July 2014

Anthem BlueCross

Working together to improve the health of our members.

Network Update

PROFESSIONAL

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Announcements and General Updates

Important provider notice: November 2014 clinical appropriateness guideline updates

On November 3, 2014, AIM Specialty Health® (AIM) will make enhancements to their Clinical Appropriateness Guidelines for Radiology. A summary of these enhancements is provided below:

Head and Neck Appropriate Use Criteria

- New pediatric head trauma CT: Appropriate use criteria incorporating the Pediatric Emergency Care Applied Research Network (PECARN) rules.
- New pediatric sinusitis CT: Appropriate use criteria addressing the imaging of sinusitis at each stage of the care continuum (screening, diagnosis, management, surveillance). This appropriate use criteria also addresses pre-and post-operative imaging and complications of sinusitis.
- New general appropriate use criteria for medical (i.e. non-dental) imaging of the temporomandibular joint (TMJ) using CT. Radiographs are required prior to CT imaging, and CT imaging is restricted to a limited list of conditions.

Musculoskeletal Appropriate Use Criteria

- Revised labral tear MRI: Appropriate use criteria according to the care continuum. These revisions will now require 4 weeks of conservative therapy prior to imaging for a superior labral anterior posterior (SLAP) tear unless specific high risk conditions are met. The appropriate use criteria also incorporate anterior and posterior glenohumeral labral tears/instability.
- Revised rotator cuff MRI: Appropriate use criteria including specific guidelines for acute and chronic rotator cuff tears. Select patients with acute rotator cuff tears can be treated with 4 weeks of conservative therapy prior to imaging.
- New Ankylosing Spondylitis (AS)/Sacroiliitis: Appropriate use criteria propose the use of MRI to both diagnose and manage patients with AS. These appropriate use criteria reflect the recent incorporation of MR imaging into the AS diagnostic criteria.

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

Updates to the specialty pharmacy prior authorization list

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 new or current medical policies are being added to our existing pre-service review process and 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).

Medical Policy or Clinical Guideline	Description	Codes	Effective Date
DRUG.00002	Injection, Golimumab, 1 mg, (Simponi Aria)	J1602	Immediately
DRUG.00062	Obinutuzumab (Gazyva®)	C9021	October 1, 2014
DRUG.00063	Ofatumumab (Arzerra™)	J9302	October 1, 2014

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.

Effective October 1, 2014: Change in California pharmacy prior authorization form

Effective October 1, 2014, all providers treating members enrolled in a California fully insured medical plan, regardless of the state where the member resides, the state where the provider is located, or the state where services are provided, must begin utilizing the uniform Pharmacy Prior Authorization form required by the Department of Managed Healthcare (DMHC) and California Department of Insurance (CDI). **Anthem Blue Cross will also require use of the California standardized pharmacy authorization form for all other funding types.** After October 1, 2014, providers must submit pharmacy authorization requests using the attached form, and may continue to submit the form using the same manner for form submission used today. For fully-insured members only, Anthem Blue Cross or its delegated medical group will notify the prescribing provider within two business days of receipt of a completed Request Form that:

(A) The prescribing provider's request is approved;

(B) The prescribing provider's request is disapproved as not medically necessary or not a covered benefit;

(C) The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the request;

(D) The patient is no longer eligible for coverage; or

(E) The request was not submitted on the required form, and must be resubmitted using the approved Request Form.

For all other funding types, existing decision response time will remain.

The new pharmacy authorization form will be available on our Anthem.com California provider portals and more details will be provided in the next California Provider Newsletter, *Network Update*.

Change in prior authorization process for medical policy MED.00005 – Hyperbaric Oxygen Therapy: Effective October 1, 2014

A pre-service clinical review is currently required for CPT code *99183 - physician attendance and supervision of hyperbaric oxygen therapy, per session* (MED.00005 – Hyperbaric Oxygen Therapy). Effective October 1, 2014, CPT code *C1300 - hyperbaric oxygen under pressure, full body chamber, per 30 minute interval* (MED.00005 – Hyperbaric Oxygen Therapy) will also require a pre-service clinical review.

Please note that this change does not apply to HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program® (FEP), State Sponsored Business (SSB) or selected National accounts. In addition, please be advised that existing requirements for review of inpatient services will continue.

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.

Operating Engineers Trust Funds has a new online healthcare portal available for all providers

We would like to share with our network providers that the Operating Engineers Trust Funds has a new portal on their website exclusively for healthcare providers. This portal enables physicians and other healthcare professionals to:

- Check the eligibility and benefits of their members, and
- Check the status of paid and pending claims

It's easy, just go to www.oefi.org and click on the *Check Claims Status* or *Check Eligibility Status* buttons on the Health & Welfare Plan drop-down menu. **Note:** First time users will need to create an account.

Enhancements in the future will include specific "benefits used" and available for their members.

Looking for benefit or eligibility information for MCS or JAA members (TPA/Other payor accounts)?

Currently, Anthem Blue Cross is receiving a large number of calls for members, whose benefits and eligibility are not stored on our system, resulting in the need to transfer calls to our TPA partners.

SAVE TIME by remembering to:

- Look at the back of the Member's ID card to identify the Customer Service phone number for the member's account
- The correct telephone numbers will direct you to the correct number, the first time, including Other Payors such as TPA, MCS and Trust Fund Accounts

Need to check the status of an authorization? Don't call – use Interactive Care Reviewer (ICR)

Our Interactive Care Reviewer (ICR) tool continues to evolve, improving the precertification process. Now, it is easier to check on the details of a precertification. Instead of waiting on the phone, ordering and servicing physicians and facilities can view information on any precertification previously submitted via phone, fax, or ICR, or other online tool, for any member covered by Anthem Blue Cross, Anthem Blue Cross and Blue Shield, or Blue Cross and Blue Shield of Georgia. Try it today!

You can access this inquiry functionality under ***Auth and Referral*** on the left navigation bar on www.Availity.com .

If your Organization is NOT currently registered for the Availity Web Portal:

- 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.

Not Sure if Your Organization is Registered?
Call Availity Client Services for registration status of your Tax ID.

If your Organization is registered for the Availity Web Portal and just needs access to inquiry:
Your Primary Access Administrator can grant you access to ***Authorization and Referral Inquiry.*** Once you have access to ***Auth and Referral*** on www.Availity.com , click on Inquiry from the left navigation bar and you can start using our tool right away.

In addition, you can now submit *both* inpatient and outpatient pre-certifications online[1]. These are the most recent enhancements to our online precertification tool but not the last. Your Primary Access Administrator can give you access to Authorization and Referral Request to allow you to start utilizing ICR today!

Need Training?
To learn more about how you can streamline the precertification process by taking advantage of ICR's many features, register today by clicking here or go to https://www.livemeeting.com/lrs/1100001891/Registration.aspx?pageName=83vbvn5cvr00ngx4
For questions regarding ICR functionality, contact Anthem Blue Cross' Network Relations Department via phone at 1-855-238-0095, or email at networkrelations@wellpoint.com. For questions related to issues accessing the ICR tool, please call Availity Client Services at **1-800-AVAILITY** (800-282-4548) or email questions to support@availity.com . Availity Client Services is available Monday-Friday, 8 a.m. to 4 p.m. PT (excluding holidays) to answer your registration questions.

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

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

Cultural competence provider trainings available (CME credits provided)

Anthem Blue Cross is very excited to offer its providers two culturally and linguistically targeted e-learning courses. These courses provide AMA Category 1 CME credits at no cost to you. The program was developed by Critical Measures, a nationally prominent consulting and training firm specializing in cross-cultural medicine.

We recognize that patients are becoming more racially, culturally and linguistically diverse. As such, there is an increased emphasis on cultural competence training for physicians, nurses and other health care professionals who interact with these patients daily. Research has shown that clinicians who are provided with multicultural training can better serve these growing patient populations. They are also more likely to improve patient satisfaction, adherence and outcomes, and increase their market share from some of the nation's fastest growing communities.

Here are brief descriptions of the e-learning courses available:

Language Access and the Law: Caring for the Limited English Proficient (LEP) Patient. Physicians and clinics that receive Medicare or Medicaid funding typically are required to provide interpreters and translated materials. This program reviews the business, medical (quality and safety) and legal basis for the language access mandate in health care. Based on a comprehensive patient case study that describes the current state of language access law and national best practices as they apply to health plans, physician clinics, emergency rooms, outpatient/pharmacy care and inpatient/hospital treatment. This program takes between 1.5 to 2 hours to complete and provides 2.25 hours of CME credit for doctors and nurses.

Viewpoints: Clinical Competence in a Globally Mobile World. Today, over 1 billion people cross international borders each year. That number is expected to double in 10 years. American medicine must adapt to the growing numbers of immigrants, refugees, students, international businesspeople and travelers to the U.S. We must also contend with the fact that U.S. citizens travel to the most remote parts of the globe and may return home with diseases that have been foreign to us up to now. In a globally mobile world, disease is no longer local. ***Viewpoints*** will better prepare physicians to treat common infectious and parasitic diseases that originate from outside the U.S. and assist them in distinguishing medical conditions commonly seen in the U.S. from those of foreign origin even when they exhibit the same symptoms. This program takes between 2.5 to 3 hours to complete and provides 6.0 hours of CME credit for doctors and nurses.

To access these courses, please view the course Quick Start guide.

We continue to grow - New Northern California providers added to ACO network

We are pleased to announce the addition of three Bay Area ACO partners to provide coordinated, evidenced-based care to PPO members with multiple chronic conditions:

- Brown and Toland Physicians
- UCSF Medical Group
- Select Sutter Health sites - are scheduled to join starting in October 2014. The sites are *Palo Alto, Mills Peninsula, Sutter Pacific and Sutter East Bay*.

They are joining the 14 other provider groups in our growing ACO network in California. These provider groups are part of a new, collaborative approach toward delivering personalized care called Enhanced Personal Health Care. This approach aims to improve the health of members primarily with chronic conditions. Members participating in Enhanced Personal Health Care will have access to a personalized health team, which includes a physician, a care coordinator and other health care practitioners as needed. It is available to a select number of PPO members at no extra cost.

Look forward to hearing more, as the ACO network continues to grow.

Enhanced personal health care learning opportunities

At Anthem Blue Cross, one of our goals is to assist primary care offices in our medical neighborhood in identifying patients who would benefit from care management, and assist their care teams in developing care coordination and care plans that would benefit their patients. One way is providing access to our educational webinars. By offering a combination of live webinars, an on-demand recording library and office hours, we are offering a package of opportunities designed to help with your practice transformation. We know placing the focus on the patient's care is powerful, since each patient is unique and their individual health differences require a treatment plan and care.

Click here to register for Collaborative Learning Opportunities available in our learning library.

Misrouted protected health information (PHI)

Providers and facilities are required to review all member information received from Anthem Blue Cross to help ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Anthem Blue Cross's provider services area to report receipt of misrouted PHI.

Billing

Reimbursement policy change: CPT code 96116

CPT code 96116: "Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face to face time with the patient and time interpreting test results and preparing the report."

Anthem Blue Cross, consistent with CPT guidance restricting billable code use to neuropsychologists and physicians, will later in 2014 limit 5 units of 96116 per year per patient to ensure the code is being used appropriately. Instances of services exceeding five (5) hours per year will be subject to review for case-specific detail. Medicaid and Medicare plans may have additional regulations and other guidance about utilization. This policy applies to all other health plans. In addition to the information provided here, you're encouraged to consult state licensing laws, CPT® resources and information provided by various professional societies such as the American Academy of Neurology or the American Academy of Pediatrics.

If you have any questions, e-mail Behavioral Health Provider Relations at BHNetworks@wellpoint.com

Update for providers managing ERA and EFT using the CAQH website

Providers using the CAQH website to register for or manage their ERA and EFT or EFT only enrollment should be advised that we are consolidating the list of some Anthem Blue Cross affiliated health plans listed on the CAQH website. Providers currently select individual check boxes representing each Anthem Blue Cross affiliated health plan when managing their enrollment in these electronic transactions. **Beginning August 18, 2014**, the following health plans will be listed together as a single check box on the CAQH website: Anthem, Empire, Blue Cross and Blue Shield of Georgia and their affiliates; BlueChoice HealthPlan Medicaid of South Carolina; Unicare Life & Health Insurance Company. This change will allow providers to select only one check box to receive ERA and EFT or EFT only for all of the above mentioned health plans. **Please note that this is an informational update only and no provider action is required.**

New 1500 claim forms should be submitted using appropriate claim software and data element requirements

In June 2013, the National Uniform Claim Committee (NUCC) announced the approval of an updated 1500 Claim Form (version 02/12) that accommodates reporting needs for ICD-10 and aligns with requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3. **On April 1, 2014**, the Protecting Access to Medicare Act of 2014 was signed into law, and this bill includes a provision that effectively delays the implementation of ICD-10 diagnosis and inpatient procedure codes for at least one year.

Anthem Blue Cross continues to accept claims submitted using the updated 1500 Claim Form (version 02/12). **Providers should take special care to ensure billing areas utilize claim software that supports the corresponding 1500 Claim Form version submitted to Anthem Blue Cross.** For example, if you are submitting paper claims on version 02/12 of the 1500 Claim Form, please be sure that your office is using claim software that supports the 02/12 version of the 1500 Claim

Form. Claims submitted with mismatched form types and data elements will be rejected. Additionally, please check the alignment of data elements on your paper claims to ensure they are properly aligned in their designated field(s).

Please follow the guidelines set forth by the NUCC for completing the new 1500 Claim Form, or your claim may be rejected. For more information about the revised 1500 Claim Form, please visit the National Uniform Claim Committee website; which provides helpful resources such as a list of changes between the 08/05 and 02/12 claim versions and the 1500 Instruction Manual.

Behavioral health audits

Anthem Blue Cross is instituting a behavioral health coding program. The program objective is to ensure that providers understand the CPT ® Coding Guidelines. When billing these codes, providers are required to clearly document the time to administer, interpret and prepare a report to support the number of units billed. One area we will focus in on will be the central nervous system assessment/test (e.g., neuro-cognitive, mental status and speech testing) CPT codes 96101-96125. Anthem Blue Cross will utilize Santé Analytics located in Nashville, Tennessee to administer these audits. These audits will begin July 2014.

Any questions related to the audit process and or results should be directed to the Santé Analytics Customer Service Line at (615) 600-0252. When calling, physicians will need to provide name, telephone number, tax ID number, and the Santé Analytic case ID (when applicable).

Why call? Behavioral Health rate information is available online

To view this secure information you need a ProviderAccess® account. Don't have a ProviderAccess account? Just click here and register today!

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

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.

Provider network education 2014 seminars and e-solutions

The Provider Network Education team develops, delivers and supports quality educational programs and materials for the staff of physicians, hospitals, medical groups, ancillary, behavioral health and other health care professionals. Our education programs offer 'blended learning', combining face-to-face and web-based opportunities. Our 'complimentary' education programs are offered to all contracted providers throughout California.

Seminars
Our Fall **'Provider Information Exchange'** seminars are interactive and offer tips, process improvements and best practices. Many relevant Anthem Blue Cross business topics of interest are presented. These seminars will be offered in twelve different locations throughout California in October and November.

In the ***Spotlight*** section of the Anthem Blue Cross website click on the **'***2014 Provider Education Seminars and Webinars'* link, which takes you to the Provider Network Education landing page and take a look at the collection of provider education tools available to view and print.

e-Solutions
The following web-based learning opportunities are available 24/7/365 from your own office and personal computer:

- SEMs – Supplemental Education Materials are available on a variety of Anthem Blue Cross business subjects. These documents will display in pdf format and can be viewed, saved or printed.
- On-Demand e-Courses offer a self-paced instruction environment. Currently there are (2) two e-Courses available for you to take. To register for an e-Course, select the click here link on the Provider Network Education landing page.
- Webinars offer 'live' interactive sessions conducted remotely through the internet and facilitated by the Network Education team and Subject Matter experts. Currently the (3) three topics offered are: "Provider Manual (Professional)", "Behavioral Heath Practitioner and Staff Orientation" and "BlueCard® (Out-of-Area) Refresher." The webinar schedule and topics are located on the Provider Network Education landing page. If you are interested in attending a webinar, select the click here link to register.
- Webinar Recordings offer our providers the opportunity to request a copy of a previously presented webinar. Simply send an email request to: network.education@anthem.com

Questions?
E-mail: network.education@anthem.com
Phone: 818-234-1016
Fax: 818-234-8959

Find answers to BlueCard® questions

As a participating provider of Anthem Blue Cross, you may render services to patients who belong to other Blue Plans and who travel or live in California. The BlueCard Program lets you conveniently submit claims to Blue Plans, including international Blue Plans, directly to Anthem Blue Cross. The *Blue Card Program Provider Manual* describes the advantages of the BlueCard Program, and provides information to make filing claims easy. It offers helpful information about verifying eligibility, obtaining pre-certification/pre-authorizations and who to contact with questions.

You can easily view the BlueCard Program Provider Manual online, go to anthem.com/ca > Providers > Communications.

Anthem Blue Cross EAP is opening the network to more California providers!

Anthem Employee Assistance Program (EAP) is now accepting applications to join the EAP from all participating CA Behavioral Health Providers. Go to Anthem EAP > Providers > scroll to Panel Consideration and follow the instructions to request an application.

Sign-up now for our *Network eUPDATE* today – it's free!

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our *Network eUPDATEs*.

Network eUPDATE is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates
- System changes
- Fee Schedules
- Medical policy updates
- Claims and billing updates

……and much more

Registration is fast and easy. There is no limit to the number of subscribers who can register for *Network eUPDATEs*, so you can submit as many e-mail addresses as you like.

Network leasing arrangements

Anthem Blue Cross 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

- Verify member grace period status electronically using Availity
- Webinar recording: Individual health care Exchange program
- Health Insurance Exchange quick reference guide

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.

2014 Medical chart review for members who have purchased plans on or off the Exchange – begins July

Each year, Anthem Blue Cross requests your assistance in our retrospective medical chart review programs. We continue to request members' medical records to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS). For example, we recently notified you of our medical chart review program for Medicare Advantage members to meet CMS requirements.

Today, we are sharing with you our plans to initiate a similar chart review program beginning in July for another subset of our member population – those members who have purchased our individual health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the Exchange). This particular effort is part of Anthem Blue Cross' compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual health plans on or off the Exchange. The members' medical record documentation helps support this data requirement.

Anthem Blue Cross engages Inovalon to conduct medical chart reviews for our Exchange members

To assist with our medical chart review program for members enrolled in our individual Exchange plans, Anthem Blue Cross is collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon's Web-based workflows will help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. Anthem Blue Cross will be working with Inovalon in retrieving and reviewing our members' medical records.

Inovalon will be using the following methods of collecting medical record information:

- Scanned or faxed medical records that providers' offices send to Inovalon
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider's EHR system

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon will follow up with a phone call to request that the providers' offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within one week.

In cases where Inovalon is requesting more than six medical records to review, the company will call the provider's office and arrange a time convenient for an Inovalon reviewer to visit the office onsite to collect the appropriate information. Before the onsite visit, Inovalon will mail or fax the provider's office a letter to confirm the upcoming visit. The Inovalon medical record review personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, an automated medical record data retrieval occurs through the provider's EHR system. Upon receiving the provider group's one-time authorization, Inovalon's systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this partnership is to both improve the medical record data extraction experience for Anthem Blue Cross' network-participating hospitals, clinics and physician offices. Anthem Blue Cross and Inovalon are working together to identify facilities and providers' offices for engagement.

Appropriate coding helps provide comprehensive picture of patients' health and services provided

As the physician of our members who have purchased health plans on and off the Exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. **When members visit your practice or office, we encourage you to document ALL of the members' health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed. By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping Anthem Blue Cross meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.**

Reminder about ICD-9 CM coding

As you are aware, the ICD-9 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, Anthem Blue Cross uses ICD-9 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for **diagnostic** coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.
- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider's overall management or treatment of that patient in the remaining three positions (total of four diagnoses allowed per claim line).
- Always assign the ICD-9 code to the highest level of specificity, using four- or five-position codes as appropriate.

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

Inovalon continues outreach efforts on Anthem Blue Cross' behalf to help identify members needing care

At Anthem Blue Cross, we are working to update health documentation for our members in the individual and small group markets who have purchased our health insurance plans on and off the Exchange. We identified members who have not seen a physician for medical care this year or appear to have some type of gap in care that could be closed by seeing a physician.

Working with our providers, we engaged Inovalon to contact our members and encourage in-office visits with their physicians. Therefore, as a physician, you may receive letters throughout the year from Inovalon on our behalf. Inovalon began contacting providers and members in January 2014. We want to help ensure you and your office staff are aware of these ongoing outreach efforts Inovalon is conducting on our behalf.

It is important to note that this is a **voluntary** program developed to encourage members to seek treatment for any conditions that may be identified during the assessment. The goal is to identify or help close gaps in care. We appreciate your cooperation should Inovalon contact your office or facility.

In the event our members do not visit their physicians, Inovalon also offers the option of a personal health visit that a medical professional from Inovalon conducts in members' homes. The member may also opt to visit a retail clinic or other Inovalon location. We'll continue to provide updates about the Inovalon engagement in upcoming editions of the *Network Update*.

Guidelines and Quality Programs

Appropriate 911/Emergency care procedures

Emergency services are services provided in or out of the service area in connection with the initial treatment of a medical or psychiatric emergency and are available 24 hours a day and seven (7) days a week.

A member who considers a medical or psychiatric condition to be an emergency should be instructed to call 911 or go to the nearest hospital emergency room immediately. Anthem Blue Cross covers emergency services that are necessary to screen and stabilize a condition. No authorization or pre-certification is needed if the enrollee reasonably believes that an emergency medical or psychiatric condition exists. Once the condition is stabilized, the member's physician should be contacted for authorization of any additional medical services. A member should be directed to call the telephone number on the back of the member's Anthem Blue Cross ID card with any questions.

A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately. Examples of medical/psychiatric emergencies include:

- Severe pain
- Chest pains
- Heavy bleeding
- Sudden weakness or numbness of the face, arm or leg on one side of the body
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Active labor
- Attempted suicide
- Suicidal/homicidal ideation
- Acute psychosis
- Hazardous drug reactions/interactions

California law requires health plans to follow the "prudent layperson" standard in providing directions 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. A "prudent layperson" is a person without medical training who draws on practical experience when making a decision regarding whether emergency medical treatment is necessary. Therefore, Anthem Blue Cross expects all HMO and PPO practitioners to instruct their after-hours answering service staff that callers who believe they are experiencing an emergency should be instructed to dial 911 or go directly to the nearest emergency room. If emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted at a later date. Answering machine instructions must also direct members to call 911 or go to the nearest emergency room if they believe they are experiencing an emergency.

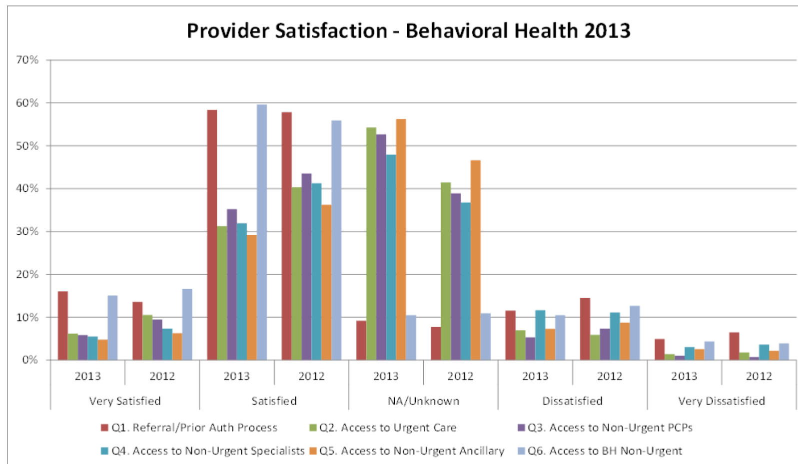
Clinical practice and preventive health guidelines available on the web

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.

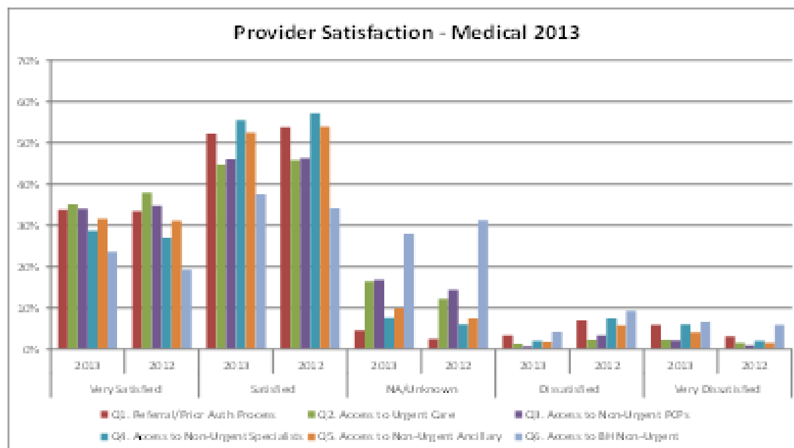
2013 Provider satisfaction survey results

At Anthem Blue Cross, we consider our relationships with you, our behavioral health and medical providers to be of critical importance as we strive to achieve our mission of improving the lives of the people we serve and the health of our communities. As part of our compliance with the Department of Managed Health Care's ("DMHC") Timely Access Regulations, the Plan participates in the annual ICE Provider Satisfaction Surveys. The survey assesses participating providers' satisfaction with behavioral health and medical networks. Behavioral health and medical networks are surveyed separately. Each year, we reach out to you to evaluate our performance. Your participation is important as this feedback influences our decisions about operational changes.

The results of our 2013 Provider Satisfaction Survey are shown in the graph below.



ICE Provider Satisfaction Survey - Medical



In compliance with the DMHC Timely Access Regulations, the Plan conducts an annual provider survey designed to solicit physicians perspective and concerns. The attached graph provides results of the 2013 provider survey. 2012 survey results are included as well for comparison purposes. Watch for the 2014 Survey – We need your feedback!

Your feedback is important to us. We firmly believe that by continuously monitoring our provider networks, and the service we provide you, we can forge a stronger collaboration, work together to solve health care issues, and truly transform health care for the better. Watch for the 2014 surveys, coming soon!

The ECHO™ member experience survey (Experience of Care and Health Outcomes) provides us with the member's perspective related to access to Behavioral Health After-Hours care. This information also helps to determine provider compliance with Accessibility Standards for Emergency Care Instructions and Access to After-Hours Care for our members. In surveying compliance with after-hours standards, participating providers' offices are called outside of normal business hours to determine if callers are given appropriate emergency instructions, and have a mechanism to reach a provider after regular hours for urgent situations. Members who have received behavioral health care within the previous year are also surveyed. This member survey is conducted via a mailing to members. These surveys combined, in addition to monitoring of member complaints, help us to identify whether access to care is available to our members after or before normal business hours.

The key to our 2014 success is….YOU!

We thank those of you who have already taken steps to comply with the standards. Your efforts make a direct positive impact to the level of service and access to care for our members. We need your continued commitment in helping us achieve the best results possible for our 2014 surveys, which will be conducted over the next few months.

In an effort to improve our results for 2014, Anthem Blue Cross is sharing the 2013 year results. For your reference, we have included them in the table.

ECHO Member Experience Survey 2012 and 2013

Question	Results
Got help or advice when calling after regular office hours	**2012:** 82.6% and **2013:** 82.8%

ICE Provider After Hours Survey 2012 and 2013

Question *Threshold > 85% of providers comply with the standard*	Results	
	2012	2013
"What would you tell a caller who states he/she is dealing with a life-threatening emergency?" Compliant Answers: Hang up and dial 911 or go to the nearest emergency room; Go to the nearest emergency room; or Hang up and dial 911.	Medical - 92.3% Behavioral Health - 73.6%	Medical - 90.3% Behavioral Health - 79.5%

Urgent Requests After Hours. **"In what time frame can the patient expect to hear from the provider or on-call provider?"** **Note:** Providers are expected to provide a specific time frame in that a member can expect a return call. If a specific time frame is not provided, the answer is considered "non-compliant".	Medical - 84.4% Behavioral Health - 77.9%	Medical - 81.5% Behavioral Health - 67.2%

Question 2 results demonstrate that the goal was exceeded in this measure for the second year in a row. There was a small drop in results in 2013 compared to 2012.

Question 3 results show a drop in our score from the prior year (2012), and it demonstrates that compliance was not met for the second year (2013). The Plan will continue to provide guidance to members and providers via newsletters regarding the After Hours Standards and expectations. Additional focused analysis will be necessary to determine the true cause of the drop in result. The plan will reach out to non-compliant providers with direction on correcting any deficiency in meeting after-hours requirements.

How Can You Make a Difference?

- Review *Anthem Blue Cross Access Standards* under the "Rights and Responsibilities" and "Quality Improvement" sections of your Anthem Blue Cross Professional Provider Manual and make sure your practice policy and procedures comply with the standards.
- Ensure your after-hours office staff; answering service and/or answering machine message specifically inform callers as to when their urgent (non-emergent) calls will be returned.
- Ensure your after-hours office staff, answering service and/or answering machine message directs callers to dial 911 or go to the nearest emergency room if they believe they are experiencing an emergency.

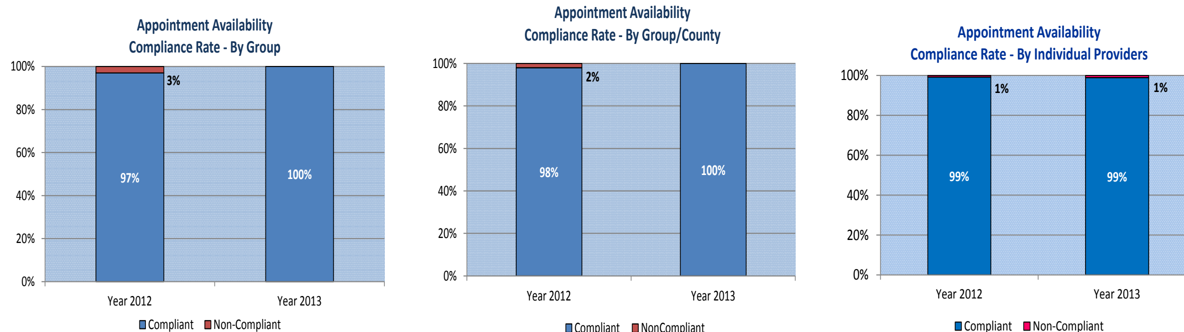
If your office was surveyed in 2013 and found non-compliant with these after-hours requirements, you will receive a letter with recommended compliance measures to ensure prompt changes are made prior to the commencement of the 2014 after-hours surveys.

Medical appointment availability survey

The Department of Managed Health Care (DMHC)'s Timely Access to Non-Emergency Health Care Services Regulations ("Timely Access Regulations")[1] became effective on January 17, 2011. The Timely Access Regulations require health plans to ensure that health care services are provided to patients in a timely manner appropriate for the nature of the patient's condition consistent with good professional practice. The regulations apply to health plans that are regulated by the DMHC.

Under the Timely Access Regulations, health plans are required to conduct two annual surveys to demonstrate that urgent and non-urgent care appointments (e.g., primary care, specialty care, urgent, ancillary, behavioral health) are offered within specified timeframes. The results must be reported to the DMHC.

Appointment Availability Survey - Health plans are required to assess appointment availability in their provider networks. To meet this requirement, health plans conduct a telephonic survey of a random sample of providers. The survey, which is expected to take approximately 10 minutes or less, will ask provider offices to identify, for individual physicians, the next available appointment (date/time) for various types of non-emergency care. We are pleased to see the high compliance rates for this survey over the two year period. See results below:



- **100%** of groups surveyed compliant for Appointment Availability, an increase from 97% in 2012.
- **100%** of groups separated by county surveyed compliant for Appointment Availability, an increase from 98%.
- **99%** of individual providers surveyed were compliant with Appointment Availability, consistent with results in 2012.
- All categories exceeded the goal.

The Appointment Availability Survey also provides information regarding contracted provider groups who offer our members *Advanced Access* appointment scheduling. A primary care provider may demonstrate compliance with the primary care time-elapsed access standards by providing advanced access to primary care appointments. 6,170 physicians (80% of all physicians surveyed) responded YES for Advanced Access for year 2013. ***Note: Please remember to alert members of your Advanced Access appointments when they are calling to schedule appointments***.

Smoking cessation for Anthem Blue Cross Select HMO Federal Employees

In an effort to help reduce future health risks the Anthem Blue Cross Select HMO Federal Employees Health Benefits program would like to introduce the Tobacco Cessation benefits that are offered to their members. The benefits provide coverage with no out-of-pocket expense and they include:

- smoking cessation programs for nicotine dependency
- physician prescribed over-the-counter (OTC) and FDA approved drugs for the treatment of tobacco use
- individual and group psychotherapy for the treatment of smoking cessation

.

Providers can help guide members to the Living Free Fitness and Health information online at anthem.com/ca>Federal Employee Programs>Value Programs>Special Offers. Members can also obtain information through their online registered account at anthem.com/ca. If you have any questions, please contact customer service at **800-235-8631**.

Medicare Advantage Updates

New 2014 Medicare Advantage precertification requirements effective July 1, 2014

There are new 2014 precertification requirements for Anthem BlueCross Medicare Advantage plans that Anthem Blue Cross made available March 28, 2014 on the Provider Forms section of the Anthem Blue Cross Medicare Advantage Public Provider Portal. These new precertification requirements will go into effect on July 1, 2014. The main changes effective in July are the requirement for providers to precertify select procedures for; **Knee Arthroscopy, Pain Management, Cardiac Catheterization, and Pacemakers (with defibrillators).** Some of these services were listed as required since January 1, 2014 but are called out here as reinforcement.

Please visit the Provider Forms section of the Anthem Blue Cross Medicare Advantage Public Provider Portal (www.anthem.com/ca/medicareprovider) to see the new precertification list that is effective July 1, 2014 as well as the precertification requirements that were effective January 1, 2014 through June 30, 2014. To obtain precertification or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member's identification card.

Y0071_14_19693_I_001

Anthem Blue Cross coordinates office visits for preventive screenings

Anthem Blue Cross is helping Medicare Advantage members make appointments for preventive screenings and other services to manage chronic conditions. If the member would like help scheduling an office visit or screening, we will place a call to the member's physician or screening facility to schedule an appointment while we're on the phone with the member. If we are unable to reach the provider while the member is on the phone, we will leave a message with the provider to call the member back to schedule an appointment. We appreciate your return calls and follow up to help ensure our Medicare Advantage members receive key services recommended by the Centers for Medicare & Medicaid Services.

Free support for Medicare Advantage members with type 2 diabetes

Patients with diabetes are faced with many challenges, such as knowing how and when to eat, avoiding complications, and getting support from family and friends. A Better Choices, Better Health® — Diabetes workshop can help patients manage these concerns.

These free workshops offer the benefit of the support of others who understand what patients with diabetes are going through, and your patients are invited to register for these free workshops.

Developed and tested at Stanford University, a Better Choices, Better Health®—Diabetes workshop can help people with diabetes:

- Understand how to eat with diabetes while still making it enjoyable
- Monitor and manage blood sugar levels
- Start or maintain a regular exercise program
- Improve communication with family, friends, and primary care team
- Design a self-management program.

Anyone 18 years or older with Type 2 diabetes can register for a workshop. Participants who are also our members will be asked if they would like to be part of the research study.

This workshop is offered free of charge as part of research study conducted by Stanford University. The study is funded by the National Council on Aging. Not all participants in the workshop will qualify for the study, but may take the workshop anyway.

Workshops are available online everywhere, or in-person in the Indianapolis, St. Louis and Atlanta areas. In person Workshops meet once a week for six weeks at the same day and time.

Participants meet in small groups. Both options offer a safe, supportive group of people with diabetes who want to share and solve problems together.

Online Workshops are a convenient way for members who live in any state to interact with peers online and take charge of their health. Members can participate from home or anywhere with Internet access by registering at **www.selfmanage.org**.

ICD-10: Another delay provides another opportunity

On April 1, 2014, the Protecting Access to Medicare Act of 2014 was signed into law. **The bill includes a provision that effectively delays the implementation of ICD-10 diagnosis and inpatient procedure codes for at least one year**. The delay also provides an opportunity to be even more prepared for the transition to come. We encourage you to continue your ICD-10 readiness activities, including:

- **Practice Assessment**: Understand where your practice stands on required tasks to comply by October 1, 2015. Carefully examine your documentation procedures. Reviewing your patient population and coding patterns will help you understand how ICD-10 will affect your practice. You may want to start with a review of the most often-used ICD-9 codes in your practice and work with your coding staff to select the appropriate corresponding ICD-10 codes. Identifying these codes will help reinforce the information to highlight when documenting patient diagnoses for ICD-10.
- **Training:** Significant time and effort will be required to bring yourself and your coders up to speed on the new ICD-10 requirements, new code sets, required documentation and associated technology.
- **IT Systems:** A variety of systems, including practice management, electronic health record and billing, must be modified to support ICD-10.
- **Documentation:** Clinical documentation improvement helps prevent high ICD-10 related denial rates and supports improved compliance with new and existing requirements. Medical record documentation plays a critical role in managing Medicare Advantage members. Accurate risk adjusted payment relies on complete and accurate medical record documentation and diagnosis coding, which ultimately impacts the benefits we are able to provide to our members. CMS requires that the medical record validate the diagnoses codes that have previously been reported by the physician. Therefore, as you make your way through your implementation plan, don't forget to include an assessment of your documentation practices. Documentation best practices rely on accurate, detailed and specific medical record documentation.
- **Coding Productivity:** Decreases in coder productivity of up to 20 percent are anticipated, creating a potential back log in cash flow. Early and thorough preparation and education may help reduce the possible negative impact on coder productivity.
- **Transition Plan:** Develop an implementation strategy that includes an assessment of the impact on your organization, a detailed timeline, and budget.

We encourage you to take this time to assess your progress, refocus if necessary and continue to move forward with your ICD-10 transition efforts. In addition to information provided on the provider portal, you may want to visit the following websites for the latest news, resources and references to help you prepare for the new deadline.

The one-page reference sheet produced by AAPC shows how the code sets are organized, with easy color coding to help you find what you're looking for. It also has mnemonic tips (such as "C is for cancer" and "T is for toxicity") to help you remember where the new codes are located.

American Medical Association physician resource page
Centers for Medicare & Medicaid Services (CMS) Provider Resources

AAPC ICD-10 Implementation and Training Opportunities

Update: Routine physical exams are covered in 2014

Anthem Blue Cross Medicare Advantage (MA) plans have returned to offering coverage for routine physicals (subject to plan benefits) through 2014 for individual and Employer Group Retiree Medicare Advantage members. Any outstanding claims with dates of service from January 1, 2014 to current will be adjusted as necessary.

When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member's plan. Anthem Blue Cross Medicare Advantage plans also will continue to provide benefits for the following Medicare covered services:

- **Initial Preventive Physical Exam** (IPPE) also known as the "Welcome to Medicare Preventive Visit"
- **Annual Wellness Visit** (AWV)

The IPPE (preventive physical exam) and AWV (wellness visit) are not a routine physical exam. Please refer to the chart below to ensure accurate coding for each type of exam.

The Welcome to Medicare Visit (IPPE) G0402	The Annual Wellness Visit (AWV initial and subsequent) G0438 & G0439	Routine Physicals/Preventive Medicine Services (99381-99397) Now covered during 2014 by Anthem Medicare Advantage Plans
G0402 Welcome to Medicare Visit/ Initial Preventive Physical Exam A preventive evaluation and management service; a face-to-face evaluation. This exam is a preventive physical exam and **not a comprehensive physical checkup.** This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a **once in a lifetime benefit**.	**G0438 *Initial* Annual Wellness Visit (AWV):** Services limited to beneficiary during the **Second** year the patient is eligible for Medicare Part B. **Only one first** AWV per beneficiary per lifetime. Includes a personalized prevention plan of services; face-to-face visit. **G0439 – *Subsequent* Annual Wellness Visit (AWV):** One year after the patient's Annual Wellness Visit. Once every 12 months. Includes a personalized prevention plan of services; face-to-face visit. This exam is a preventive physical exam and **not a comprehensive physical checkup.** **Note**: The AWV is intended to build upon the previously established "Welcome to Medicare Visit" physical exam.	**99381-99397 – Preventive Medicine Services:** The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient's age, gender, and identified risk factors; face-to-face visit. "The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors." Includes clinical laboratory tests.

Ob/Gyn providers please note: A Pap test and pelvic exam for our Medicare Advantage members is covered annually *only* if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past three years. Otherwise a Pap test and pelvic exam is covered every two years for women at normal risk. These services should be filed as separate codes from the routine physical, if they are rendered.

Medicare Advantage member benefits are subject to change from year to year – please review 2015 benefits when they are posted on the Medicare Advantage Providers page of the Anthem Blue Cross provider portal in late 2014. Annual summaries of Medicare Advantage plan changes also can be found under Important Medicare Advantage Updates. This will advise what coverage of what will and/or will not take place for routine physicals.

For further information or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member's identification card.

Y0071_14_20031_I 05/27/2014

Tips for improving HEDIS documentation on Asthma

While delayed, ICD-10 changes ultimately will impact your documentation related to Asthma. For instance, ICD-9 has no codes to identify members with persistent asthma. This will change with ICD-10. Health Effectiveness Data Information Set (HEDIS) ® will include members with persistent asthma in the eligible population. These new codes will improve identification of members through a combination of provider visits along with medication use.

Listed below is the portion of ICD-10-CM (J45) with codes specific to persistent asthma:

Codes	***Description***
J45.30	*Mild persistent asthma, uncomplicated*
J45.31	*Mild persistent asthma with (acute) exacerbation*
J45.32	*Mild persistent asthma with status asthmaticus*
J45.40	*Moderate persistent asthma, uncomplicated*
J45.41	*Moderate persistent asthma with (acute) exacerbation*
J45.42	*Moderate persistent asthma with status asthmaticus*
J45.50	*Severe persistent asthma, uncomplicated*
J45.51	*Severe persistent asthma with (acute) exacerbation*
J45.52	*Severe persistent asthma with status asthmaticus*
J45.901	*Unspecified asthma with (acute) exacerbation*
J45.902	*Unspecified asthma with status asthmaticus*

To use codes J45.3x, J45.4x and J45.5x-documentation must state whether the asthma was mild persistent, moderate persistent or severe persistent. Persistent asthma is defined as having one or more of the following both this year and last year: ED visit for asthma, four outpatient visits on different dates with asthma as part of diagnosis, along with four asthma medication dispensing events among those age 5 to 64.

To improve your HEDIS score even more, document any education to member and significant others about the use of and compliance with their asthma action plan. Provide information to members on using metered inhalers, avoiding asthma triggers, smoking cessation and schedule their next appointment for regular assessments of asthma severity and control. NCQA plans to monitor the use of these codes to assess the validity of using a simpler method to identify this population.

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

Measure members' body mass index regularly

Per Healthcare Effectiveness Data and Information Set (HEDIS)* guidelines, **adults 18 to 74 years of age should receive a Body Mass Index (BMI) assessment at the time of an office visit**. By meeting this requirement, you can help manage and ideally prevent members' obesity and related comorbidities.

Specific recommendations:

- Measure members' height and weight at least annually and calculate BMI
- Incorporate appropriate nutritional and weight management questioning and counseling into your routine clinical practice
- Identify, plan and integrate lifestyle interventions for the treatment of obesity into members' management plans
- Document the BMI percentile for members younger than 19 years of age, which will also meet the following HEDIS criteria:
    - BMI percentile documented as a value (e.g., 85th percentile)
    - BMI percentile plotted on an age-growth chart

When completing an encounter claim, use the appropriate V code from the tables below. Please note: The V code cannot be used as a primary diagnosis code. A more detailed BMI measurement chart is enclosed for office use.

Under Healthy Weight	
BMI	**V Code**
<19	V85.0

Healthy Weight	
BMI	V Code
19 – 24	V85.1

Overweight	
BMI	**V Code**
25	V85.21
26	V85.22
27	V85.23
28	V85.24
29	V85.25

Obese I	
BMI	**V Code**
30	V85.30
31	V85.31
32	V85.32
33	V85.33
34	V85.34

Obese II and III			
BMI	**V Code**	**BMI**	**V Code**
35	V85.35	40 – 44.9	V85.41
36	V85.36	45.0 – 49.9	V85.42
37	V85.37	50.0 – 59.9	V85.43
38	V85.38	60.0 – 69.9	V85.44
39	V85.39	70 & > (adult)	V85.45

Pediatric	
Percentile	**V Code**
Less than 5th percentile for age	V85.51
5th percentile to < 85th percentile for age	V85.52
85th percentile to < 95th percentile for age	V85.53
Greater than or equal to 95th percentile for age	V85.54

* HEDIS is a registered trademark of The National Committee for Quality Assurance

Advanced illness care planning available for Anthem Blue Cross members

Anthem Blue Cross Medicare Advantage members now have access to Vital Decisions, a program designed to improve the quality of the communication regarding end of life issues and planning among Medicare Advantage members, their family and their providers.

Vital Decisions uses proprietary predictive modeling to identify Medicare Advantage members who will benefit from this program. Vital Decisions counselors have advanced degrees and specialized training and evaluate a variety of criteria before any Medicare Advantage member is contacted for advanced illness care planning. The member must have a diagnosis of a terminal illness. The counselors work with Medicare Advantage members to ensure they are actively involved in decision making and communicate their care plan wishes to family, caregivers and providers.

Through telephonic clinical counseling sessions, Vital Decisions counselors help the member identify the barriers to effective quality of life communications and decision making and help the member develop the motivation and confidence to overcome those barriers.

Providers who would like to learn more about Vital Decisions or provide information about the program to Medicare Advantage members facing end of life decisions should call provider services at 1-877-811-3107.

Reminder: Please precertify cardiac catheterizations

This is a reminder that providers should precertify elective or non-emergent cardiac catheterizations for our Medicare Advantage members. Cardiac catheterization and other precertification requirements were posted on the Medicare Advantage Public Provider Portal in late 2013 and again in 2014. The following cardiac catheterization procedures should be precertifed:

93458	93454	93456	93453
93460	93451	93455	93457
93459	93461	93452	

Precertification is the determination that selected medical services meet medical necessity criteria under the member's benefits contract. For the member to receive maximum benefits, the health plan must authorize or "precertify" these covered services prior to being rendered. Precertification includes a review of both the service and the setting.

Submit all required clinical information at least three business days before the requested procedure to allow a thorough clinical analysis. For Institutional Admissions, all facilities must notify us within 24 hours or the next business day (whichever is earlier) after admission. In an urgent or emergent situation, the above time frames will be waived. Please provide notice to the plan as soon as possible.

Precertifications can be obtained at the following phone or fax numbers:

State	Phone	Fax
CA, CO, NV, OH, IN, KY, MO,WI, GA, VA, ME, NH	866-797-9884	800-959-1537

A complete list of precertification requirements can be found at the Provider Forms section of the Anthem Blue Cross Medicare Advantage Public Provider Portal (www.anthem.com/ca/medicareprovider).

To verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member's identification card. That number also may be used to obtain precertification.

Y0071_14_19855_I 05/02/2014

Avoid second fills of high risk medications

Anthem Blue Cross is required to monitor prescription activity for high-risk medications as defined by The Centers for Medicare and Medicaid Services (CMS) to improve patient safety.

To ensure providers are aware of any high-risk medications prescribed for our Medicare Advantage members, we fax a list of high-risk medication claims to providers each week.

Anthem Blue Cross also distributes a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication fax or report from us, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed here.

Improve Medicare Advantage members' medication adherence with 90-day prescriptions

To help improve medication adherence, Anthem Blue Cross will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. Ninety- day prescriptions help improve the adherence of our Medicare Advantage members by having them travel to their pharmacy less often. When medically appropriate, we request that you convert the member's prescription to a 90-day supply to improve patient adherence and outcomes without compromising the quality of care. Please note that we do *not* intend to transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.

Anthem Blue Cross to fax ADA guideline reminders, coordinate office visits for members with diabetes

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. We will send a fax to providers who are treating Medicare Advantage members with diabetes and hypertension not on a RAS antagonist (ace inhibitor, angiotensin receptor blocker, direct renin inhibitor). If you would like Anthem Blue Cross to coordinate an office visit for these members, please indicate that on the fax.

Y0071_14_20054_I 05/27/2014

Pharmacy

Pharmacy information available on anthem.com/ca

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit http://www.anthem.com/pharmacyinformation. The drug list is reviewed and updates are posted to the web site quarterly.