

Network Update

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Professional Network Update

Health Care Reform Updates (including Health Insurance Exchange)

Colonoscopy billing reminder – preventive vs. diagnostic

The Affordable Care Act (ACA) requires non-grandfathered health plans to cover outlined preventive care and screenings without member cost sharing, when the services are rendered by an in-network provider and/or facility. Colorectal cancer screenings are included as a covered preventive care service under these guidelines.

Since colonoscopies are rendered for both screening and diagnostic purposes, it is very important for providers to use appropriate ICD-9 diagnosis coding guidelines when reporting colonoscopies (or ICD-10 diagnosis coding guidelines, once implemented). When inappropriate ICD-9 diagnosis codes are submitted on claims, it can result in incorrect provider payment and/or incorrect member cost sharing.

To reduce claim adjustments and your corresponding refunds to members, we recommend the following approach when coding a colonoscopy claim.

- In a situation where an individual presents for treatment solely for the purpose of a screening exam, without any signs or symptoms of a disease, then such a procedure should be considered a screening. The appropriate use of diagnosis codes and screening procedure codes is valuable in promoting appropriate adjudication of the claim.
- In a circumstance where an individual presents for a screening exam (without signs or symptoms), and an issue is encountered during that preventive exam, then such a circumstance would warrant the use of the PT modifier. The procedure and diagnosis codes that would typically be used in such an instance may not clearly demonstrate that the service began as a screening procedure but had to be converted to a diagnostic procedure due to a pathologic finding (e.g. polyp, tumor, bleeding) encountered during that preventive exam.
- In the instance that an individual presents for treatment due to signs or symptoms to rule out or confirm a suspected diagnosis, such an encounter should be considered a diagnostic exam, not a screening exam. In such a situation, the modifier PT *should not* be used and the sign or symptom should be used to explain the reason for the test.

Redesigned explanation of benefits (EOB) easier to read

Starting later this fall, Anthem Blue Cross members who purchased health insurance through the Exchange will begin receiving the new redesigned explanation of benefits (EOB). The new EOB is easier to read and understand. Members will be able to compare their EOB against their provider statement.

The new EOB gives members a complete picture of:

- Services rendered
- Covered services
- Amount paid
- Amount owned by patient/member

Our goal for our improved EOB includes helping members understand their health care benefits and responsibilities for out of pocket costs.

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New incentive opportunity for physicians in California who treat members enrolled in exchange plans

As part of our compliance with the Affordable Care Act (ACA), Anthem Blue Cross is updating the health documentation for our member population. This effort applies to our members who have purchased health plans on or off the Health Insurance Marketplace or commonly referred to as the exchange. To comply with ACA requirements, we're asking physicians to conduct health assessments for select members. The information we are gathering will help us determine an appropriate risk profile and provide a clearer picture of these members' health.

Anthem Blue Cross is working with Inovalon – a vendor and independent company that provides secure, clinical documentation services – to contact physicians on our behalf. Throughout the benefit year, Inovalon may contact you to conduct patient assessments and submit your findings to Inovalon using the vendor's secure, electronic tool called ePASS® OR using the Encounter Subjective, Objective, Assessment and Plan (SOAP) Note provided with mailings Inovalon sends for each identified patient.

To help make the process easier for you, Inovalon will include the following in packages the vendor mails should one or more of your Anthem Blue Cross patients be identified for a patient assessment:

- A convenient scheduling list to help you schedule appointments with your Anthem Blue Cross patients
- An ePASS® bookmark with step-by-step instructions for using the Web-based tool
- A paper SOAP Note for each patient identified containing that patient's clinical profile and recent claims history if you prefer a paper form; and
- An instruction form for completing the paper SOAP Note

Opportunity to increase reimbursement – Incentives

We understand that completing these requests may take time, and we would like to offer you the opportunity to increase your reimbursement. Beginning with patient assessments completed for dates of service on or after June 1, 2015, you are eligible to receive **\$100** in addition to your office visit fee for **each properly submitted electronic SOAP Note** submitted through Inovalon's ePASS tool.

You may also elect to submit your patient assessment data for the members we request using the paper SOAP Note option and send to Inovalon at the vendor's secure fax line at **1-866-682-6680**. For each **paper SOAP Note** submitted for patient assessments performed, you will receive **\$50** in addition to your office visit fee.

Questions

If you have questions about Inovalon, the outreach process, completing SOAP Notes correctly or using ePASS, please refer to the frequently asked questions document on our website at anthem.com/ca – just select this [LINK](#). Or, if you prefer, you can contact Inovalon directly toll-free at **1-877-448-8125**.

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](#).

Professional Network Update

Announcements and General Updates

Recovery of overpayments

Combating fraud and abuse is a service to our overall provider network and our members. In December 2014, the Sacramento County Superior Court ([Case No. 34-2014-80001733](#)) entered a judgment issuing a writ of mandate and granting declaratory relief following Anthem Blue Cross' challenge to the DMHC's 2012 Cease and Desist Order. In its ruling, the Court agreed with Anthem Blue Cross "that allegations of upcoding and unbundling are sufficient to invoke the fraud/misrepresentation exception because upcoding and unbundling are, by definition, a type of health care fraud." The Court also indicated that "[i]ntentional miscoding is fraud" and "[m]iscoding done without any reasonable ground for believing it to be compliant is negligent misrepresentation." Therefore, providers who engage in upcoding, unbundling, intentional miscoding, or miscoding done without any reasonable ground for believing it was correct, may be deemed to have made a misrepresentation to the health plan.

Consistent with the Court's judgment, and Title 28 California Code of Regulations section 1300.71(b)(5), Anthem Blue Cross intends to resume overpayment recovery efforts that may involve overpayments that are greater than 365 days old, if the overpayment was caused in whole or in part by fraud or misrepresentation.

Anthem Blue Cross will discontinue mailing paper remittances to all ERA registered providers beginning October 1, 2015

In support of HIPAA Administrative Simplification requirements, Anthem Blue Cross will discontinue mailing paper remittances to all providers registered for Electronic Remittance Advices (ERAs) beginning October 1, 2015. Some paper remits will continue to be mailed for up to six weeks after October 1, 2015, until the process of discontinuing paper remits is complete. If you are a provider, currently registered for ERAs and have continued to receive paper remittances in the mail for any reason, your paper remits will begin to stop on October 1, 2015, and you will no longer receive any paper remits on or about November 10, 2015.

Providers can continue to conveniently access copies of their "paper" remittances online via ProviderAccess or the [Availity Web Portal](#). **If you are an ERA registered provider, please ensure you have completed the steps to access copies of your paper remittances online immediately.** Read instructions to access copies of your paper remittances online via ProviderAccess or the Availity Web Portal [here](#).

Additionally, Anthem Blue Cross will introduce an online capability for providers to manage the mailing of their paper remittances. This online process will replace all paper remittance election processes currently used today. Anthem Blue Cross will also implement a new online process for providers to register for ERA only. The new process will eliminate the use of all paper ERA registration forms. The new online ERA only registration form and paper remittance election form will be available Anthem Blue Cross' EDI website at anthem.com/edi beginning October 12, 2015.

Professional Network Update

Important update to the Prepayment Review Program section of the Professional Provider Manual

Fraud, Waste and Abuse Detection

Anthem Blue Cross ("Anthem") 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 accordingly maintains a program, led by Anthem's Special Investigations Unit (SIU), to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans.

Pre-Payment Review

One method Anthem utilizes to detect fraud, waste and abuse is through pre-payment claim review. Through a variety of means, certain Providers, or certain Claims submitted by Providers, may come to Anthem's attention for behavior that might be identified as unusual, or for coding or billing or claims activity which indicates the Provider is an outlier as compared to his/her/its peers. For example, Anthem uses computer algorithm software tools designed to identify Providers whose coding or billing practices indicate conduct that is unusual or outside the norm of the Provider's peers.

Once a Claim or a Provider is identified as an outlier, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual Claim, coding or billing practice. If the investigation results in a determination that the Provider's actions may involve fraud, waste or abuse, the Provider is notified and given an opportunity to respond.

If, despite the Provider's response, Anthem continues to believe the Provider's actions involve fraud, waste or abuse, or some other inappropriate activity, the Provider will then be notified the provider is being placed on pre-payment review. This means the Provider will be required to submit medical records with each Claim for Anthem to review the services being billed. Failure to submit medical records to Anthem in accordance with this requirement will result in a denial of a Claim under review. Providers will be given the opportunity to request a discussion of his/her/its pre-payment review status.

Under the pre-payment review program, we may review coding and other billing issues. In addition, we may use one or more of our clinical utilization management guidelines in the review of Claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to members.

The Provider will remain subject to the pre-payment review process until Anthem is satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from our Provider network.

Finally, Providers are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other coding or billing issue, or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable Provider Agreement and state law. Providers also may appeal such determination in accordance with applicable grievance and appeal procedures.

Updates to EFT enrollment may impact NPI enumeration

Providers enrolled in electronic funds transfer (EFT) with multiple bank accounts may be impacted by upcoming changes, if their EFT enrollment information is updated after October 8, 2015. CAQH CORE Administrative Simplification rules allow EFT payments to be aggregated at either the Tax Identification Number (TIN) or National Provider Identifier (NPI) level when updating the EFT enrollment tool, [EnrollHub™](#), a CAQH Solution™. **If you make updates to your EFT enrollment after October 8, 2015, and you currently have multiple EFT bank accounts associated to only one TIN and NPI combination, you will be required to associate to a single bank account.**

What does this change mean for providers?

- No immediate action is required.
- Be aware that any updates providers make to EFT enrollments on [EnrollHub](#) after October 8, 2015, will apply to all remittance information.
- If a provider enrolls at the TIN aggregation level, only one bank account will be allowed. If providers select TIN as the **Aggregation Preference** on [EnrollHub](#), all affiliated NPIs will be associated to a single bank account.

What should providers do if more than one bank account is required?

- Each bank account must be associated with one billing NPI. To preserve multiple bank accounts, providers must enumerate with different TIN and NPI combinations (for example, TIN123456789 + NPI987654321 = Bank ABC; TIN123456789 + NPI000000000 = Bank DEF).
- Evaluate your current NPI enrollments to determine if you need to apply for more NPIs.
- Register on [EnrollHub](#), select **NPI aggregation**, and enroll each separate NPI with the assigned separate banking account information.

For more information about CAQH CORE Administration Simplification rules associated with EFT enrollment, please visit caqh.org/CORE_phase3.php.

Update for providers managing ERA and EFT using EnrollHub

Providers using [EnrollHub™](#), a CAQH Solution™ to register for or manage their EFT or EFT and ERA enrollment should be advised that we are consolidating the list of all Anthem Blue Cross affiliated health plans on the [EnrollHub](#) tool. Providers currently select individual check boxes representing some Anthem Blue Cross affiliated health plans when managing their enrollment in these electronic transactions. Beginning October 9, 2015, all Anthem Blue Cross affiliated health plans will be listed together as a single check box on the [EnrollHub](#) tool: *Anthem, Empire, Blue Cross and Blue Shield of Georgia and their affiliates; BlueChoice HealthPlan Medicaid of South Carolina; Unicare Life & Health Insurance Company*. This change will allow providers to select only one check box to receive EFT or EFT and ERA for all of the above mentioned health plans. **Please note that this is an informational update only and no provider action is required.**

Specialty pharmacy updates

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. Listed below, are specialty pharmacy codes from our new or current medical policies that will be added to our existing pre-service review process.

All changes referenced in this notification only apply to Local Plan members. Please note that these recommendations do not apply to BlueCard 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 November 1, 2015.

| Medical Policy or Clinical Guideline | Drug Name | Drug Code |
|--------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| DRUG.00076 | Blinatumomab (Blincyto™) | Existing code C9449 and J9999 - Not Otherwise Classified (when specified as Blincyto) |
| DRUG.00075 | Nivolumab (Opdivo®) | J9999 - Not Otherwise Classified, antineoplastic drugs when specified as Nivolumab) |
| CG-DRUG-09 | Immune Globulin (Ig) Therapy – HyQvia added to existing UM Clinical Guideline | J3490, J7799 – Unclassified drugs (when specified as HyQvia) |
| CG-DRUG-16 | White Blood Cell Growth Factors - Filgrastim-sndz (Zarxio) added to existing UM Clinical Guideline | J3490 - Unclassified drugs [when specified as filgrastim-sndz (Zarxio)] |

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.

Reminder: Pre-service clinical review of specialty pharmacy claims will transition to AIM

As providers are aware, the pre-service clinical review of specialty pharmacy infusion/injectable drugs will be handled by AIM Specialty Health® (AIM), on behalf of Anthem Blue Cross, for Fully-Insured members starting on September 1, 2015. (ASO members will remain with Anthem Blue Cross.)

Also beginning on September 1, providers will see a new message when requesting prior authorization for specialty pharmacy drugs online via AIM. This message encourages providers to select from a list of providers who offer specialty infusion/injectable medications in an in-office, home health care, or infusion setting that may cost less and be more convenient for the member. The message providers will see is: "Please select a provider from the list below that may be more cost effective and convenient for the member if you believe it is clinically appropriate to do so." We hope this reference will help members save on potential out-of-pocket costs or have access to convenient locations for their treatment.

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

- **Online Requests** – Pre-service clinical review will be available online via AIM through their web-based application which is available twenty-four hours a day, seven days a week. It is fully interactive, processing requests in real-time using clinical criteria. The AIM web-based application may be accessed online through the Availity Web Portal at www.availity.com.

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To Submit a Pre-authorization Request online

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

- Log in to the [Availity Web Portal](http://www.availity.com) at 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.

For more information on how to access online authorizations via Availity, reference our [AIM Specialty Health Quick Reference Guide](#). Go to anthem.com/ca | [Providers](#) | [Provider Home](#) | [Self-Service and Support](#) | [AIM Specialty Health Quick Reference Guide](#).

Phone Requests – Requests for pre-service clinical review can also be submitted to AIM via phone. Providers can call AIM toll-free at **1-877-291-0366** Monday through Friday 5:00 a.m. – 5:00 p.m. (PST) to request pre-service review. Once the transition occurs, Anthem Blue Cross' phone prompts will be changed to include a Specialty Pharmacy prompt that will automatically route the caller to AIM for pre-service clinical reviews.

Reminder of the most recent update to the Cancer Care Quality Program

Attention Oncologists, Hematologists and Urologists

As a reminder, Anthem Blue Cross' Cancer Care Quality Program ("Program"), a quality initiative, provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways ("Pathways"). Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.

Effective September 1, 2015, Anthem Blue Cross is making the following changes to some cancer treatment Pathways for the Cancer Care Quality Program.

New Pathways added to the Program include:

- Pathways for bladder cancer
- Carfilzomib+lenalidomide+dexamethasone (CRD) treatment pathway for multiple myeloma, 2nd and subsequent lines of therapy
- Nivolumab treatment pathway for non-small cell lung cancer, 2nd line, squamous histology
- Nivolumab treatment pathway for metastatic melanoma, 1st line
- Dabrafenib+trametinib treatment pathway for metastatic melanoma, BRAF mutations, 2nd line

Pathways removed from the Program include the following regimens that will be moving from "on" pathway to "off" pathway status:

- Lenalidomide+dexamethasone (RD) for multiple myeloma, 2nd and subsequent lines of therapy
- Dabrafenib for metastatic melanoma, BRAF mutations, 1st and subsequent lines of therapy
- Pembrolizumab for metastatic melanoma, 2nd and subsequent lines of therapy

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This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members' benefit plans.

The following regimens remain "on" pathway but the following changes apply:

- FOLFIRI+panitumumab, FOLFOX+panitumumab, and irinotecan+panitumumab for metastatic colorectal cancer have been removed from 1st line and added to 2nd line therapy, RAS wild-type
- Ipilimumab for metastatic melanoma has been removed from 1st line and added to 2nd line therapy

The Pathways developed for this Program are intended to support quality cancer care. To access the full Pathways document, go online to CancerCareQualityProgram.com, our dedicated provider website.

Note: Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway.

BRCA testing alternatives

Public awareness of genetic testing continues to grow. In response, more labs are providing this type of testing. For example, did you know that the number of labs offering the BRCA test has increased significantly and Anthem Blue Cross now contracts with multiple labs for this service? This gives you and most of your patients* greater choice in BRCA testing, and an opportunity to compare costs and potentially save money. The following are some additional network options now available:

- Ambry Genetics
- BioReference
- Counsyl
- LabCorp
- Quest

* Some Plans may restrict BRCA testing to specific labs in network. Please refer to ProviderFinder for more detail by Plan. Have your office staff check benefit plan information for coverage terms and conditions.

NEW – reference based benefits for CVT members

Effective October 1, 2015, **California's Valued Trust (CVT)** will be implementing a Reference Based Benefit design for; Hip Replacement, Knee Replacement, Hysterectomy and Laminectomy surgeries. This benefit design will apply to CVT's PPO, HDHP, and Wellness plans.

These four procedures will have a reference price point (benefit maximum) based on the member's geographic region. Members are responsible for obtaining their reference price point (through Anthem Blue Cross's Customer Service) prior to the surgery and are encouraged to have the surgery performed at a facility whose charges won't exceed the benefit allowed amount. Amounts over the benefit maximum may not be payable under regular plan benefits and may be applied as member responsibility.

Reference Based Benefits maximums apply only to the facility charges and do not apply to Retiree or Medicare Supplement plans.

Professional Network Update

Important notice regarding Self-Insured Schools of California (SISC) members

Effective October 1, 2015, an Anthem Blue Cross will be eliminating coverage for some services when provided by non-contracting providers. Self-Insured Schools of California (SISC) has decided to eliminate out-of-network coverage for the following services through its PPO Plan:

- Diagnostic Xray and Lab
- Durable Medical Equipment (DME)
- Chiropractic Services and physical therapy services

SISC is a large multi-employer group with over 400 participating school districts covering over 175,000 covered members.

Please remember to always refer members to other contracting providers – especially SISC members. If for some reason, you think that in-network coverage is not available, please contact Anthem Blue Cross on the back of the member's ID card.

Blue Distinction and Blue Distinction Plus

The National Blue Cross Blue Shield Association (BCBSA) has created a program to recognize specialty programs that deliver quality care at contracting hospitals around the country. Blue Distinction is the brand name for this Centers of Excellence program. Each Blue Plan from each state nominates specialty programs that are then evaluated based on quality criteria established by the BCBSA. Blue Distinction designations are given for the following specialty programs:

- Transplants
- Bariatric Surgery (Band and Stapling)
- Spine Surgery
- Hip and Knee Replacements
- Rare and Complex Cancers

After a hospital receives a Blue Distinction designation, there is an additional evaluation done based on cost. Hospitals can then achieve a Blue Distinction **Plus** designation if its cost is determined to be reasonable.

Many Anthem Blue Cross clients are now offering incentives for their members who use these programs. Many employers see value in quality and are also looking for reasonable cost for services. Please note that the Self-Insured Schools of California (SISC) which has over 170,000 Anthem Blue Cross members will be require that their employees and dependents use Blue Distinction Plus facilities effective October 1, 2015.

In California Blue Cross Blue Shield are two separate plans; Anthem Blue Cross has a specific list of designation hospitals. A current listing of hospitals in California that have the Blue Distinction and Blue Distinction+ designations can be found at <http://provider.bcbs.com/> or by calling the customer service number on the member's ID card. When using the website, please make sure to use the member's three letter prefix from their ID card and select the appropriate Blue Distinction designation from the Blue Distinction filter.

Provider secure messaging enhancements


If you are a current user of secure messaging, a feature available from the Claim Status Detail page on the Availity Web Portal, please take note of recent upgrades.

Anthem Blue Cross can now send you follow-up messages on your claim inquiry. These may share pertinent detail or request additional specific information. You will know if Anthem Blue Cross has sent you a new message because a new column, titled *Messages Needing Attention*, has been added to your inbox. In this column, if you have a new message, you will see *Attention Needed*. If you use Secure Messaging, check your inbox periodically for this indicator. It will look like this:

Inbox Outbox Log Out

Inbox Message List ★

IMPORTANT NOTE: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating. This applies to Protected Health Information accessible in any Anthem online tool, or sent in any other medium including mail, email, fax, or other electronic transmission.

| Select All | Inquiry # | Member ID | Claim Number | Received | Messages Needing Attention |
|--------------------------|------------|------------|--------------|----------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | XXXXXXXXXX | XXXXXXXXXX | XXXXXXXXXX | Received: 08/10/2015 10:00:00 AM | Attention Needed  |
| <input type="checkbox"/> | XXXXXXXXXX | XXXXXXXXXX | XXXXXXXXXX | Received: 08/10/2015 10:00:00 AM | Attention Needed |
| <input type="checkbox"/> | XXXXXXXXXX | XXXXXXXXXX | XXXXXXXXXX | Received: 08/10/2015 10:00:00 AM | |
| <input type="checkbox"/> | XXXXXXXXXX | XXXXXXXXXX | XXXXXXXXXX | Received: 08/10/2015 10:00:00 AM | |
| <input type="checkbox"/> | XXXXXXXXXX | XXXXXXXXXX | XXXXXXXXXX | Received: 08/10/2015 10:00:00 AM | |

Also, when you view your message, look for a new option, *Download Secure Message*, which is located to the right of the message. Use *Download Secure Message* to save or print the content of the entire message. This eliminates the need for multiple print screens in order to capture the message detail.

Misrouted protected health information (PHI)

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



Professional Network Update

Billing

CMS 1500 claim form version 08/05 for paper claims no longer accepted effective October 1, 2015

Effective October 1, 2015, Anthem Blue Cross will no longer accept the old CMS 1500 Claim Form version 08/05 for paper claims. Paper claims will only be accepted on the CMS 1500 Claim Form **version 02/12**.

Any paper claims *received* on or after October 1, 2015, using the old CMS 1500 Claim Form version 08/05 will be rejected. This applies to claims that may have been submitted prior to the October 1, 2015, effective date, but have not been received by Anthem Blue Cross by the October 1, 2015, effective date.

Anthem Blue Cross began accepting the CMS 1500 Claim Form version 02/12 in January 2014. We suggest that you transition to using the updated CMS 1500 Claim Form version 02/12 now, if you have not already done so.

For information on how to complete the updated 1500 Claim Form version 02/12, follow the guidelines set forth by the National Uniform Claim Committee (NUCC). Please visit the NUCC website at www.nucc.org which provides helpful resources such as a list of changes between the 08/05 and 02/12 claim form versions and the 1500 Instruction Manual.

ICD-10 Updates: No delay yet!

It's August 2015, and though there is some proposed legislation suggesting another ICD-10 delay, to date none of them have been successful in moving the October 1, 2015, compliance date. So, contrary to prior years, it's really looking like ICD-10 will happen in ***about two months***.

Are you ready?

Prior delays may have slowed, or even stopped, your implementation plans. If you fall in this category, the truth is you have a lot of work to do in a short period of time. However, if you move quickly, a successful ICD-10 implementation can still happen for your practice before the October 1, 2015, deadline.

Here are some suggestions:

Need a plan to get started? [CMS's Road to 10](#) provides a complete roadmap for small and medium practices to follow to get you to your ICD-10 destination by October 1, 2015.

Need to practice using ICD-10-CM codes? Coders with some training can take advantage of the free scenario-based Coding Practice Tool we are offering (accessed through [Anthem's ICD-10 webpage](#)). It's designed to give physicians and their coders the opportunity to test their knowledge of the ICD-10 code set by applying it to medical scenarios.

Want to work on improving your clinical documentation? CMS is offering [Interactive Case Studies](#) designed can help you understand key ICD-10 documentation concepts. The case studies include sample clinical scenarios, short quizzes on related coding concepts, and documentation tips. New scenarios are added weekly.

Check our [ICD-10 Updates – Resources](#) webpage for more suggested resources that can help you prepare for ICD-10.

Professional Network Update

Workers' compensation referrals to participating providers

Anthem Workers' Compensation has recently noticed a high volume of referrals to non-participating workers' compensation providers. This note is a reminder that as required by your Anthem Agreement, referrals to a specialist or other contracted Providers, hospitals, ambulatory surgery centers, ancillary and Behavioral Health providers must be within the Anthem Workers' Compensation Network or for clients that have an MPN, within the client's MPN. To ensure that you utilize the correct online directory please refer to the list of Other Payors for Workers' Compensation Network Leasing, which is available on the Anthem secure portal for ProviderAccess site. Click on link for "Network Leasing Arrangements" to download the list and search for Payors that have a specific directory web address. The Workers' Compensation online Provider directory is available by visiting www.anthemwc.com/find_a_doctor.asp and selecting "California." Assistance is also available by calling **1-866-700-2168**. This online Provider directory will identify Providers who treat work-related illness or injuries.

Refer within the MPN. For employers and carriers accessing the Anthem Blue Cross Prudent Buyer Network for Workers' Compensation, this means referrals **must be made to Providers participating in the Anthem Workers' Compensation Network that are included in the MPN.** Contact our MPN Services department at **1-866-700-2168** for assistance or refer to the "Other Payor" listing, which may include MPN Program Contact and/or the online Provider search websites for clients that utilize the Anthem network for their MPN.

Please note that referrals to non-participating providers could result in non-payment of that workers' compensation bill. We value your participation in our network and want to work with you to make your daily operations smooth. If you have any questions regarding who is contracted for workers' compensation contact workers' compensation customer service at **1-866-700-2168**. Please be aware that workers' compensation resources are also available at www.bclhwcmcs.com.

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

New! Update your Anthem Blue Cross provider demographic information via the Availity Web Portal

You can now submit on-line changes for your practice profile (i.e. address changes, name change, tax ID changes, provider leaving a group, phone/fax numbers, directory listings for medical groups, physicians/other healthcare professionals, opening/closing a practice location, etc.) using the electronic **Provider Maintenance Form** which now can be found under the: *Payer Resources Page / Anthem / Physician Change Requests / Provider Maintenance Form* on the Availity Web Portal Main Menu.

All requests must be received 30 days prior to change/date.

- Any request received with less than 30 days' notice may be assigned a future effective date
- Contractual agreement guidelines may supersede effective date of request
- Please provide 120 days' prior notice for contract termination requests
- You will receive an auto-reply e-mail acknowledging receipt of your request

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.

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.

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. You will need to provide your business name and TaxID.

Thank you for your service to our members.

Professional Network Update

Updates to Anthem Blue Cross' "Find a Doctor" tool

The [Find a Doctor](#) tool at Anthem Blue Cross is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans.

Beginning this fall, you'll notice some updates to our [Find a Doctor](#) tool that will make it even easier to search for providers. These changes include:

- An updated screen layout with cues to encourage members to login for the most accurate results, or search as a guest by selecting a plan to find in-network doctors and hospitals.
- Guided assistance asking a short set of questions to personalize and narrow the plan selection list.
- Quick search links for users familiar with the state and plan they are searching.
- More prominent placement of the *Provider Name* search option, to help users determine if a doctor is in-network after selecting a plan.

We believe these updates will improve the consumer, member, broker, and provider experience when using the [Find a Doctor](#) tool.

New ACO provider in Northern California

We are pleased to announce that San Benito Medical Associates has joined our Accountable Care Organization (ACO) network, effective July 1, 2015, to provide coordinated, evidenced-based care to members with multiple chronic conditions. San Benito Medical Associates, located in Hollister, serves members in the San Benito County area.

They are joining the 19 other provider groups in our growing ACO network in California. These provider groups are part of a collaborative approach toward delivering personalized care called Enhanced Personal Health Care. This approach aims to improve the health of members primarily with chronic conditions. Members participating in Enhanced Personal Health Care will have access to a personalized health team, which includes a physician, a care coordinator and other health care practitioners as needed. It is available to a select number of PPO members at no extra cost or product change.

Look forward to hearing more exciting news about Enhanced Personal Health Care in 2015.

2015 Fall seminars and e-solutions

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

In the **Spotlight** section of the Anthem Blue Cross website click on the '*2015 Provider Education Seminars and Webinars*' link, which takes you to the Provider Network Education landing page and take a look at the collection of provider education tools available to attend, view and print.

Seminars

Our Fall '**Contracted Provider Information Exchange**' seminars are interactive and offer tips, process improvements and best practices. Many relevant Anthem Blue Cross business topics of interest are presented. These seminars will be offered in twelve different locations throughout California in October and November. **All contracted providers are welcomed to attend!** [Click here to register](#) and view the schedule.

e-Solutions

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

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- [SEMs – Supplemental Education Materials](#) are available on a variety of Anthem Blue Cross business subjects. These documents will display in pdf format and can be viewed, saved or printed.

On-Demand e-Courses offer a self-paced instruction environment. Currently there are (3) three e-Courses available for you to take at your convenience! To register for an e-Course, select the click [here](#) link on the Provider Network Education landing page.

Webinars offer 'live' interactive sessions conducted remotely through the internet and facilitated by the Network Education team and Subject Matter experts. Currently the recorded (3) three topics offered are:

- Behavioral Health Practitioner and Office Staff Orientation
- BlueCard® (Out-of-Area) Refresher
- Provider Manual (Professional)

Our *new* "Listening Library" of recorded webinar sessions is available for your convenience on our Provider Network Education landing page.

Webinar Recordings offer our providers the opportunity to request a copy of a previously presented webinar. Simply send an email request to: network.education@anthem.com

Questions?

E-mail: network.education@anthem.com

Phone: 818-234-1016

Fax: 818-234-8959

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.

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Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem Blue Cross members. As such, they're entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payors* list on ProviderAccess®, which can be accessed through the Anthem Blue Cross website at www.anthem.com/ca. If you don't have internet access, please contact us at 1-855-238-0095 for assistance.



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Guidelines and Quality Programs

HEDIS® 2015: Provider incentive winners announced!

We have completed the 2015 HEDIS data collection for commercial products and want to thank all of our provider offices and their staff who assisted us. Your partnership in this process allows us to achieve the best HEDIS results possible.

This is the 4th year for our incentive program to acknowledge some of our providers who either responded in a timely manner or went "Above & Beyond" to help make our HEDIS data collection successful. Any practices that responded within 5 business days of our initial request or who went out of their way by taking additional steps to help us with data collection were entered in a drawing to receive a gift. In the event an office was not able to accept a tangible gift, a special written recognition was given. We are pleased to announce our incentive winners as follows:

Fax/Mail Drawing

- Franklin A Ho, MD
- Prima Medical Group OB/GYN
- Mercy Medical Group Midtown
- Riverwalk Pediatric Clinic
- Seneca District Hospital

Above & Beyond

- Sutter Medical Foundation
- DCHS/San Jose Medical Group
- Beaver Medical Group
- Family Medical Group of Turlock
- Peachwood Medical Group
- Glendora Pediatrics

Thanks again to all of our provider offices and their staff for assisting us in collecting HEDIS data. Our HEDIS results reflect the excellent care you provide to our members. An overview of our HEDIS rates will be published in the 4th quarter provider newsletter. In addition more information on HEDIS can be found by visiting the provider portal at: www.anthem.com > provider > state > Health & Wellness > Health & Wellness > Quality Improvement and Standards > HEDIS Information.

We look forward to working with you next HEDIS season!

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

Free program provides information and resources to help employers support employees facing cancer

Easy to use, web-based tool helps support communication between managers and employees to ensure a healthy and productive workplace

Returning to work after being touched by a cancer diagnosis or treatment can be psychologically and physically challenging for many people. Today, *The Workplace Transitions for People Touched by Cancer* program provides companies of all sizes with an innovative, tested, and free resource to support a healthy and productive experience when an employee is facing cancer.

The web-enabled toolkit provides managers and human resources staff with actionable guidance that complements existing company policies and procedures. Managers will find important information and resources on topics such as privacy, disability, medical leave and insurance along with practical ideas for workplace adjustments and accommodations and suggestions for managing changes and challenges with sensitivity.

Additionally, the e-toolkit provides employers with further awareness on the law regarding employees with disabilities, which may include those who have been diagnosed with cancer. In fact, the timing of the e-toolkit's release aligns with the 25th anniversary of the Americans with Disabilities Act, which has focused on removing barriers and empowering people.

The e-toolkit was launched last year as a pilot with Anthem, Ernst Young LLP, Merck, North American Mission Board, Northrop Grumman, and Verizon. Reaction to the program is positive with the majority of managers who accessed the e-toolkit reporting that it is easy to access and helpful, especially when it comes to providing their employees with needed emotional support and the guidance to create a positive environment for their employees.

The Workplace Transitions for People Touched by Cancer program is a collaboration among Anthem, Cancer and Careers, Pfizer, SEDL, an affiliate of American Institutes for Research (AIR), and the US Business Leadership Network. To access the free resource please visit: www.workplacetransitions.org

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. From there, select "Provider" and your state> then Health & Wellness> Practice Guidelines.

Professional Network Update

Medi-Cal Managed Care Updates

ICD-10 updates: No delay yet?

In the "ICD-10 update" section of this edition of the *Network Update*, we are sharing the latest details we have around the upcoming implementation on October 1, 2015. The implementation of ICD-10 impacts all our lines of business including Medical. Please refer to the article on page 13 in this edition or select this [link](#) for further details regarding ICD-10.

Hypertensive diseases: Documentation and coding

Documentation and Coding

The medical record documentation for patients with hypertension should include each of the following:

- Type of hypertension – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- Complications – body system such as heart or kidney that are affected by hypertension
- Specific conditions – details about the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)
- Assessment/treatment – all measures aimed at controlling the hypertension and treating symptoms from complications

Diagnosis code assignment is based on provider documentation and the medical record must support the codes submitted on the claim.

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).

Essential (primary) hypertension 401

Code assignment is based on the type of hypertension documented (benign, malignant, or unspecified). Statements such as high blood pressure, hypertension, and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign code 796.2 elevated blood pressure reading without diagnosis of hypertension. Terms such as controlled and uncontrolled indicate the status of the condition and do not have a bearing on the code assignment for hypertension.

Hypertensive heart disease 402

Assign category 402 hypertensive heart disease, when a cardiac condition is stated (due to hypertension) or implied (hypertensive). The physician must document cause and effect between the two conditions. Category 402 is further specified based on the presence of heart failure. Use additional codes 428.0 - 428.43 to specify the type of heart failure, if known.

Hypertensive chronic kidney disease 403

Assign codes from category 403 hypertensive chronic kidney disease, along with additional codes for the stage of the disease, from category 585 chronic kidney disease.

Hypertensive heart and chronic kidney disease 404

When documentation supports heart and kidney complications with hypertension, there is an assumed cause and effect. Instructional notes state to use additional codes 428.0 - 428.43 to specify the type of heart failure, if known, and the stage of chronic kidney disease from category 585 chronic kidney disease. The ICD-10 equivalent code category is I1 hypertensive heart and chronic kidney disease.

Secondary hypertension 405

Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

Important change to code assignment for hypertensive diseases in ICD-10

ICD-10 coding does not require type of hypertension documentation for correct code assignment. Providers are required to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

| | |
|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| I10 | Essential (primary) hypertension |
| I11 | Hypertensive heart disease (with or without heart failure) Use an additional code from I50 to specify type of heart failure (if present). |
| I12 | Hypertensive chronic kidney disease Use an additional code from N18 to identify stage of chronic kidney disease. |
| I13 | Hypertensive heart and chronic kidney disease Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease. |
| I15 | Secondary hypertension Requires two codes; one for the underlying cause and one from category I15 to identify secondary hypertension. Sequencing is based on circumstances of the visit and documentation. |

Contact our Medi-Cal Customer Care Center at **1-800-407-4627** (outside Los Angeles County) or **1-888-285-7801** (inside Los Angeles County) to get more information about hypertension disease documentation and coding.

Behavioral health and utilization management guideline update

Anthem Blue Cross is pleased to provide the updated Behavioral Health Medical Policies and Clinical Utilization Management Guidelines. **The updated policies listed below are effective for service dates on and after August 15, 2015.**

The revised policies and changes are summarized below. Please refer to the specific policy for coding, language, and rationale updates and changes that are not summarized below.

Revised Medical Policies and Adopted Clinical UM Guidelines effective August 15, 2015:

- **CG-BEH-07 Psychological testing**
This document addresses psychological testing. The medical necessity criteria outlined in this document for psychological testing include two categories – severity of illness and intensity of service.
 - Removed language addressing time limitations from medically necessary clinical indications for intensity of service
 - Removed note from clinical indications section
 - Updated discussion, reference and index sections

- **CG-LAB-09 Drug testing or screening in the context of substance abuse and chronic pain**
This document addresses the use of urine drug testing (UDT) in the outpatient setting for adherence monitoring of controlled substance use as part of the management of chronic pain and for individuals undergoing treatment for opioid addiction and substance abuse.
 - Revised language in clinical indications section to address presumptive (previously qualitative) and definitive (previously quantitative) testing
 - Clarified that presumptive urine drug testing is medically necessary up to 24 times per year, beginning at the start of treatment (for example, a rolling year, not calendar year)
 - Updated discussion, definition and reference sections

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- **CG-MED-22 Neuropsychological testing**

This document addresses the use of neuropsychological testing, also known as psychometric testing, which refers to a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders.

- Added two notes to clinical indications regarding which types of testing are considered to be neuropsychological testing
- Updated discussion, reference, and index sections

- **CG-DRUG-21 Naltrexone (Vivitrol®) injections for the treatment of alcohol and opioid dependence**

This document addresses extended-release, injectable naltrexone, which is an opioid antagonist that binds to opioid receptors, blocking the euphoric effects of exogenous opioids in those who are opioid or alcohol dependent.

- Made minor formatting and grammar changes throughout clinical indications
- Clarified not medically necessary statement
- Updated description, discussion and reference sections

Anthem Blue Cross Medical Policies and Clinical UM Guidelines are developed by our Medical Policy and Technology Assessment Committee. The committee, which includes Anthem medical directors and representatives from practicing physician groups, meets quarterly to review current scientific data and clinical developments. Medical Policies and Clinical UM Guidelines are subject to the approval of the Physician Relations Committee.

All coverage written or administered by Anthem Blue Cross excludes from coverage services or supplies that are investigational or not medically necessary. A member's claim may not be eligible for payment if it was determined not to meet medical necessity criteria set forth in the Anthem Blue Cross Medical Policies. Review procedures have been refined to facilitate claim investigation.

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on the Anthem Blue Cross' [website](#).

Helping your patients prevent falls

Falls Prevention Awareness Day is **September 23, 2015** — not surprisingly, the first day of fall! The goal of Falls Prevention Awareness Day is to raise awareness about fall prevention and fall-related injuries among older adults. Falls are the most common cause of accidental death and serious injury in the home. It is estimated that one out of three adults age 65 and older fall each year, and that rate increases sharply the older one becomes. Falls can cause older adults to feel fearful, which can rob them of their sense of independence, many times resulting in nursing facility or other supervised living placement.

There is assistance that providers can offer their Medi-Cal Managed Care patients to help prevent falls:

- Ask and advise them to exercise regularly to improve balance and strength.
- Do fall-risk assessments and ask patients about recent falls.
- Review your patients' medicines at least annually, including over-the-counter drugs, to check for side effects that could increase your patients' falling risk. Remind them to take medications only as prescribed.
- Refer and remind patients to get annual vision and hearing exams.
- Suggest to your patients that they conduct a home safety inspection – a convenient checklist is available from the National Council on Aging (NCOA) [website](#).

Health care providers can help reduce their patients' chances of falling. The STEADI tool kit offers providers information and tools for assessing their older patients' risk of falling. For a STEADI provider tool kit, publications and other resources *at no cost*, visit the Centers for Disease Control and Prevention (CDC) [website](#) or call the CDC at **1-800-CDC-INFO (1-800-232-4636)** or **1-770-488-1506**.

Visit the [NCOA website](#) for more information and for no-cost materials for promoting National Falls Prevention Awareness Day in your office and in your community.

Professional Network Update

HEDIS® rates improved in 2015

Thank you for the quality care you provide for our members. Anthem Blue Cross is pleased to report that the HEDIS rates for Medi-Cal Managed Care in 2015 have improved.

- All of the diabetes measures improved when compared to the 2014 reported rates, with the diabetes nephropathy rate reaching the 50th percentile as defined by national standards.
- The childhood immunization Combo 10 rate and the weight assessment and counseling for BMI also reached the 50th percentile.
- The HPV vaccine rate for females met the 75th percentile.

| MEASURE | Reported 2014 | Reported 2015 | Minimum performance level* | High performance level * |
|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|----------------------------|--------------------------|
| Nephropathy screening | 77.43% | 80.74% | 75.67% | 86.86% |
| Childhood immunizations (Combo 10) | 36.34% | 38.66% | 25.75% | 49.67% |
| HPV for female adolescents | NR | 27.78% | 15.28% | 28.90% |
| WCC- BMI total | 65.05% | 67.13% | 41.85% | 82.46% |
| Control high blood pressure | 47.93% | 45.12% | 48.53% | 69.79% |
| Avoidance of antibiotic treatment in adults with acute bronchitis (a higher rate indicates appropriate treatment of adults with acute bronchitis) | 29.43% | 27.29% | 20.20% | 38.66% |

*The minimum performance level (MPL) based on the national Medicaid 25th percentile and the high performance level (HPL) based on the national Medicaid 90th percentile calculated by NCQA.

While HEDIS 2015 showed marked improvement in rates, there are still some areas for improvement, such as controlling high blood pressure and the avoidance of antibiotic treatment in adults with acute bronchitis.

For the remainder of 2015, Anthem Blue Cross will continue focused improvement strategies on the following topics:

- Diabetes
- Childhood immunization
- Childhood immunization
- Children well visits
- Prenatal and postpartum visits
- Medication monitoring for members with asthma
- Medication management for members on persistent medications

We appreciate your caring for Anthem Blue Cross' Medi-Cal members, and we will coordinate our improvement strategies for the remainder of 2015 with you to further enhance our quality of care. We continue to ask for your support as we work together to ensure our members receive the best care possible.

Information about these HEDIS scores and the Medi-Cal Quality Improvement program are available under [Provider Resources](#) on our provider access page, 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).

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

Professional Network Update

August is national immunization awareness month

This is a great opportunity for Anthem Blue Cross providers to promote the importance of immunizations, which can help prevent diseases such as measles, mumps, rubella and varicella.

For a complete list of the 2015 vaccine schedules for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices (ACIP), visit the U.S. Centers for Disease Control and Prevention ([CDC website](#)).

The Vaccines for Children Program

The Vaccines for Children (VFC) program, established by Congress in 1993, helps families by providing free vaccines to doctors who serve eligible children through 18 years of age. The VFC program is administered at the national level by the U.S. Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. CDC contracts with vaccine manufacturers to purchase vaccines at reduced rates. Enrolled VFC providers are able to order vaccines through their state VFC program, receiving routine vaccines at no cost. This enables providers to administer routine immunizations to eligible children without out-of-pocket costs.

The California VFC program is managed by the California Department of Public Health, Immunization Branch. All Medi-Cal Managed Care providers must participate in the VFC program. The *2015 Program Participation Requirements at a Glance* summary is now available for providers at the [VFC website](#).

California Immunization Registry

The California Immunization Registry (CAIR) is a secure, confidential, statewide computerized immunization information system with 10 regional affiliates covering the state. CAIR users pay nothing for the software, training, or help desk support.

CAIR can:

- Remind providers which vaccines are due or over-due
- Inform PCP which vaccines need to be reordered
- Provide labels for mailing patient reminders
- Consolidate records when children have been immunized by different providers

Immunization information can be loaded into CAIR from electronic medical record systems, eliminating the need to enter the information into two systems.

To sign-up, visit CAIR Account Management and New Enrollment [online](#) and for electronic data submissions, visit CAIR IZ [portal registration](#).

Anthem staff is available to meet with providers and office staff if there are questions or if additional assistance is needed.

- Northern Region 1-888-252-6331
- Central Region 1-559-353-3500
- Southern Region 1-866-465-2272

Tobacco cessation updates

The Medi-Cal Incentives to Quit Smoking (MIQS) program was introduced in **March 2012**, offering free nicotine patches and incentive gift cards for enrollees. To date, more than 43,000 tobacco users have enrolled for cessation services and incentives. The MIQS program was a huge success, exceeding program goals. While the program will end on **July 31, 2015**, Medi-Cal members are encouraged to utilize the free tobacco cessation services offered by the California Smokers' Helpline at **1-800-NO-BUTTS**.

- *Note: Please discontinue using and remove any MIQS promotional materials you may have promoting the program.*

The Smoking Cessation Leadership Center (SCLC) is a national program that collaborates with health professionals and institutions to increase competency in those helping smokers quit. The SCLC, located at the University of California, San Francisco since 2003, provides various resources, including presentations, online training, publications, toolkits, and curriculums. For more information about webinars for continuing education (CE), tobacco cessation updates or training, visit the [SCLC website](#).

For questions about tobacco cessation, contact the Medi-Cal Health Education department.

Anthem Blue Cross launches the Safe Choice Program

Making Prescription Drug Safety a Priority

In **June 2015**, Anthem Blue Cross launched the Safe Choice Program for Medi-Cal Managed Care members. This program is designed to interact with providers, members, and pharmacies to protect members from the overuse of prescription opiates. The goal of the Safe Choice Program is to ensure that members have access to needed medications while reducing the possible harm associated with misuse and abuse. Through monthly reviews, Anthem Blue Cross identifies members who may be receiving duplicate drug therapies, visiting multiple prescribers or pharmacies for similar medications, or receiving opiates at levels beyond those generally accepted in clinical practice.

When Anthem Blue Cross finds an area of concern, it will reach out to the member and his or her provider, gather information, and assist by coordinating services. The objective is to get help for the member through assessments and treatment interventions, pain management, or referrals for substance abuse treatment. By limiting the member to one pharmacy for obtaining prescribed medications, the Safe Choice Program reduces the risk of multiple prescriptions being filled at multiple locations.

In June 2015, providers began receiving letters from Anthem Blue Cross, identifying members who have been enrolled in the Safe Choice Program. Members and pharmacies also received a letter explaining the program. Providers play a critical role in the success of this program. We ask that providers discuss the Safe Choice Program with their members during their appointments, explaining the value of using a single pharmacy to avoid drug interactions and duplicate therapies.

For more information on this program, please contact Anthem Blue Cross at **1-800-407-4627**.

Medicare Advantage Updates

Participating home health providers: Physician orders are required; precertification and face-to-face evaluations are not required

Anthem Blue Cross requires a physician's order for home health services for our individual and group-sponsored Medicare Advantage members. Precertification for home health services is not required. **At this time**, contracted Home health providers are not required to present evidence of a face-to-face evaluation for home health services claims.

HIPPS codes required for all skilled nursing and home health providers

All claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) received **July 1, 2014**, and after must contain a valid HIPPS code. **This pertains to Contracted and Non-Contracted Providers.** The Centers for Medicare & Medicaid Services requires that Anthem include this information on **all processed claims** data we submit to CMS.

- SNFs should bill the HIPPS code derived from the "Admission Assessment"
- HHAs should bill the HIPPS code derived from the "Start of Care Assessment"
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable PPS Revenue Code (022 or 023), the HIPPS code, 1 unit, and billed charges of 0.00.
- This billing instruction applies to all Medicare Advantage Plans including Dual Eligible Special Needs Plans.
- This does not apply to Medicare Supplemental Plans.
- HHAs are not required to bill Treatment Authorization Codes.
- If you currently have a contract with Anthem, the CMS mandated addition of the HIPPS code on your claim will not affect your payment.

Medicare Advantage pre-certification requirements available on Availity

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. Detailed Prior Authorization requirements for individual Medicare Advantage members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. Go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Blue Cross 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 www.anthem.com/ca/medicareprovider to learn more about this online provider self-service tool.

Non-contracted providers should contact the Health Plan. General information on 2015 Medicare Advantage precertification requirements can be found [here](#).

Professional Network Update

Appeals information for participating Medicare Advantage providers

Anthem Blue Cross Medicare Advantage plans have a separate and distinct Contracted Provider Appeal Process. Contracted Providers who appeal any determination that does not involve Medicare Advantage member liability under Federal regulations [CFR §422.568(c) and (d)], have separate Medicare Advantage processing and timeframe guidelines. There are no second level appeals for Anthem Blue Cross Medicare Advantage products.

As previously required, the Provider Appeal should be accompanied by a letter that explains why the provider believes the decision should be overturned. Any information necessary to review the appeal must be included with the letter, such as the complete medical records needed to justify the services for which the provider is seeking payment. As Anthem Blue Cross will only be reviewing one level of appeal, we expect providers to provide all the information needed to justify the requested services with the request for appeal. All appeals must be submitted within 180 days of the initial decision. Appeals received outside of the 180 day timeframe may not be processed.

Please note that Anthem Blue Cross Medicare Advantage plans administer Medicare coverage for our Medicare Advantage members and follow Medicare guidelines with regard to coverage of certain items and services. If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the initial request for coverage to allow for an appropriate decision to be made; we may not request additional information to support payment for the services you are requesting.

Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can only be made when the documentation supports the service/item.

A Medicare Advantage appeal is initiated by writing or sending a fax to the Anthem Blue Cross Medicare Advantage Appeals Department within one hundred eighty (180) calendar days of our initial decision at:

Medicare Advantage Grievance and Appeals
Mail location OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 1-888-458-1406

Participating providers: Bill Medicare Part D for shingles or tetanus vaccination claims

Providers who have administered a shingles (90736; regardless of any diagnosis) or tetanus vaccine (90714, 90715, 90718 & 90723; regardless of any diagnosis) to our individual and group-sponsored Medicare Advantage plan members with pharmacy benefits should bill the Medicare Part D Benefit. Providers will encounter a denial if these claims are billed to the Medical benefit because the claim is covered under Medicare Part D only. This applies to the vaccine and the administration charges. Please note you can refer your patients to their local pharmacy for administration as well.

For Medicare Part B benefit of tetanus vaccine (90703; diagnosis range 800.00 to 897.99), this may be submitted as a medical claim for processing.

Providers who are delegated and capitated for Part B services, according to the Division of Financial Responsibility (DOFR) found in the Provider Services agreement, should continue to submit related encounter data even though claims will not be processed for payment.

More information can be found [here](#).

Professional Network Update

Labs: Anthem Blue Cross Medicare Advantage plans accept G codes for definitive drug testing

To help ensure alignment with the Centers for Medicare & Medicaid services billing guidelines, Anthem Blue Cross' Medicare Advantage plans accept G Codes for definitive drug testing. Therefore, labs should use codes G6030-G6058 for definitive drug testing for Anthem Blue Cross individual and group-sponsored Medicare Advantage members.

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.

Adult BMI and medical records – please record exact number, not range

Please document Body Mass Index (BMI) as an exact number and not a range. BMI Can be documented by billing CPT 3008F and the appropriate V code. Adding the BMI to the claim helps to decrease the number of chart reviews needed throughout the year and during the HEDIS collection season. Greater precision in charting the member's BMI will help members achieve or remain at a healthy weight.

Important screenings for Medicare Advantage members

Anthem Blue Cross appreciates your help in ensuring that our Medicare Advantage members receive key services recommended by the Centers for Medicare & Medicaid Services, including:

- Diabetes
 - Diabetic members ages 18-75 require a yearly dilated retinal exam (DRE), kidney function test
 - Diabetic members ages 18-75 require a HbA1C every three to six months
- Colorectal screening -- members ages 50 to 75 require a colorectal cancer screening
 - Screenings include Fecal Occult Blood Test (FOBT) during the measurement year, flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year and/or colonoscopy during the measurement year or the nine years prior to the measurement year.

Proton pump inhibitors – consider less costly alternatives

To help manage rising healthcare costs, Anthem Blue Cross removed Nexium and the generic from the majority of individual 2015 Medicare Advantage formularies and group-sponsored closed formularies. Lower-cost alternatives (omeprazole and pantoprazole) and over-the-counter proton pump inhibitor (Prilosec, Nexium) are available in this class and on the non-preferred generic tier in majority of Anthem Blue Cross Medicare Advantage formularies. (The group-sponsored MAPD open formulary does cover Nexium at this time.) Nexium brand and generic pricing is significantly higher than the generic proton pump inhibitors, pantoprazole and omeprazole, which are less than \$20 per prescription.

Please consider prescribing **omeprazole and pantoprazole**, the lower-cost alternatives for members with excess stomach acid.

Professional Network Update

Medicare Supplement Plan N ID cards have a new look

Medicare Supplement Plan N includes an Office Visit benefit. The member is responsible for 20% coinsurance of the Medicare approved amount up to a maximum \$20 copay for each office visit.

The identification card previously indicated "Office Visit \$20 copay" or "Office Visit \$20."

Going forward the wording on the new identification cards is "Office Visit up to \$20." The office visit benefit is not changing. The new wording on the ID cards is a clarification of the benefit. The new wording will be on ID cards issued to new members and members requesting a duplicate card.

53569WPPENMUB 06/04/2015

Facilities: Failure to precertify an admission or provide notice of emergent inpatient admission results in administrative denial

Facilities and network physicians are required to obtain precertification for specified services for individual and group-sponsored MA members, including an admission to any inpatient facility. For the member to receive maximum benefits, the health plan must authorize or precertify the covered services prior to being rendered. As previously communicated, please notify Anthem Blue Cross 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 a facility does not obtain the required precertification within the specified timeframe, the claim will be administratively denied due to failure to notify Anthem Blue Cross of the admission. The facility will not receive payment for the service. Facilities cannot bill the member for these denied admissions.

If you do not notify us within the required timeframe, you may file an appeal. As part of the appeal, providers must demonstrate that they did notify Anthem Blue Cross or attempted to notify Anthem Blue Cross AND that the service is medically necessary. Anthem Blue Cross also reminds all providers – network physicians and facilities -- that they cannot bill the member if the services are denied for the failure to obtain a required precertification.

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 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 Blue Cross individual MA members also can be initiated via the Availity web portal at www.Availity.com. To access this new functionality, go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Blue Cross 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 www.anthem.com/medicareprovider to learn more about this online provider self-service tool.

54092WPPENMUB 06/15/2015

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.

52734WPPENMUB 03/27/2015



Professional Network Update

August 2015

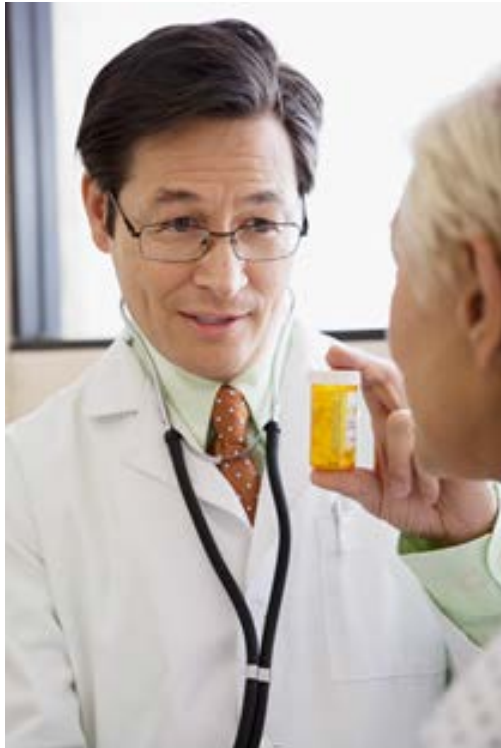
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Pharmacy

Pharmacy information available on anthem.com/ca

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. 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."



Professional Network Update