

# Network Update

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# Health Care Reform Updates (including Health Insurance Exchange)

## Medical chart reviews begin July for members with plans on or off the exchange

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

In July 2015, we will continue our chart review program for **those members who have purchased our individual health insurance plans on or off the Health Insurance Marketplace** (commonly referred to as the exchange). This particular effort is part of Anthem Blue Cross' compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual health plans on or off the exchange. The members' medical record documentation helps support this data requirement.

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

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

Inovalon is using the following methods of collecting medical record information:

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

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the providers' offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within 30 days.

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

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

## Professional Network Update

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

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. **When members visit your practice or office, we encourage you to document ALL of the members' health conditions, especially chronic diseases.** As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.

**By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping Anthem Blue Cross meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.**

### Reminder about ICD-9 CM coding

As you are aware, the ICD-9 CM coding system, (and soon ICD-10 coding which is scheduled to implement October 1, 2015) serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, Anthem Blue Cross uses ICD-9 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

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

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

### Reminder about completing SOAP Notes

The SOAP Note – the standardized documentation format of a medical record – stands for Subjective, Objective, Assessment, and Plan. SOAP Notes are used with the Inovalon outreach efforts and are meant to be a supplement to providers' usual documentation process. When submitting information to Inovalon, providers have the option of completing SOAP Notes electronically using Inovalon's ePASS® Web-based tool or using a paper format. Here are some tips for completing SOAP Notes that we hope you find helpful.

- ✓ The exam date for the patient must match the exam date on the completed SOAP Note
- ✓ A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note
- ✓ The provider signature date should be the actual date the SOAP Note is signed
- ✓ All "mandatory" fields on the paper SOAP Note must be completed
- ✓ The exam date must occur between January 1, 2015, and December 31, 2015, for this benefit year
- ✓ All "mandatory" fields on the paper SOAP Note must be completed properly and accurately

For additional information about SOAP notes, the medical record review process or the outreach effort, please refer to the frequently asked questions document available on our [website](#).

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

# Professional Network Update

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

At Anthem Blue Cross, we are working to update health documentation for our members in the individual markets who have purchased our health insurance plans on and off the exchange. Working with our providers, we engaged Inovalon to contact our members and encourage in-office visits with their physicians. Therefore, as a physician, you may receive letters throughout the year from Inovalon on our behalf. Inovalon began contacting providers and members in January 2014. In 2015, we are continuing these efforts and want to help ensure you and your office staff are aware of these ongoing outreach efforts Inovalon is conducting on our behalf.

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

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

If you have questions about the Inovalon effort and this ongoing outreach effort, we've compiled a list of questions and responses for your reference on our website [HERE](#).

### 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](http://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](#).

# Announcements and General Updates

## Important: Pre-service clinical review of specialty pharmacy drugs will transition to AIM Specialty Health®

On September 1, 2015, with the exception of those members with benefit plans noted below, Anthem Blue Cross will transition pre-service clinical review of Specialty Pharmacy Drugs that fall under the medical benefit on fully insured accounts to AIM Specialty Health® (AIM), a separate company providing outpatient specialty pharmacy utilization management services on behalf of Anthem Blue Cross.

Please note that the transition of pre-service clinical review of specialty pharmacy drugs to AIM does not apply to the following plans:

- National accounts
- Federal Employee Plan® (FEP)
- Medicare
- Medicare Supplement plans
- Medicare Advantage HMO and PPO plans
- Medicaid
- ASO Accounts

Once this transition occurs, providers will be able to contact AIM through the following processes to submit a request for pre-service clinical review:

**Internet Requests** - Online pre-service clinical review will be available via AIM's web-based application, the ProviderPortal<sup>SM</sup>. AIM's ProviderPortal is available twenty-four hours a day, seven days a week. It is fully interactive, processing requests in real-time using clinical criteria. The ProviderPortal may be accessed directly at [www.providerportal.com](http://www.providerportal.com).

**Telephone Requests** - Requests for pre-service clinical review can also be submitted to AIM via telephone. Providers can call AIM toll-free at 1-877-291-0360, Monday through Friday 5:00 a.m. – 5:00 p.m. (PT) to request pre-service review. Once the transition occurs, Anthem's phone prompts will be changed to include a Specialty Pharmacy prompt that will automatically route the caller to AIM for pre-service clinical reviews.

Please note that AIM is already reviewing pre-service requests for certain specialty pharmacy oncology drugs on behalf of Anthem under the Cancer Care Quality Program for national account members residing in California, as well as Medicare Advantage HMO and PPO members. Oncologists and hematologists are encouraged to continue to submit cancer treatment regimens to AIM for review against evidence-based clinical criteria. (For more information on the Cancer Care Quality Program, please visit [www.cancerqualityprogram.com](http://www.cancerqualityprogram.com).)

## Notice of post-payment audit

Beginning July 1, 2015, Anthem Blue Cross will begin a new process to verify the accuracy of information received on the pre-service notifications for select specialty drugs. Specialty Pharmacy claims may be audited post-payment. Medical records will be requested in order to validate the claim.

Examples of specialty drugs:

- Botox
- Remicade
- Synagis
- IVIG
- Erythropoietin
- Synvisc
- HGH

Inaccurate information may result in overpayment recovery or other action by the Plan to address the issue.

## Medical policy update: Lipoprotein testing

**Advanced lipoprotein testing is considered investigational and not medically necessary for cardiovascular disease (CVD) risk assessment and management. Therefore, for dates of service effective October 9, 2015, claims submitted with these codes will be denied.**

Advanced lipoprotein testing includes any test that is not included in a basic lipid panel. A basic lipid panel consists of:

- Total cholesterol levels (TC),
- Low-density lipoprotein cholesterol (LDL-C),
- Triglycerides (TG) and
- High-density lipoprotein cholesterol (HDL-C) levels.

The following are some examples of tests that fall into the advanced lipoprotein testing category:

1. Apolipoprotein A-I (apoA1);
2. Apolipoprotein B (apoB);
3. Apolipoprotein E (apoE);
4. Intermediate density lipoproteins (IDL);
5. Lipoprotein(a) (Lp(a)) enzyme immunoassay;
6. Lipoprotein-associated phospholipase A2 (Lp-PLA2);
7. Small density lipoproteins.

Without a clear link to a therapeutic decision and improved clinical outcomes, testing is not recommended by national guidelines and experts in the field. Similarly for the other advanced lipoprotein tests, the usefulness of testing is not yet clear and further clinical trials are needed.

Codes that will not be reimbursed include:

Code	Description
82172	Apolipoprotein, each
83695	Lipoprotein (a)
83698	Lipoprotein-associated phospholipase A2 (Lp-PLA2)
83700	Lipoprotein, blood; electrophoretic separation and quantitation
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)
83704	Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy)

Anthem launches digital magazine featuring tested resources for all people touched by cancer

## Stronger together



### Resources for people touched by cancer

Working with community organizations to bring free digital tools to everyone

[Stronger Together](#) is a new digital magazine featuring tested resources available at no charge to all people touched by cancer. Anthem's Community Health Initiatives department worked with leading national organizations to make these resources available to providers, patients/survivors, caregivers, workplace managers and employees.

Stronger Together addresses the needs of primary care providers and specialists seeking tested resources for themselves and all patients regardless of health plan.

"The resources can be used by people with cancer and caregivers to support their journey through treatment and survivorship, as well as those who play a crucial role in their health and well-being" said Jennifer Hausman, public health program director, Community Health Initiatives."

We hope you will share Stronger Together with your patients and colleagues.

### Anthem Blue Cross cost transparency

As an Anthem Blue Cross (Anthem) participating provider, you may have received our November 2014 and/or May 2015 correspondence regarding Anthem Cost Transparency. We informed you in those letters that in response to consumer demand for transparency in health care costs, Anthem released its first cost transparency tool, *Anthem Care Comparison*, and later its successor, *Estimate Your Costs*, a tool available to members on our anthem.com website, which includes functionality allowing members to estimate their out-of-pocket impact and view the estimated costs for many procedures.

# Professional Network Update



Enclosed in the correspondence was also a summary of the methodology used to generate the cost information housed in the National Consumer Cost Tool (NCCT), the source data used to display costs in *Estimate Your Costs*. The treatment categories for which costs are displayed and the methodology are defined by the Blue Cross Blue Shield Association. As indicated in the correspondence, NCCT cost data is updated twice annually; the most recent update completed in May of 2015, and the next update scheduled for November 2015. Please look for further information on this in our calendar year 2015 Provider Newsletters posted to [anthem.com/ca](http://anthem.com/ca).

Should you wish to see your specific cost information shown on *Estimate Your Costs*, or the methodology, please contact us by email at [CAContractSupport@anthem.com](mailto:CAContractSupport@anthem.com) requesting such information. You will need to provide your business name and TaxID.

Thank you for your service to our members.

## AIM Specialty Health® enhancing web portal experience for servicing providers

AIM Specialty Health® (AIM) will enhance their web portal experience effective May 11, 2015, to enable servicing providers (those free-standing or hospital facilities that perform imaging procedures) to initiate *and complete* diagnostic imaging requests through AIM. Previously, servicing providers could only initiate requests for review of diagnostic imaging exams by phone. Online authorizations are available 24 hours a day, seven days a week.

As a reminder, servicing providers should continue to coordinate care with the member's ordering provider.

### AIM online Pre-authorization Requests (for Ordering and Servicing Providers) can be accessed via the Availity Web Portal

Your office can save time, save money, and eliminate hassles by requesting and obtaining pre-authorizations online for radiology, cardiology, sleep, oncology, and specialty drugs. Information is available for both ordering and servicing providers. Ordering providers can request and obtain a pre-authorization online. Servicing providers can inquire about an authorization, as well as obtain pre-authorization, prior to rendering services to a member.

#### To Submit a Pre-authorization Request

*If you have an Availity User ID and Password, use the following steps:*

- Log in to the [Availity Web Portal at www.availity.com](http://www.availity.com)
- Enter your Availity User ID and Password
- Click the **Auths & Referrals** link, from the left side navigation menu
- Then select **AIM Specialty Health**
- Click **Continue** to accept the Anthem Blue Cross and Blue Shield Internet Hyperlink Disclaimer
- Once logged into AIM, from the **My Homepage** screen, click **Start Your Order Request Here**
- Complete requested information. If submitted information meets criteria, an authorization number will be issued.

**Note:** *The user must have an active User ID on ProviderAccess to access the AIM system through Availity. The Availity PAA must complete the Anthem Services Registration for each User to access AIM.*

For more information on how to access online authorizations via Availity, reference our [AIM Specialty Health Quick Reference Guide](#).

## Billing

# Professional Network Update

## Workers' Compensation fee schedule update

The California Official Medical Fee Schedule (OMFS) for services rendered to ill/injured workers' has been updated for services rendered on or after March 1, 2015. Some of the changes include:

- 1) The OMFS was adjusted to conform to relevant changes in the Medicare Federal Register for services rendered on or after March 1, 2015. Including adjustment factors update to include the 2015 Medicare adjustment factors corrected in January 2015.
- 2) The OMFS was adjusted to changes to the Medi-Cal rates file for services rendered on or after March 1, 2015.
- 3) The OMFS was updated to adopt and incorporate Medicare's Practitioner Services MUE Table – Updated April 1, 2015.
- 4) The OMFS was updated to adopt and incorporate the Physician Correct Coding Edits – Updated April 1, 2015.
- 5) The OMFS also had changes to several other CPT code reimbursement; and more details can be found on the Division of Workers' Compensation website: <http://www.dir.ca.gov/dwc/OMFS9904.htm#7>

## Air ambulance claim filing requirements

### Where do you file claims for air ambulance services for your Blue Cross and Blue Shield patients?

Generally, as a health care provider, you should file claims for your Blue Cross and Blue Shield patients to the local Blue Plan. However, there are unique circumstances when claims filing directions will differ based on the type of service rendered. To that point, effective April 19, 2015, Anthem Blue Cross will implement air ambulance claim filing requirements that reflect a Blue Cross and Blue Shield Association (BCBSA) mandate.

The BCBSA requirements stipulate that claims for air ambulance services must be filed to the Blue Plan in whose Exclusive Service Area (ESA) the point of pick-up zip code is located.

**NOTE:** If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan

**Effective April 19, 2015**, air ambulance providers are required to follow the air ambulance claim filing requirements listed in the chart below, to help avoid your claims rejecting because Anthem Blue Cross is not the correct Plan to process. This is a reminder to the written notice mailed earlier in the year.

Service Rendered	How to file (required fields)	Where to file	Example
Air Ambulance Services	<p><b>Point of Pickup ZIP Code:</b></p> <ul style="list-style-type: none"> <li>– Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup</li> <li>– For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.</li> <li>– Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital</li> </ul>	<p>File the claim to the Plan in whose service area the point of pickup ZIP code is located*.</p> <p>*BlueCard rules for</p>	<ul style="list-style-type: none"> <li>• The point of pick up ZIP code is in Plan A service area.</li> <li>• The claim must be filed to Plan A, based on the point of pickup ZIP code.</li> </ul>

# Professional Network Update

Service Rendered	How to file (required fields)	Where to file	Example
	<p><i>charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.</i></p> <ul style="list-style-type: none"> <li>– <i>Form Locators (FL) 39-41</i></li> <li>– <i>Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.</i></li> <li>– <i>Value: Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.</i></li> <li>– <i>For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.</i></li> </ul>	<p><i>claims incurred in an overlapping service area and contiguous county apply.</i></p>	

1. The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
2. Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling **1-800-676-BLUE**.
3. Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Anthem network manager.
4. Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
5. Providers who wish to establish Trading Partner Agreements with other Plans should contact the Plans directly if they are not currently billing through a clearinghouse. Clearinghouses can assist providers with setting up access for electronically billing other Plans. In order to avoid claims rejections, these providers should set up Trading Partner agreements with Plans with whom they don't currently contract.
  - Our contracted ancillary providers can call the EDI HelpDesk at 800-470-9630, or go to <http://www.anthem.com/edi> to request assistance with submitting to other Anthem Plans (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI), Anthem Blue Cross, Empire Blue Cross and Blue Shield and Blue Cross and Blue Shield of Georgia.
6. If you have any questions about where to file your claim, please contact provider customer service at the phone number on the back of the member ID card.

**Important reminder for providers and facilities regarding written correspondence**

# Professional Network Update

To expedite your written correspondence, the first important step is to get it to the correct area for processing. You can assist Anthem Blue Cross' operation departments by **including the complete member ID including the 3 letter alpha prefix** on all correspondence. When incoming mail does not have a complete valid member ID, the inquiry will default to the wrong queue, or be returned for more information.

Either scenario creates unnecessary delays in the processing of your request. In nearly all cases, the complete member ID can be found on the front of the member's health plan ID card.

## ICD-10 updates: ICD-10 pre-authorizations to begin in June for service dates 10/1/2015 or after

Starting June 1, 2015, we will begin accepting and processing **preauthorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015**, the mandated ICD-10 compliance date. Note that you must continue to use ICD-9 codes to pre-authorize services scheduled through September 30, 2015. Some pre-authorizations may span the October 1, 2015 compliance date. The code set of the preauthorization will vary, depending on the scenario. This chart will help you determine what code set to use for your pre-authorizations.

A printable version of this chart is available on Anthem Blue Cross' ICD-10 Updates [Anthem's ICD-10 webpage](#).

Type of Service	Begins	Ends	Pre-authorization	Claim
<b>Inpatient</b>	Admission begins <i>on or after</i> 10/1/2015	Discharge <i>on or after</i> 10/1/2015	Pre-authorization must be requested with ICD-10 codes	Claim for services rendered <i>on or after</i> 10/1/2015 must be billed with ICD-10 codes.
<b>Inpatient with <u>unknown</u> discharge date</b>	Admission begins <i>on or after</i> 10/1/2015	Unknown at the time of admission, then discharge occurs <i>on or after</i> 10/1/2015	Pre-authorization must be requested with ICD-9 codes. This pre-authorization will be valid for the entire admission.	The code set used on the claim will be based on the discharge date, so the entire claim must be billed with ICD-10 codes.
<b>Inpatient with <u>known</u> discharge date</b>	Admission begins <i>before</i> 10/1/2015	Known discharge <i>on or after</i> 10/2/2015	Pre-authorization should be requested with ICD-10 codes.	The code set used on the claim will be based on the discharge date, so the entire claim must be billed with ICD-10 codes.
<b>Outpatient Services</b>	Service <i>on or after</i> 10/1/2015	N/A	Pre-authorization should be requested with ICD-10 codes.	Claim must be filed with ICD-10 codes.
<b>Long-term Outpatient Services (such as Physical Therapy, Radiation Therapy, Chemotherapy, etc.)</b>	Services begin <i>before</i> 10/1/2015	Services end <i>on or after</i> 10/1/2015	Pre-authorization obtained in ICD-9 will be valid for services rendered <i>on or after</i> 10/1/2015.	The claims for these services need to be separated and filed with the correct code set for the date(s) of service. Claims with both codes sets, or mixed claims, will not be accepted.

## Contracted provider claim escalation process

# Professional Network Update

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](mailto:CAContractSupport@anthem.com) to answer questions you have about the process, if you need clarification.

## Network

# Professional Network Update

## Provider webinars: June sessions – last chance!

**Last chance** ... Join us at our 2015 second quarter webinars! Our Provider Network Education team offers quality educational programs and materials specially designed for the office staff of physicians, hospitals, medical groups, ancillary and other health care professionals. Our 'complimentary' education programs offer 'blended learning' via face-to-face and web-based learning opportunities exclusively for our contracted provider network.

For a complete schedule of our seminar, webinars, job aids, and on-demand e-courses, log on to the Anthem Blue Cross website: <http://www.anthem.com/ca/home-providers.html>. Scroll down to the **SPOTLIGHT** section and click on the [2015 Provider Education Seminars and Webinars](#) link.

**Webinars:** offer a "live" interactive, 60 minute session with Q&A, conducted remotely via the internet and facilitated by the Provider Network Education team and Subject Matter Experts.

Here is the schedule of the topics and June dates:

Time: 2:00pm – 3:00pm [PST]  
"Complimentary"

DATES	TOPIC	AGENDA	WHO SHOULD ATTEND
June 2	BlueCard [Out-of-Area] Refresher	<ul style="list-style-type: none"> <li>How to verify out-of-area eligibility and benefits</li> <li>Ancillary Claim Filing</li> <li>Electronic Provider Access (EPA)</li> <li>The BlueCard Program Provider Manual</li> </ul>	All Contracted Providers and billing staff.
June 10	Facility Manual Overview	<ul style="list-style-type: none"> <li>What the Provider Manual is</li> <li>Which Provider Manual to use</li> <li>Where the Facility Manual is located</li> <li>Facility Manual navigation</li> <li>Facility Manual "critical content" sections</li> <li>How to use the Facility Manual "search" tool.</li> </ul>	All Contracted Facility and Institutional Providers and intake/billing staff that bill on a UB-04 claim form.
June 24	Behavioral Health Provider Resources – Online Access	<ul style="list-style-type: none"> <li>Learn the Behavioral Health Provider Resources Web page on <a href="http://anthem.com/ca">anthem.com/ca</a></li> <li>Navigate the Web page to find what you need for Behavioral Health services – Availity Web Portal, forms, guidelines, EOB, and more.</li> <li>Use all Behavioral Health Provider business and service tools on <a href="http://anthem.com/ca">anthem.com/ca</a></li> </ul>	All Contracted Behavioral Health Providers and Staff.

QUESTIONS: phone: 1-818-234-1016 or email at: [network.education@anthem.com](mailto:network.education@anthem.com)

Moved your office?

# Professional Network Update

To ensure proper processing of all changes to addresses, tax ID numbers and provider profiles, please e-mail them to [Provider\\_Database-Anthem-Wellpoint@Wellpoint.com](mailto:Provider_Database-Anthem-Wellpoint@Wellpoint.com). You can also send your changes by fax to **1-818-234-2836** or **1-866-243-3183**. Keep in mind that all changes must be submitted on the physicians or medical group's letterhead and signed by the physicians or authorized personnel.

Other convenient online options for updating practice information can be easily found on [anthem.com/ca](http://anthem.com/ca):

- [Physician/Physician Group Change Form](#)
- [Behavioral Health/EAP Practice Profile](#)
- [Institutional Provider Change Request Form](#)

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

In 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 **1-855-238-0095** for assistance.

## Guidelines and Quality Programs

# Professional Network Update

## Clinical practice and preventive health guidelines available online

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to the "Provider" home page at [anthem.com/ca](http://anthem.com/ca). From there, select "Provider" and your state> then Health & Wellness> Practice Guidelines.

## Medi-Cal Managed Care Updates

# Professional Network Update



## Free language assistance programs

Our members count on our providers for medical care and treatment, but they may experience language barriers that make it difficult for them to ask questions or to communicate their concerns. Anthem Blue Cross is committed to reducing the impact of language barriers for our Medi-Cal Managed Care (Medi-Cal) patients to obtain language assistance.

### Telephonic interpreters

During regular business hours, providers and members can call the Medi-Cal Customer Care Center using the number located on the back of members' ID cards. After-hours, the 24/7 NurseLine at **1-800-224-0336** can take the call. When requesting interpreter assistance:

- Give the customer care associate the member's ID number.
- Explain the need for an interpreter and the language needed.
- Wait on the line while the connection is made.
- Once connected, the interpreter, an Anthem associate or nurse, introduces the Medi-Cal member, explains the reason for the call, and begins the dialogue.

### Face-to-Face interpreters including sign language

Providers and members may call the Medi-Cal Customer Care Center to schedule face-to-face interpreter services for medical appointments during regular business hours. Seventy-two hours (nine business days) advance notice is required to schedule face-to-face interpreter services and cancellations require 24 hour notice (three business days). Providers may also schedule face-to-face interpreter services by e-mailing [spp.interpret@anthem.com](mailto:spp.interpret@anthem.com). This is a secure email requiring registration; type "secure" in the subject line.

### Members with hearing loss or speech impairment

Members with hearing or speech impairments can use the Medi-Cal Customer Care Center teletypewriter (TTY) number during regular business hours, and after-hours, the 24 hour NurseLine TTY number can be used. Members can also use the state relay service line by dialing **711**. Customer Care Center associates can also assist non-TTY users by contacting those who only utilize TTY equipment, such as providers needing to contact members with TTY assistive devices.

### Translation of materials

Members can request health plan materials in alternative formats such as Braille, large print, audio CD, verbal interpretations, and non-English languages at no cost by contacting the Medi-Cal Customer Care Center number on the back of their ID cards.

## Health education classes available

Health education classes are available at no charge to Anthem Blue Cross Medi-Cal Managed Care (Medi-Cal) members and are accessible through self-referral or referral by network providers. Typically, these classes take place with our hospital and community organization colleagues and their availability varies by county.

### Topics include:

- Asthma management
- Childbirth/Lamaze/prenatal education
- Diabetes management
- Injury prevention
- Nutrition
- Parenting/well child

# Professional Network Update

- Smoking cessation/tobacco prevention
- Substance abuse

For more information about referring members to health education classes, members or providers can call the Medi-Cal Customer Care Centers at **1-800-407-4627** (outside Los Angeles County) or **1-888-285-7801** (inside Los Angeles County).

In addition, Anthem Blue Cross has an extensive selection of health education materials available in both English and Spanish on the provider resources webpage. Select [Health Education Resources](#) under the Health Education section to find downloadable health tips.

These materials can be translated in additional languages upon request. They are also available in alternative formats, including Braille, large print, and audio by contacting the Medi-Cal Customer Care Center number on the back of the member's ID card. Translations and alternative formats are available free of charge.

## New online referral tool fast tracks patients to tobacco cessation counseling

In addition to telephonic counseling, the Helpline also offers web-based referrals and electronic referrals through electronic health records.

- **Web-Based referral:** This online service offers providers a quick and easy method for referring patients to the Helpline. Providers may request a report summarizing the aggregate number of participants referred, reached, not reached, counseled, who received materials, or refused service. [Enroll now for online services.](#)
- **Electronic referral:** For health professionals who utilize electronic health records, the Helpline can establish an interface so that referrals are received electronically and individual-specific referral data is sent back to the provider. For more information, contact the Helpline Communications department at **1-858-300-1010**.

## Tobacco cessation – counseling offered in Asian languages

The California Smokers' Helpline offers free, evidence-based tobacco cessation services in multiple languages to help smokers quit. Helpline has served Chinese, Korean, and Vietnamese speaking callers since 1992, and research has shown that these services are well-utilized and effective. Asian language callers receive one-on-one guidance, self-help materials, and free nicotine patches sent directly to their homes. Asian Smokers Quitline (ASQ) is promoted throughout the U.S., and local public health programs are encouraged to help get the word out to their Asian community members:

- Chinese - **1-800-839-8917**
- Korean - **1-800-556-5564**
- Vietnamese - **1-800-778-8440**

For more information and to get tobacco cessation materials at no cost to your office, visit <http://www.nobutts.org/>.

## Body mass index and obesity: Claims documentation and coding tips

Services that help address unhealthy weight are known as obesity-related services. Anthem Blue Cross covers a range of services to prevent and reduce obesity, including BMI screening, education and counseling about nutrition and physical activity, prescription drugs, and surgery. Health care providers should conduct height, weight and nutrition assessments as part of all well-child visits and adult annual checkups. If primary care providers counsel patients regarding obesity, there are procedure codes that can be billed to report the services for reimbursement. Providers should ensure the correct diagnosis and BMI codes are billed that correlate to obesity to support the counseling.

### Claims Documentation and coding

# Professional Network Update

Obesity codes are located in the Endocrine, Nutritional and Metabolic Diseases chapter of ICD-9-CM. The codes are to be applied when documentation supports a clinical diagnosis from physician documentation.

ICD-9 Codes for Reporting Weight-related Clinical Diagnoses	
Description	Code
Obesity unspecified	278.00
Morbid obesity	278.01
Overweight	278.02

A coding instructional note listed with category 278.0 states to code BMI using codes V85.0-V85.54. Assign both the clinical diagnosis and the BMI code on your claim. ICD-9 Coding Guidelines define morbid obesity as BMI greater than 40.

#### AHA Coding Clinic advice

1. Per the American Hospital Association's Coding Clinic 2010, Q2, BMI itself may be retrieved from nonphysician documentation such as a dietician; however, the clinical diagnosis must come from physician documentation.
2. Per AHA Coding Clinic 2011, Q3, individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the BMI code meets the requirement for clinical significance when obesity is documented.

#### Obesity and BMI coding in ICD-10

Document the type (i.e., morbid, obese, overweight) and cause of obesity for ICD-10 (e.g., excess calories, drugs, etc).

ICD-10 Codes for Reporting Weight-related Clinical Diagnoses	
Description	Code
Overweight	E66.3
Obesity, other causes	E66.8
Obesity, unspecified	E66.9
Morbid obesity, due to excess calories	E66.01
Other obesity due to excess calories	E66.09
Body mass index	Z68

#### Distinct procedural service coding update

# Professional Network Update

On **January 1, 2015**, the Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers to define subsets of the -59 modifier used to define a Distinct Procedural Service.

### **How is the coding for this modifier changing?**

Currently, the -59 modifier is used when a code for a service, which would usually be bundled, is being considered separate and distinct from another service.

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier). These modifiers, collectively referred to as -X{EPSU} modifiers, are as follows:

- XE Separate Encounter — A service that is distinct because it occurred during a separate encounter
- XP Separate Practitioner — A service that is distinct because it was performed by a different practitioner
- XS Separate Structure — A service that is distinct because it was performed on a separate organ/structure
- XU Unusual Non-Overlapping Service — The use of a service that is distinct because it does not overlap usual components of the main service

Anthem Blue Cross will begin following the CMS Modifiers for Distinct Procedural Services. We will continue to recognize the -59 modifier; however, CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the -59 modifier; it would be incorrect to include both modifiers on the same line.

Anthem Blue Cross will be accepting the -X{EPSU} modifiers prior to the National Corrective Coding Initiative (NCCI) edits update. Anthem Blue Cross requires the use of selective modifiers instead of the general -59 modifier when the -X{EPSU} modifiers provide more clarity for the service/procedure performed.

### **For more information**

If you have questions about this communication, please contact your local Provider Relations representative or call one of our Medi-Cal Customer Care Centers at **1-800-407-4627** (outside Los Angeles County) or **1-888-285-7801** (inside Los Angeles County).

## **Medicare Advantage Updates**

# **Professional Network Update**

## New CLIA & ADI requirements effective 7/1/2015 for individual Medicare Advantage

Effective July 1, 2015, Anthem Blue Cross Medicare Advantage will deny claims billed without CMS-required criteria back to the provider who submitted the claim. The denials will include:

- Advanced Diagnostic Imaging (ADI) supplier is not accredited for the service it is billing.
- Clinical Laboratory Improvement Amendment (CLIA) certification is missing or invalid, based on the laboratory code billed. CLIA certification should be billed in Box 23 on the claim form. February's *Network Update* erroneously stated that an informational message will be included starting on your March remittance when you bill a laboratory code that requires certification. This message was not included on your March remittance, however the message will appear on your remittance in the coming months.

Please ensure your billing staff is aware of these CMS requirements. If you have any questions, please contact the Provider Services number on the back of the member's ID card.

## Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 and older. Once a woman has had a fracture, she has a four times greater risk of another fracture, reports the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

Anthem Blue Cross asks that providers encourage women 67-85 who have had a fracture or may be a risk for a fracture to have a Bone Mineral Density screening or be placed on osteoporosis medication if appropriate. Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the *Journal of Rheumatology*.

## DMARDs help prevent long-term disability

The American College of Rheumatology recommends that persons with Rheumatoid Arthritis are prescribed a Disease Modifying Anti-Rheumatic Drug to prevent long-term disability and damage. To help ensure your Medicare Advantage RA patients have these important prescriptions, we will review medical and pharmacy claims looking for members who have an RA diagnosis and do not appear to have a claim for a DMARD. Providers who have members with a diagnosis of RA and not on a DMARD may receive a monthly fax reminder. **Please be sure to use correct diagnosis codes for RA and be careful not to use a RA code for ruling out RA, Osteoarthritis and Joint Pain.**

## Encourage Medicare Advantage members to control high blood pressure

According to the Centers for Disease Control, almost one in three American adults has high blood pressure but only about half have their blood pressure under control. Anthem joins you in encouraging our Medicare Advantage members to know and control their blood pressure to lower their risk of heart attack, heart disease, stroke and kidney disease.

## Please follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Anthem Blue Cross follows Centers for Medicare & Medicaid Services' [Medicare Part B Immunization Billing](#) guidelines.

# Professional Network Update

Please use the following forms when filing flu, pneumonia or Hepatitis B claims for Anthem individual and group-sponsored Medicare Advantage members.

- Professional claims should be filed on the CMS 1500 form with the appropriate Current Procedural Terminology code and/or Health Care Procedural Code for the vaccine and administration.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes  
Revenue Codes (except Rural Health Clinics and Federally Qualified Health Centers):  
0636 – vaccine (and CPT or HCPC)  
0771 – administration (and HCPC)  
Rural Health Clinics and Federally Qualified Health Clinics – 052X revenue code series

Please refer to page three of the [Medicare Part B Immunization Billing Guide](#) for specifics on institutional billing.

## Failure to pre-certify an admission or provide notice of emergent inpatient admission will result in administrative denial effective May 1, 2015

Network physicians and facilities are required to obtain precertification for specified services for individual and group-sponsored Medicare Advantage members, including an admission to any inpatient facility. For the member to receive maximum benefits, the health plan must authorize or pre-certify the covered services prior to being rendered.

Please notify Anthem **as soon as possible** for planned or unplanned inpatient admissions, **but no later than within one business day of admission**.

**Effective May 1, 2015**, if the required precertification is not obtained within the specified timeframe, **the claim will be administratively denied due to failure to notify** Anthem of the admission. The provider will not receive payment for the service. **Providers cannot bill the member for these denied services.**

If you do not notify us within the required timeframe, you may file an appeal.

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem Blue Cross provider home page at [www.anthem.com/ca](http://www.anthem.com/ca) for further information on existing precertification requirements.

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

Pre-certifications for Anthem individual Medicare Advantage members also can be initiated via the Availity web portal at [www.Availty.com](http://www.Availty.com). To access this new functionality, go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the Precertification look-up tool.

Please visit the [Medicare Advantage provider portal](#) to learn more about this online provider self-service tool.

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## ICD-10-CM: Human Immunodeficiency Virus (HIV) Status

# Professional Network Update

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015.

The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient's Human Immunodeficiency Virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

The table below reflects the crosswalk from ICD-9 to ICD-10.

ICD-9 Code(s)	ICD-10 Code(s)
<ul style="list-style-type: none"><li>• V08- Asymptomatic human immunodeficiency virus (HIV) infection status</li><li>• 042- Human immunodeficiency virus [HIV]</li><li>• 079.53- Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site</li></ul>	<ul style="list-style-type: none"><li>• Z21- Asymptomatic human immunodeficiency virus [HIV] infection status</li><li>• B20- Human immunodeficiency virus [HIV] disease</li><li>• B97.35- Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere</li></ul>

To further assist in preparation for ICD-10, please see the following resources:

- Centers for Medicare & Medicaid Services (CMS): [Provider Resources](#)
- American Academy of Professional Coders: [AAPC ICD-10 Resources](#)
- World Health Organization: [WHO ICD-10 Training](#)

## Medicare Advantage pre-certification requirements available on our provider portal

Network physicians are required to obtain precertification for specified services for Medicare Advantage members. For the member to receive maximum benefits, the health plan must authorize or precertify the covered services prior to being rendered. Additional information on 2015 Medicare Advantage precertification requirements can be found [here](#).

## Dual eligible special needs plans - new for 2015

In 2015, Anthem Blue Cross is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are \$0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors' appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items.

More information about D-SNPs and a list of Frequently Asked Questions can be found [here](#).

**Special needs plan members – CMS requires annual medication, supplement review**

Medicare requires that Primary Care Physicians review all prescription and non-prescription drugs, vitamins, herbals, and other supplements at least once per year for members in a Special Needs Plan (SNP).

SNP members age 66 or older also should have one functional status assessment each year. According to HEDIS® guidelines, notations for a complete functional status assessment should include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed (includes bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking).
- Notation that Instrumental Activities of Daily Living (IADL) were assessed (includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances).
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - Assessment of Living Skills and Resources (ALSAR)
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
  - Bayer Activities of Daily Living (B-ADL) Scale
  - Barthel Index
  - Extended Activities of Daily Living (EADL) Scale
  - Independent Living Scale (ILS)
  - Katz Index of Independence in Activities of Daily Living
  - Kenny Self-Care Evaluation
  - Klein-Bell Activities of Daily Living Scale
  - Kohlman Evaluation of Living Skills (KELS)
  - Lawton & Brody's IADL scales
- Notation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Sensory ability (including hearing, vision and speech)
  - Other functional independence (e.g., exercise, ability to perform job)
  -

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

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

## Medicare Advantage reimbursement policies available on our provider portals

For Anthem Blue Cross Medicare Advantage reimbursement policy updates, please see [Important Medicare Advantage Updates](#). To review our complete set of reimbursement policies, [select Medicare Advantage Reimbursement Policies](#). Our reimbursement policies apply to participating providers who serve Individual Anthem Blue Cross Medicare Advantage business unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

## Reminder: Individual MA membership moved to new claims system

Effective January 1, 2015, Anthem Blue Cross moved Individual (non-group) MA members to a new claims processing system. Please continue to check [Important Medicare Advantage Updates](#) on your [provider portal](#) for additional information.

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## Pharmacy

# Professional Network Update



## Pharmacy information available on [anthem.com/ca](http://anthem.com/ca)

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit [anthem.com/pharmacy](http://anthem.com/pharmacy) information. 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 "Marketplace Select Formulary" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List."