursement policies – professional
The following professional reimbursement policies received an annual review and may have word changes or clarifications however they do not have significant changes to the policy position or criteria:

- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Duplicate Reporting of Diagnostic Services Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Once per Lifetime Procedures
- Physical and Manipulative Maintenance Services
- "Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Three Dimensional Rendering of Imaging Studies

Significant Edits for 2016
- We have updated our Significant Edits posting to reflect the 2016 analysis of claims data for significant code pair edits based on data for claims processed between April 1, 2016 and June 30, 2016. Anthem defines a significant edit as: A code pair edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial of payment for a particular CPT or HCPCS code more than two-hundred and fifty (250) times per year in Anthem’s service area.
- The Significant Edit information is available on our secure provider portal. Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the Significant Edit pdf.

Coding Tip: 2017 Presumptive Drug Tests – professional
Effective January 1, 2017, CPT has deleted presumptive drug class screening codes 80300 – 80304 and has added replacement codes 80305 – 80307. The new codes 80305 – 80307 have the same description as G0477 – G0479 and HCPCS Coding Standards: Levels of
Use state “... When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used.” Providers are encouraged to follow HCPCS coding guidance and report the 80305 – 80307 CPT codes for presumptive drug screening services. Do not report both 80305 – 80307 and G0477 – G0479 for same date(s) of service as this would represent a duplication of services.

Coding Tip: 2017 Modifier 95 for Telehealth Services – professional

Effective January 1, 2017, CPT is adding modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). Based on CPT instruction, modifier 95 is to be used only with the services listed in Appendix P of the CPT codebook when those services are rendered via real-time (synchronous) interactive telecommunication.

System Updates for 2017 – professional

As a reminder, our ClaimsXten (or other proprietary) editing software package will be updated quarterly in February, May, August and November of 2017. These updates will:

- reflect the addition of new and revised CPT/HCPCS codes and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

Notice of reimbursement policy modifications due to these updates will continue to be published in the Network Update and on our secure provider portal, ProviderAccess.

Reimbursement Policies and Clear Claim Connection are available on our secure provider portal, ProviderAccess

Please review the full policy for any changes referenced above for further information. All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com, and select the Provider link at the bottom of the page. Select Colorado from the drop down list, and enter. From the Provider Home page, go to the ProviderAccess Login tool (blue box on the left side of the page), and select Medical from the drop down list and click on the login button.

Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Professional Reimb & Admin Policies”. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select Continue. Select link titled “Anthem’s Professional Reimbursement & Administrative Policies – By Type”, then select the Reimbursement link, and next the Policy you would like to view.

Clear Claim Connection™ is our web-based editing tool from McKesson and includes an interface that will allow you to view the clinical rationale for ClaimsXten edits when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Follow the directions listed above to log into ProviderAccess. Once logged in, from the Claims tab, select the Clear Claim Connection link. Please note: Any Cotiviti Healthcare edits will not be included in the Clear Claim Connection tool. These edits will be available by calling provider customer service at the number on the back of the member’s ID card.

CPT® is a registered trademark of the American Medical Association

ClaimsXten® is a registered trademark of McKesson Information Solutions LLC
Clinical Practice and Preventive Health 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 anthem.com. Select the “Provider” link at the bottom of the page. Select Colorado from the drop down list, and enter. Select the Health & Wellness tab, then the link title “Practice Guidelines”. You can then choose from Clinical Practice Guidelines, Preventive Health Guidelines, or Behavioral Health Clinical Practice Guidelines.

Pharmacy information available on anthem.com

Visit http://www.anthem.com/pharmacyinformation 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 certain drugs. The commercial drug list is reviewed and updates are posted to the website quarterly (the first of the month for January, April, July and October).

To locate the “Marketplace Select Formulary” and pharmacy information for Health Plans offered on the Exchange Marketplace, go to www.anthem.com, select Customer Support, select Colorado, Download Forms, Anthem Blue Cross and Blue Shield Drug Lists, and then choose Colorado Select Drug List.

Website links for the Federal Employee Program formulary Basic and Standard Options are Basic Option: https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and Standard Option: https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org | Benefit Plans │ Brochures and Forms │ Medical Policies.

Important information about Utilization Management

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

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on Anthem’s Web site at anthem.com. Select Provider link (at the bottom of page), then Colorado (from the drop down list), and enter. On the Provider Home page, from the Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements tout (2nd blue box on the left side of page), select enter. Click on the link titled “Medical Policies and Clinical UM Guidelines (for Local Plan Members)”. For Clinical UM Guidelines for Local Plan members: Follow the information for Medical Policies listed above. From the Medical Policies and Clinical UM Guidelines page for Local Plan members, at the bottom of the page, before the “continue” button, is a link titled “Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Colorado”. Please note all of our Clinical UM Guidelines for our entire organization are displayed by clicking the “continue” button, but not all of them apply to Colorado. Please reference the Colorado specific link to determine which Clinical UM Guidelines have been adopted by Colorado.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below.

December 2016

Colorado

Network Update is produced monthly by Anthem Blue Cross and Blue Shield.
Editor: Jackie Ferguson, 700 Broadway, Denver, CO 80273, E-mail: Jackie.Ferguson@anthem.com.

The content of this update is for informational purposes only and should not be construed as treatment protocols or required practice guidelines, nor should anything herein be construed as legal advice. Readers are strongly advised to consult their own legal counsel as necessary. Diagnoses, treatment recommendations and the provision of health care services for Anthem Blue Cross members are the responsibility of physicians and providers.

In Colorado: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Nevada: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
We work with providers to answer questions about the utilization management process and the authorization of care. Here’s how the process works:

- Call us toll free from 8:30 a.m. - 5 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 a.m. – 7 p.m. Eastern.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

<table>
<thead>
<tr>
<th>Member Type</th>
<th>To discuss UM Process and Authorizations</th>
<th>To Discuss Peer-to-Peer UM Denials w/Physicians</th>
<th>To Request UM Criteria</th>
<th>TTY/TDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local member</td>
<td>1-800-832-7850</td>
<td>Local: 1-303-764-7227 Toll-free: 1-866-287-1654</td>
<td>1-800-797-7758</td>
<td>711 or 800-659-2656(T) / 800-659-3656(V)</td>
</tr>
<tr>
<td>Federal Employee Program® (FEP®)</td>
<td>Phone 800-860-2156 FAX 800 732-8318 (UM) FAX 877 606-3807 (ABD)</td>
<td>Phone 800-860-2156 FAX 800 732-8318 (UM) FAX 877 606-3807 (ABD)</td>
<td>Phone 800-860-2156 FAX 800 732-8318 (UM) FAX 877 606-3807 (ABD)</td>
<td></td>
</tr>
</tbody>
</table>

For language assistance, members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

**Members’ Rights and Responsibilities**

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

It can be found on our website. Go to [anthem.com](http://anthem.com), and select Provider link at the bottom of the page. Select Colorado from drop down list and enter. From Health & Wellness tab, select the link titled “Quality Improvements and Standards”, and then the link titled “Member Rights and Responsibilities”. Practitioners may access the FEP member portal at [www.fepblue.org/memberrights](http://www.fepblue.org/memberrights) to view the FEPDO Member Rights Statement.

**Medicare Advantage Updates**

**Medicare Supplement members should be using new ID cards**

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

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM’s online registration tool, OptiNet. OptiNet will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services. Areas of assessment include facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

These data will be used to calculate site scores for providers who render imaging services for our individual Medicare Advantage members.

All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey by January 1, 2017 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements. Participating providers who have already completed the survey but scored less than 76 can use the online registration at any time to update their information and improve their score. All providers, including those who score less than 76, will receive individualized information they can use to improve their score. **Act now to avoid line-item claims denials**

Providers are strongly encouraged to register and improve their scores as needed before the line-item denials for claims submitted for dates of service on or after January 1, 2017 begins. Facilities billing on a UB-04 claim form will be excluded from line item denials at this time.

The provider registration is available online at [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb).

- Select Anthem MA from the drop down menu
- Only those providers who have completed the provider registration will be able to view their information online
- If you have questions or need help completing the registration, please call AIM Customer Service at 800-252-2021

To learn how to complete your survey, attend a webinar and find out how to:

- Access the OptiNet Assessment.
- Copy previously completed OptiNet Assessments to your Anthem Medicare Advantage account.
- Complete a new AIM OptiNet registration.
- Interpret and improve your site score.

To register for the webinar sessions:

Please contact [ronald.younger@anthem.com](mailto:ronald.younger@anthem.com) if you would like an invite sent to your calendar for the following webinar:

**Dec. 7, 2016, 4-5 p.m. ET**
Dial 866-308-0254
Pass code 804 205 7402#
Smart Phone 1-Click Dial 866-308-0254,*,8042057402#

Additional information will be available at anthem.com/medicareprovider under Important Medicare Advantage Updates.
2017 Medicare Advantage individual benefits and formularies available

Summary of benefits, evidence of coverage and formularies for 2017 Individual Medicare Advantage plans will be available at anthem.com/medicareprovider. A few notable benefit changes for 2017 are listed below. An overview of additional 2017 benefit changes will be available later this month at www.anthem.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information.

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

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

  Please note: Certain places of service; including but not limited to, inpatient hospital, outpatient hospital, emergency room and urgent care will only assess one member copayment for each visit.

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

Routine physical exams are covered in 2017

The majority of Anthem Medicare Advantage (MA) plans will continue to supplement Medicare covered preventive services and offer coverage for routine physicals in 2017 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay or coinsurance as applicable by the member’s plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider. Please call the number of the back of the member’s ID card for specific coverage information.

Additional information is available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

Dual Eligible Special Needs Plans – provider training required

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

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

Additional information will be available at anthem.com/medicareprovider under Important Medicare Advantage Updates.
Avoid needless claims denials

Tips for avoiding unnecessary claims denials are available at anthem.com/medicareprovider under Important Medicare Advantage Updates, including such things as:

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

Keep up with Medicare news

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

- September reimbursement policy provider bulletin
- Medicare Advantage reimbursement policies
- Providers must enroll with Medicare to be able to Prescribe Part D Beginning Feb. 1, 2017
- Medicare Notices and provider requirements
- Clinical Cumulative Morphine Equivalent Dosing Point of Sale Edit effective January 1, 2017
- Prior authorization requirements for intracardiac electrophysiological studies and catheter ablation
- Prior authorization requirements for Erelzi, Amjevita, Voretigene neparovvec, Nanacog and Lartruvo
- Prior authorization requirements for Cuvitru, Ocrevus and Lutathera
- Prior authorization requirements for continuous interstitial glucose monitoring
- Diabetic Supply Coverage for Individual Medicare Advantage Members

Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)

Please check out these recent postings to the Health Care Reform Updates and Notifications page:

Important information about billing habilitative and rehabilitative services

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance marketplace / affordable care act information may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance marketplace / affordable care act, and all achieved articles, go to anthem.com; select the Provider link at the bottom of the page. Select Colorado from the drop down list, and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Marketplace / Affordable Care Act information.