Drug fee schedule update

CMS average sales price (ASP) third quarter fee schedule with an effective date of July 1, 2015 will go into effect with Anthem Blue Cross and Blue Shield (Anthem) on August 1, 2015. To view the ASP fee schedule, please visit the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

Diabetes Prevention Program expansion

Proactively prevent diabetes among your patients

Adults at high risk for developing type 2 diabetes can reduce their risk of developing the disease by as much as 58 percent by participating in a lifestyle intervention program that promotes reducing calories and increasing physical activity.¹

Anthem has contracted with Viridian Health Management to administer the Diabetes Prevention Program. Originally when we launched our program in April, it was specifically available for our CU Health Plan members. We are now expanding the program to include all of our Local Plan members and Health Insurance Marketplace/ACA members*. The Diabetes Prevention Program is offered as a covered preventive benefit at no additional charge for those members participating in Affordable Care Act (ACA) compliant plans. (Some members may still be on grand-fathered or grand-mothered plans; therefore, these members may have a preventive care cost share to participate in this program).

The Diabetes Prevention Program is an evidence-based lifestyle behavior change diabetes prevention program that has broad support from the Centers for Disease Control and Prevention (CDC) as well as the American Medical Association (AMA) as a strategy to reduce the incidence of diabetes and associated healthcare costs through sustainable lifestyle changes. http://www.ama-assn.org/sub/prevent-diabetes-stat. Viridian coordinates the delivery of the program through recommendations to a network of community-based DPP program providers recognized by the CDC (https://nccd.cdc.gov/DDT_DPRP/Registry.aspx).

Diabetes Risk Factors:

- Women who have given birth to a baby weighing more than 9 pounds
- African-Americans, Hispanics, American Indians, Asian-Americans and Pacific Islanders
- Overweight or obese: BMI 24 kg/m² (≥ 22 if Asian)
- Inactivity or sedentary lifestyle
- Age between 45 and 64 years of age and/or have a family history of type 2 diabetes
- 65 years of age or older
Criteria for Diabetes Prevention Program Participation:

- BMI $\geq 24$ (≥ 22, if Asian)
- 18 years of age or older
- Blood-based diagnostic test:
  - A1C: 5.7 - 6.4%
  - Fasting Plasma Glucose: 100 - 125 mg/dL
  - 2-hour (75 gm glucose load) Plasma Glucose: 140 - 199 mg/dL
- Clinically diagnosed / self-reported GDM in prior pregnancy
- OR
- CDC’s Self Pre-Diabetes Risk Assessment results indicating high risk

Diabetes Prevention Program Features:

- **Social support**
  - Members will learn the skills needed to lose weight, become more physically active, and manage stress with the help of a trained lifestyle coach and the support of fellow group members.

- **Lifestyle health coaching**
  - Programs are conducted by lifestyle coaches who are trained on the evidence-based, CDC-approved diabetes prevention curriculum.

- **Offered in convenient locations**
  - Onsite in-person classes will be held in a variety of convenient locations throughout Colorado by CDC recognized DPP providers.
  - Classes will be offered with program start dates, times and locations that are convenient for members, including both daytime and evening hours.
  - Participants can also select a virtual class guided by a trained lifestyle coach using a mobile app on their smartphone or tablet.

- **Weekly in-person classes**
  - Participants meet in groups with a trained lifestyle coach once a week for 16 weeks, and then once a month for 6 months to learn ways to incorporate healthier eating, moderate physical activity, and problem-solving and coping skills into their daily lives.

- **Fun, engaging content**
  - Adult learning based curriculum with interactive activities.

- **6 monthly maintenance classes**
  - Once participants have completed the 16 weeks of classes, they will also have monthly meetings for 6 months to ensure adherence into their daily lives.

What you can do to help your patients:

Patients look to their primary care providers more than any other source for information on promoting health and preventing diseases. Health care providers likely see patients every day who are living with prediabetes and are at high risk for developing type 2 diabetes; however, 9 out of 10 patients are unaware that they have prediabetes. As a health care provider, you play a vital role in helping to prevent or delay the onset of type 2 diabetes by assessing and discussing patients’ risk of type 2 diabetes, testing patients for prediabetes and recommending participation in a diabetes prevention program for those at risk.
Recommending and referring your patients with prediabetes or those at risk for type 2 diabetes to the Diabetes Prevention Program is simple.

**Diabetes Prevention Program dedicated webpage:**

We’ve created a Diabetes Prevention Program webpage that includes an easy to complete *Patient Recommendation Form*. To access our dedicated web page, go to our public website at www.anthem.com. Select the **Provider** link in top center of the page. Select **Colorado** from the drop down list and then **Enter**. From the **Provider Home page**, under the **Health & Wellness heading**, select the link titled **Diabetes Prevention Program**.

**Recommending a patient is as easy as 1-2-3:**

1. Simply fill out the short *Patient Recommendation Form* with the patient you’d like to recommend for this program
2. Fax the completed form to Viridian Health Management, fax number: 602-391-2667 (also included on form)
3. Viridian will contact your patient directly to provide options for participation in the program

**Communication with the member’s PCP:**

Viridian will provide individual patient reporting to physicians at the following intervals: completion of week 4, completion of week 9, completion of week 16, and monthly thereafter. Viridian will inform the Member’s PCP via e-fax by the Provider contact information included on the *Patient Recommendation Form*.

This program provides patients with numerous options for participation. Feel free to recommend patients participate in this and/or any diabetes prevention programs your practice may already have in place.

If you have any further questions about the Diabetes Prevention Program, please contact Viridian Health Management at 855-717-8813 or [www.viridianhealth.com](http://www.viridianhealth.com). For specific benefit questions, please contact the appropriate Provider Customer Service unit on the back of the members ID card.

* Please reference our Alpha Prefix Reference List to help identify Local Plan members and Health Insurance Marketplace/ACA members by their alpha prefix. Please note: National Account members are excluded at this time. Some National Account members may live in Colorado and utilize the same alpha prefixes as other Local Plan members. We encourage you to direct all of your patients to the program regardless and Viridian Health will determine if patient is eligible as part of their preventive care benefit coverage. If the member is participating in a National Account plan that is out of scope for the program, the member will always have option to participate in the program as a self-pay option.

**References:**


**Availity to launch new eligibility and benefits functionality**

The Availity Web Portal launched new eligibility and benefits (E&B) functionality and features on June 27, 2015. These changes will make finding eligibility and benefits easier and faster for you. Here’s a list of the new features:
<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Request page</td>
<td>A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.</td>
</tr>
<tr>
<td>Patient history list</td>
<td>The results list automatically summarizes user’s most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus, only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).</td>
</tr>
<tr>
<td>Menu by benefit type</td>
<td>Located under the ‘Coverage and Benefits’ tab, this interactive list displays all service types and benefits returned from the health plan.</td>
</tr>
<tr>
<td>Patient snapshot</td>
<td>The summary of patient information is easily found at the top of the page.</td>
</tr>
<tr>
<td>Clearer display of details</td>
<td>Users have a clearer and more complete view of specific benefit and financial information.</td>
</tr>
<tr>
<td>Advanced Printing</td>
<td>By selecting which sections to print, users save paper and can customize prints to target necessary information.</td>
</tr>
<tr>
<td>Real-Time feedback</td>
<td>Feedback buttons on every returned eligibility status allows users to provide instant feedback of missing or inaccurate information.</td>
</tr>
</tbody>
</table>

**Free Training Opportunities**

To learn more about these time-saving features:

- **Join Availity for a live webinar:**
  - Click the live webinar link above, or under Live Webinars locate New Eligibility and Benefits Inquiry Training and click Register Now, to register for a live training webinar.

- **View a recorded webinar:**
  - Click the recorded webinar link above, or under Recordings locate New Eligibility and Benefits Inquiry Training and click View Recording, to view a recording of the live webinar.

- **Take a quick tour:**
  - Click the quick tour link above, or locate New Eligibility and Benefits Inquiry - Quick Demo and click View Demo, to view a short demo.

**Spring 2015 Provider Webinars – recorded versions now available online**

Even if you missed one of our “in-person” meetings or one of our “webinars”, you still have the opportunity to listen to one of our recorded versions. The sessions included important updates and information to make it easier to do business with us. We split our seminar content into two portions; Part 1 (general content), and Part 2 (Provider Connectivity/Availity specific content). Decide which content portion most applies to you, and listen to Part 1, Part 2, or both! To access a recorded version, go to anthem.com and select the Provider link (top center of page). Next, select Colorado from the drop down list and enter. On the Provider Home page, select the Provider Seminars link under the Communications and Updates section. From the Provider Seminars landing page, select either the Part 1 or Part 2 recorded version: Spring 2015 Provider Webinar – Part 1 (General Content), recorded version or Spring 2015 Provider Webinar – Part 2 (Provider Connectivity/Availity content), recorded version.
Access online Remittance Advices in ProviderAccess, via the Availity Web Portal

Online remittance advices are available to providers on our secure provider portal, ProviderAccess, via the Availity Web Portal. Your organization’s Primary Access Administrator (PAA) is responsible for registering Users and granting access to functionalities in Availity.

Following are step-by-step instructions that are required to gain access to online remittance advices.

Adding a new User to ProviderAccess

The Account Administrator for ProviderAccess should follow the steps below to grant access to new Users:

1. Log in to ProviderAccess (or go directly to url: https://provider2.anthem.com/wps/portal/ebpmybcbsco)
2. Select the Account Admin tab
3. Select Create User and complete the required fields to obtain a new User ProviderAccess User ID (aka “Health Plan User ID”)

Anthem Services Registration – Linking the ProviderAccess User ID and the Availity User ID

Once a User is granted access to ProviderAccess, the PAA must register the ProviderAccess User ID (aka “Health Plan User ID”) by completing the following steps on Availity:

1. Log in to the Availity Web Portal at www.availity.com
2. Select My Account, from the left side navigation menu
3. Select Anthem Services Registration
4. Select Non Registered Users
5. Enter the ProviderAccess User ID into the Health Plan User ID field
6. Click Register

Please note, Users must log out of Availity and log back in for new functions to take effect.

Accessing Remittance Advices online

After a User is registered on Availity, the User can access online remittances by following the steps below:

1. Log in to the Availity Web Portal
2. Select My Payer Portals, from the left side navigation menu
3. Select Anthem Provider Portal
4. Click I agree on the redirection page to be routed to the secure home page of ProviderAccess
5. Once routed to ProviderAccess, select the Claims tab
6. Then select Remittance Advice Inquiry. You may select one of the following search criteria options:
   - Date range (Date Range must be no more than 7 days)
   - Check Number/EFT#
   - Paid Amount

Remittance Advice Inquiries are available for the following member types

- Local Plan members (including Health Insurance Marketplace/Affordable Care Act members)
- BlueCard/Out-of-area members
Federal Employee Program® (FEP®) members – Now available!
CalPers – Now available to search by Check Number and Paid Amount!

Note: Remittance Advices are available for up to 18 months after the issue date

Update to Claims Processing Edits and Professional Reimbursement Policies

We have updated ProviderAccess, with the following revisions to our professional reimbursement policies:

Frequency Editing

Effective January 1, 2015, Current Procedural Terminology (CPT®) published new codes for Definitive Drug Testing. Beginning with claims processed on or after May 18, 2015, Anthem updated the Frequency Editing policy to implement a frequency limit of one per date of service for the following definitive drug test codes: 80321 – 80322, 80324 – 80337, 80344, 80346 – 80347, 80350 – 80352, 80361 – 80364, 80369 – 80370, and 80375 – 80377. This limit is supported by CPT nomenclatures that these codes are multiple unit codes therefore they should only be reported once per date of service.

In addition, for claims processed on or after May 18, 2015, based on manufacturer’s guidelines, we have implemented frequency limits on the following prescription drugs:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency Limit</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>J2800</td>
<td>Injection, methocarbamol, up to 10 ml (Robaxin)</td>
<td>3 units per date of service</td>
<td>Based on manufacturer’s guidelines</td>
</tr>
<tr>
<td>J0696</td>
<td>Injection, ceftriaxone sodium, per 250 mg (Rocephin)</td>
<td>16 units per date of service</td>
<td>Based on manufacturer’s guidelines</td>
</tr>
</tbody>
</table>

Modifier Rules

The Modifier Rules policy has been updated to revise the language for modifiers RA and RB.

Coding Reminder

Drugs should be coded based on the Health Care Common Procedure Coding System (HCPCS Level II) drug code description.

Examples:

- J2800 Injection, methocarbamol, up to 10 ml (Robaxin);
  - 30 ml (10ml x 3 units) per day is coded as 3 units, not 30 units.
- J0696 Injection, ceftriaxone sodium, per 250 mg (Rocephin);
  - 4000 mg (260 mg x 16 units) per day is coded as 16 not 4000.

Reimbursement Policies and Clear Claim Connection are available on our secure provider portal, ProviderAccess

Please review the full policy for any changes referenced above for further information. All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com, and select the Provider link in the top center of the page. Select Colorado from the drop down list, and enter. From the Provider Home page, go to the ProviderAccess Login tout (blue box on the left side of the page), and select Medical from the drop down list and click on the login button.
Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Professional Reimb & Admin Policies”. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select Continue. Select link titled “Anthem’s Professional Reimbursement & Administrative Policies – By Type”, then select the Reimbursement link, and next the Policy you would like to view.

Clear Claim ConnectionTM is our web-based editing tool from McKesson and includes an interface that will allow you to view the clinical rationale for ClaimsXten edits when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Follow the directions listed above to log into ProviderAccess. Once logged in, from the Claims tab, select the Clear Claim Connection link.

**Fraud, Waste and Abuse Detection**

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 review. Through a variety of means, certain Providers of health care or certain claims submitted by Providers may come to Anthem’s attention for some reason or behavior that might be identified as unusual, or which indicates the Provider is an outlier with respect to his/her/its peers. One such method is through computer algorithms that are designed to identify a Provider whose billing practices or other factors indicate conduct that is unusual or outside the norm of his/her/its peers.

Once such an unusual claim is identified or a Provider is identified as an outlier, further investigation is conducted by SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual claim. 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, we continue to believe the Provider’s actions involve fraud, waste or abuse or some other inappropriate activity, the Provider is notified he/she/it is being placed on pre-payment review. This means that the Provider will be required to provide medical records with each claim submitted so that we will be able to review them compared to the services being billed. Failure to submit medical records to Anthem in accordance with this provision may result in a denial of a claim under review. The Provider will be given the opportunity to request a discussion of his/her/its pre-payment review status. Under this program, we may review coding and other billing issues. In addition, we may use one or more 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 Plan’s members.

The Provider will remain subject to the pre-payment review process until we are 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 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 procedures.
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 anthem.com. Select the "Provider" link in the top center of the page. Select Colorado from the drop down list, and enter. Select the Health & Wellness tab, then the link title "Practice Guidelines". You can then choose from Clinical Practice Guidelines, Preventive Health Guidelines, or Behavioral Health Clinical Practice Guidelines.

Pharmacy information available on anthem.com

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

To locate the “Marketplace Select Formulary” and pharmacy information for Health Plans offered on the Exchange Marketplace, go to www.anthem.com, select Customer Support, select Colorado, Download Forms, Anthem Blue Cross and Blue Shield Drug Lists, and then choose Colorado Select Drug List.

Case Management Program

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

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

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

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone 888-613-1130</td>
<td><a href="mailto:Case.management@anthem.com">Case.management@anthem.com</a></td>
<td>Monday–Thursday, 8:00am to 9:00pm</td>
</tr>
<tr>
<td>Fax 800-947-4074</td>
<td></td>
<td>Friday, 8:00am to 8:00pm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saturday, 8:00am to 4:30pm</td>
</tr>
</tbody>
</table>
Important information about Utilization Management

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

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on Anthem’s Web site at anthem.com. Select Provider link (top center of page), then Colorado (from the drop down list), and enter. On the Provider Home page, from the Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements tout (2nd blue box on the left side of page), select enter. Click on the link titled “Medical Policies and Clinical UM Guidelines (for Local Plan Members)”. For Clinical UM Guidelines for Local Plan members: Follow the information for Medical Policies listed above. From the Medical Policies and Clinical UM Guidelines page for Local Plan members, at the bottom of the page, before the “continue” button, is a link titled “Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Colorado”. Please note all of our Clinical UM Guidelines for our entire organization are displayed by clicking the “continue” button, but not all of them apply to Colorado. Please reference the Colorado specific link to determine which Clinical UM Guidelines have been adopted by Colorado.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below.

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

- Call us toll free from 8 a.m. – 5 p.m. ET, Monday through Friday (except on holidays).
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

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

<table>
<thead>
<tr>
<th>To discuss UM Process and Authorizations</th>
<th>To Discuss Peer-to-Peer UM Denials w/Physicians</th>
<th>To Request UM Criteria</th>
<th>TTY/TDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-832-7850</td>
<td>Local: 1-303-764-7227</td>
<td>1-800-797-7758</td>
<td>711 or</td>
</tr>
<tr>
<td></td>
<td>Toll-free: 1-866-287-1654</td>
<td></td>
<td>800-659-2656(T) / 800-659-3656(V)</td>
</tr>
</tbody>
</table>

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

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

Members’ Rights and Responsibilities

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

It can be found on our Web site. Go to anthem.com, and select Provider link in upper right corner. Select Colorado from drop down list and enter. From Health & Wellness tab, select the link titled “Quality Improvements and Standards”, and then the link titled “Member Rights and Responsibilities”.

Medicare Advantage Updates

Osteoporosis Screening, medication encouraged for women

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

Anthem asks that providers encourage women 67-85 who have had a fracture or may be at risk for a fracture to have a Bone Mineral Density screening or be placed on osteoporosis medication if appropriate.

Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the Journal of Rheumatology.

DMARDs help prevent long-term disability

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

Encourage Medicare Advantage members to control high blood pressure

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

ICD-10-CM: Human Immunodeficiency Virus (HIV) status

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015. The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient’s Human Immunodeficiency Virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider’s diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.
The table below reflects the crosswalk from ICD-9 to ICD-10.

<table>
<thead>
<tr>
<th>ICD-9 Code(s)</th>
<th>ICD-10 Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V08 – Asymptomatic human immunodeficiency virus (HIV) infection status</td>
<td>Z21 – Asymptomatic human immunodeficiency virus (HIV) infection status</td>
</tr>
<tr>
<td>042 – Human immunodeficiency virus (HIV)</td>
<td>B20 – Human immunodeficiency virus (HIV) disease</td>
</tr>
<tr>
<td>079.53 – Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site</td>
<td>B97.35 – Human immunodeficiency virus, type 2 (HIV 2) as the cause of diseases classified elsewhere</td>
</tr>
</tbody>
</table>

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

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

52734WPPENMUB 03/27/2015

**Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)**

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance marketplace / affordable care act information may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance marketplace / affordable care act, and all achieved articles, go to anthem.com; select the Provider link in the top center of the page. Select Colorado from the drop down list, and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Marketplace / Affordable Care Act information.