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Professional Network Update is produced bi-monthly by Anthem Blue Cross and comments may be addressed to:

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855-238-0095

CANL (01/15)
## Network
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- Network leasing arrangements

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- $0 Copay medications available to Medicare Advantage members with chronic conditions
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Health Care Reform Updates (including Health Insurance Exchange)

Access more information about the three month grace period status electronically

The Affordable Care Act (ACA) mandates a three month grace period for individual members who 1) purchase an ACA-compliant health plan on the exchange, 2) receive a government-subsidized Advanced Premium Tax Credit or APTC (often referred to as a premium subsidy), and 3) are delinquent in paying their portion of premiums. Read more about the ACA-mandated three month grace period [here](#).

In 2014, Anthem Blue Cross implemented a unique eligibility status message to help providers identify members in the second or third month of a grace period when using our real-time electronic, 271 eligibility and benefit transaction available via the Availity Web Portal or EDI. Members in the second or third month of a member grace period display the eligibility status "INACTIVE – PENDING INVESTIGATION".

Anthem Blue Cross is pleased to announce that we have expanded the level of detail available to providers related to member grace periods. The following information is now available via the electronic 271 transaction for members in a grace period:

- **2100C/D DTP:**
  - DTP01 = “343” (Premium Paid to Date End)
  - DTP03 = This message provides the date for which the premium is paid through (the last day of coverage for which a premium payment has been received). This is the last day of the month before the beginning of the grace period.

- **2110C/D DTP (1st iteration):**
  - DTP01 = “193” (Period Start)
  - DTP03 = This message provides the date that represents the first day of the first month of the grace period.

- **2110C/D DTP (2nd iteration):**
  - DTP01 = “194” (Period End)
  - DTP03 = This message provides the date that is the last day of the third month of the grace period.

- **2110C/D MSG:**
  - MSG01 = “Health Insurance Exchange - HIX GRACE PERIOD.” This message indicates that a member is in the second or third month of a grace period, and that claims for this member will pend until premium is paid.

If you previously called Anthem Blue Cross’ Provider Service department to confirm grace period status for a member, you may save valuable time by accessing member grace period information electronically via the Availity Web Portal or EDI.
**INDIVIDUAL PLAN NAME UPDATE**

Anthem Blue Cross has established new plan names for Individual Health Benefits policies marketed off the Covered California Exchange for the 2015 plan year. Plan names for Individual health benefit policies marketed on the Covered California Exchange will remain the same as in 2014.

Please note that benefits for plans marketed off the Covered California Exchange mirror those marketed on the Covered California Exchange. These new plan names will enable you to more readily distinguish between Individual policies marketed on the Covered California Exchange from those not. Below is a grid which lists the Plan names from 2014 and 2015, the applicable metal levels, and benefits types (EPO, HMO, and PPO).

<table>
<thead>
<tr>
<th>2015 Full Marketing Product Name Marketed On Exchange</th>
<th>Metal Level</th>
<th>Plan Type</th>
<th>2015 Full Marketing Product Name Marketed Off Exchange</th>
<th>Metal Level</th>
<th>Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Bronze 60 EPO</td>
<td>Bronze</td>
<td>EPO</td>
<td>Anthem Bronze Pathway PPO 5750/20%</td>
<td>Bronze</td>
<td>PPO</td>
</tr>
<tr>
<td>Anthem Bronze 60 PPO</td>
<td>Bronze</td>
<td>PPO</td>
<td>Anthem Bronze Pathway EPO 5750/20%</td>
<td>Bronze</td>
<td>EPO</td>
</tr>
<tr>
<td>$0 Cost Share Al-AN</td>
<td>Bronze</td>
<td>PPO</td>
<td>Anthem Bronze Pathway PPO 5000/25%</td>
<td>Bronze</td>
<td>PPO</td>
</tr>
<tr>
<td>$0 Cost Share Al-AN</td>
<td>Bronze</td>
<td>PPO</td>
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<td>EPO</td>
</tr>
<tr>
<td>$0 Cost Share Al-AN</td>
<td>Bronze</td>
<td>EPO</td>
<td>Anthem Bronze Pathway PPO 6250/20%</td>
<td>Bronze</td>
<td>EPO</td>
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<tr>
<td>$0 Cost Share Al-AN</td>
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</tr>
<tr>
<td>Anthem Bronze 60 Health Savings Account EPO</td>
<td>Bronze - HSA</td>
<td>EPO</td>
<td>Anthem Bronze 60 D EPO</td>
<td>Bronze</td>
<td>EPO</td>
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<tr>
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<td>Anthem Bronze 60 D PPO</td>
<td>Bronze</td>
<td>PPO</td>
</tr>
<tr>
<td>Anthem Minimum Coverage PPO</td>
<td>Catastrophic</td>
<td>PPO</td>
<td>Anthem Bronze 60 D EPO</td>
<td>Bronze</td>
<td>EPO</td>
</tr>
<tr>
<td>Anthem Minimum Coverage EPO</td>
<td>Catastrophic</td>
<td>EPO</td>
<td>Anthem Bronze 60 D PPO</td>
<td>Bronze</td>
<td>PPO</td>
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<tr>
<td>Anthem Gold 80 EPO, a Multi-State Plan</td>
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<td>EPO</td>
<td>Anthem Bronze 60 D Health Savings Account EPO</td>
<td>Bronze - HSA</td>
<td>EPO</td>
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<tr>
<td>Anthem Gold 80 PPO, a Multi-State Plan</td>
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<td>PPO</td>
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<tr>
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<td>PPO</td>
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<td>Platinum</td>
<td>HMO</td>
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<td>Platinum</td>
<td>EPO</td>
</tr>
<tr>
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<td>Anthem Platinum 90 D PPO</td>
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<td>PPO</td>
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<td>Product Name Marketed On Exchange</td>
<td>Metal Level</td>
<td>Plan Type</td>
<td>Product Name Marketed Off Exchange</td>
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<td>Plan Type</td>
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<tr>
<td>$0 Cost Share AI-AN</td>
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<td>Anthem Silver Pathway PPO</td>
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<td>PPO</td>
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<td>Anthem Silver 94 EPO, a Multi-State Plan</td>
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<td>EPO</td>
<td>Anthem Silver Pathway EPO</td>
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<td>EPO</td>
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<tr>
<td>Anthem Silver 70 PPO, a Multi-State Plan</td>
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<td>PPO</td>
<td>Anthem Silver Pathway PPO</td>
<td>Silver</td>
<td>PPO</td>
</tr>
<tr>
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<td>Silver</td>
<td>EPO</td>
<td></td>
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</tr>
</tbody>
</table>

**ID CARDS**

ID Cards for the 2015 benefits year will be mailed to existing enrollees in December 2014. The new ID cards will continue to indicate at the bottom the name of the Provider Network that supports Individual Plans Purchased on and off the Exchange.

<table>
<thead>
<tr>
<th>Individual Health Benefits</th>
<th>Network Name (which will appear on Member ID cards)</th>
<th>Exchange (purchased ON or OFF Exchange)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPO</td>
<td>Pathway X - Tiered</td>
<td>Purchased ON Exchange</td>
</tr>
<tr>
<td>EPO</td>
<td>Pathway Tiered</td>
<td>Purchased OFF Exchange</td>
</tr>
<tr>
<td>PPO</td>
<td>Pathway X - PPO</td>
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</tr>
<tr>
<td>PPO</td>
<td>Pathway PPO</td>
<td>Purchased OFF Exchange</td>
</tr>
<tr>
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<tr>
<td>HMO</td>
<td>Pathway HMO</td>
<td>Purchased OFF Exchange</td>
</tr>
</tbody>
</table>

If you have any questions, please feel free to contact our Network Relations staff via e-mail at that CAContractSupport@anthem.com.
Member ID card update for 2015: Affordable Care Act compliant health plans

Members purchasing or continuing an Affordable Care Act (ACA) compliant individual health plan for the 2015 plan year will receive new Anthem Blue Cross member ID cards. New ID cards have a similar format to other Anthem Blue Cross member ID cards, but some information on the card may be new or look slightly different. This information is critical, as it provides details about member benefits and the provider network supporting the member’s health plan. Some ACA-compliant health plans have limited or no out-of-area and/or out-of-network benefits. Please read this information carefully and share with your office staff as appropriate.

The following summary shares information about member ID cards for 2015 ACA-compliant health plans offered by Anthem Blue Cross. At the end of the summary, we’ve included sample copies of these Anthem Blue Cross member ID cards for your reference.

<table>
<thead>
<tr>
<th>Card Detail</th>
<th>Description</th>
<th>Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Information</td>
<td>Member ID cards continue to include benefit information such as the health plan deductible, coinsurance, or out of pocket details.</td>
<td>Providers should continue to verify eligibility and benefit information for all members via Availity Web Portal or by contacting Provider Service using the phone number indicated on the member ID card.</td>
</tr>
<tr>
<td>Claim and Contact Information</td>
<td>The back of the ID card includes the claim submission address and important contact information, such as the phone numbers for Provider Service and preauthorization requests.</td>
<td>The claim submission address and contact information for pediatric dental benefits are indicated on the back of the member ID card.</td>
</tr>
<tr>
<td>Drug List Name</td>
<td>ID cards for ACA-compliant plans indicate the name of the drug list utilized by the health plan.</td>
<td>Many ACA compliant health plans sold on and off the exchange use the new Select Drug List, which covers a select number of medications in all therapeutic categories and classes. Providers may receive questions from members about their current prescriptions as they make decisions about their health care coverage. Find more information about the Select Drug List.</td>
</tr>
<tr>
<td>Group Number</td>
<td>The presence of a group number on an ACA-compliant member ID card indicates that the plan is a small group policy.</td>
<td>If the member ID card does not have a group number, this indicates that the plan is an individual health plan.</td>
</tr>
<tr>
<td>Limited Benefit Disclaimer</td>
<td>PPO health plans with limited out-of-area benefits include a disclaimer on the back of the member ID card.</td>
<td>This disclaimer advises providers when PPO plan benefits may be limited to Urgent or Emergency care outside of the member’s Home Plan service area.</td>
</tr>
<tr>
<td>Network Name</td>
<td><strong>IMPORTANT</strong> - This field reflects the name of the provider network that supports the member’s health plan. The Network Name field is located on the bottom front of the ID card.</td>
<td>Some plans include little or no out-of-network benefits. Services rendered by non-contracted providers will be processed as out-of-network. <strong>Providers should always review the network name indicated on the member ID card and confirm that the provider participates in the network that supports the member's health plan.</strong></td>
</tr>
<tr>
<td>Prefixes</td>
<td>Member ID cards include prefixes as part of the member identification number. Prefixes are specific to medical ACA-compliant health plans sold on and off the exchange, which can be viewed in our Health Insurance Exchange Quick Reference Guide.</td>
<td>Prefixes can help providers identify members with medical ACA-compliant health plans.</td>
</tr>
<tr>
<td>Product Name</td>
<td>The product name is indicated on the top right side of the member ID card. While many 2015 health plans will have a new product name, some plan names will remain the same.</td>
<td>The 2015 product names for ACA compliant health plans purchased on or off the exchange include the reference to a metal level (bronze, silver, gold, or platinum).</td>
</tr>
<tr>
<td>--------------</td>
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<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Suitcase Logo</td>
<td>Member ID cards for PPO health plans purchased on the exchange may include a PPO suitcase logo followed by the letter “B”.</td>
<td>The presence of the PPOB suitcase logo on a(n) Anthem Blue Cross member ID card indicates the member has access to the National BlueCard PPO Basic Network (the national exchange network) for covered services received out-of-area. More information about BlueCard for exchanges is provided below. PPO health plans with limited out-of-area benefits include a disclaimer on the back of the member ID card. Providers should continue to verify eligibility and benefits for all members.</td>
</tr>
<tr>
<td></td>
<td>Member ID cards for PPO health plans purchased off the exchange include the PPO suitcase logo. Some on exchange health plans may also include the PPO suitcase logo.</td>
<td>The presence of the PPO suitcase logo (without the letter B) indicates a member has access to the BlueCard PPO Network for covered services received out-of-area. If you are participating in Anthem Blue Cross' Pathway X PPO network in California, and a member from another state is seeking care, then you are participating in the BlueCard PPO Network (PPO). PPO health plans with limited out-of-area benefits include a disclaimer on the back of the member ID card. Providers should continue to verify eligibility and benefits for all members.</td>
</tr>
<tr>
<td>Covered California logo is included on Anthem Blue Cross ID cards, as required by the California state exchange.</td>
<td>ID cards for members with HMO health plans include the blank suitcase logo.</td>
<td>The presence of the blank suitcase logo indicates a member has access to the BlueCard Traditional Network for services received out-of-area that are urgent or emergency care only. Providers should continue to verify eligibility and benefits for all members.</td>
</tr>
</tbody>
</table>

**Member ID card sample**

*Please note that this is a sample copy of a member ID card. The policy and benefit information indicated on this sample does not necessarily represent actual information for any member health plan. Policy and benefit information on actual member ID cards will vary by plan and final copies of member ID cards may vary slightly from this sample.*

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**Front of member ID card (sample)**

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BlueCard for exchanges and Multi-State Plan products

Under the Affordable Care Act (ACA), the Office of Personnel Management (OPM) is required to offer OPM sponsored products on the exchange and implement a Multi-State Plan (MSP) product. For coverage beginning January 1, 2015, Blue Cross and Blue Shield health plans will participate in this program by offering Multi-State Plans on exchanges in 33 states and in the District of Columbia.

BlueCard is an existing national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan’s service area. Because of the possibility that variations may exist on how exchange plans operate from state to state, the Blue Cross and Blue Shield Association, along with Blue Plans, has developed a Blue System Multi-State Plan Program that operates within the BlueCard program. This enhanced BlueCard program is supported by the national exchange network called the National BlueCard PPO Basic Network. Anthem Blue Cross’ PPO health plans utilizing this national exchange network for out-of-area covered services will carry the new suitcase logo “PPOB” on the member ID card.

Please note, other Blue Plans acting as the Home Plan make their own decisions regarding which networks their PPO exchange members will have access to when traveling out-of-area. Providers should continue to verify eligibility and benefits for all out-of-state members.

Important information available online

We invite you to go to our website to learn about the many ways health care reform and health insurance exchange may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance exchange, and all archived articles, go to anthem.com/ca, 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.
Important information regarding use of Clinical UM Guidelines

Anthem Blue Cross recognizes the importance of preventing, detecting, and investigating fraud, waste, and abuse, and is committed to protecting and preserving the integrity and availability of health care resources for our members, clients and business partners. Anthem Blue Cross has processes to review claims before and after the claim is processed to detect fraud, waste and abuse.

Beginning in December 2014, Anthem Blue Cross will include the following language in all Clinical Utilization Management Guidelines on the provider public portal about use of Clinical UM Guidelines for a variety of purposes. For example, Clinical UM Guidelines may be generally adopted for reviewing the medical necessity of services; used for provider education; and used for reviewing the medical necessity of services by a provider who has received notice about certain billing practices or claims, even if a guideline is not used for all providers delivering that service to Anthem Blue Cross’ members. The language states the following:

Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline. Alternatively, commercial or FEP® plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

Please refer to your Provider Manual for further details on a new program to deter fraud waste and abuse that is scheduled to be rolled out for commercial business and FEP plans throughout 2015.
Important updates to our pharmacy authorization form

Effective January 1, 2015, all providers treating members enrolled in a California Commercial fully insured medical plan, Medi-Cal Managed Care (Medi-Cal), Medi-Cal LA Care Health Plan, Medi-Cal Assistance Program formerly known as Access for Infants and Mothers (AIM) and Major Risk Medical Insurance Program (MRMIP) Health Plan, including any delegated Primary Medical Group (PMG) performing UM review for any prescribed medication, 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), when utilizing a form for submission.

The DMHC requires all health plans and their delegated entities reviewing drug prior authorization requests for all retail and medical pharmacy benefit, including Synagis and other medical injectables to use this form no later than January 1, 2015. All Primary Medical Groups (PMGs) performing UM review for any prescribed medication must also post this new PA form on their individual websites for providers to be able to access and use for their drug PA requests. The uniform Pharmacy Prior Authorization form for California Commercial fully insured members is attached and it is also available on the following Anthem website: https://www.anthem.com/ca/pharmacyinformation

The form is also available on the Anthem Pre-Service Medical Review for Specialty Drugs website: http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f1/s0/t0/pw_a119408.htm&label=Pre-Service%20Medical%20Review%20for%20Specialty%20Drugs

> Pre-Service Medical Review Request Form > Prescription Drug Prior Authorization Request Form.

The uniform Pharmacy Prior Authorization form for Medi-Cal Managed Care (Medi-Cal), Medi-Cal LA Care Health Plan, Medi-Cal Assistance Program formerly known as Access for Infants and Mothers (AIM) and Major Risk Medical Insurance Program (MRMIP) Health Plan and any delegated Primary Medical Group (PMG) performing UM review for any prescribed medication for members is attached on: http://www.anthem.com/ca/home-providers.html, then the sub-menus:

| <State Sponsored Plans> | <Additional Programs and Services> | <Pharmacy> | Medi-Cal | <Prior Authorization Process> |

All Primary Medical Groups (PMGs) performing UM review for any prescribed medication must also post this new PA form on their individual websites for providers to be able to access and use for their drug PA requests.
New Prior Authorization Form Effective Dates:

Commercial and HIX – CDI Members: The form MUST be used after October 1, 2014.
- If you are a delegated entity performing drug prior authorization review, you must notify providers within two business days of your treatment authorization decision effective January 1, 2015.

Medi-Cal, Medi-Cal LA Care Health Plan, Medical Assistance Program (AIM), MRMIP and Primary Medical Group Members: The form MUST be used effective January 1, 2015.
- If you are a delegated entity performing drug prior authorization review for all retail and medical pharmacy benefit requests, including Synagis and other medical injectables, you must notify providers within one business day of your authorization decision effective January 1, 2015.
- If you are a Primary Medical Group (PMG) that performs UM review for any prescribed medication then you must post this new PA form to your website by January 1, 2015.

In order to prepare you for this important operational change, we have prepared a FAQ answering key questions which will assist you in submitting the pharmacy drug authorization form to Anthem Blue Cross.

Q: What happens if I do not submit my prior authorization using the new CA standardized drug authorization form?

A: You will receive a denial notice with a request to re-submit the prior authorization on the new CA standardized drug authorization form.

Q: What does the new CA standardized drug prior authorization form look like?

A: The California Commercial fully insured document is available on our Anthem Prior Authorization website at https://www.anthem.com/ca/pharmacyinformation and also on our Anthem Pre-Service Medical Review for Specialty Drugs website at http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f1/s0/t0/pw_a119408.htm&label=Pre-Service%20Medical%20Review%20for%20Specialty%20Drugs > Pre-Service Medical Review Request From > Prescription Drug Prior Authorization Request Form.

The uniform drug Prior Authorization form for Medi-Cal Managed Care (Medi-Cal), Medi-Cal LA Care Health Plan, Medi-Cal Assistance Program formerly known as Access for Infants and Mothers (AIM) and Major Risk Medical Insurance Program (MRMIP) Health Plan and Primary Medical Group members is available at: http://www.anthem.com/ca/home-providers.html, then the sub-menus: <State Sponsored Plans> <Additional Programs and Services> <Pharmacy> -- Medi-Cal <Prior Authorization Process >.

Also for your convenience, the uniform Pharmacy Prior Authorization form is below.

Q: What CA standardized drug authorization form must be used on and after January 1, 2015, for DMHC members?

A: All providers treating members enrolled in a California Commercial fully insured medical plan, Medi-Cal Managed Care (Medi-Cal), Medi-Cal LA Care Health Plan, Medi-Cal Assistance Program formerly known as Access for Infants and Mothers (AIM), Major Risk Medical Insurance Program (MRMIP) Health Plan and Primary Medical Groups performing UM review for any prescribed medication to members must use the CA standardized drug prior authorization form provided for DMHC members on and after January 1, 2015. The new form will be used for all retail and medical pharmacy benefit prior authorization requests, including Synagis and other medical injectables.
Q: May I submit the CA standardized drug prior authorization form after January 1, 2015, for ASO members?

A: Yes. If you prefer to continue using existing CA drug prior authorization forms for ASO members, we will accept existing CA drug prior authorization forms for ASO members. Please keep in mind existing decision response timeframes will remain.

Q: May I submit the CA Commercial standardized drug prior authorization form after January 1, 2015, to the same fax number, mail address or portal in the same manner I do today?

A: Yes, you may continue to submit your CA Commercial standardized drug prior authorization form using existing methods however a new fax number specific for the CA standardized drug prior authorization form is posted on the Anthem Prior Authorization Website along with the new form.

Please note that effective for dates of service on or after November 1, 2014, chemotherapy requests should be submitted to AIM Specialty Health (see “The Cancer Care Quality Program begins November 1, 2014” on page 3). The CA standardized drug prior authorization form can also be accessed through AIM’s at https://providerportal.com. The Provider Portal can also assist by automating completion of the authorization form.

Q: May I submit the CA Medi-Cal Managed Care (Medi-Cal), Medi-Cal LA Care Health Plan, Medi-Cal Assistance Program formerly known as Access for Infants and Mothers (AIM), Major Risk Medical Insurance Program (MRMIP) Health Plan and Primary Medical Group standardized drug prior authorization form after January 1, 2015, to the same fax number, mail address or portal in the same manner I do today?

A: Yes

Q: When will I be notified regarding an outstanding drug prior authorization request for a fully insured Commercial and HIX – CDI and DMHC member after January 1, 2015?

A: For Commercial and HIX CDI AND DMHC 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:
1. The prescribing provider’s request is approved;
2. The prescribing provider’s request is disapproved as not medically necessary or not a covered benefit;
3. The prescribing provider’s request is disapproved as missing material information necessary to approve or disapprove the request;
4. The patient is no longer eligible for coverage; or
5. The request was not submitted on the required form, and must be resubmitted using the approved Request Form.

Q: When will I be notified regarding an outstanding drug prior authorization request for a Medi-Cal, Medi-Cal LA Care Health Plan, Medical Assistance Program (AIM) MRMIP and PMG member after January 1, 2015?

A: For Medi-Cal, Medi-Cal LA Care Health Plan, Medical Assistance Program (AIM) MRMIP and Primary Medical Group members only, Anthem Blue Cross or its delegated medical group will notify the prescribing provider within one business day of receipt of a completed Request Form that:
1. The prescribing provider’s request is approved;
2. The prescribing provider’s request is disapproved as not medically necessary or not a covered benefit;
3. The prescribing provider’s request is disapproved as missing material information necessary to approve or disapprove the request;
4. The patient is no longer eligible for coverage; or
5. The request was not submitted on the required form, and must be resubmitted using the approved Request Form.

For any additional questions, please contact your provider relations representative or your contract manager.
Updates to our prior authorization list; effective April 15, 2015

To reduce unexpected post-service claim denials, we are revising and standardizing services that are reviewed, either pre or post service. Please note that these recommendations do 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 stays will continue.

The changes listed below will become effective on April 15, 2015.

The following clinical guidelines and medical policies will require prior authorization/precertification review for the following services:

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURG.00028</td>
<td>Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions</td>
<td>52441, 52442</td>
</tr>
<tr>
<td>SURG.00033</td>
<td>Implantable Cardioverter-Defibrillator (ICD)</td>
<td>33270, 33271, 33272, 33273, 93260, 93261, 93644</td>
</tr>
<tr>
<td>SURG.00055</td>
<td>Cervical Artificial Intervertebral Disc</td>
<td>22858, 0375T</td>
</tr>
<tr>
<td>SURG.00103</td>
<td>Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)</td>
<td>0376T</td>
</tr>
<tr>
<td>CG-SURG-09</td>
<td>Temporomandibular Disorders</td>
<td>20606, S8262</td>
</tr>
<tr>
<td>GENE.00011</td>
<td>Gene Expression Profiling for Managing Breast Cancer Treatment</td>
<td>81519</td>
</tr>
<tr>
<td>MED.00005</td>
<td>Hyperbaric Oxygen Therapy (Systemic/Topical)</td>
<td>G0277</td>
</tr>
<tr>
<td>SURG.00067</td>
<td>Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty, Sacroplasty)</td>
<td>22510, 22511, 22512, 22513, 22514, 22515</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.

Updates to the specialty pharmacy prior authorization list

In order to reduce unexpected post-service claim denials, Anthem Blue Cross will be adding specialty pharmacy drug codes to the Specialty Pharmacy Prior Authorization list. The specialty pharmacy codes from new or current medical policies are being added to our existing pre-service review process are listed below.

All changes referenced in this letter only apply to Local Plan members. Please note that these recommendations do not apply to Blue Card out-of-area, HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program (FEP), State Sponsored Business (SSB), or selected National accounts.
The changes listed below will become effective on April 15, 2015.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00065-Recombinant Coagulation Factor IX, Fc Fusion Protein (rFIXFc)</td>
<td>Alprolix</td>
<td>J7199</td>
</tr>
<tr>
<td>DRUG.00067-Ramucirumab (CyramzaTM)</td>
<td>Cyramza</td>
<td>J3590</td>
</tr>
<tr>
<td>DRUG.00068-Vedolizumab (Entyvio™)</td>
<td>Entyvio</td>
<td>J3590</td>
</tr>
<tr>
<td>DRUG.00069-Recombinant Antihemophilic Factor, Fc Fusion Protein (Eloctate™)</td>
<td>Eloctate</td>
<td>J7199</td>
</tr>
<tr>
<td>DRUG.00070-Siltuximab (Sylvant™)</td>
<td>Sylvant</td>
<td>J3590</td>
</tr>
<tr>
<td>DRUG.00071-Pembrolizumab (Keytruda®)</td>
<td>Keytruda</td>
<td>J9999</td>
</tr>
<tr>
<td>DRUG.00017- Hyaluronan Injections in Joints Other than the Knee</td>
<td>Monovisc</td>
<td>J7327</td>
</tr>
<tr>
<td>DRUG.00062-Obinutuzumab (Gazyva)</td>
<td>Obinutuzumab (Gazyva)</td>
<td>J9301 (replaces J3490)</td>
</tr>
<tr>
<td>DRUG-03 Peginterferon Beta-1a</td>
<td>Plegridy</td>
<td>J3490</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.

**Anthem cost transparency**

Responding to consumer demand for transparency in health care costs, Anthem initially released *Anthem Care Comparison*. Its successor, *Estimate Your Costs*, Anthem’s current Cost Transparency solution, is a tool available to members on our anthem.com website, which includes functionality allowing members to view the estimated costs for many procedures, and estimate their out-of-pocket impact.
In November we sent a mailing to Anthem facility, ancillary and professional providers whose costs display in *Estimate Your Costs*, including a description of the methodology for the cost information displayed. The treatment categories for which cost display and the corresponding methodology are defined by the Blue Cross Blue Shield Association. The cost data is updated twice annually, with the next update currently scheduled for May of 2015. Please look for further information on this in our calendar year 2015 Provider Newsletters, posted to anthem.com/ca.

While the methodology document should provide you an explanation of how this cost data is compiled, should you wish to see your specific cost information shown on *Estimate Your Costs*, authorized personnel representing participating facilities, ancillary and professional practices may contact us by email at CAContractSupport@anthem.com requesting such information.

**Cal Index: A new way for doctors to share information**

Anthem Blue Cross is taking part in the California Integrated Data Exchange (Cal INDEX). Cal INDEX is a comprehensive collection of electronic patient records, which includes clinical data from all participating health care providers and health insurers. Cal INDEX lets participating doctors, nurses and hospitals across California see available health records quickly and easily, so they can offer better care. It’s like an “index” of each person's health history.

**How it works**

If an Anthem Blue Cross member is being treated by more than one participating doctor, each doctor gets brought up to speed on all medical information available in Cal INDEX in a flash. That means the time you spend with your patients is more efficient.

This new, innovative solution isn’t just about saving time at the doctor’s office. It’s about helping to save lives and giving our members the best care possible:

- **Health information can be accessible in an emergency.** If a member goes to a participating hospital or emergency room, health care professionals there can get the health records available in Cal INDEX right away. This can be life-saving.

- **Doctors can know what medicines a person is taking.** This helps avoid dangerous drug interactions. It also lets doctors know what medicines a person is allergic to.

- **Doctors can share test results.** This helps avoid costly, duplicate testing.

Member enrollment in the program is automatic and there is nothing you need to do. We value each member’s health data and the importance of keeping it secure. We follow all federal and state guidelines for keeping health information secure and require Cal INDEX to do the same.

*Note: Only doctors who participate in Cal INDEX and who treat an Anthem Blue Cross member can see that member’s information.*

**2015 FEP® benefit information available online**

To view the 2015 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to anthem.com/fep>select state>Coverage Options>Standard or Basic Option. Here you will find the Service Benefit Plan Brochure and Plan Benefit Summary information for year 2015. For questions please contact FEP Customer Service at (800) 284-9093.
Creating a LGBT friendly practice – Online experience available

What you may not know about your Lesbian, Gay, Bisexual, or Transgender (LGBT) patients may be putting their health at risk. Studies have shown that many LGBT patients fear they will be treated differently in health care settings and that this fear of discrimination prevents them from seeking primary care. Anthem Blue Cross joins you in striving for the best clinical outcomes for everyone, including LGBT populations. That's why Anthem Blue Cross has created an online experience that provide strategies, tools and resources to providers interested in attracting or maintaining a LGBT patient panel.

Hopefully, as a result of increasing LGBT-friendly practices, Anthem Blue Cross, along with the entire health care industry, will see an increase in primary care and disease prevention among LGBT patients. Like you, Anthem Blue Cross strives to meet the needs of our diverse membership and upholds access to consistently high quality standards across our networks. We believe that by offering our providers these types of experiences, we can help keep all our members healthy. In addition, this online experience reinforces our commitment to equality for our LGBT members as referenced in our provider contractual non-discrimination provisions.

Visit the provider pages at anthem.com for free 24/7 access to the experience – either via your computer, tablet or smartphone. You will gain an increased understanding of how to create an LGBT-friendly practice, which may improve the health of your patients.

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

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

The following charts compare our results from 2013 with those in 2014. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem Blue Cross. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile. This is the level we encourage our network physicians to strive to achieve.

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

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2013</th>
<th>2014</th>
<th>Trend 2013 vs. 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rating of Physician</strong> 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>79%</td>
<td>86%</td>
<td>↑</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>78%</td>
<td>75%</td>
<td>↓</td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>72%</td>
<td>74%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Getting Care Quickly</strong> 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>77%</td>
<td>84%</td>
<td>↑</td>
</tr>
<tr>
<td>Got appointment for check-up or routine care as soon as needed</td>
<td>80%</td>
<td>NA</td>
<td>--</td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>75%</td>
<td>82%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Doctor’s Communication with Patients</strong> 2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>93%</td>
<td>95%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>92%</td>
<td>94%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>93%</td>
<td>96%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>89%</td>
<td>92%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Shared Decision Making</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons to take a medicine? 3</td>
<td>41%</td>
<td>42%</td>
<td>↑</td>
</tr>
<tr>
<td>Doctor discussed reasons not to take a medicine? 3</td>
<td>23%</td>
<td>20%</td>
<td>↓</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you? 4</td>
<td>78%</td>
<td>75%</td>
<td>↓</td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness? 4</td>
<td>77%</td>
<td>78%</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Continuity of Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did your personal doctor seem informed about care you received</td>
<td>77%</td>
<td>75%</td>
<td>↓</td>
</tr>
<tr>
<td>from other health providers? 2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding “Usually” or “Always.”
3 =% responding “A lot” or “Some”
4 = % responding “Yes”
5 = Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
DNA = Data Not Available
NA = Number of survey respondents too low to be valid.
Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

*The source of data contained in this report is Quality Compass ® 2014 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA.*
Improving your patient's health care experience

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

Simply log onto our website at www.anthem.com/ca and follow this path: Providers>Enter>Communications>Guide to Improving the Patient Experience.

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

New cancer support program for businesses

Workplace Transitions for People Touched by Cancer is testing an actionable and interactive resource with six large companies in an effort to support employers and their employees' healthy and productive return to work after a cancer diagnosis. The goal is to offer the resource for free to all businesses this year after it has been tested. The program would provide managers with a web-enabled toolkit that includes useful information and guidance while empowering them to manage situations that arise when someone on their team has been diagnosed with cancer, including how to talk to someone who has just been diagnosed.

The main goals of the eToolkit are to ensure a supportive work environment and support the employee's quality of life. As part of the project, researchers will survey employees from several large businesses to determine if the eToolkit does what it is intended to do.

The Workplace Transitions for People Touched by Cancer program, a collaboration among the U.S. Business Leadership Network, Cancer and Careers, Pfizer, Anthem, Inc., and SEDL, a nonprofit educational research firm, is funded by a $250,000 grant from the Anthem Foundation.

"Returning to work after being diagnosed with cancer or undergoing cancer treatment can be psychologically and physically challenging. It often brings mixed emotions of fear, relief, and hope," said Dr. Sam Nussbaum, WellPoint’s chief medical officer. "Addressing a cancer patient's psychosocial concerns, which includes transitioning back to work, can help improve their health and quality of life. This pilot is focused on providing tools to help businesses ensure a healthy and productive work environment for their employees following a cancer diagnosis, and help ensure that individuals feel comfortable returning to work."

Nearly 80 percent of people diagnosed with cancer say continuing work after diagnosis aids recovery, according to a 2013 survey from Cancer and Careers and Harris Interactive. Still, just as many respondents said they struggle to find support navigating the work/life balance of employment with cancer.

A recent survey of 188 employers conducted by Anthem, Inc. discovered that only 15 percent of managers believed they had the tools and resources they needed to support employees in a cancer situation.

“At least one survey has found that the biggest predictor of return to work for people diagnosed with cancer is work accommodations,” said Rebecca Nellis, vice president, programs and strategy, Cancer and Careers. “It’s really about stimulating a dialogue between the employee, the supervisor and human resources so that they can work together to identify issues, find solutions and keep employees with cancer who want to work working to their full ability."

It can be something as simple as shifting an office location for someone who is nauseated post-chemotherapy by the smell of the adjacent cafeteria or adding a printer to the desk of an employee with cancer who is too fatigued to climb up several floors to a shared printer.
“As an employer, if we can support our employees in the way they need to be supported during one of the most psychological, emotional and physical challenges of their lives, we know they will be more productive and that we'll have a better chance of retaining them in the long term,” said Peter Nigro, executive director, Merck global employee health. “We want our employees to know that we are here for them in these challenging times and that together we can lead the way for other employers and employees.”

“Cancer is not a one-size-fits-all experience for employers or employees,” said Jill Houghton, executive director, U.S. Business Leadership Network. “It's important that we measure results of the resource to ensure we can truly meet our goals of providing resources that support employers and their employees' health and productive return to the workplace.”

**Reminder: User profiles and HIPAA compliance**

If you are the Availity Primary Access Administrator (PAA) and/or Anthem Blue Cross ProviderAccess Administrator, please keep your USER lists up-to-date.

In order to remain compliant with your contractual usage agreements on your portals, please review your USER lists at least quarterly to disable the profiles of any individuals in your organization who are no longer employed by your organization and ensure all current employees have the access they need to enable them to use our secure web portals.

Please ensure that all individuals in your organization, who access our secure portals, have their own individual USER ID and password for each system and have registered under their name and with their own individual contact information.

Also, if you, the site Administrator, are changing roles or leaving your organization, be sure to assign someone in your organization to replace you in the role of responsibility and update your portal access profiles. We would like to remind all Anthem Blue Cross users of the following:

*The sharing of USER ID and Password information on our secure portals is not compliant with Anthem Blue Cross' Information Security Policy.* Please take a few moments to update your USER list now.

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

**HEDIS® 2015: Easy submission of commercial HEDIS medical records**

We want to make returning HEDIS medical records as easy as possible for your office. To return the time sensitive medical record documentation back to us in the recommended 5 day turnaround time, simply choose one of these options:

1. **Upload to our secure portal.** This is quick and easy. Logon [www.submitrecords.com](http://www.submitrecords.com), enter the password: *wphedis57* and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.

   **OR**

2. **Send a secure fax to (888) 251-2985**

   **OR**

3. **Mail to us via the US Postal Service** to:
   
   Anthem Blue Cross, 10897 S. River Front Parkway, Suite 110H, South Jordan, UT 84095-9984

We will begin requesting medical records in January and February via a phone call to your office followed by a fax. Contact information will be included with the fax should you have any questions. We thank you in advance for your support of HEDIS.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*
New employer group, UA Local 355 – Effective December 1, 2014

Anthem Blue Cross is pleased to announce that effective December 1, 2014; UA Local 355 will be a new National Account with us. This new group will offer various plans to their members. Their alpha prefix is JQZ.
Billing

Important information regarding 2015 CPT/HCPCS code updates and reimbursement treatment

On January 1, 2015, the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) will be releasing new CPT® and HCPCS codes. Many codes released as part of their updates will be accepted by Anthem Blue Cross; however, the following new 2015 codes will not be eligible for reimbursement for our Commercial products only:

1. Codes G6030 – G6058 (Definitive Drug Testing) – Reimbursement will only be provided for the applicable new 2015 CPT codes.
2. Code G0276 (Blinded procedure for lumbar stenosis, clinical trial) – This code would only be payable for Medicare patients in their CED project.
3. Code G0472 (Hepatitis C antibody screening for high risk) – Reimbursement will only be provided for the applicable existing CPT code.
4. Code G0473 (Group behavioral obesity counseling) – Reimbursement will only be provided for the applicable existing CPT code.
5. Code 99490 (Chronic Care Management service) – Chronic care management services are an integral component of Anthem Blue Cross’ value based payment innovation programs.
6. Codes 99497 - 99498 (Advance Care Planning service) – Advance Care Planning services are an integral component of Anthem Blue Cross’ value based payment innovation programs.
7. Code 34839 (Physician planning for endograft) – Physician planning for surgery is an integral component of the surgical procedure.

Web site changes you will like for your third party administrators, self-funded and union trust fund patients!

We are making it easier for you to find information for patients serviced by Managed Care Services (MCS):
- Self-Administered Plans
- Third Party Administrators (TPA)
- Union Trust Funds

Anthem Blue Cross has network access arrangements with many of these organizations, and answers about these types of accounts can be found in a few places.

Inquiries related to claim payment, verification of eligibility and benefits should be addressed directly to the Payer. The contact information for the Payer can be found on the back of the member’s Identification Card. We realize that it’s not always handy, and have made changes to the Availity Web Portal to make the search easier and more convenient.

The information available when a provider attempts to look up eligibility and benefit information for MCS members has been streamlined with clear communication indicating that eligibility and benefits are handled by another payer. The provider is given the plan administrators contact details including name and phone number.

On December 13, 2014, when providers access Eligibility & Benefits on the Availity Web Portal for MCS member, providers can now view the name and phone number of the plan administrator with the message to Contact Following Entity for Eligibility or Benefits Information under the OTHER or ADDITIONAL PAYER tab.
A new payer drop down menu was added to all provider user profiles with offices in CA, NV and CO via the Availity Web Portal.

When providers select Managed Care Services (MCS) they can access the MCS member’s claim information. Providers will see the following information for an MCS member:

- Claim Number
- From / To Date of Service
- Date Processed
- Billed Amount
- Allowed Amount

Note: For MCS products, Anthem Blue Cross only prices the claims. The MCS claims do not have any check, payment or adjudication information on the Availity Web portal. The provider needs to contact the plan administrator directly for any questions.

Continue to look for updates and enhancements through the provider newsletter, Network Update.
Contracted provider claim escalation process

In an effort to better service our contracted providers right the first time, Anthem Blue Cross has improved our provider claim escalation process. Just click Provider Claim Escalation Process to read, print, download and share the improved process with your office staff.

Our Network Relations Team is available by e-mail at CAContractSupport@anthem.com to answer questions you have about the process, if you need clarification.
Network

Enhancements to Anthem Blue Cross’ find a doctor tool

The Find a Doctor tool at anthem.com/ca is used by consumers, members, and providers to identify in-network physicians and other health care providers supporting member health plans. Specifically, providers often use the Find a Doctor tool as an online resource when referring members to other in-network providers.

Beginning this fall, you’ll notice some enhancements to our Find a Doctor tool that will make it even easier to search for providers. These enhancements include:

- A new screen layout that guides users more effectively to a specific health plan, helping ensure provider searches are conducted within the plan's corresponding provider network.
- A simplified “Select a Plan/Network” option to help narrow searches.
- A more organized display of the health plans a doctor or hospital accepts.

We believe these enhancements will improve the consumer, member, and provider experience when using the Find a Doctor tool.

No cost cultural competency trainings for providers – CME/CEU credits awarded

Your 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 healthcare professionals who interact with these patients on a daily basis. Research shows that clinicians that are provided with multicultural training are better able to serve these growing patient populations, and are more likely to improve patient satisfaction, adherence, and patient outcomes, as well as increase their market share from some of the nation’s fastest growing communities.

We are excited to offer providers the following two culturally and linguistically targeted e-learning courses: 1) Viewpoints: Clinical Competence in a Globally Mobile World and 2) Language Access and the Law: Caring for the Limited English Proficient (LEP) Patient. These courses are offered to providers and appropriate office staff at no cost and provide AMA Category 1 CME/CEU credits.

To learn more about how to register for and complete these free trainings, visit our course summaries web page.

Did your practice or provider information change?

As you know it is critical that your patients/our members receive accurate and current data related to provider availability. As outlined in your contract with Anthem, please be sure to notify us on a regular basis (within 10 business days of the change is requested) of all changes listed below. Please note tax ID changes must be accompanied by a W-9 to be valid.

- Telephone number for members to schedule appointments at your practice location
- Practice location address
- Practice Office Hours
- Provider name
- Practice name
- Practice affiliation changes (i.e. provider joined another group)
- Providers leaving, retiring or joining your practice
- Billing address
- Tax ID number
- Specialties
- Hospital privileges
- Accepting new patients
- Handicapped Accessibility
- Languages offered

Please send us this information timely, preferably **within 10 business days**, in one of the following ways:

- **Online form**: Go to www.anthem.com/ca and select “Provider”, then click on “Enter” and choose answers@anthem. Under “Tools and Resources” click on “Provider Forms”. The form can also be accessed via http://www.anthem.com/ca/provider/f0/s0/t0/pw_a109986.pdf?refer=provider
- **E-Mail Address**: Provider_Database-Anthem-Wellpoint@Wellpoint.com
- **Fax Number**: (818) 234-2836 or (866) 243-3183
- **Address**: Anthem Blue Cross, P.O. Box 70000, Van Nuys, CA 91470

**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](http://www.anthem.com/ca). If you don't have internet access, please contact us at *(855) 238-0095* for assistance.
Guidelines and Quality Programs

Important postpartum visit reminder for OB/GYNs

As you may know, the National Committee for Quality Assurance (NCQA) specifies that the postpartum visit should be completed 21 to 56 days (3 to 8 weeks) after delivery. This visit is distinct from the cesarean section visit or incision check your patient may have had before that time.

The most current data shows that postpartum visits occur in a timely manner, overall. When a random sample of 2013 medical charts were reviewed, we found postpartum visits between 21 and 56 days in California occurred 76% and 82% of the time for HMO and PPO plans, respectively. The top 10% of health plans nationally have a compliance rate of at least 91% among HMO and at least 86% among PPO members.

2013 Medical Chart Review Findings from a Sample of the Non-Compliant Women in CA:
- 57% of HMO patients and 64% of PPO patients had insufficient evidence of postpartum care, with a majority (73% of HMO and 76% of PPO) not documenting the date of the postpartum visit.
- 27% and 25% of HMO and PPO women, respectively, with a documented date were not seen in the appropriate timeframe:
  - 12% of HMO and 8% of PPO were seen before 21 days
  - 7% of HMO and 14% of PPO were seen between 56 and 63 days
  - 8% of HMO and 2% of PPO were seen one or more months after the 56th day
- 2% of the women with an HMO plan had a caesarian section check only, without a postpartum visit.

What can you do?
- Make sure that every woman who delivers has a postpartum visit scheduled between 21 and 56 days after delivery. If possible, schedule the mother’s postpartum visit upon or prior to hospital discharge. You may even be able to schedule it at the “last” prenatal visit, or two weeks prior to the expected delivery date. A study published in March 2011 found that postpartum follow-up rates were significantly higher (86.1% compared with 71.7%, P=.012) when a visit was scheduled prior to discharge (Tsai, Pai-Jong, et. Al. “Postpartum Follow-Up Rates Before and After the Post-Partum Follow-up Initiative at Queen Emma Clinic.” Hawaii Medical Journal. March 2011: 70(3): p 56-59).
- Specify the postpartum visit date on the claim and use the Category II CPT Code 0503F (indicating a postpartum visit) on the global delivery code with the delivery date. Using this supplemental tracking code would reduce the time and disruption to your office that the health plan would need to request to review patient charts for evidence of postpartum care.
- When you see a woman for their postpartum visit, remember to clearly indicate the date, complete physical findings, and counseling/discussion points in the patient’s chart. For your convenience, the “Quick Reference Guide for Clinicians” for Postpartum visits/counseling by the Association of Reproductive Health Professionals can be accessed by the following link: https://www.arhp.org/uploadDocs/QRGPostpartumCounseling_Checklist_1.pdf

Please take less than 30 seconds to give us your feedback: https://www.surveymonkey.com/r/8H3G8JF
One of the HEDIS measures we are collecting this year is **Controlling High Blood Pressure**. This measure is collected on members ages 18 to 85 with a diagnosis of hypertension. The following items are needed from the member’s medical record:

1. **The earliest documented date of hypertension (prior to 7/1/14) found in your medical record.** This diagnosis date can be any time prior to 7/1/14, but cannot be on 7/1/14 or after. For example, the earliest documented date does not have to be in 2014 – it can be in 1998, 2000, 2005, and 2010 – **ANYTIME prior to 7/1/14**. The diagnosis can be found on a dated history form, a problem list, or a progress note.

2. **Blood pressure (BP) reading(s) from the LAST TWO visits in 2014.** This does not have to be from a hypertension diagnosis; the last two blood pressure readings can be from any diagnosis in 2014. Please note – the blood pressure readings **cannot** be from the same date as the earliest documented hypertension date listed above, or from the same day as a major diagnostic or surgical procedure. Please include all BP readings for the last two visits documented in progress notes and/or vital signs flow sheets.

Only **IF** the following applies to the member do we need this requested documentation:

- Documentation of End Stage Renal Disease, renal dialysis or renal transplant with date of occurrence
- If the member was pregnant in 2014, provide documentation of pregnancy
- If the member had a non-acute inpatient admission during 2014 provide documentation

Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures.

We look forward to working with you this HEDIS season and thank you in advance for your continued cooperation and support of HEDIS.

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

**There’s still time left – what to do for HEDIS®!**

**What is HEDIS?**

You have probably heard of HEDIS (Healthcare Effectiveness and Data Information Set) measures. These are quality measures that the National Committee on Quality Assurance (NCQA) has developed to evaluate quality care delivered by health plans. These measures include Children’s Health, Women’s/Maternal Health and General/Diabetes health. Every year, all health plans across the nation collect data about care rendered the previous year for study as well as comparison with other health plans.

Anthem depends on you, our providers, to help us get the highest scores possible for HEDIS. The care you provide and document is key to demonstrating the quality care you provide our members.

**What Do I Need to do?**

Every primary care provider (PCP) has members who fall in one or more of the areas covered by the HEDIS measures. Some of the HEDIS measures involve getting recommended testing done to show that a disease is under control. Other measures involve annual checkups or testing. Still others involve medication monitoring.

- Determine which of your patients have not had the required testing or checkup (table with measures below).
- Contact the patient to schedule an appointment by the end of the year.
- Provide the service and order the labs or tests.

Below is a grid indicating the measure, the type of patient (child, pregnant woman, patient with diabetes, etc.) and the service required before the end of the year.

After the service has been provided, please be sure to submit the claims form to document the care you have rendered. Don't forget to also complete a PM-160 for your pediatric patients.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*
*CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.*

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<thead>
<tr>
<th>Name of Service/Test</th>
<th>Type of Patient</th>
<th>What Needs to Be Done</th>
<th>Billing Codes</th>
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</table>
| **Childhood Immunizations** | **Pediatric—child is turning 2 before the end of 2014** | Before age 2 child needs to have: Four DTaP; three polio (IPV); one MMR; two H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines | IPV CPT®: 90698, 90713, 90723  
DTaP CPT®: 90698, 90700, 90721, 90723;  
Hib CPT®: 90645-90648, 90698, 90721, 90748  
Hep B CPT®: 90723, 90740, 90744, 90747, 90748;  
HCPCS: G0010  
Prevnar CPT®: 90669, 90670; HCPCS: G0009  
VZV CPT®: 90710, 90716; ICD-9-CM: 052, 053  
MMR CPT®: 90707, 90710  
Measles CPT®: 90705 ICD-9-CM: 055  
Measles and Rubella CPT®: 90708  
Mumps CPT®: 90704 ICD-9-CM: 072  
Rubella CPT®: 90706 ICD-9-CM: 056  
Hep A CPT®: 90633; ICD-9-CM: 070.0, 070.1  
Flu CPT®: 90655, 90657, 90661, 90662;  
HCPCS: G0008  
RV 90680 (2 dose) and RV 90680 (3 dose) |
| **Well Child Visits**   | **Pediatric—child is age 3 thru 6 in 2014** | An annual comprehensive well visit | Codes to Identify Well-Child Visits:  
CPT®: 99381-99385, 99391-99395, and 99461  
ICD-9-CM: V20.2, V20.3, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8 and V70.9  
HCPCS: G0438, G0439 |
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<tbody>
<tr>
<td>Adolescent Immunizations</td>
<td>Pediatric—child is turning 13 in 2014</td>
<td>Before age 13, a child needs: One dose of meningococcal vaccine (between 11th and 13th birthday) and one dose of Tdap or Td (between 10th and 13th birthday)</td>
<td>Meningococcal CPT®: 90733 and 90734 Tdap CPT®: 90715 Td CPT®: 90714 and 90718 Tetanus CPT®: 90703 Diphtheria CPT®: 90719</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Women's Health—Women ages 21-64 or Women ages 30-64</td>
<td>Documentation of results for 21-64 year olds of a cervical cytology performed every 3 years (if no proof, schedule appointment for PAP) or Documentation of results for 30-64 year old of a cervical cytology/HPV co-testing performed every 5 years (if no proof, contact the member and schedule appointment for PAP) Or documentation of Complete Hysterectomy</td>
<td>CPT®: 88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88175 HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 UB Revenue: 0923 Same codes as above and CPT®: 87620-87622</td>
</tr>
<tr>
<td>Prenatal Care</td>
<td>Maternity—Pregnant woman</td>
<td>A prenatal visit within first trimester and subsequent visits per ACOG standard of care.</td>
<td>CPT®: 59400, 59510, 59610, 59618, 59425, 59426, 99201-99205, 99211-99215, 99241-99245 and 99500 CPT® Cat II: 0500F, 0501F, 0502F HCPCS: H1000-H1004, H1005</td>
</tr>
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| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | 3-17 year old members | Evidence of the following during the measurement year:  
• BMI percentile if under 17 years (may be a BMI value for adolescents 16-17)  
• BMI date and value  
• Weight date and value  
• Height date and value  
• Counseling for Nutrition (diet)  
• Counseling for Physical Activity (sports participation/exercise) | **CPT ® for Nutrition:** 97802-97804  
**ICD-9-CM:** BMI V85.5, Nutrition V65.3, and Physical Activity V65.41  
**HCPCS for Nutrition:** G0447, G0270, G0271, S9449, S9452, S9470  
**HCPCS for Activity:** G0447, S9451  
**Codes to Identify Outpatient Visits:**  
CPT ®: 9201-9205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456  
**HCPCS:** G0402, G0438, G0439  
**UB Revenue:** 051x, 0520-0523, 0526-0529, 0982, 0983 |
| Diabetic Care | Pediatric and Adult patients with Diabetes during 2014 | At least one blood test in 2014 | **Diabetes Diagnosis:**  
**ICD-9-CM:** 250, 250.0-250.9, 357.2, 362.0, 362.01-362.07, 366.41, 648.0  
**HbA1c Screen CPT®:** 83036 and 83037;  
CPT ®Cat II: 3044F, 3045F, 3046F  
**Eye Exams CPT®:** 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245  
**CPT ®Cat II:** 2022F, 2024F, 2026F, 3072F  
**HCPCS:** S0620, S0621, S0625, S3000 |
<p>| HbA1c testing | | | |
| HbA1c &gt;9 | If result is greater than 9%, do what is necessary (such as adjusting meds) to improve A1c to below 9% |  |
| HbA1c &lt;8 | If result is not less than 8%, do what is necessary (such as adjusting meds) to improve A1c to below 8% |  |
| Nephropathy | Check urine for protein |  |
| Eyes | Refer the member for a retinal eye exam with a network ophthalmologist. The member can also access a VSP provider without a referral. |  |</p>
<table>
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</table>
| Blood Pressure       |                | Latest BP measurement was <140/90; if no BP measurement or if latest not under 140/90, bring pt in to determine necessary treatment to get it below 140/90 | LDL C Screen CPT*: 80061, 83700, 83701, 83704, 83721  
CPT® Cat II: 3048F, 3049F, 3050F  
Nephropathy Screen CPT*: 82042, 82043, 82044 and 84156  
CPT® Cat II: 3060F, 3061F |
| General—Medication Monitoring | Pediatric and Adult patients taking the specified medications during 2014 | 1. Ensure patients with asthma are taking their meds.  
2. Ensure patients with persistent asthma on short acting beta-agonist meds (e.g. albuterol) are ALSO taking controller meds (e.g. inhaled corticosteroids) this is verified by checking pharmacy records. You can check with patient's pharmacy to be sure they are picking up their controller and beta agonist meds. | Asthma ICD-9-CM: 493.0, 493.00-493.02, 493.1, 493.10-493.12, 493.8, 493.81-493.82, 493.9, 493.90-493.92  
Codes To Identify Outpatient Visits:  
CPT®: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456  
HCPCS: G0402, G0438, G0439  
UB Revenue: 051x, 0520-0523, 0526-0529, 0982, 0983 |
| ACE inhibitors/ARBs  |                | Get a chem panel or at least a K+ and creatinine | |
| Digoxin             |                | Get a chem panel or at least a K+ and creatinine AND serum digoxin | |
| Diuretics           |                | Get a chem panel or at least a K+ and creatinine | |

If you need help contacting your patients, or if you have any questions about HEDIS, please call your regional office at the number listed on the bottom of the front of this newsletter.

We are happy to be partners with you on our quality of care efforts! Thank you for your ongoing commitment and caring for our members!

**We believe in continuous improvement**

Commitment to our members’ health and their satisfaction with the care and services they receive is the basis for the **Anthem Blue Cross Quality Improvement Program**. Annually, Anthem Blue Cross prepares a quality program description that outlines the plan’s clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual

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**Professional Network Update**

January 2015
evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of Anthem Blue Cross’ quality program and most current outcomes, visit us at www.anthem.com/ca.

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.

Members’ rights and responsibilities

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

It can be found on our Web site. To access go to www.anthem.com/ca. From there, select >Provider> >Enter> >Home Page> and then Health & Wellness > Quality > Member Rights & Responsibilities.

Important information about utilization management

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

Anthem’s medical policies are available on Anthem’s website at anthem.com/ca.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. UM criteria are also available on our website. Just select “Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider home page at www.anthem.com/ca.

We work with providers to answer questions about the utilization management process and the authorization of care. Here’s how the process works:

- Call us toll free from 5 a.m. - 2 p.m. Pacific Time. Monday through Friday (except on holidays).
- After business hours, you can leave a confidential voicemail message. Please leave your contact information so one of our associates can return your call the next business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

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

<table>
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<tr>
<th>800-531-4450 (NH)</th>
<th>800-437-7162</th>
<th>800-437-7162</th>
<th>800-735-2964 TTY/Voice</th>
<th>800-437-7162</th>
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<td>800-392-1016 (ME)</td>
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<td>800-238-2227 (CT)</td>
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TTY/TDD

For Medicare:
Phone: 1-877-657-6115
Fax: 877-236-5165 – SNF/Acute Rehab
800-464-5891 – Acute
800-464-5930 – SNF Concurrent Review
800-464-5942 – Preempt

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

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

**Coordination of care**

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross would like to take this opportunity to stress the importance of communicating with your patient’s other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem Blue Cross urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)
In an effort to facilitate coordination of care, Anthem Blue Cross has several tools available on the Provider website including a Coordination of Care template and cover letters for both Behavioral Health and other health care Practitioners. * In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.**

*Access to the forms and cover letters are available at anthem.com/ca>Providers>Provider Home>Answers@Anthem
**Access to the Toolkit is available at anthem.com/ca>Providers>Provider Home>Health and Wellness

**Case management program**

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross is available to offer assistance in these difficult moments with our **Case Management Program**. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

**How do you contact us?**

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
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<tbody>
<tr>
<td>Phone (888) 613-1130</td>
<td><a href="mailto:Case.management@wellpoint.com">Case.management@wellpoint.com</a></td>
<td>Monday - Friday 8:00 a.m. – 5:00 p.m.</td>
</tr>
<tr>
<td>Medicare (866)797-9884</td>
<td><a href="mailto:CM-concierge@wellpoint.com">CM-concierge@wellpoint.com</a></td>
<td>Monday - Friday 8:00 a.m. – 5:00 p.m. EST</td>
</tr>
</tbody>
</table>

**An overview of medical necessity review process**

A medical necessity review may be called many things - including utilization review (UR), utilization management (UM) or medical management - within the Explanation of Coverage agreement. Requirements for medical necessity review vary based on the member’s benefit plan. Reviews of a medical service may occur:

- when it is requested or planned (prospective or pre-service review)
- during the course of care (inpatient or outpatient ongoing care review)
- after services have been delivered (retrospective or post-service review)

With so many variables, it may help to get a clear picture of what to expect and how the process works.

**Timing is Important**

We are committed to deciding cases quickly and professionally. Here are several time frames you can expect:
### Type of review
<table>
<thead>
<tr>
<th>Type of review</th>
<th>The maximum amount of time from receipt of the information in which a health plan must decide medical necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent pre-service</td>
<td>5 business days for fully insured and HMO/POS members, 15 calendar days for self-funded members</td>
</tr>
<tr>
<td>Urgent pre-service</td>
<td>72 hours</td>
</tr>
<tr>
<td>Urgent inpatient or outpatient ongoing care</td>
<td>24 hours (in specific instances, no later than within 72 hours of receiving a request)</td>
</tr>
<tr>
<td>Retrospective/post-service</td>
<td>30 calendar days</td>
</tr>
</tbody>
</table>

**Notification of Delay in Review Determination**

If we do not have the information we need to make our decision, we will try to get it from the physician or other health care provider who is requesting the service, medical procedure or equipment. If a delay is anticipated because the information is not readily available, we will notify the member as well as the requesting physician or other health care provider in writing. Delay letters include a description of the information we need to make a decision and also specify when the decision can be expected once the information is received. If we do not receive the necessary information, we will send a final letter explaining that we are unable to approve access to benefits due to lack of the information requested.

**We Use Professional, Qualified Reviewers**

Experienced clinicians review requests for services using medical criteria, established guidelines and Anthem Blue Cross Medical Policy. Requests for covered benefits meeting those standards are certified as medically necessary.

**Only a Peer Clinical Reviewer May Determine That a Service is Not Medically Necessary**

Peer Clinical Reviewers (PCRs) are health care professionals qualified and clinically competent to evaluate the specific clinical aspects of the request and/or treatment under review. PCRs are licensed in California in the same license category as the requesting physician or other health care provider. If you need to discuss a Medical Policy or a medical necessity review decision, an Anthem Blue Cross medical director or physician reviewer is available at (800) 794-0838. If the PCR is unable to approve a service, the requesting physician, another health care provider or the member has the right to request an appeal.

**Decisions Not to Approve Are in Writing**

Written notice is sent to the member and the requesting physician or other health care provider within two business days of the decision. This written notice includes:

- a clear and concise explanation of the reason for the decision
- the name of the criteria and/or guidelines used to make the decision
- the name and phone number of the Peer Clinical Reviewer who made the decision, for peer-to-peer discussion
- instructions for how to appeal a decision
- specific provisions of the contract that excludes coverage if the denial is based upon benefit coverage

**Access to Criteria is Open**

Anthem Blue Cross medical necessity guidelines and criteria for specific services are available to members, member representatives, health care providers and the public. Members may call the number on the back of their ID card for a copy of the guidelines used to determine their case. Anthem Blue Cross Medical Policy is also available at www.anthem.com/ca. Providers can access UM criteria by selecting “Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider Home page; or call (800) 794-0838 to request that a paper copy be sent to you. The requested criteria is provided free of charge.

**A Determination of Medical Necessity Does Not Guarantee Payment or Coverage**

The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of a member’s coverage at the time of service. These terms include certain exclusions, limitations and other conditions, as outlined in the member’s Evidence of Coverage. Payment of benefits could be limited for a number of reasons, for example:
- the information submitted with the claim differs from that given at time of review
- the service performed is excluded from coverage
- the member is not eligible for coverage when the service is actually provided

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

We Are Available for Questions
If you need to request precertification, need information about our UM process, or have questions or issues, call our toll-free number: (800) 274-7767. Our associates are available Monday through Friday (except holidays), 7:30 a.m. to 5:00 p.m., Pacific Time. If you call after hours or do not reach a "live" person during business hours, you may leave a confidential voice mail message. Please leave your name and phone number; we will return your call no later than the next business day during the hours listed above, unless other arrangements are made.

Language Assistance
For those who request language services, Anthem Blue Cross provides service in the requested language through bilingual staff or an interpreter, to help members with their UM issues. Language assistance is provided to members free of charge. Oral interpretation is available at all points of member contact regarding UM issues.

TDD/TTY Services
TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. If you have a hearing or speech loss, dial 711 to use the National Relay Service or one of the numbers below. A special operator will contact Anthem Blue Cross to help with member needs.

(800) 735-2929 – English TTY, (800) 735-2922 – English Voice
Medicare Advantage Updates

Routine physical exams are covered in 2015

Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2015 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider, 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 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.

<table>
<thead>
<tr>
<th>The Welcome to Medicare Visit (IPPE) G0402</th>
<th>The Annual Wellness Visit (AWV initial and subsequent) G0438 &amp; G0439</th>
<th>Routine Physicals/Preventive Medicine Services (99381-99397) Continued coverage in 2015 by Anthem Medicare Advantage Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 <strong>not a comprehensive physical checkup</strong>. This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a <strong>once in a lifetime benefit</strong>.</td>
<td>G0438* Initial Annual Wellness Visit (AWV): Services limited to beneficiary during the <strong>Second</strong> year the patient is eligible for Medicare Part B. <strong>Only one first AWV per beneficiary per lifetime.</strong> Includes a personalized prevention plan of services; face-to-face visit. <strong>G0439 – Subsequent Annual Wellness Visit (AWV):</strong> 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 <strong>not a comprehensive physical checkup</strong>. <strong>Note:</strong> The AWV is intended to build upon the previously established “Welcome to Medicare Visit” physical exam.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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*The Welcome to Medicare Visit (IPPE) G0402 is also included in the Initial Preventive Physical Exam (IPPE) G0402, as is the Initial Annual Wellness Visit (AWV) G0438.*
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 on the Medicare Advantage Providers page of the Anthem provider portal. 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.

Individual MA membership has moved to a new claims system

Effective January 1, 2015, Anthem Blue Cross will move Individual (non-group) MA members to a new claims processing system. This new system will have some new and updated MA reimbursement policies. These policies will be in effect unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Please continue to check Important Medicare Advantage Updates on your provider portal for additional information.

Home health claims – please split dates of service for 2014 and 2015

January 1, 2015, individual Medicare Advantage members (not group sponsored plan members) moved to a new claims system. Please review the following information to help ensure your claims are processed accurately and efficiently. To expedite the processing of your claims, please split the date of services for your 2014 and 2015 services.

When billing for your Home Health services please bill the dates of services using calendar year format.

Example:
- Actual Dates of Services 12/18/2014 thru 01/20/2015
- Submit a claim for:
  - Dates of Service 12/18/2014 thru 12/31/2014
  - Dates of Service  01/01/2015 thru 01/20/2015

Please submit no more than one place of service per claim

Medicare Advantage providers should not submit claims with more than one place of service. Please submit separate claims for each place of service.

Law excludes some Part D drugs; customer service ready to help with members’ questions

There are some drugs that are excluded from the majority of Medicare Part D coverage by law. These include:

Drugs for:
- Anorexia, weight loss or weight gain (except to treat physical wasting caused by AIDS, cancer or other diseases)
- Fertility
- Cosmetic purposes or hair growth
- Relief of the symptoms of colds, like a cough and stuffy nose
- Erectile dysfunction
- Durable medical equipment
  - Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
  - Non-prescription drugs (over-the-counter drugs)

A few plans may cover the above as an Enhanced Benefit. If there is a question of coverage, please have the member call their customer service line on the back of their benefit card.

$0 copay medications available to Medicare Advantage members with chronic conditions

New to Individual MAPD plans in 2015, select drugs will be available at a $0 member co-pay for the following conditions: high blood pressure, high cholesterol and diabetes. Medications include Glipizide, Lisinopril, Losartan, Metformin HCl and Simvastatin.

Group-sponsored plans will continue to offer the Select Generics benefit, which offers $0 copay for select generic drugs.

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 at www.anthem.com/ca/maprovidertoolkit).

Compounded drugs no longer a covered benefit for individual MAPD and PDP plans

Effective January 1, 2015, compounds are no longer a covered benefit for individual MAPD and PDP plans. Members who had a compound prescription filled in the last six months of 2014 were notified of this coverage change via mail and/ or phone.

Please note that members of group sponsored MAPD and PDP plans will have coverage for only the Part D eligible drugs that are part of a compound.

If you believe the compounded medication you have prescribed is medically necessary, the patient may request an exception. The prescriber must provide a statement along with the exception request that explains the medical reasons for supporting the exception.
Provider requirements and Medicare notices

The Centers for Medicare and Medicaid Services (CMS) requires providers to deliver the **Notice of Medicare Non-Coverage (NOMNC)** to every Medicare beneficiary at least two (2) days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the **Important Message from Medicare About Your Rights (IM)** notice to every Medicare beneficiary within 2 calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than 2 calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, Anthem Blue Cross periodically conducts IM and NOMNC Audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

Our audit findings show providers would benefit from focusing in on the following elements required by CMS:

**NOMNC Notices:**
- Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
- Include the beneficiaries Health Care Identification Number or Medical Record Number on page one
- Include the specific type of services ending on page one
- Include the Health Plans contact information on page two
- Have the beneficiary or authorized representative sign and date page two at least two (2) days prior to the end of services
- Retain a copy of the signed notice, both page one and page two.

**IM Notices:**
- Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
- Include the physician's name on page one
- Have the beneficiary or authorized representative sign and date page one within 2 calendar days of the date of an inpatient hospital admission
- Call the authorized representative to deliver the IM when the beneficiary is unable to sign
- Deliver the IM, or copy of the IM again, no sooner than 2 calendar days before discharge
- Retain a copy of the signed notice, both page one and page two.

To download the standardized IM/NOMNC Notices required by CMS, along with accompanying instructions, go to CMS website at [www.cms.hhs.gov/bni](http://www.cms.hhs.gov/bni) or refer to the specific links below:


**IMPORTANT UPDATE:** Quality Improvement Organizations (QIO’s) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see [http://www.qioprogram.org/contact](http://www.qioprogram.org/contact) to locate your QIO.
ICD-10-CM: ICD-9 vs. ICD-10 for atrial fibrillation and flutter

In previous articles, we shared some basic information and recommendations to help identify how specific ICD-9 codes will be impacted by the implementation of ICD-10.

The diagnoses data we receive from providers is critical for help meet the health care needs of our members and remain compliant with Centers for Medicare & Medicaid (CMS) regulatory requirements. The information below supports accurate and complete diagnoses reports and ensures the medical chart documentation for each encounter supports and validates the reported diagnoses codes. This helps avoid unnecessary and costly administrative revisions as a result of an audit.

This article focuses on atrial fibrillation and flutter. According to the ICD-10 codebook, atrial fibrillation and flutter are the most common abnormal heart rhythms (arrhythmia) presenting as irregular/regular, rapid beating (tachycardia) of the heart’s upper chamber. The ICD-10 code set provides multiple codes that represent a progressive path (severity of illness) for atrial fibrillation, requiring more specificity for accurate code assignment. The table below demonstrates what terms need to be documented in ICD-10 to appropriately capture the type of atrial fibrillation and flutter.

<table>
<thead>
<tr>
<th>ICD-9 (Single code)</th>
<th>ICD-10 (Multiple specific codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td></td>
</tr>
<tr>
<td>• 427.31 (Established or Paroxysmal)</td>
<td></td>
</tr>
<tr>
<td>o Irregular, rapid atrial contractions</td>
<td></td>
</tr>
<tr>
<td>Atrial Flutter</td>
<td></td>
</tr>
<tr>
<td>• 427.32</td>
<td></td>
</tr>
<tr>
<td>o Regular rapid atrial contractions</td>
<td></td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td></td>
</tr>
<tr>
<td>• I48.0 Paroxysmal</td>
<td></td>
</tr>
<tr>
<td>o Occurs periodically</td>
<td></td>
</tr>
<tr>
<td>• I48.1 Persistent</td>
<td></td>
</tr>
<tr>
<td>o Rapid contractions of the upper heart chamber</td>
<td></td>
</tr>
<tr>
<td>• I48.2 Chronic</td>
<td></td>
</tr>
<tr>
<td>o Permanent atrial fibrillation</td>
<td></td>
</tr>
<tr>
<td>Atrial Flutter</td>
<td></td>
</tr>
<tr>
<td>• I48.3 Typical</td>
<td></td>
</tr>
<tr>
<td>o Type I atrial flutter</td>
<td></td>
</tr>
<tr>
<td>• I48.4 Atypical</td>
<td></td>
</tr>
<tr>
<td>o Type II atrial flutter</td>
<td></td>
</tr>
<tr>
<td>Unspecified atrial fibrillation and flutter</td>
<td></td>
</tr>
<tr>
<td>• I48.91 Unspecified atrial fibrillation</td>
<td></td>
</tr>
<tr>
<td>o Type not specified</td>
<td></td>
</tr>
<tr>
<td>• I48.92 Unspecified atrial flutter</td>
<td></td>
</tr>
<tr>
<td>o Type not specified</td>
<td></td>
</tr>
</tbody>
</table>

In future articles, we will continue to bring you helpful coding tips to assist you and your coding staff with the transition from ICD-9 to ICD-10.

CMS will not accept ICD-9 codes for dates of service beginning on October 1, 2015. It will be critical to keep this in mind as all encounters/claims submitted with ICD-9 codes will reject beginning October 1, 2015, resulting in delay or denial of payment. We all must be prepared to meet CMS guidelines.
To further assist you in your preparation we are providing the following references, helpful links and additional resources:

- 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

New D-SNP plans offered in 2015; D-SNP training available

Anthem Blue Cross now offers Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs coordinate Medicare and Medicaid programs and provide enhanced member benefits.

Anthem Blue Cross is offering an introduction to D-SNP plans, including claims submission, coding procedures and model of care information. Providers can access the training as it becomes available under Important Medicare Advantage Updates.

Prior authorization required for members

Anthem Blue Cross wants to remind providers that they are required to request a prior authorization for Medicare Advantage members for services that require prior authorization. Failure to obtain a prior authorization will result in an administrative denial. The 2015 prior authorization requirements were posted to the Provider Forms section of the Anthem Blue Cross Medicare Advantage Public Provider Portal October 4, 2014.

Members cannot be balance billed for an administrative denial. To obtain prior authorization or to verify member eligibility, benefits or account information, please call the telephone number listed on the member’s plan membership card.

Please visit the Provider Forms section of the Anthem Blue Cross Medicare Advantage Public Provider Portal at www.anthem.com/ca/medicareprovider to see the prior authorization list that is effective for 2015.

New 2015 precertification fax number for skilled nursing, long-term acute care inpatient rehab

Effective January 1, 2015, we will have a separate fax number for providers and facilities to use. The new fax numbers should only be used when submitting precertification requests or additional clinical information for the following services:

- Skilled Nursing Facility (SNF)
- Long-Term Acute Care (LTAC)
- Inpatient Rehabilitation

Please note, submitting requests for services not listed above may cause a delay in processing requests.
2015 California Medicare Advantage plan changes

Annual benefits changes for Medicare Advantage plan members will be effective January 1, 2015.

The below changes apply to members enrolled in Blue Cross Senior Secure (HMO) and Anthem Blue Cross Medicare Preferred Standard (PPO). You can help members manage their health care costs by being aware of these changes. In addition, remember to check the Member identification card at the beginning of each calendar year, as the member may have changed plans.

Notable 2015 benefits changes and highlights by plan type.

Anthem Blue Cross Medicare Preferred Standard (PPO) Highlighted Plan Changes

- 2015 Plans may include changes to Medical and Part D benefits, copayments and/or coinsurance, deductibles, formulary coverage, pharmacy network, premium and out-of-pocket maximums. Please check the member’s benefits for the new Plan year changes, by visiting our website at www.anthem.com/ca/medicareprovider or calling Provider Services at the number on the back of the member’s ID card.

- Our plan will no longer cover unlimited inpatient days for acute care illness or injury.

- Blood glucose test strips and glucometers may be purchased through an in-network pharmacy or through our mail-order service. A member may no longer purchase these supplies through any other provider, such as Durable Medical Equipment (DME) Provider, or at a physician’s office.

- These plans will offer a new benefit called LiveHealth Online. LiveHealth Online provides convenient access for members to interact with a doctor via live, two-way video on a computer or mobile device.

- These plans will offer one routine physical exam in addition to the Medicare-covered “Welcome to Medicare” exam or Annual Wellness Exam. 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. It also includes clinical laboratory tests. Providers should bill 99381-99397 (Preventive Medicine Services) for the routine physical exam. When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physcials completed by out-of-network providers will be subject to member co-pay as applicable by the member’s plan.

- Preventive dental consisting of 1 exam and 1 cleaning and preventive vision consisting of 1 eye exam are new covered benefits in 2015. Members have the option of purchasing an optional supplemental benefit package beyond this coverage.

- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.
New Plans and Service Area Changes:

1. The Anthem Blue Cross Medicare Preferred Standard (PPO) in Los Angeles, Ventura, Sonoma, Fresno and Tulare counties will be non-renewing for 2015.

2. Blue Cross Senior Secure (HMO) is available in Los Angeles, Ventura, and Fresno counties and Anthem Blue Cross Select Advantage (HMO) is available in Los Angeles County.

3. Members also have the option of enrolling in an Anthem Blue Cross Medicare Supplement and a stand-alone Prescription Drug Plan in all of the non-renewing counties.

Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the service area changes described above for PPO plans.

Blue Cross Senior Secure (HMO) Highlighted Plan Changes

2015 Plans may include changes to Medical and Part D benefits, copayments and/or coinsurance, deductibles, formulary coverage, pharmacy network, premium and out-of-pocket maximums. Please check the member's benefits for the new Plan year changes, by visiting our website at www.anthem.com/ca/medicareprovider or calling Provider Services at the number on the back of the member’s ID card.

- Our plans will no longer cover unlimited inpatient days for acute care illness or injury.
- Blood glucose test strips and glucometers may be purchased through an in-network pharmacy or through our mail-order service. A member may no longer purchase these supplies through any other provider, such as Durable Medical Equipment (DME) Provider, or at a physician’s office.
- These plans will offer one routine physical exam in addition to the Medicare-covered “Welcome to Medicare” exam or Annual Wellness Exam. 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. It also includes clinical laboratory tests. When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member.
- Preventive dental consisting of 1 exam and 1 cleaning and preventive vision consisting of 1 eye exam are new covered benefits in 2015. Members have the option of purchasing an optional supplemental benefit package beyond this coverage.
- Please check the member ID card for any identification and/or group number changes that may affect claim submissions.

New Plans and Service Area Changes:

1. In 2015, we will be offering new HMO plans. Blue Cross Senior Secure (HMO) will now be available in Fresno and San Francisco counties.

2. In 2015, we will begin offering Anthem Blue Cross Select Advantage (HMO), which features a focused network of doctors, in Los Angeles and Orange counties. These plans will offer $0 or low copays and additional services including Dental, Vision, Silver Sneakers, and Transportation.

3. In 2015, we will be launching Anthem Blue Cross Dual Advantage (HMO SNP), a Dual-Eligible Special Needs Plan for beneficiaries with Medicare and Medicaid. Servicing the counties of Fresno, Kern, San Francisco, and Ventura, these plans provide coverage for Medicare covered services and prescription drugs. Additional services such as routine Dental, Hearing, Vision, Silver Sneakers, and Transportation are included with the coverage.
Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the service area changes described above for HMO plans.

Optional Supplemental Benefits (OSB)
For 2015, many of our Medicare Advantage plans will offer three Optional Supplemental Benefit (OSB) packages for an additional premium. OSB packages allow the Medicare Advantage plan to be tailored for additional dental and vision coverage.

We will offer the below Optional Supplemental Benefit (OSB) packages on select plans. Members will have up to 90 days from their plan effective date to enroll in one of the below packages:

1.) Preventive Dental Package
2.) Dental and Vision Package
3.) Enhanced Dental and Vision Package

New Year! New Formulary Changes!

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes in the upcoming year include: tier changes, drug removals, and new Prior Authorization and Quantity Limit requirements.

Your patients will have formulary changes and will need your help to ensure they get their needed treatments at the most affordable cost.

Please encourage your patients to review the 2015 formulary information within their Annual Notice of Change (ANOC) mailing, or to view the information online when it is available, beginning October 1. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications in a lower cost-sharing tier that may meet their needs.

- Initial Coverage Limit (ICL) for Medicare Part D will increase from $2,850 to $2,960.
- TROOP amount will increase from $4,550 to $4,700.
- Tier 6 has select care drugs at a $0 to low cost share for the following conditions: high blood pressure, high cholesterol and diabetes and will have the following drugs on it: GLIPIZIDE, LISINOPRIL, LOSARTAN POTASSIUM, METFORMIN HCL, and SIMVASTATIN.
- The pharmacy network includes preferred and other network retail pharmacies. Members save more by paying a lower cost-sharing amount at preferred cost-sharing pharmacies. Our preferred cost-sharing pharmacies include CVS/Pharmacy (participating pharmacies include CVS and Longs Drugs), Giant Eagle Pharmacy, Hannaford Brothers (participating pharmacies include Hannaford and Food Lion), Harris Teeter Supermarkets, Kroger Co. participating preferred pharmacies include Kroger, Fred Meyer, King Soopers, City Market, Fry’s, Smith’s, Dillons, Ralph’s, QFC, Baker’s, Scott’s, Owen’s, Pay Less, Gerbes and JayC), Target and Wal-Mart (Walmart participating preferred pharmacies include Walmart, Neighborhood Market and Sam’s Club. Members can fill a prescription at a network retail pharmacy, but their cost-sharing amount may be higher.) Please note: Rite Aid will no longer offered preferred cost sharing for member, but will continue as part of the standard retail network

Deductible:
In 2015, Anthem Blue Cross Medicare Preferred Standard (PPO) will have a Part D deductible that will apply to Tier 2: Non preferred Generic, Tier 3: Preferred Brand and Tier 4: Non preferred Brand Drugs. Blue Cross Senior Secure (HMO) plans in Fresno, Los Angeles, Orange, and San Francisco counties will also have a Part D deductible applicable to only Tier 3 and Tier 4. This deductible will have to be met before those tiers’ regular copays/coinsurance will apply.

In 2015, when a member reaches the gap for this plan, they will be expected to pay a 65% coinsurance for all generics, or a 45% coinsurance (plus a portion of the dispensing fee) for their brand drugs until they reach the catastrophic phase.
During the Catastrophic Coverage Phase: Members will pay 5% or $2.65 whichever is more for generic drugs, and members will pay 5% or $6.60 for brand drugs.

Group Sponsored Medicare Advantage Health Benefit Plans are not impacted by the changes described above for Pharmacy plans.

Diabetic Supplies:

Effective January 1, 2015, all of our individual Medicare Advantage plans will only cover certain diabetic supplies if they are purchased at one of our network pharmacies or through our mail-order service. Durable Medical Equipment (DME) providers as well as physicians will no longer be able to bill for these supplies.

HCPC codes that will no longer be covered when purchased through a DME provider or other physicians:

- A4253 blood glucose test strips
- E0607 home blood glucose monitor
- E2100 blood glucose monitor with integrated voice synthesizer
- E2101 blood glucose monitor with integrated lancing/blood sample

Members impacted by this change will be notified in October through their Annual Notice of Change and Evidence of Coverage plan benefit materials.

To be covered for a $0 copay, the members must purchase these supplies at an in-network retail or mail-order pharmacy supplier.

Covered blood glucometers and blood glucose test strips in 2015:

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

Other blood glucometer or blood glucose test strip brands or quantities of more than 100 test strips per month are not covered unless you as the doctor or provider tell us another brand or a larger quantity is medically necessary for the member’s treatment, no other brand or larger quantity limit will be covered.

- If our member is currently using LifeScan, Inc, OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products and using an in-network retail or mail-order pharmacy supplier, you don’t need to do anything!
- If our member is not using LifeScan, Inc, OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products or using an in-network retail or mail-order pharmacy supplier, then our member will need to get new prescriptions for the supplies by January 1st for these claims to be covered by us.
- You should discuss these coverage changes and possible new prescriptions with our member/your patient. If it is medically necessary for them to continue using a different brand of blood test strips or glucometer and/or more than 100 blood test strips per month, you will need to communicate this to us by requesting an exception. If your patient purchases their supplies through the pharmacy or the ESI mail-order service exceptions may be requested by calling (800) 338-6180.

The benefit and brand limitations described above generally do not apply to our Group Sponsored Medicare Advantage Health Benefit Plans. Please contact Provider Services for benefit information.

Insulin Exclusivity
As a reminder for 2015 Individual MAPD plans have an insulin exclusivity contract with Eli Lilly, the manufacturer of Humulin and Humalog human insulins. Other insulins are considered non-formulary and are not eligible for coverage.

**Balance Billing Reminder:**

The Centers for Medicare and Medicaid Services and our plan does not allow you to “balance bill” Medicare Advantage HMO and PPO members for Medicare covered services. CMS provides for an important protection for Medicare beneficiaries and our members such that, after our members have met any plan deductibles, they only have to pay the plan’s cost-sharing amount for services covered by our plan. As a Medicare provider and/or a plan provider, you are not allowed to balance bill members for an amount greater than their cost share amount. This includes situations where we pay you less than the charges you bill for a service. This also includes charges that are in dispute.

**Claim payment guidelines: Anthem Dual Advantage (HMO SNP):**

To fulfill state and federal contractual requirements, this plan applies the Medicare statutory amounts to Medicare covered services. The remaining Medicare Advantage deductible, coinsurance or copayment amounts are then applied to the member’s Medicaid benefits; those claims are processed subject to Medicaid processing guidelines.

Under Medicaid, additional payment may be available dependent upon the Medicaid rate of reimbursement. If the Medicaid rate of reimbursement is more than the filed Medicare benefit, the difference will be paid to the provider. If the Medicaid rate is less than what the filed Medicare benefit has already paid on that claim, no additional payment will be made. Providers are prohibited from balance billing members for any portion of that Medicare cost share that is deemed not covered under their Medicaid benefit.

**Employer or Union Group Retiree Changes:**

Group Sponsored Medicare Advantage Benefit Plan benefits vary from the Blue Cross Senior Secure (HMO), Anthem Blue Cross Select Advantage (HMO), Anthem Blue Cross Dual Advantage (HMO SNP), and Medicare Preferred Standard (PPO): mentioned here. **Employer or Union Group Plan names and benefit changes may be different than what is described above.** For Group Sponsored Medicare Advantage Health Benefit Plan members, please refer to the member’s Evidence of Coverage or call Provider Services at the number on the member ID card for more benefit detail. Medicare Advantage member ID cards contain a CMS identifier in the lower right corner of the card. The number will be five characters (XXXXX) followed by three characters (XXX). The member is in a Group Sponsored Medicare Advantage Health Benefit Plan when the last three digits start with an eight (8XX).

Providers should reference the member’s ID card for changes at every visit to help ensure proper billing. You can also assist your patients by passing on any ID card prefix or benefit change information to any ancillary providers who will be asked to serve your patient.

**What Does the Annual Wellness Visit Cover?**

All of our Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs.

For the first visit, providers should bill G0438 for the AWV which includes the Personalized Prevention Plan Service. Thereafter, providers should bill G0439 for the AWV and Personalized Prevention Plan Service, subsequent visit.

**Annual Wellness Visit**

All Medicare Advantage plans cover the AWV. Members are encouraged to use this annual benefit as one way to help assess current health status and future needs. **What if Additional Services Are Provided at the Same Time As the AWV?**

If other evaluation and management services are provided in conjunction with the AWV, use CPT Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) as appropriate.
Prior Authorization Updates for Medicare Advantage Plans

Providers are required to periodically review and comply with the latest Medicare Advantage Prior Authorization requirements found at www.anthem.com/ca/medicareprovider on the document named: Medicare Advantage Precertification Requirements (updated 10/01/2014)

Referral Process Updates for Individual Medicare Advantage Plans

In most situations, our members may need to receive a referral from their PCP before they can use specialists in the Plan's network. Examples of specialists include Cardiologists, Dermatologists, Orthopedic Surgeons, Oncologists and Urologists. However, referrals from a PCP are not required for emergency care or urgently needed care. There are also other kinds of care members can obtain without having approval in advance from their PCP. Please visit our website at www.anthem.com/ca/medicareprovider for more detailed product information or contact Provider Services at the number on the back of the member's ID card. You can find important Medicare Advantage updates in the Plan & Administrative Changes/Update section. Contact your provider representative for participation details for our contracted plans.

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Pharmacy

Pharmacy information available on anthem.com/ca

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

To locate the “Marketplace Select Formulary” and pharmacy information for Health Plans offered on the Exchange Marketplace, go to Customer Support, select your state, Download Forms and choose “Select Drug List.”