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Announcements and General Updates

Expansion of Estimate Your Cost tool

Anthem Blue Cross continues to support cost transparency, which involves sharing provider cost information with members. We do this via our consumer transparency tools Anthem Care Comparison and Estimate Your Cost. We only display costs for procedures that are “shoppable,” non-emergency, high cost, high volume, and common services, such as a knee replacement. For these inpatient and outpatient procedures, Anthem Blue Cross determines a cost range for the “total episode of care,” which includes all services provided during an admission or outpatient visit – facility, professional and ancillary. These costs are based on historical negotiated rates.

Beginning in the first quarter of 2014, we are expanding the cost information that will be made available to members through the Estimate Your Cost (“EYC”) tool. Members using EYC will be able to view provider-specific costs for additional professional and ancillary services, including provider-specific office visit cost data.

Our disclosures of provider cost transparency information will continue to comply with all applicable contractual and legal requirements, and will only be available to Anthem Blue Cross members.

If you have questions regarding Anthem Care Comparison, Estimate Your Cost, or our expanded transparency initiatives, please contact your network representative.

AIM Clinical appropriateness guideline updates

On April 21, 2014, AIM Specialty Health® (AIM) will make enhancements to its Clinical Appropriateness Guidelines for Radiology and Cardiology.

A summary of these enhancements is provided below:

MRI and CT Upper and Lower Extremity

- Recent changes to MRI and CT of the upper and lower extremity for conservative therapy (e.g., physician-supervised physical therapy, medications and rest) prompted very useful feedback from health plan medical directors and the provider community. Based upon this feedback, the requirement for physician-supervised physical therapy prior to imaging has been removed from the following indications:
  - Ligament and tendon injuries
  - Epicondylitis
  - Persistent lower extremity pain (excluding the knee joint)
  - Acute and chronic tendon injuries – foot and ankle

- For chondromalacia patella, the conservative treatment timeframe criteria will be reduced from 12 weeks to 4 weeks.

- In addition, the imaging indication of hemarthrosis will be modified to include instances when arthrocentesis may be contraindicated (e.g., non-traumatic causes of hemarthrosis such as sickle cell, anticoagulant, or hemophilia).

Transcatheter Aortic Valve Implantation / Replacement (TAVI / TAVR)

Transcatheter Aortic Valve Implantation (TAVI), also known as Transcatheter Aortic Valve Replacement (TAVR), has emerged as an alternative to traditional aortic valve replacement in some subgroups of patients with aortic stenosis. In preparation for the TAVI/TAVR
procedure, it is important to examine the aortic root in order to properly size the aortic valve prosthesis. It is also necessary to evaluate the aorta itself as well as the femoral and iliac arteries to be sure there is a clear pathway for the catheters necessary to do the procedure.

The following guidelines will be modified to add an indication for the evaluation of the aortic root and aortic, iliac, and femoral vessels in patients undergoing evaluation for TAVI / TAVR:

- Cardiac CT (cardiac structure)
- Cardiac MRI
- CTA/MRA of the Chest
- CTA/MRA of the Abdomen
- CTA/MRA of the Pelvis
- CT of the Chest
- CT of the Abdomen
- CT of the Pelvis

The current and revised guidelines can be accessed at [www.aimspecialtyhealth.com](http://www.aimspecialtyhealth.com) or on the Anthem Blue Cross web site at [www.anthem.com/ca](http://www.anthem.com/ca), select “Provider”, and then click on “Enter”, under the “Provider Home” tab click on Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements. Please note that these changes are not effective until April 21, 2014.

**Medical policy and clinical guideline updates**

In order to reduce unexpected post-service claim denials, we are adding specialty pharmacy drug codes to the Specialty Pharmacy Prior Authorization list. The specialty drug codes from current medical policies and clinical guidelines that are being added to our existing pre-service review process are listed below. Please note that these recommendations do not apply to HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program (FEP), or State Sponsored Business (SSB).

The changes listed below will become effective on June 1, 2014.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00057</td>
<td>Ilaris</td>
<td>J0638</td>
</tr>
<tr>
<td>DRUG.00058</td>
<td>Berinert, Cinryze, Kalbitor, Firazyr</td>
<td>J0597, J0598, J1290, J1744</td>
</tr>
<tr>
<td>DRUG.00059</td>
<td>Romiplostin (Nplate)</td>
<td>J2796</td>
</tr>
<tr>
<td>DRUG.00060</td>
<td>Plerixafor (Mozobil)</td>
<td>J2562</td>
</tr>
<tr>
<td>CG-DRUG-03</td>
<td>Beta Interferons or Glatiramer Acetate for Treatment of Multiple Sclerosis</td>
<td>J1595, J1826, J1830, Q3025, Q3026</td>
</tr>
</tbody>
</table>

**Note:** If the service is not prior authorized/pre-certified, records will be requested for post service review based on the same criteria listed in the medical policy or clinical guideline.
Referenced based benefit

In early 2013 Anthem Blue Cross announced their collaboration with Castlight Health, a third party transparency vendor. At that time Anthem Blue Cross began offering a new employer group benefit option for expanded transparency. In 2014, Anthem Blue Cross will build on the collaboration with Castlight Health to offer a jointly-developed Referenced Based Benefit product.

Reference Based Benefits (also referred to as “reference pricing”, a “reference-based plan” or “RBB”), limits benefits for certain covered services to a maximum dollar amount. The goal of RBB is to have members engage in their health choices by giving them an incentive to shop for cost-effective providers and facilities. RBB plan designs hold the member responsible for any expenses above a calculated ceiling (called the “reference cost” or “reference price point”) for a single episode of service (subject to applicable out-of-pocket expense limits).

Anthem Blue Cross and Castlight Health are working together to offer an RBB product to encourage deeper consumer engagement via the use of a robust web capability, and a broad set of services to which RBB can be applied.

What Does RBB Mean to Providers

There are no additional steps providers need to take with a member enrolled in an RBB product. Claims are to be submitted under current Blue billing practices. Taking into account both the plan’s payment up to the RBB amount and the member’s payment for any amount in excess of the RBB amount, providers can continue to expect to receive their contracted rate for all procedures included in the applicable RBB plan design. To determine whether professional and facility charges are subject to a reference price point for the member, providers can call the member’s plan via the Blue Eligibility number (800-676-2583).

For additional questions about Anthem Blue Cross Reference Based Benefits and our collaboration with Castlight Health, please contact your network representative.

ICR now offers inquiry capability and accepts inpatient requests

Our ICR (Interactive Care Reviewer) tool continues to evolve, improving the precertification process. In the latest upgrade, ordering and servicing physicians and facilities can make an inquiry to view information on any precertification previously submitted via phone, fax, ICR, or other online tool (for example, AIM, Behavioral Health, eReview, etc.) for any member covered by Anthem Blue Cross, Anthem Blue Cross and Blue Shield, or Blue Cross and Blue Shield of Georgia.

In addition, new functionality now offers you the ability to submit both inpatient and outpatient precertifications online. These are the most recent enhancements to our online precertification tool but not the last, so please stay tuned ...

In the meantime, if you have not already done so, we invite you to attend one of our upcoming informational webinars. To learn more about how you can streamline the precertification process by taking advantage of our ICR’s many features, register today by clicking here or go to https://www.livemeeting.com/lrs/110001891/Registration.aspx?pageName=83ybf5cvr00ngx4.

As a reminder, you can access our ICR tool free of charge via the Availity® Web Portal. If your organization has not yet registered for access, go to www.availity.com and click on “Get Started” under Register Now for the Availity Web Portal. If your organization already has access to the Availity Web Portal, your Primary Access Administrator (PAA) can grant you access to Authorizations and you can start using our tool right away.
For questions regarding our ICR, please contact your local Network Management consultant. For questions on accessing our tool, call Availity Client Services at 800-AVAILITY (800-282-4548) or email questions to support@availity.com. Availity Client Services is available Monday-Friday, 5 a.m. to 4 p.m. PT (excluding holidays) to answer your registration questions.

*Note: ICR is not currently available for Medicare Advantage, Medicaid, FEP, BlueCard®, and some National Account members; requests involving Behavioral Health or transplant services; or services administered by AIM Specialty Health℠. For these requests, follow the same precertification process that you use today.

Availity, an independent company, provides claims management services for Anthem Blue Cross.

**Important: Final notice – you must register and use Availity now!**

On March 14, 2014, member eligibility, benefits and claim status inquiry functions are moving exclusively to the Availity Web Portal! You will no longer be able to utilize these inquiry functions on ProviderAccess®. As you know, Anthem Blue Cross has partnered with Availity to offer a multi-payer portal solution that gives you secure, single sign-on access to multiple payers’ information. Right now, you can access eligibility, benefits, claims status, patient care summary, care reminders and member certificate booklets (EOCs) on the Availity Web Portal at no charge.

Availity Web Portal also provides access for you to ask questions about Anthem Blue Cross claims using Secure Messaging, direct-link out to ProviderAccess for online remits and EOBs, and AIM Specialty Health™ (AIM). Don’t forget to access Interactive Care Reviewer, our new on-line precertification tool, for inpatient and outpatient procedures and inquiries.

**IMPORTANT: On March 14, 2014, we are SHUTTING DOWN the following functions on ProviderAccess*:**

- Eligibility and Benefits Inquiry
- Claim Status Inquiry

If your organization is NOT currently registered for Availity:

- The designated Administrator for your organization should go to www.availity.com
- Click on “Get Started” under Register now for the Availity Web Portal, then complete the online registration wizard
- The administrator will receive an e-mail from Availity with a temporary password and next steps

To minimize business disruption, it’s important that all users STOP using ProviderAccess and become familiar with Availity before the shutdown date. Please ensure that every individual has their own User ID and password for Availity. You cannot share login IDs. If your organization has multiple TINs, please also ensure that individuals are registered to every TIN to which they will require access.

**One More Important Step!**

Users can now navigate easily with a “single sign-on” between the Availity Web Portal and ProviderAccess. Here’s how:

1. Your organization’s administrator needs to enter each user’s ProviderAccess User ID into the Anthem Services Registration tool on Availity, and:
2. Check the box to select Anthem Provider Portal, then:
3. Users can go to My Payer Portal/Anthem Provider Portal on the Availity Web Portal and navigate to ProviderAccess without entering another login and password.

**Free Availity Training**

Once you log in to the Availity Main Menu page, you’ll have access to many resources to help jumpstart your learning, including free live training, frequently asked questions, and comprehensive help topics. To view the current training webinar schedule, click Free Training at the top of any page in the Availity portal or click www.rsvpbook.com/AvailityWest to find a current schedule of FREE Availity workshops and webinars.
Client service representatives are also available Monday through Friday, 5:00 a.m. – 5:00 p.m. PST, to answer your questions at 800-AVAILITY (800-282-4548).

*Note: Electronic transactions submitted via our Enterprise EDI Gateway are unaffected; you may continue to submit all X12 transactions through your current EDI transmission channels.

Availity, an independent company, provides claims management services for Anthem Blue Cross.

**Billing**

The CalPERS value based program

The CalPERS Value Based program is utilized for three frequently used, routine outpatient hospital procedures. Wide geographic and treatment cost variations exist in California for routine outpatient procedures. Services can be 2.5 to 3 times more costly in an outpatient hospital setting than at a free standing Ambulatory Surgical Center.

Value Based Site of Care establishes a **payment threshold for 3 targeted routine procedures** when the service is received at an outpatient hospital. Site of Care will apply to:

- Colonoscopy ($1,500 threshold)
- Cataract surgery ($2,000 threshold)
- Arthroscopy ($6,000 threshold).

There will be no benefit change when a participating, free standing Ambulatory Surgical Center is used. Members can be referred to their Evidence of Coverage booklet for further details or contact Customer Service at (877) 737-7776 to verify that you are a Value Based Site of Care.

If the procedure **must** be performed at a hospital or hospital based surgery center due to distance or medical safety reasons, contact Customer Service for instructions on how to receive an exception.

**Important information about new paper claim requirements**

As previously communicated, Anthem Blue Cross will begin accepting the updated CMS-1500 Claim Form version 02/12 starting on January 6, 2014. The National Uniform Claim Committee’s transition timeline for use of the 1500 Claim Form version 08/05 includes a dual submission period from January 6, 2014 – March 31, 2014.

Additionally, effective March 15, 2014, Anthem Blue Cross will return **incomplete** paper claims submitted on professional provider CMS 1500 Forms (either 08/05 or 02/12 versions) and institutional provider UB-04 Forms. Providers should ensure that paper claims are complete and follow data element usage, required fields, and valid code sets as defined in the National Uniform Claim Committee CMS-1500 Health Insurance Claim Form Reference Instruction Manual and the National Uniform Billing Committee Official UB-04 Data Specifications Manual.

**The following chart outlines instructions for the CMS-1500 Form:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number</td>
<td>1a</td>
<td>Enter valid ID numbers exactly as they appear on members' ID cards, including the alpha prefix. For members enrolled</td>
</tr>
<tr>
<td>Field</td>
<td>Locator</td>
<td>Instructions</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient’s Name (Last Name, First Name, and Middle Initial)</td>
<td>2</td>
<td>Insert name exactly as it appears on the ID card.</td>
</tr>
<tr>
<td>Health Plan Policy owner</td>
<td>4</td>
<td>Name of health plan policy owner (Insured) who is responsible for the policy.</td>
</tr>
<tr>
<td>Date of Current Illness, Injury, Pregnancy</td>
<td>14-new form</td>
<td>The date and accompanying Qualifier (431 or 484)</td>
</tr>
<tr>
<td>Other Date</td>
<td>15—new form</td>
<td>The date and accompanying Qualifier (090, 091, 304, 439, 444, 453, 454, 455, or 471)</td>
</tr>
<tr>
<td>Diagnosis Codes</td>
<td>21-new form</td>
<td>Diagnosis codes in consecutive order- A, B, C, D, E to L</td>
</tr>
<tr>
<td>Federal Tax ID Number</td>
<td>25</td>
<td>Indicate if Social Security # or Employer ID #</td>
</tr>
<tr>
<td>NPI Number</td>
<td>33A &amp; 24J</td>
<td>NPI of rendering (billing provider)</td>
</tr>
<tr>
<td>Total line charge</td>
<td>24F</td>
<td>Enter total amount for line of service. This is NOT the Medicare allowed amount</td>
</tr>
<tr>
<td>Diagnosis Pointers</td>
<td>24E-new form</td>
<td>Pointers with Alpha characters</td>
</tr>
<tr>
<td>Accurate total charge</td>
<td>28</td>
<td>Line charges must add up to correct total charge</td>
</tr>
</tbody>
</table>

The following chart outlines instructions for the UB-04 The Form:

<table>
<thead>
<tr>
<th>Field</th>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number</td>
<td>60</td>
<td>Enter valid ID numbers exactly as they appear on members’ ID cards, including the alpha prefix. For FEP members, use R plus eight numeric digits.</td>
</tr>
<tr>
<td>Patient’s Name (Last Name, First Name, and Middle Initial)</td>
<td>08</td>
<td>Enter patient’s first and last name as appropriate</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
<td>10</td>
<td>Enter Patient’s Date of Birth</td>
</tr>
<tr>
<td>Insured’s Name</td>
<td>58</td>
<td>Identifies name of health plan policy owner (insured) who is responsible for the policy</td>
</tr>
<tr>
<td>Federal Tax ID Number</td>
<td>5</td>
<td>No Special Characters and 9 digits</td>
</tr>
<tr>
<td>Patient Admission Type</td>
<td>14</td>
<td>Enter valid patient admission type</td>
</tr>
<tr>
<td>Admission SRC</td>
<td>15</td>
<td>Enter valid patient admission SRC, for Inpatient and Outpatient</td>
</tr>
<tr>
<td>Status</td>
<td>17</td>
<td>Enter valid patient Status, for Inpatient and Outpatient</td>
</tr>
<tr>
<td>Total line charge</td>
<td>47</td>
<td>Enter total amount for line of service. This is NOT the Medicare allowed amount</td>
</tr>
<tr>
<td>Accurate Total Charge</td>
<td>47 (line 23)</td>
<td>Check line charges to ensure they add up to correct total charge</td>
</tr>
<tr>
<td>Description</td>
<td>43</td>
<td>Enter any description verbiage, if appropriate, in the description field on facility claims</td>
</tr>
<tr>
<td>NPI Number</td>
<td>56</td>
<td>Enter accurate 10-digit National</td>
</tr>
<tr>
<td>Provider Identifier number</td>
<td>Provider Identifier number</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------</td>
<td></td>
</tr>
<tr>
<td>Admitting Diagnosis</td>
<td>Enter an admitting diagnosis if required for “type of bill” as indicated in the NUBC manual</td>
<td></td>
</tr>
<tr>
<td>Value or Monetary Amount</td>
<td>Submit a value code with its associated value amount (value or monetary amount) if needed</td>
<td></td>
</tr>
<tr>
<td>POA Indicators</td>
<td>Include valid present on admission (POA) indicators as appropriate</td>
<td></td>
</tr>
<tr>
<td>Patient Reason for Visit</td>
<td>Required on Outpatient</td>
<td></td>
</tr>
</tbody>
</table>

### Facilities must ensure all UB-04 fields are correct

Some facilities submit paper claims to Anthem Blue Cross with information missing from fields 39, 40 and 41. **Beginning March 15, 2014, paper claims with missing information, illegible information, and/or incorrect amounts will be returned.**

The following is a quick overview of the most common errors on fields 39, 40 and 41 when Medicare is primary and Anthem Blue Cross is secondary:

- Value codes are missing Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value code 06 is blood deductible.
- The member deductible is missing or does not match the Explanation of Medicare Benefits (EOMB). If there is a deductible amount indicated on the primary payer’s remittance advice, the UB-04 must include the member’s deductible (A1, B1 or C1 value code) and amount.
- The coinsurance amount is missing. If there is coinsurance on the primary payer’s remittance advice, the UB-04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).
- Blood deductible is not noted. If there is blood deductible on the payer’s remittance advice, the value code 06 must be on the claim along with the amount.
- There are errors in listing multiple value codes. If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.

### Helpful hints for all paper claims:

- Check the printing of your claims from time to time ensure proper alignment and that characters are easy to read.
- Ensure all characters are located inside the fields and do not “lie” on the lines or extend beyond the appropriate field. Claims will be returned if we are unable to clearly identify or read the data within a given box/field.
- In addition, please follow these guidelines when the following circumstances apply.
  - When submitting a multiple-page claim, the word “continued” should be noted in the total charge field on each page, with the actual total charge inserted on the LAST page of the claim.
  - When submitting a multiple-page claim, do not staple over any information, as this can make the information on the claim illegible when the staple is removed.
ICD-10: It’s time to test with Anthem Blue Cross

Anthem Blue Cross has started acceptance testing for providers who are EDI direct-submitters. We have chosen TIBCO Validator® as our primary testing tool that offers unlimited testing of your EDI HIPAA transactions. This self-guided, web-based processing application is equipped to test file formats and edits as they pertain to ICD-10. If you are not a direct submitter, you will need to partner with your claims submission vendor (clearinghouse, billing company, etc.) to test with us.

To get started, visit the “Free On-Line HIPAA Validation Testing” section on our Anthem EDI webpage. This is where you can find links to registration information and the guidelines for using the tool.

For more updates on ICD-10, visit the ICD-10 Updates webpage.

The new California official medical fee schedule (OMFS) for Workers’ Compensation

The RBRVS based Schedule has a changed the rate of reimbursement for many CPT Codes. A challenging issue is reports. Physicians have felt that the New Schedule does not encompass the time or review of records required for the generation of a WC Report, especially concerning items that are expected in such a report. This can include a detailed review of records, opinion concerning impairment, causality, future medical care, and the justification for these opinions. At the time of the composing of this Newsletter, we are in communication with the DWC, Insurance Carriers, and others, to clarify and resolve this issue.

HIPAA compliance reminder

Anthem Blue Cross is required to offer Electronic Fund Transfers to Providers. Should a Provider or Facility elect to receive payments via Electronic Fund Transfer, such election may be deemed effective by Anthem for any Claim your Agreement with Anthem pertains to. In support of CAHQ Administrative Simplification rules, Anthem may share information about Providers or Facilities, including banking information, with third parties to facilitate the transfer of funds to Provider or Facility accounts.

Coding tips

For claims processed on or after May 19, 2014, ClaimsXten® will automatically administer a frequency edit of one per date of service per member per provider for blood collection codes 36415, 36416, and S9529. Beginning on December 1, 2012, this frequency limit was documented in our Laboratory and Venipuncture policy.

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 to answer questions you have about the process, if you need clarification.
Network

Anthem Blue Cross information security policy

We would like to remind all ProviderAccess® or Availity users of the following: the sharing of User ID and Password information on our secure site is not compliant with Anthem Blue Cross’s Information Security Policy. Please ensure that all individuals who access our secure portal have their own individual User ID and password for each system, registered under their name and with their own individual contact information. In order to remain compliant with your contractual usage agreements on our portal, please also review your user lists at least quarterly to disable the profiles of any individuals who are no longer employed, and ensure all current employees have the access they need to enable them to use our secure web portal. Please take a few moments to do this now.

Attention all hi-tech diagnostic imaging providers: Register your sites in OptiNet℠!

To better serve our members by providing physicians with quality and cost information of imaging services available within our network, we remind all hospitals, free-standing imaging centers and physician practices who perform high-tech diagnostic imaging services to complete an OptiNet on-line survey for each participating imaging site. OptiNet is a healthcare transparency tool that displays both quality and cost information about diagnostic imaging services available to our members. Completing the registration ensures ordering physicians have quality and cost information available to them, and ensures compliance with Quality Improvement activities as outlined in the Provider Manual.

We thank those of you that have already completed your surveys, which is a requirement of this Quality Improvement Program. We remind you to keep your survey updated to prevent your site score from being adversely effected. A site score cannot be determined until the survey is complete. Be sure to periodically review your OptiNet registrations for completeness and imaging cost information. If costs are missing, please contact AIM at the phone number below.

Member Outreach Program

This Program highlights facilities offering high quality, affordable imaging services and involves outreach to Anthem members. During this outreach, members will have an opportunity to choose high quality services and potentially reduce their healthcare expenses by selecting high-quality, lower-cost providers. When Anthem receives preauthorization requests for certain MRI and CT services (oncology & pediatric cases excluded), members will be called and given information so they understand the provider choices available to them.

This program is voluntary; members are not required to choose a lower-cost option. Our goal is simply to provide members with information to make informed choices about their health care.

Calls will be placed to members when authorizations are granted for CT or MR services:
   a. at a site without a completed OptiNet survey (resulting in no site score),
   b. at a site with a low score, or
   c. at a site with a high score when nearby providers with the same or better score and significantly lower costs are available

Anthem Health Outreach staff will offer members nearby sites that have good site scores and lower costs. It is important that all Network providers of MRI or CT services complete the OptiNet on-line survey for all sites where MRI or CT is performed.
To access OptiNet, visit AIM at www.aimspecialtyhealth.com/marketing/goweb, or login to ProviderAccess® and select the Referrals and Pre-AUTH tab. You will be directed to the AIM Provider Portal from there. A checklist and interactive tutorial are available to assist you. For assistance in completing your registration, or for requesting direct access to the AIM Provider Portal, call AIM at 877-291-0360, option 3. For general questions about OptiNet, please reference the FAQ's and other materials available on the Provider Home page in ProviderAccess or contact Anthem Blue Cross’ Network Relations at 855-238-0095.

Thank you in advance for completing your OptiNet surveys, and for your continued services to our members!

Provider webinars: April, May, and June sessions

Join us at our 2014 second quarter webinars! Our Provider Network Education team offers quality educational programs and materials specially designed for the office staff of physicians, hospitals, medical groups, ancillary and other health care professionals. Our ‘complimentary’ education programs offer ‘blended learning’ via face-to-face and web-based learning opportunities exclusively for our contracted provider network.

For a complete schedule of our seminar, webinars, and on-demand e-Courses, log on to the Anthem Blue Cross website: http://www.anthem.com/ca/home-providers.html. Scroll down to the SPOTLIGHT section and click on the 2014 Provider Education Seminars and Webinars link.

Webinars - offer a “live” interactive, 90 minute session conducted remotely via the internet and facilitated by the Provider Network Education team and Subject Matter Experts. Registration opens March 24th.

Here is a listing of the topics and dates:

Time: 10:00am – 11:30am [PST]
“Complimentary”

- April 9 - Provider Manual Overview [Professional]
- April 16 - Behavioral Health Practitioner & Office Staff Orientation
- April 23 - BlueCard [Out-of-Area] Refresher

- May 7 - Provider Manual Overview [Professional]
- May 14 - Behavioral Health Practitioner & Office Staff Orientation
- May 21 - BlueCard [Out-of-Area] Refresher

- June 11 - Provider Manual Overview [Professional]
- June 18 - Behavioral Health Practitioner & Office Staff Orientation
- June 25 - BlueCard [Out-of-Area] Refresher

We also offer ... On-Demand, e-Courses: quick, short, informative, self-paced instruction on a variety of individual topics. Our e-Courses are available 24/7 at your convenience. A listing of the topics is available on the Provider Network Education web page.

QUESTIONS: email us at: network.education@anthem.com
What your patients need to know about emergency care

When your patient needs care right away, deciding where to send them can be a tough call. The emergency room (ER) may seem like a natural choice. But if it’s not a true emergency, you might save the patient money and time by directing them somewhere else where they can still be treated by a doctor, nurse or physician assistant. True emergencies need ER care or a 911 call. But with non-emergencies, consider other options. ER wait times are at an all-time high. Plus, an ER visit can be expensive for the patient.

So, what could you do when your patient needs care right away, but it’s not an emergency, and your schedule is full for the day? Consider these options for your patients. Retail health clinics and urgent care centers can take care of many of the same health issues, illnesses or injuries that your office and/or an ER can. Most retail health clinics and urgent care centers are open weeknights and weekends. As the primary doctor, you are still the best first choice. You know your patients better than anyone else. But if you are booked up for the day and can’t see the patient soon enough, or if it’s after hours, finding a clinic or an urgent care center is easy. Just go to http://www.anthem.com/eralt/UrgentCareCenters.pdf for a listing in the area that can handle your patients’ needs.

If it’s not an emergency, try these options:

- Retail health clinic (for covered individuals with PPO-type coverage): A clinic staffed by health care professionals who give basic health care services to walk-in patients. Most are often in a major pharmacy or retail store.
- Urgent care center without X-ray: A doctor’s office that doesn’t require the patient to be an existing patient or have an appointment and can handle routine care and common family illnesses.
- Urgent care center with X-ray: A group of doctors who treat conditions that should be looked at right away but aren’t as severe as emergencies. They can often do X-rays, lab tests and stitches.

Each clinic or center may have different services. Before you direct your patient, be sure to remind them to call and ask the clinic or center:

- What are your hours?
- Do you have services that I need?
- What age range do you treat—all ages?
- Are you in the patient’s health plan network?

Anthem covered individuals can also contact the 24/7 NurseLine at the telephone number listed on the identification card 24 hours a day, seven days a week. A registered nurse will listen to their questions and concerns and help the patient decide which type of care makes the most sense. The number is on the back of the patient’s health care ID card.

Now that you know more about covered individual options, we hope that the next time your patient is faced with a health problem. This information will assist you in helping the covered individual to get timely and appropriate care. Sometimes, the ER will be the right answer. Sometimes it won’t. But knowing the difference can save the covered individual time and money without sacrificing the quality of care.

Moved your office?

To ensure proper processing of all changes to addresses, tax ID numbers and provider profiles, please e-mail them to Provider_Database-Anthem-Wellpoint@Wellpoint.com. You can also send your changes by fax to 818-234-2836 or 866-243-3183. Keep in mind that all changes must be submitted on the physicians or medical group’s letterhead and signed by the physicians or authorized personnel.
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.

Medical provider networks

The Department of Workers’ Compensation (DWC) has been working throughout 2013 to develop regulations to meet SB 863 legislative requirements. At the time this newsletter was sent to press, the final regulations had not been posted. The proposed regulations currently allow a grace period through July 2015 for MPN applicants to obtain separate written signatures from providers who affirm to participate in the MPN’s for which they have been selected. Once the regulations are final, Anthem will send a communication that instructs you how to access a provider affirmation portal that will allow you to identify the MPN’s you are selected for and affirm your participation or decline your participation with an electronic signature. We appreciate the patience you have demonstrated as we await the final regulations.

Referrals to other providers in the Anthem Workers’ Compensation network

Remember that the Anthem Contract specifies referral to Anthem Contracted Laboratory, Ambulatory Surgery Center, or another Anthem Physician. Insurance Carriers, TPAs, and Employers are beginning to look critically at referral patterns and expect this to be consistent with the Anthem Contract.

Network leasing arrangements

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call Other Payors. Other payors and affiliates use the Anthem Blue Cross network.

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem Blue Cross members. As such, they’re entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. You can obtain the Other Payors list on ProviderAccess®, which can be accessed through the Anthem Blue Cross website at www.anthem.com/ca. If you don’t have internet access, please contact us at 855-238-0095 for assistance.
Health Care Reform Updates (including Health Insurance Exchange)

New articles available online

- Updated contact information for new ERA & EFT registration processes – January 2014
- Important message to hospitals, physicians and other healthcare providers about Anthem’s Health Insurance Exchange Plans – January 2014

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 achieved articles, go to anthem.com/ca, select the Provider link in the top center of the page, and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Information.

Guidelines and Quality Programs

HEDIS®: The childhood adolescent measures

Each year we collect records for multiple childhood measures and we know they can be confusing. In fact, some of you told us so in the recent provider survey. Perhaps we can help clarify. We have addressed each of the Childhood measures and have underlined the required minimum necessary chart documentation for each measure.

The Childhood Immunization (CIS) measure requests the immunization record for children who turned 2 in the measurement year (currently we are measuring 2013). It seeks to demonstrate that these children have received all recommended immunizations by that birth date. When copying records for this measure we also ask that for children who are not current you include any office notes explaining why they are not current. If your record does not indicate that Hepatitis B was given at birth we will ask you for any birth records that might show it was given. If a child has an allergic reaction to a vaccine or has a medical condition that precluded their receiving the vaccine we need a copy of that progress note. Sometimes parents request a delayed schedule or completely refuse immunizations so this documentation is important in our efforts to educate members and in analyzing our data. It is helpful to know that we didn’t miss a record or make an error.

The Immunization for Adolescents (IMA) measure asks for the immunization record in order to verify that a Tdap orTd was given within the age 10 – 13 timeframe and that the meningococcal vaccine was administered between ages 11 – 13, as recommended. If these immunizations are not noted on the record please check the progress notes and send copies of any notes recommending these immunizations, contraindications such as allergy to the vaccine or parental refusal. We see that this age group often doesn’t present for well visits so we ask that when they come in with a sprained ankle, etc. that you review the immunizations and provide those needed to maintain optimum health and compliance with recommendations.

Human Papillomavirus Vaccine (HPV) measures the number of adolescent females who received all three immunizations between their 9th and 13th birthdays. When given before or after this date range they are non-compliant, but we still need the immunization record to show this. We also need documentation of why they were not given if this is the case, such as the parent refused or an allergy to the vaccine. In this case progress notes may be needed for documentation of these reasons.
**Lead Screening (LSC)** requires both the date the lead screening was performed, prior to the second birthday and the result or finding. Please send **all lead screening tests and results** until the second birthday.

**Weight Assessment and Counseling for Nutrition and Physical Activity (WCC)** is probably one of the more confusing measures and applies to children aged 3 - 17. This measure is not limited to well child visits since referral for nutrition or physical activity may be discussed at other times. If you are not sure of what to send please send **all progress notes for the measurement year** in addition to the BMI Growth Chart.

This measure has three components including a BMI (body mass index) which must be documented as a percentile. Adult BMI’s are expressed as a value but the BMI percentile takes into consideration the child’s age and gender as well so it is quite different. The best place for documentation of this percentile is on the BMI Growth Chart, or graph but please remember the weight and height growth charts do not usually have this information. It must be the BMI chart/graph. Please note that BMI thresholds or ranges are no longer allowed, it must be the specific percentile.

The second component of this measure is the counseling for nutrition. Each child/parent should be having a discussion with the provider about their current eating patterns, types of foods, quantities of foods, junk food consumption, etc. This discussion may be documented as such in the progress note or your office may use a form with a check box for anticipatory guidance. Please note that the nutrition box must also be checked in order to be compliant. Educational materials may be provided and should be documented as to what exactly was given. Referrals for nutrition may also be counted so please send documentation.

The third component is the physical activity counseling. It is similar to the above nutrition counseling in that it requires discussion of what specific activities the child engages in and how much time is spent in that activity. A large problem area is activity counseling for the very young children in that developmental milestones do not count for compliance. In addition to those milestones it requires notes such as a child enjoys riding a tricycle and does so outside for 1 hour every day.

Compliance may also be reached through checking off the Anticipatory Guidance and making sure the physical activity section is also checked. Please note that American Academy of Pediatrics forms do not contain anticipatory guidance for physical activity. Again, educational materials may be given and should be specifically documented. If a sports physical is documented please copy the actual sports physical form.

**Well Child visits In the First 15 Months of life (W15) and Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)** are at times confusing since we are not limited to well visits. Preventive services can be provided at any visit and may occur over multiple visits, with the exception being inpatient and ER visits. For this reason we ask that you send **all visits for the measurement timeframe** (first 15 months of life for W15 and the measurement year for W34).

Each measure requires documentation of 1) a health and developmental history (including physical and mental), 2) a physical exam including height, weight, (head circumference for W15) and (for W34 BMI percentile, vision and hearing screen and blood pressure) as well as exam of heart, lungs, abdomen and extremities for both measures and 3) health education/anticipatory guidance such as injury/illness prevention, nutrition, oral health, no smoking in home, social skills and constructive family relationships, etc.

**The Adolescent Well Care Visits (AWC)** measure requires **all progress notes from the measurement year** including the sports physicals forms. This measure may be collected from OB/GYN providers since that may be the only provider seen by a member in the measurement year. Health education, anticipatory guidance and the health and developmental history are required for each member. Some of these services may occur during visits for illness/injury so we ask for **all visits in the measurement year** to meet compliance.
Thanks for the high quality care you provide, the documentation and the time and effort you and your staff put into getting this information to us in a timely manner. We hope this information is helpful to you and reduces the number of calls your office receives from us in order to get the precise information we need for these measures. To further reduce the number of calls you receive, please remember this is a chart audit so a portion of the chart is required. We look forward to these results in obtaining the highest HEDIS rates yet!

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

Timely access regulations

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

There are many activities that are conducted to support compliance with the regulations and we need you, as well as members, to help us attain the information that is needed. Some of these studies are sponsored by the Industry Collaborative Effort (ICE), allowing for consistency across Health Plans. These studies allow our Plan to determine compliance with the regulations. The activities include, but are not limited to the following:

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

These surveys are currently in process. Please make note of this with your office staff to ensure that they are prepared and that they understand the importance of each providers’ participation in each of the surveys.

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

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

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

**Advanced Access:** The primary care appointment availability standard may be met if the primary care physician office provides “advanced access.” “Advanced access” means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician’s assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).
We hope this clarifies Anthem's expectations and your obligations regarding compliance with the Timely Access Regulations. Our goal is to partner with our providers to successfully meet the expectations for the requirements with the least amount of difficulty and member abrasion. See below for a chart that outlines the Accessibility Standards for providers.

**Access Standards for Medical Professionals**

<table>
<thead>
<tr>
<th>Access to</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent appointments for Primary Care (PCP)</td>
<td>Must offer the appointment within 10 business days of the request</td>
</tr>
<tr>
<td>Urgent Care appointments not requiring prior authorization</td>
<td>Must offer the appointment within 48 hours of request</td>
</tr>
<tr>
<td>Non-urgent appointments with Specialist Physicians (SCP)</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 (this is an existing Anthem Blue Cross requirement and is not part of the Timely Access regulation)</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 foe non-emergent (urgent) matters information when to expect to receive a call back</td>
</tr>
<tr>
<td>Emergency Care (California law requires health plans to follow the “prudent layperson” standard in providing direction for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any “prudent layperson” would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go the emergency room if the caller believes they are experiencing an emergency)</td>
<td>Immediate Access to Emergency Care</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%) Member Nurse line available 24/7</td>
</tr>
</tbody>
</table>
### Access Standards for Behavioral Health and EAP Practitioners

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care Instructions <em>(California law requires health plans to follow the “prudent layperson” standard in providing direction for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any “prudent layperson” would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller believes they are experiencing an emergency).</em></td>
<td>Members are directed to 911 or the nearest emergency room</td>
</tr>
<tr>
<td>Non-Life Threatening Emergency Care</td>
<td>6 hours</td>
</tr>
<tr>
<td>Urgent Care (that does not require prior authorization)</td>
<td>48 hours</td>
</tr>
<tr>
<td>Urgent Care (that requires prior authorization)</td>
<td>96 hours</td>
</tr>
<tr>
<td>Routine Office Visit/Non-urgent Appointment</td>
<td>15 Business days (Psychiatrists)</td>
</tr>
<tr>
<td></td>
<td>10 Business days (Non-Physician Mental Health Care Providers)</td>
</tr>
<tr>
<td></td>
<td>5 Business days (EAP)</td>
</tr>
<tr>
<td>Access to After-hours Care</td>
<td>Available 24 hours / 7 days. Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Behavioral Health/EAP provider, and be informed when the call will be returned.</td>
</tr>
<tr>
<td>In office waiting room time</td>
<td>Usually members do not have to wait longer than fifteen (15) minutes after their scheduled appointment to see a Behavioral Health/EAP provider.</td>
</tr>
</tbody>
</table>

Members also have access to Anthem Blue Cross’ 24/7 NurseLine. The phone number is located on the back of the member’s health insurance ID card. In addition, Members and Providers have access to Anthem Blue Cross’ Customer Service team at the telephone number listed on the back of the members’ ID card. A representative may be reached within 10 minutes during normal business hours.

*If you have further questions, please contact Network Relations at 855-238-0095.*

For additional information about the regulations, please visit the Department of Managed Health Care’s website at: [http://www.healthhelp.ca.gov/library/reports/news/fstimelyaccess.pdf](http://www.healthhelp.ca.gov/library/reports/news/fstimelyaccess.pdf).
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/ca select > Provider > Enter > Home Page and then Health & Wellness>Practice Guidelines.

ConditionCare Program

Anthem Blue Cross members have additional resources available to help them better manage chronic conditions. The ConditionCare program is designed to help participants’ improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor’s orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

Engagement methods vary by risk level but can include:
- Education about their condition through mailings, telephonic outreach, and/or online tools and resources.
- Round-the-clock phone access to registered nurses.
- Guidance and support from Nurse Coaches and other health professionals.

Physician benefits:
- Save time for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and their staff.
- Support the doctor-patient relationship by encouraging participants to follow their doctor’s treatment plan and recommendations.
- Inform the physician with updates and reports on the patient’s progress in the program.

Nurse Coaches’ encourage participants to follow their physician’s plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician’s instructions, we collaborate with the treating physician to understand the member’s plan of care and educate the member on options for their treatment plan. Please visit the www.anthem.com/ca website to find more information about the program such as program guidelines, educational materials and other resources. Go to < www.anthem.com/ca > and click on Providers. Select your state and click Enter. Go to Health and Wellness and then click on ConditionCare. Also on our website is the Patient Referral Form, which you can use to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call 877-681-6694. Our nurses are available Monday-Friday, 6:30 a.m. to 7 p.m. PST, and Saturday, 7 a.m. to 5:30 p.m. PST.
Medicare Advantage Updates

2014 Coverage changes for diabetic supplies for DME

Effective January 1, 2014, all of our individual Medicare Advantage plans will only cover LifeScan, Inc., OneTouch® or Roche Diagnostics, ACCU-CHEK® diabetic glucometers and blood test strips. This benefit change is meant to help control out-of-pocket expenses while not compromising on quality.

Covered glucometers and blood test strips in 2014:

- LifeScan, Inc., OneTouch®
- Roche Diagnostics, ACCU-CHEK®
- A limit of 100 blood test strips per month

We will not cover other brands and manufacturers, or more than 100 test strips per month unless an exception is received from the member’s provider stating it’s medically necessary.

Click here for additional information including Transition Period, Precertification, and Covered Codes.

CMS introduces new patient management quality measures

The Centers for Medicare and Medicaid Services (CMS) introduced several new quality performance measures to help improve the general health status of Medicare beneficiaries. The new measures include:

1. Pharmacotherapy Management of COPD Exacerbation (PCE)
   - CMS measures the percent of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter and
     - were dispensed a systemic corticosteroid within 14 days of the event.
     - were dispensed a bronchodilator within 30 days of the event.

2. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
   - CMS measures the percent of adult members with a new episode of alcohol or other drug (AOD) dependence who received initiation of AOD treatment.

3. Medication Therapy Management Program Completion Rate for Comprehensive Medication Reviews (for Medicare Part D members)
   - CMS measures the completion rate for Comprehensive Medication Review (CMR), including:
     - The percent of beneficiaries who met eligibility criteria for the Medication Therapy Management (MTM) program and who received a CMR.
     - CMS defines a CMR as an interactive person-to-person or telehealth medication review and consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider. It is designed to:
       - improve patients’ knowledge of their prescriptions, over-the-counter (OTC) medications, herbal therapies and dietary supplements
       - identify and address problems or concerns that patients may have
       - empower patients to self manage their medications and their health conditions.
4. **Adult BMI and Medical Records – Please Record Exact Number, Not Range**

Healthcare Effectiveness Data and Information Set (HEDIS) is updating the medical records specifications for Adult Body Mass Index. In the past, it was acceptable to record a range for BMI, such as >30. **In 2014, HEDIS specifies that the exact BMI number should be recorded** in the medical record, such as 32. Greater precision in charting the member’s BMI will help the provider help the member achieve or remain at a healthy weight.

Thank you for reviewing these changes and your attention to these important patient management quality measures.

**Speaking the language of ICD-10: Part 4**

Our previous articles have discussed the importance of learning to speak the new language of ICD-10 in preparation for the upcoming code set conversion which begins October 1, 2014. We have made several suggestions on how to prepare for ICD-10 that have hopefully benefitted you and your staff. In this issue we provide an overview of the most common ICD-10 documentation concepts.

We know your primary focus is always on providing good patient care. Good patient care requires good documentation. Anyone who picks up your patient’s medical record should have a clear, concise, and accurate picture of the services and care provided to your patient. Your documentation includes outcomes, orders, and other information needed to provide continuing care for your patient. Once you achieve that goal, everything else falls into place, including the coding regardless of the code set.

In ICD-10, there are approximately 21 unique documentation concepts. Mastering the five most common documentation concepts as opposed to trying to remember all of the codes in the ICD-10 code set should be much less daunting.

**The 5 most common documentation concepts are as follows:**

- **Laterality** - ICD-10-CM contains the concept of laterality. If there is a right side or left side, proximal or distal in play, documentation should clearly state it. Coding will capture this concept. Veer away from the use of unspecified codes when laterality is indicated.

- **Type** - When the condition includes variations, documentation should include which type of condition the patient has. This could impact future resources, such as services, medications, procedures, and proof of medical necessity for each patient’s clinical condition. Your documentation will help other providers become better able to treat the patient when addressing underlying conditions or manifestations.

- **Cause** - If the patient’s condition is due to another condition, then documentation should indicate the cause. The linking of the two conditions should be clearly stated and should be stated with specificity.

- **Manifestations or complications** - Many conditions have complications or manifestations and all should be documented, as many require additional treatment plans or resources.

- **Anatomical location** - The location of the condition should always be documented as precisely as possible.

In addition to enhancing patient care, complete and accurate medical record documentation and diagnosis coding plays a critical role in managing our Medicare Advantage membership and meeting two CMS challenges. First, your coding and documentation plays a key role in helping you comply with CMS’s requirement that you report all member health conditions to CMS - and that you properly document all member health conditions. Secondly, coding and documentation are instrumental in our ability to receive accurate risk adjustment payment from CMS, which will impact the services and benefits we are able to provide to our membership.

For more information about ICD-10 you may want to visit the following websites:
Billing for Medicare primary members – correct use of the GY modifier

In October, Anthem Blue Cross implemented new guidelines to help reduce the administrative work associated with Medicare crossover claims filing. To help ensure timely and accurate payment, please review the following information for filing claims for Medicare statutorily excluded services.

The Centers for Medicare & Medicaid Services has a list of statutorily excluded services or services that Medicare will not reimburse. CMS has established a GY modifier to indicate to secondary and tertiary payers a statutorily excluded service. While Medicare never covers statutorily excluded services, in some instances, a secondary payer, such as Anthem Blue Cross, may cover all or a portion of those services.

To expedite payment when submitting a claim for statutorily excluded services, only services with the GY modifier should be submitted on the claim. If other non-statutorily excluded services are rendered, those services should be split off the claim and submitted on a separate claim.

If providers submit combined line claims (some lines with the GY modifier, some without) to their local plan, the provider’s local plan will deny the claims, instructing the provider to split the claim and resubmit.

**Original Medicare** -- The GY modifier *should* be used when service is being rendered to a Medicare primary member for statutorily excluded service and the member has Blue secondary coverage, such as a <Plan Name> Medicare Supplement plan. The value in the SBR01 field should not be “P” to denote primary.

**Medicare Advantage** -- Please ensure SBR01 denotes “P” for primary payer within the 837 electronic claim file. This helps ensure accurate processing on claims submitted with a GY modifier.

**The GY modifier should not be used when submitting:**
- Commercial claims
- Federal Employee Program claims
- In-patient institutional claims. Please use the appropriate condition code to denote statutorily excluded services.

Providers can call the E-Solutions HelpDesk at (800) 470-9630 or go to http://www.anthem.com/edi to request assistance with submitting electronic claims to us. For questions regarding where to file paper claims, please contact the provider call center. If you are located in California, Nevada, Colorado, Georgia, Maine or New Hampshire please call 1- 877-811-3107.
CMS monitors Medicare Part D patient safety

The Centers for Medicare and Medicaid Services (CMS) monitors a number of Part D safety measures. Medication safety indicators monitored by CMS include:

High Risk Medications:
- Monitors the percent of Medicare Part D beneficiaries 65 years or older with two or more fills for a high risk medication, a subset of the Beers list medications.
- Goal: Reduce the use of medications for which there may be a safer alternative.

Making progress to improve patient safety: avoiding second fills on high-risk medications
- Our plan is required to monitor prescriptions activity for high-risk medications as defined by The Centers for Medicare and Medicaid Services (CMS). The goal is to improve patient safety.
- Anthem Blue Cross is now regularly updating a database of all our members who are at least 65 years old and take medications that may be inappropriate for older patients. We use this database to generate a list of claims for patients who are taking medications on the CMS list.
- If one of your patients fills a prescription for a medication on this list for the first time this year, we will send you a fax. We want to help avoid second fills on prescriptions for these high-risk medications.
- If you receive a fax from us, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed here.

Diabetes Treatment:
- Monitors the percent of members with pharmacy claims for diabetes and hypertension medications
- Goal: Support the use of angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) therapy as indicated in Medicare Part D beneficiaries with diabetes.
- The Centers for Medicare & Medicaid Services (CMS) tracks several performance and quality measures in place for Medicare Part D members. To ensure that we are in alignment with CMS, one of the measures we’ll be focusing on for the remainder of this year is medication treatment for patients with diabetes and hypertension.
- The American Diabetes Association guidelines recommend that ACE inhibitors or ARB medications be given to patients with diabetes and hypertension to help reduce the risk of cardiovascular events and the progression of nephropathy indicated by levels of microalbuminuria/albuminuria. If your patients have diabetes and hypertension, we ask that you please consider whether an ACE inhibitor or ARB medicine may be an appropriate treatment at this time.

Medication Adherence: Monitors the percent of Medicare Part D beneficiaries with < 80% adherence with the prescribed medication.
- Goal: To support medication adherence Includes:
  ○ Adherence for Oral Diabetes Medications
  ○ Adherence for ACE-I, ARB or direct renin-inhibitors
  ○ Adherence for Statins

Anthem Blue Cross has a comprehensive program to support member medication use related to these goals. Members are mailed information on care opportunities. Members receive additional support over the phone. Medication adherence tips are provided by phone and nurses and pharmacy staff are available to triage clinical questions the beneficiary may have on these medications. Beneficiaries on diabetes and hypertensive medications receive calls from pharmacy staff to discuss the benefits of ACE-I or ARB therapy.

Providers are also mailed or faxed potential care opportunities tied to these goals, as identified through claims analysis.
**Update: Medicare Advantage Specialty Pharmacy Unit phone option number**

To pre-certify specialty drugs for Medicare Advantage members, please dial 1-866-797-9884 and choose option 5. An incorrect phone number was published in the previous edition of Network Update. If you participate in the e-review process, please continue to submit requests to the secure Medicare Advantage e-review box at MAspecialtypharm@wellpoint.com.

If you have additional questions, please contact your local Network Relations consultant.

**2011 medical records required for Anthem Blue Cross Medicare Advantage plans national RADV audit**

Anthem Blue Cross Medicare Advantage plans were selected to participate in this year's Centers for Medicare & Medicaid Services 2012 National Risk Adjustment Data Validation Audit, which means we will once again be reaching out to our providers for help. Each year, after final risk adjustment diagnosis data is submitted by Medicare Advantage health plans to CMS, CMS conducts an audit of the diagnosis data submitted by the health plan. The audit helps CMS verify the accuracy of diagnosis data that was sent to CMS for medical services that were provided to health plan members. This year’s RADV audit covers dates of service that occurred during the 2011 calendar year. As a provider (i.e. hospital or physician) who treated one or more of our members during the 2011 calendar year, you are required to participate in this year’s audit if any of your patients covered by Anthem Blue Cross’s Medicare Advantage plans are selected by CMS for inclusion in this year’s 2012 National RADV Audit.

CMS randomly selected contracts and members for inclusion in this year’s National RADV Audit. The RADV Audit process begins 02/05/2014 and will end 16 weeks later at midnight on 05/30/14. To verify the accuracy of diagnosis data that was sent to CMS for medical services that were provided to Medicare Advantage health plan members, CMS requires Anthem Blue Cross to submit medical records that support and validate the reported diagnosis data.

Anthem Blue Cross is using a contracted vendor to assist us in retrieving the medical record. If one or more of your patients covered by an Anthem Blue Cross Medicare Advantage product is included in this year’s RADV Audit, you will receive a written request for medical records from Verisk Health after the audit start date of 02/05/2014. This written notice will provide details of the request and directions for submitting the requested medical records to Verisk.

**What do you need to do?** Based on Anthem Blue Cross’s records, if you are identified as a provider that treated one of the members included in the audit, CMS asks that you respond to a medical record request by supplying all medical records with a 2011 date of service for the member(s) in question. Once we receive a copy of the requested medical record, we will send it to CMS to help them verify the member’s diagnosis data. Your compliance with this request is extremely important to us and to CMS. Without your assistance and commitment to this process, we will be unable to meet our RADV audit obligations.

**Are you required to provide the requested medical record?** Yes, for several very important reasons. According to CMS, the risk adjustment data can only be verified by reviewing the member’s 2011 medical record documentation. Also, CMS requires that the Medicare Advantage health plan and its providers provide medical records for purposes of verifying the risk adjustment diagnosis data (42 CFR 422.310). Finally, don’t forget that Medicare Advantage health plans and their providers agree to maintain records for a period of 10 years (42 CFR 422.504(d)) and are obligated to provide CMS with access to facilities and records, including medical records, used in determining health plan payments. (42 CFR 422.504(e)(2)-(4)).
Thank you in advance for your assistance. We realize your time is valuable and we appreciate your cooperation and timely response.

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**Anthem Blue Cross moves from 17th to 18th edition of MCG Guidelines effective April 28, 2014**

Anthem Blue Cross Medicare Advantage plans will begin using with the MCG™ Guidelines (formerly Milliman Care Guidelines®) 18th Edition as a utilization management and case management resource effective April 28, 2014, Anthem Blue Cross will continue to use the MCG™ Guidelines 17th edition until then.

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**Medicare Advantage members receive personalized checklist for preventive services**

We plan to mail a personalized healthy checklist to Medicare Advantage members mid-year 2014. The checklist is specific to each member’s health status. The checklist reminds members to ask you about preventive care and screenings they may need. Members may bring the checklist to their office visits. We encourage you to review the checklist with them to help ensure they understand and receive any preventive care or screenings they may need.

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**Pharmacy**

**Pharmacy information available on anthem.com/ca**

Visit [http://www.anthem.com/pharmacyinformation](http://www.anthem.com/pharmacyinformation) for more information on copayment/coinsurance requirements and their applicable drug classes, Drug Lists and 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.