



Working together to improve the health of our members.

Network Update

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

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Health Care Reform Updates (including Health Insurance Exchange)

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](#).



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Announcements and General Updates

Agreement reached with state regulator regarding speech and occupational therapy coverage

Anthem Blue Cross (Anthem) and the California Department of Managed Health Care (DMHC) have entered into a settlement agreement concerning medically necessary speech and occupational therapy coverage. While we believe we administered such benefits in compliance with the law, both Anthem and the DMHC agree that the settlement is in the best interest of our members.

Under the settlement, Anthem will reimburse current and former members for medically necessary speech or occupational therapy services (ST/OT services) if all of the following are satisfied:

- The member was enrolled in an Anthem health insurance plan regulated by the DMHC at the time ST/OT services were rendered
- Medically necessary ST/OT Services were rendered during the period beginning January 1, 2010 through October 15, 2015
- The member received ST/OT services from an appropriately licensed health care provider
- The member incurred out-of-pocket expenses for ST/OT services that were unpaid or denied by Anthem
- The member submits a claim for reimbursement prior to December 31, 2016

Anthem will notify its current and former members. Anthem will review the medical necessity of ST and OT requests based on the Anthem Clinical UM Guidelines CG-REHAB-05 and CG-REHAB-06. If Anthem's guidelines conflict with California law, California law will supersede the guidelines. Anthem and its delegated medical groups may periodically reassess a member's clinical condition and progress to evaluate the medical necessity of continued speech or occupational therapy services. Anthem will not, however, interrupt or stop the services during the period in which services have been authorized in order to conduct the review.

Should you have any questions, we encourage you to contact Anthem Provider Services at **1-800-677-6669**.

Important information about providing services to out-of-state Medicaid members

Beginning April 18, 2016, Anthem Blue Cross (Anthem) will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims. Additional information may require the provider to enroll in the member's out-of-state Medicaid program, or provide missing Medicaid encounter data.

Enrolling in an out-of-state Medicaid program

At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Some state Medicaid programs require providers to enroll in a member's state Medicaid program when services are performed for their members (Section 1902(kk)(7) of the Social Security Act, 42 CFR 455.410, and 42 CFR 455.440). If a provider submits a claim for a Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. Anthem will also send the provider a letter with information about how to enroll in the member's state Medicaid program online.

Providers are encouraged to always verify member eligibility and benefits prior to performing services. This step will help determine if a member is enrolled in an out-of-state Medicaid program, and if provider enrollment is required. Whenever possible, the enrollment process

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should take place prior to submitting the claim to prevent delays in processing the claim. If the claim has been denied prior to enrollment, providers are advised to resubmit the claim for processing once enrollment is complete.

Medicaid encounter data

Encounter data includes records of health care services for which managed care organizations pay. In order to process a claim and apply appropriate benefits, providers are asked to submit all encounter data when billing for Medicaid services. The list below reflects fields that are needed and if not included can result in claim denial. The provider should submit the claim following the directions on the back of the member's identification card.

If an out-of-state Medicaid claim is denied, Anthem will send a letter to indicate the encounter data needed. Upon return of this information, the claim will be reprocessed.

Professional Encounter Data		
Actual ambulance mileage	Performing provider taxonomy code	Service facility location state
Billing provider address	Referring provider number and Referring provider number qualifier	Service facility location ZIP
Billing provider middle initial	Performing provider NPI	National drug code
Provider NPI	Service facility name	Condition code
Institutional Encounter Data		
Actual ambulance mileage	Occurrence span code	Operating physician number and operating physician number qualifier
Attending physician number and attending physician number qualifier	Occurrence date	Performing provider taxonomy code
Condition code	Occurrence from date	Provider NPI
National drug code	Occurrence to date	Value amount
Occurrence code	Referring provider number	Value code
837 Field Name	Claim Type	
Claim or line note text	Institutional and professional	
Certification condition applies indicator and Condition indicator - early and periodic screening diagnosis and treatment (EPSDT)	Institutional and professional	
Service facility name and location information	Institutional	
Ambulance transport information	Professional	
Ordering provider identifier and identification code qualifier	Professional	

Important updates to our medical policies and clinical guidelines: Effective May 1, 2016

To reduce unexpected post-service claim denials, we are revising and standardizing services that are reviewed, either pre or post service. Please note that these recommendations do not apply to HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program[®] (FEP[®]), State Sponsored Business (SSB) or selected National accounts. In addition, please be advised that existing requirements for review of inpatient stays will continue.

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The changes listed below will become effective on May 1, 2016.

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

Medical Policy or Clinical Guideline	Description	Codes
SURG.00127	Sacroiliac Joint Fusion	Adding 27279 to existing policy (27280 already requires prior authorization)
SURG.00047	Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia	43192, 43201, 43236, 43257, 43499, 43210

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.

Specialty pharmacy updates

In order to reduce unexpected post-service claim denials, Anthem Blue Cross (Anthem) will be adding specialty pharmacy drug codes to the Specialty Pharmacy Prior Authorization list. Listed below, are specialty pharmacy drugs that have been added to existing medical policies which will be added to our 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 May 1, 2016.

Medical Policy	Drug Name	Drug Code
DRUG.00066 - Antihemophilic Factors and Clotting Factors	Coagadex	J7199
DRUG.00066 - Antihemophilic Factors and Clotting Factors	Nuwiq	J7192

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 has transitioned to AIM

As providers are aware, the pre-service clinical review of outpatient specialty pharmacy infusion/injectable drugs has transitioned to AIM Specialty Health® (AIM), on behalf of Anthem, for Fully-Insured members as of September 1, 2015. (ASO members will remain with Anthem Blue Cross at this time.)

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

In 2015, AIM Specialty Health® (AIM) enhanced their web portal experience 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. As a reminder, servicing providers should continue to coordinate care with the member's ordering provider.

AIM Pre-authorization Requests (for Ordering and Servicing Providers) can be accessed online 24 hours a day, seven days a week

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 and servicing providers may submit online pre-certification requests to AIM by either of the following options:

- Access AIM *ProviderPorta*SM directly at www.providerportal.com, or
- Access AIM via the Availity Web Portal at www.availity.com

To Submit a Pre-authorization Request through Availity

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 AIM Specialty Health Internet Hyperlink Disclaimer, that you are leaving the Availity site and being routed to AIM
- Once routed to 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](#).

Attention medical providers accepting workers compensation patients: Your immediate attention is required for MPN physician acknowledgments

According to the California Department of Workers Compensation, as authorized by California Code of Medical Provider Network (MPN) Regulations Title 8 Chapter 4.5 Subchapter 1 Article 3.5 Section 9767.5.1, an "MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN." MPNs have the exclusive right per California Labor Code 4616 (d) to determine the members of their MPN; however licensed physicians must acknowledge that MPN participation.

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem's Provider Affirmation Portal, go online to the Provider Affirmation Portal to view a complete listing of the MPNs that have selected you for participation in their MPN. Go to [Availity](#) and login. Click on Payer Resources at the top and look for the link to the Anthem Workers Compensation MPN Provider Affirmation Portal. If the MPN Applicant (insurance carrier, self-insured employer, Entities Providing Physician Network Services) has selected you to participate in their MPN, you will find their MPN(s) listed. There you can also affirm participation by simply viewing the page and clicking "submit" at the bottom of the page. You also have an option to "opt out" of each MPN as well.

If you cannot go online, call Anthem Workers' Compensation at **1-866-700-2168** and we can take action on your behalf in the Provider Affirmation Portal. The regulations (§9767.5.1) allow the physician, an employee of the physician, or if authorized by the physician(s), an agent or representative of a medical group to take action on behalf of a medical provider.

Precision Medicine: Cancer Care Quality program expansion supports NCI-MATCH

The Cancer Care Quality Program is expanding to include enhanced reimbursement for treatment planning and care coordination services provided by network providers for those eligible members who enroll in [NCI-Molecular Analysis for Therapy Choice](#) (NCI-MATCH), a National Cancer Institute clinical trial. NCI-MATCH seeks to determine whether treating cancers according to their molecular abnormalities will show evidence of effectiveness.

The Cancer Care Quality Program Precision Medicine expansion provides a unique opportunity to support the White House's Precision Medicine Initiative through the National Cancer Institute to accelerate knowledge and learn as rapidly as possible which genes and therapies are clinically effective. It also supports your practice with enhanced reimbursement for treatment planning and care coordination services provided to those eligible members who enroll in NCI-MATCH.

Learn more

Visit our special website to learn more about the program:

- How to participate
- Member eligibility
- Enhanced reimbursement
- Frequently asked questions

Go to: www.CancerCareQualityProgram.com/PrecisionMedicine

Revisions to the 2016 coverage of mental health, substance use disorder benefits

Anthem Blue Cross (Anthem) has revised some mental health and substance use disorder benefits within currently effective individual, small group, and large group plans effective January 1, 2016. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, and California Health and Safety Code section 1374.76 and Covered California regulations require these changes. The revisions likely represent changes from information you or your patients have already received on cost-sharing, treatment limits, and evidence of coverage (EOC) disclosures regarding Anthem's mental health and substance use disorder benefits.

Revisions to Cost-Sharing

Some cost-sharing for certain mental health and substance use disorder services has changed. When your office contacts Anthem to determine enrollee patient cost-sharing amounts, our cost-sharing database will reflect these cost-sharing changes. If you have questions about the correct cost-sharing amount to collect or bill for the type of mental health or substance use disorder services rendered, please login to Availity at Availity.com or call the toll-free phone number on the back of the patient's identification (ID) card.

Revisions to EOCs Concerning Mental Health and Substance Use Disorder Services

Anthem has also revised EOCs with any cost-sharing changes and text to clarify the types of inpatient and outpatient services and treatment that Anthem provides for mental health and substance use. The most significant text changes can be found in the following EOC sections: Benefits Summary, Mental Health and Substance Abuse (Chemical Dependency) Services Inpatient Facility Services and Outpatient Facility Services Out-of-Network, and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.

Questions

If you have questions about the revisions, want a copy of an EOC or policy and procedure, or would like more information about Anthem's coverage of mental health and substance use disorder services, please contact us call the toll-free the number on the back of the patient's ID card.

2016 FEP benefit information available online

To view the 2016 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2016. For questions please contact FEP Customer Service at 1-800-284-9093.

Please note: The Federal Employee Program® Medical Policy Manual may be accessed at www.fepblue.org > Benefit Plans > [Brochures and Forms](#) > Medical Policies.

Billing

Medical record submissions must include member identification numbers

Anthem Blue Cross (Anthem) requires all medical records be submitted with the corresponding Anthem member identification (ID) number. The member ID number is a critical piece of information, as it allows us to better locate and identify medical records, reduce the amount of repeated requests for outstanding medical records, and more quickly process provider claims. Providers should include the member ID number exactly as it appears on the Anthem member identification card, including the prefix, on the first page of each medical records submission.

Beginning January 1, 2016, if the member identification number is not present on medical records received, Anthem will respond to the submitting provider with a letter explaining that we cannot identify the member and request the provider resubmit the documentation with the member ID number and prefix.

If you have any questions about this process, please contact the Provider Service phone number on the back of the member identification card.

Anthem Blue Cross to discontinue delivery of multiple F checks in the HIPAA 835 payment cycle

Anthem Blue Cross (Anthem) will eliminate the use of the 'F' check number in the HIPAA 835 and combine **ALL** claims, paid and zero pay' into a single 835 file for each payment cycle. This single 835 file will contain one check number. The 835 will report all finalized claim activity for that weekly payment cycle.

Change: The HIPAA 835 transaction file can contain both paid and rejected claims under the assigned check number. This is consistent with what is reported on the Provider voucher/EOP.

In the event that there is not a monetary payment, the 835 associated with the non-paid claims reported under that 835 will be grouped in a single file.

Effective December 19, 2015, when the HIPAA 835 transaction file has all zero pay claims, there will not be a check/EFT number. The number mapped in TRN02 (check number field of the HIPAA 835 transaction) will be the vouchers FDSN (Financial Document Serial Number).

The FDSN will start with 'V' and be followed by up to 9 numbers (Example: V123456789). This number, minus the 'V' is located at the bottom right of the Provider voucher/EOP, under the page number.

There is no change to the Provider voucher/EOP, or where the FDSN is located.

Note: Blue Exchange 835s will not be impacted by this change and will continue to produce single 835s for non-paid claims.

To view Provider Voucher examples, go to anthem.com/edi, select state, click on Communications then EDI Latest News link.

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

California Contract Support/Network Relations toll free number discontinued

Effective **January 1, 2016**, the CA Contract Support/Network Relations phone line, **1-855-238-0095**, was changed to an outgoing message line only. Voicemail messages cannot be left on this number, and it is not answered by a live person.

The phone line message gives the providers several options to get their questions answered:

- To reach Provider Services, please dial the number on the back of the member's ID card.
- To request an application to join our network, or for questions pertaining to an application status, please email CAPhysicianApp@anthem.com.
- For California contracting inquiries, or to obtain a listing of all Anthem Blue Cross provider contacts, please email CAContractSupport@anthem.com, or visit www.anthem.com/ca > Providers > and select the "Contact Us" link located in the upper right-hand corner of the Home page.

Anthem Blue Cross: "Find a doctor tool"

The [Find a Doctor](#) tool at Anthem Blue Cross (Anthem) is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To ensure Anthem has the most current and accurate information, please take a moment to access the Provider Finder tool (www.anthem.com/ca) and review how you and your practice are being displayed. To report discrepancies please contact Anthem by sending an email to ProviderDatabaseAnthem@anthem.com.

Providers 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.

Please note that your Provider Agreement requires that any change in your practice must be reported to Anthem Blue Cross within ten (10) days of the change.

- Any request to update provider demographic or practice information may take up to 20 days to be reflected in Provider Finder.
- 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

Professional Network Update

Anthem Blue Cross cost transparency

As an Anthem Blue Cross (Anthem) participating provider, you may have received our May or November 2015 correspondence, or read the articles in our August, October or December Network Updates regarding Anthem Cost Transparency. We informed you in those letters and articles 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 just completed in November this year, and the next update scheduled for May 2016. Please look for further information on this in our calendar year 2016 Provider Newsletters posted to anthem.com/ca.

We are pleased to announce that starting with the November 2015 refresh participating Anthem provider costs are now available in a secure section of the AVAILITY provider portal. Authorized representatives of participating facilities and professional practices can login to AVAILITY at www.availity.com, and register to view the costs for their facility or practice. Costs will be made available to our participating providers no less than 30 days before they become available to our members on Anthem.com in the *Estimate Your Costs* function.

Should you wish to review the methodology, you may request a copy by sending an email request to the Anthem California contract support team at CAContractSupport@anthem.com.

Thank you for your service to our members.

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.

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Network leasing arrangements

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

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem members. As such, they're entitled to the same Anthem 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 website at www.anthem.com/ca. If you don't have internet access, please e-mail us at CAContractSupport@Anthem.com.



Guidelines and Quality Programs

Appropriate 911/Emergency care procedures

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

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

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

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

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

Commercial HEDIS® 2016 starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax. The fax will contain:

1. A cover letter with contact information if you have any questions;
2. A member list, which includes the member and HEDIS measure(s) they were selected for; and
3. An instruction Sheet listing the details for each HEDIS measure. As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within **five business days**. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in the 3rd quarter provider newsletter.

To return the medical record documentation back to us in the recommended 5-day turnaround time, simply choose one of these options:

1. Upload to our secure portal. This is quick and easy. Logon to www.submitrecords.com, enter the password: **wphedis57** and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.
OR
2. Send a secure fax to **1-888-251-2985**
OR
3. Mail to us via the **US Postal Service** to:
Anthem, Inc., 10897 S. River Front Parkway, Suite 110H, South Jordan, UT 84095-9984

Thank you in advance for your support of HEDIS.

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

Clinical practice and preventive health guidelines available on the Web

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

Note: A summary of the 2016 Behavioral Health related clinical UM guidelines were mailed on January 15, 2016, to the entire Behavioral Health Network. The summary highlights material changes effective April 15, 2015. If you have questions regarding the Behavioral Health Clinical UM Guidelines, contact the Utilization Management Department toll-free at **1-800-274-7767**.

Professional Network Update

Improving documentation of high blood pressure

Hypertension (HTN) is the most common condition seen in primary care practices and if managed well can reduce the burden of cardiovascular disease for a patient¹. The Eighth Joint National Committee (JNC 8) guideline on the management of adult hypertension was released in 2014. The new changes recommend physicians treat to 150/90 mmHg in patients over age 60 and 140/90 for everybody else, including those patients who have diabetes.

Each year, health plans collect data from provider records to look at patients with hypertension to see if their blood pressure (BP) is under control. The National Committee for Quality Assurance (NCQA) made changes to the 2015 Healthcare Effectiveness Data and Information Set (HEDIS®) to the Controlling High Blood Pressure (CBP) measure to align with the new JNC8 guidelines.

Improvements in documentation of the diagnosis and blood pressure can make a big difference in whether CBP is considered compliant or not. The 2015 medical record review findings from provider offices that contributed to decreased scores included:

- No Diagnosis confirmed
 - Diagnosis must be noted in the chart on or before 6/30 of the measurement year being reviewed.
- Diagnosis confirmed, but either no BP was taken since diagnosis or no BP was taken at all during the measurement year
- Diagnosis was listed as prehypertension
 - Pre-hypertension is not acceptable for confirming a diagnosis of HTN. Also, "rule out HTN," "possible HTN," "white-coat HTN," "questionable HTN" and "consistent with HTN" are not sufficient to confirm Diagnosis.
- BP documented as exactly 140/90
 - Blood pressure must be **less than 140/90** mmHg unless your patient is 60-85 years of age and not a diabetic, then the blood pressure needs to be less than 150/90 mmHg.
- BP out of control
 - Many times, there are no follow-up visits in the chart or additional BPs are not taken the same day as an elevated BP reading.

You can take the Journal of American Medical Association CME course to earn a maximum of 1 *AMA PRA Category 1 Credit*[™] for the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JAMA. 2014;311(5):507-520).

You access the course and JNC8 guidelines at the following link:

<http://jama.jamanetwork.com/article.aspx?articleid=1791497&tab=cme>

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

¹: 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, JAMA. 2014;311(5):507-520 Retrieved on 12/10/2015 from: <http://jama.jamanetwork.com/article.aspx?articleid=1791497>

Timely Access Regulations

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

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

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

These surveys should be concluding by now, however please make note of this with your office staff so they are prepared and understand the importance of each providers’ participation in each of the surveys.

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

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

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

Advanced Access: The primary care appointment availability standard may be met if the primary care physician office provides “advanced access.” “Advanced access” means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician’s assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

We hope this clarifies Anthem’s expectations and your obligations regarding compliance with the Timely Access Regulations. Our goal is to partner with our providers to successfully meet the expectations for the requirements with the least amount of difficulty and member abrasion. **See below for a chart that outlines the Accessibility Standards for providers.**

Access Standards for Medical Professionals	
Access to	Standard
Non-urgent appointments for Primary Care (PCP)	Must offer the appointment within 10 business days of the request

Urgent Care appointments not requiring prior authorization	Must offer the appointment within 48 hours of request
Non-urgent appointments with Specialist Physicians	Must offer the appointment within 15 business days of the request
Urgent Care (that requires prior authorization)	Must offer the appointment within 96 hours of request
Non-urgent appointment for ancillary services (for diagnosis or treatment of inquiry, illness, or other health condition)	Must offer the appointment within 15 business days of the request
In-office waiting room time	Usually members do not wait longer than 15 minutes to see a physician or his/her designee
After Hours Care	Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back
Emergency Care (California law requires health plans to follow the "prudent layperson" standard in providing direction for emergency care and prohibits plans from denying payment for emergency services, even if the situation was discovered not to be emergent, if any "prudent layperson" would have considered the situation to be an emergency. Therefore, Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller believes they are experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go the emergency room if the caller believes they are experiencing an emergency)	Immediate Access to Emergency Care. Members are directed to 911 or the nearest emergency room
Member Services by Telephone. Access to Member Service to obtain information about how to access clinical care and how to resolve problems (this is a plan responsibility and not a physician responsibility; and this also applies to our Behavioral Health members)	Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate <5%) Member Nurse line available 24/7

Professional Network Update

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

Members also have access to Anthem Blue Cross' 24/7 NurseLine. The phone number is located on the back of the member's health insurance ID card. In addition, Members and Providers have access to Anthem Blue Cross' Customer Service team at the telephone number listed on the back of the members' ID card. A representative may be reached within 10 minutes during normal business hours. **If you have further questions, please contact Network Relations at CAContractSupport@anthem.com.**

Professional Network Update

Medi-Cal Managed Care Updates

Important information about providing services to out-of-state Medicaid members

Beginning April 18, 2016, Anthem Blue Cross (Anthem) will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims. Additional information may require the provider to "enroll" in the member's out-of-state Medicaid program, or provide missing Medicaid encounter data.

If a Medi-Cal Managed Care provider sees a Medicaid patient from another state, and that state Medicaid program requires the provider to be enrolled, the servicing provider must enroll in that state Medicaid program in order to be paid.

Read more about providing services to out-of-state Medicaid members [here](#).

H.P. Acthar Gel will require prior authorization

Effective **May 1, 2016**, Anthem Blue Cross providers must receive prior authorization before prescribing Anthem Medi-Cal Managed Care members H.P. Acthar® Gel.

H.P. Acthar® Gel (Repository Corticotropin Injection) is used for the treatment of infantile spasms and corticosteroid-responsive conditions when all other well established treatment routes for corticosteroid therapy cannot be used and where documentation exists explaining why these therapies cannot be used.

For more detail reference Anthem Clinical UM Guideline CG-DRUG-24: (J0800=Injection, corticotropin, up to 40 units)

Prior authorization is designed to encourage appropriate use of medications. When a medication requires prior authorization, a prior authorization form must be completed by the prescriber for submission to Anthem Medi-Cal Managed Care. To obtain a prior authorization form, you can contact our pharmacy benefit manager's Prior Authorization Center at **1-800-338-6180** for more information. Use this link to access the Prescription drug prior authorization form.

ICD Indicator required on paper claim forms

As a result of the implementation of ICD-10 on **October 1, 2015**, it may be appropriate to report either ICD-9 or ICD-10 codes depending upon the dates of service. Paper claim forms have an ICD indicator that identifies the ICD code set being reported on the claim. **Anthem Blue Cross requires that the ICD indicator field is populated on paper claim forms for all Medi-Cal Managed Care member claims. Claims submitted without the ICD indicator field populated will be rejected.** [Use this link for an example of a corrected populated ICD indicator field.](#)

Anthem Blue Cross diabetes management classes in Glendale and Tarzana

Anthem Blue Cross (Anthem) Health Education department is partnering with Providence Tarzana Medical Center to provide a three-part diabetes management class for Medi-Cal Managed Care members. The class series will cover important topics such as self-management, the importance of monitoring blood sugars, nutrition and exercise and action plan development. Anthem will also offer this class series at the CareMore Care Center in Glendale. [Get the class schedule here.](#)

Professional Network Update

Seeking interested providers for a health education pilot program

The Anthem Blue Cross Health Education department is seeking providers for a unique opportunity to work on developing a new model of health education delivery to serve Medi-Cal Managed Care members. The Clinic Days pilot program places one of our trained health educators onsite at the provider's office. This allows members to get personalized health education services when they are thinking about their health and where they can benefit from the ability to receive immediate advice on how to manage their conditions. [Use this link to learn more about participation.](#)

Health education classes available

Anthem Blue Cross health education classes are available at no charge to 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. [Learn more about referring Medi-Cal members.](#)

Introducing Nipro Diagnostics, Inc.

By now, your Anthem Blue Cross Medi-Cal Managed Care patients are using the TRUEresult meter, but few providers know about the benefits Nipro Diagnostics offers by helping track compliance and progress for their diabetic patients. [Read more about getting all of the capabilities from the TRUEresult meter.](#)

February is Heart Month

Many patients go about their day and don't think much about the organ that makes it all possible: the heart! It is the hardest working muscle in the human body. [Use this link to share with patients the six must-do steps for keeping a healthy heart.](#)

Tobacco Cessation clinical training available for continuing education credit

The Smoking Cessation Leadership Center (SCLC) recently announced their latest webinar recordings, eligible for continuing education credits for physicians and allied health professionals. [Get course and sign-up information here.](#)

Free language assistance programs

Anthem Blue Cross (Anthem) 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 is committed to reducing the impact of language barriers for our Medi-Cal Managed Care (Medi-Cal) patients through language assistance. [Use this link for useful information about telephonic interpreters.](#)

Professional Network Update

Cal MediConnect Plan Update

This section of the newsletter addresses information about the Medicare-Medicaid Plan or MMP. Members are enrolled in both Medicare and Medicaid under the Anthem Blue Cross Cal MediConnect Plan.

Chronic care improvement program

Federal regulations require the Anthem Blue Cross Cal MediConnect Plan to conduct a chronic care improvement program in addition to the quality improvement project. The chronic care improvement program (CCIP) will be conducted over a five year period with an emphasis on preventing and reducing cardiovascular disease. Goals for the CCIP are the management and treatment of hypertension, with a focus on medication adherence and care coordination for our members. [Read more about the CCIP.](#)

Being there when members need you

Health care doesn't take weekends or evenings off. That often means you don't get to, either. We appreciate your dedication to Anthem Blue Cross Cal MediConnect Plan members, by keeping them healthy – no matter how busy you are or what time of day.

Primary Care Providers (PCPs), specialty providers and behavioral health providers are required to maintain appointment access standards. [Learn more about appointment standards by using this link.](#)

CAHPS access and availability

Anthem Blue Cross Cal MediConnect Plan will begin collecting member satisfaction data in 2016 for services received in 2015. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey includes, but is not limited to, member access and availability, for example:

Getting Care Quickly

- Getting care right away (urgent)
- Getting appointment as soon as needed (routine)
- Doctor seen within 15 minutes of appointment time

Getting Needed Care

- Easy to get appointment with specialist
- Easy to get care, tests and treatment believed necessary

You can learn more about CAHPS by visiting the website www.achps.arhq.gov.

Healthcare effectiveness data and information set (HEDIS)

HEDIS® is a set of standardized performance measures that compare the performance of managed health care plans. HEDIS measures the performance of our health plan and participating practitioners for important aspects of preventive, acute and chronic health care established by the National Committee for Quality Assurance. The state of California requires Anthem Blue Cross Cal MediConnect Plan and our network physicians to comply with HEDIS initiatives and to report the results to the state. [Use this link to learn more about Anthem Blue Cross Cal MediConnect Plan measurement year.](#)

Professional Network Update

Diabetic complications in ICD-10

A benefit of ICD-10 codes is that providers can now report more clinical details concerning diabetic complications than they could in ICD-9. The increased specificity is possible because ICD-10 contains expanded combination codes for diabetic complications. A combination code describes two or more conditions within a single code. The ICD-10 code categories E08-E13 contain the combination codes for diabetic complications. The codes include the type of diabetes mellitus, the body system affected and the complications affecting that body system.

[Get this useful coding tip sheet for diabetic complications here.](#)

Boniva to require prior authorization

Anthem Blue Cross (Anthem) Cal MediConnect Plan (Medicare-Medicaid Plan) is adding Boniva to the list of injectables/infusibles requiring prior authorization when prescribed to members enrolled in the Cal MediConnect Plan. As of **March 15, 2016**, providers must receive prior authorization when prescribing these drugs to Cal MediConnect Plan members. Boniva (ibandronate) is used to treat osteoporosis (J1740).

Prior authorization is designed to encourage appropriate use of medications. A prior authorization form must be completed by the prescriber and submitted to Anthem. The pharmacy **prior authorization form** is available on the **provider web site** at www.mediproviders.anthem.com/ca. From the *Member Eligibility & Benefits* header select *Pharmacy Benefits*. If you have questions regarding a prior authorization request call **1-800-338-6180**.

Avoid diagnostic claims denials by completing item 20 (CMS 1500) correctly

The Centers for Medicare & Medicaid Services requires that providers billing for diagnostic tests subject to anti-markup payment limitation complete Item 20 on the CMS-1500 form. A "yes" check indicates that an entity other than the billing entity performed the diagnostic test. A "no" check indicates "no anti-markup tests are included on the claim." When checking "yes," providers are required to complete item 32.

Claims for Anthem Blue Cross Cal MediConnect Plan members received with item 20 checked "yes" and there is incomplete or missing information in item 32, the claim will be denied with denial Z01 "*claim must be billed with provider's NPI.*" To prevent unnecessary claims denials, only complete Item 20 when you are billing diagnostic tests subject to the anti-markup payment limitation.

HIPPS codes required for Skilled Nursing and Home Health

All claims from Skilled Nursing Facilities (SNF) and Home Health Agencies (HHA) received **July 1, 2014**, and after must contain a valid Health Insurance Prospective Payment System (HIPPS) code. Read more in the Medicare section on page 27.

We care about our providers

When you receive your provider satisfaction survey this winter, please complete it and return it as quickly as possible! Your satisfaction is a top priority. The results from the provider satisfaction survey are used as a basis for our continued improvement.

Professional Network Update

Medicare Advantage Updates

Medicare Advantage webinar for all imaging providers: Learn how to complete the AIM OptiNet imaging services registration

Anthem Blue Cross (Anthem) is collecting information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of a number of outpatient diagnostic imaging services for our individual Medicare Advantage members.

AIM's online registration tool, OptiNet®, will collect modality-specific data from providers who render X-ray, ultrasound, Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

This data will be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. **All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, should complete the registration. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements.** Previous communications incorrectly indicated that the OptiNet imaging services registration was not applicable to providers with delegated risk agreements.

Providers who score less than 76 or who do not complete the survey by 2nd quarter will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

Anthem strongly encourages any provider who scores below 76 to improve their site score for the applicable modality before the line item denial of claims for dates of service on or after 2nd quarter. Providers who have not registered and therefore have no score also will be subject to line-item denials for claims submitted for dates of service on or after 2nd quarter.

Attend one of the webinars below to learn how to:

- Access the OptiNet Assessment
- Copy previously completed OptiNet Assessments to your Anthem Medicare Advantage account
- Complete a new AIM OptiNet registration
- Interpret and improve your site score

Choose one of the sessions below to register for the webinar.

[Thursday, February 4, 11 a.m. – 12 p.m.](#)

[Thursday, February 18, 9 a.m. – 10 a.m.](#)

Check [Important Medicare Advantage Updates](#) at www.anthem.com/ca/medicareprovider for [additional information](#).

Professional Network Update

Anthem Blue Cross encourages care coordination for Medicare Advantage members with depression

Anthem Blue Cross (Anthem) encourages care coordination and continuity of care for members with a diagnosis of depression who have been admitted to a hospital. To enhance care coordination efforts Anthem behavioral health case coordinators will ensure that care plans are sent to the hospital, the member, the members' primary care physician and/or the members' behavioral health provider upon notice of an inpatient admission.

HIPPS codes required for SNF and HHA claims

All claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) received 07/01/14 and after must contain a valid HIPPS code. **This pertains to Contracted and Non-Contracted Providers.** CMS requires Anthem to include this information on **all processed claims** data that we submit, regardless of the payment methodology. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including Medicare-Medicaid Plans. This does not apply to Dual Special Needs Plans (D-SNPs) or Medicare Supplement plans.

SNFs

- SNFs should bill the HIPPS code derived from the "Admission 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 Revenue Code (0022), the HIPPS code, 1 or more units, billed charges of 0.00 or one cent.

HHAs

- HHAs should bill the HIPPS code derived from the date of assessment
- Bill the first line with the applicable Revenue Code (0023), the HIPPS code, date of the first covered visit, one or more units, billed charges of 0.00 or one cent.
- HHAs are not required to bill Treatment Authorization Codes.

If you currently have a contract with Anthem Blue Cross, the CMS mandated addition of the HIPPS code on your claim will not affect your contracted rate but is required to process your claim for payment.

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Additional support available for individual Medicare Advantage members with rare conditions

The following information does not apply to delegated providers

Anthem Blue Cross (Anthem) will be working with Accordant Health Services to provide targeted disease management services for our individual Medicare Advantage PPO members only with rare medical conditions, including:

Amyotrophic Lateral Sclerosis (ALS)	Hemophilia	Sickle Cell Disease
Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)	Multiple Sclerosis (MS)	Systemic Lupus Erythematosus
Crohn's Disease	Myasthenia Gravis	Ulcerative Colitis
Cystic Fibrosis	Parkinson's Disease	
Dermatomyositis	Polymyositis	
Epilepsy	Rheumatoid Arthritis	
Gaucher Disease	Scleroderma	

Members in your care who may benefit from additional outreach and information may receive letters, emails or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention.

If you feel that an individual Medicare Advantage member would benefit from this program, please have the member contact AccordantCare via phone or fax at **1-866-247-1150**.

Provider requirements and Medicare notices

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

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

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

For more information about compliance with the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Federal Clinical Compliance Department -- phone: 1-317-287-0196, fax: 1- 877-261-2134, email: carol.bossingham@anthem.com.

Check [Important Medicare Advantage Updates](#) at www.anthem.com/ca/medicareprovider for additional information.

SNFs Home Health and LTC: Please Contact OrthoNet for outpatient OT and PT precertifications

Anthem Blue Cross (Anthem) is collaborating with OrthoNet, LLC to conduct medical necessity reviews for outpatient physical therapy and occupational therapy for our individual Medicare Advantage members.

Effective April 1, 2016, OrthoNet will accept precertification requests for outpatient and home-based Occupational Therapy and Physical Therapy from Skilled Nursing Facilities, home health providers and long-term care facilities. SNF and LTC providers please note: Inpatient PT/OT services rendered as part of a Skilled Nursing level of care are excluded from this authorization process.

Check [Important Medicare Advantage Updates](#) at www.anthem.com/ca/medicareprovider for additional information.

Help ensure Anthem Blue Cross members have accurate information about your practice

Please keep Anthem Blue Cross (Anthem) aware of any changes to street address, phone number, office hours or any other change that affects your availability to see existing Anthem Medicare Advantage members. In addition, Anthem also needs to know if you are accepting new patients or if you stop accepting new patients. This helps ensure that our Medicare Advantage members have accurate information about your practice.

Please review formulary changes to help members find best medication values

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes for 2016 include: tier changes, drug removals and new Prior Authorization and Quantity Limit requirements. Our members will need your help to ensure they get their medications at the most affordable cost.

Please, encourage your patients to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications that will meet their needs at a lower cost.

Current and previous year Medicare Advantage formularies for plans sold directly to individuals are published at www.anthem.com/ca/medicareprovider. An overview of plan changes for 2016, including notable formulary changes, can be found at www.anthem.com/ca/medicareprovider under [Important Medicare Advantage Updates](#). See [2016 Medicare Advantage Plan Changes](#) dated October 1, 2015.

Drug coverage provided to members of group-sponsored Medicare Advantage Plans and Part D Pharmacy Plans varies by employer or union. Patients who have group-sponsored Medicare Advantage or Part D Pharmacy coverage receive a new formulary booklet prior to the start of each calendar year that they can bring to their appointment with you.

Professional Network Update

Keep up with Medicare Advantage news

Please continue to check [Important Medicare Advantage Updates](#) at www.anthem.com/ca/medicareprovider for the latest Medicare Advantage information, including:

[Durable Medical Equipment amendment FAQs](#)

[Medicare Advantage reimbursement policies](#)

[Providers must enroll with Medicare to be able to prescribe Part D beginning June 1, 2016](#)

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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."

Website links for the Federal Employee Program formulary Basic and Standard Options are **Basic Option:**

https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and **Standard Option:**

https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated quarterly.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies.



Professional Network Update