ICD-10 Updates: No Delay Yet? Then This Might REALLY Happen!

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

Are you ready?

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

Here are some suggestions:

**Need a plan to get started?** CMS’s *Road to 10* provides a complete roadmap for small and medium practices to follow to get you to your ICD-10 destination by October 1, 2015.

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

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

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

**Access Anthem’s ICD-10 webpage**

Go to [anthem.com](http://anthem.com). Select the **Provider** link (top center of the page), then select **Colorado** from the drop down list, and click **Enter**. From the **Provider Home page**, look for the link titled **ICD-10 Updates**.

**National Uniform Billing Committee (NUBC) UB-04 Code Change**

The National Uniform Billing Committee (NUBC) previously implemented a change to require an Admission Date be submitted on specific Outpatient Institutional Claim Type of Bills. Anthem will continue to require the submission of an Admission Date on all Inpatient...
Institutional Claim Type of Bills. Anthem will enforce this ruling to include the defined Outpatient Institutional Claim Type of Bills starting on October 1, 2015.

- Admission Date Required – Type of Bills (TOB): 12X, 22X, 32X, 34X, 81X and 82X

**Type of Bill Descriptions:**

<table>
<thead>
<tr>
<th>Type of Bill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12x</td>
<td>Hospital Inpatient Part B</td>
</tr>
<tr>
<td>22x</td>
<td>SNF Inpatient Part B</td>
</tr>
<tr>
<td>32x</td>
<td>Home Health</td>
</tr>
<tr>
<td>34x</td>
<td>Home Health (Part B Only)</td>
</tr>
<tr>
<td>81x</td>
<td>Nonhospital based hospice</td>
</tr>
<tr>
<td>82x</td>
<td>Hospital based hospice</td>
</tr>
</tbody>
</table>

Please make sure everyone on your billing staff is aware of this change. Changes affect Commercial, Federal Employee Program® (FEP®) and Medicare Advantage products.

**Updated Escalation Contact List**

We have updated our Escalation Contact List with changes to our Provider Relations Representatives and Contract Managers. This list will help outline the appropriate process for escalating an issue, if needed, to ensure you have the best provider experience possible and the quickest resolution to your issue. The updated Escalation Contact List is located online. Go to anthem.com, and select Provider link in the top center of page. Select Colorado from drop down list and enter. From Provider Home tab, select the link titled “Contact Us (Escalation Contact List & Alpha Prefix List)”, and then the link titled “Escalation Contact List”.

**Reminder: Pre-service clinical review of specialty pharmacy claims transitioned to AIM**

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

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

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

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

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

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

For more information on how to access online authorizations via Availity, reference our AIM Specialty Health Quick Reference Guide. Go to anthem.com │ Provider │ Colorado │ Provider Home │ AIM Specialty Health Quick Reference Guide.

- **Phone Requests** – Requests for pre-service clinical review can also be submitted to AIM via phone. Providers can call AIM toll-free at 877-291-0366, Monday through Friday 8:00 a.m. – 8:00 p.m. (EST) to request pre-service review. Once the transition occurs, Anthem’s phone prompts will be changed to include a Specialty Pharmacy prompt that will automatically route the caller to AIM for pre-service clinical reviews.

**Have a question about a claim? Check out the recent Secure Messaging enhancements via the Availity Web Portal**

Secure Messaging is a feature available from the Claim Status Detail page on the Availity Web Portal that allows you to ask a question about a claim. This can be used for Local Plan, BlueCard and Federal Employee Plan® (FEP®) claim questions.

If you are a current user of secure messaging, please take note of recent upgrades.

Anthem can now send you follow-up messages on your claim inquiry. These may share pertinent detail or request additional specific information. You will know if Anthem has sent you a new message because a new column, titled Messages Needing Attention, has been added to your inbox. In this column, if you have a new message, you will see “Attention Needed”. If you use Secure Messaging, check your inbox periodically for this indicator. It will look like this:
Also, when you view your message, look for a new option, Download Secure Message, which is located to the right of the message. Use Download Secure Message to save or print the content of the entire message. This eliminates the need for multiple print screens in order to capture the message detail.

Don't have access to Secure Messaging yet?

The Anthem Services Registration process needs to be completed by your Availity Primary Access Administrator (PAA) in order to use the Secure Messaging tool. Users need to be registered on ProviderAccess, in addition to Availity. When the PAA performs the Anthem Services Registration process on Availity, they will be asked to enter the Users “Health Plan User ID”; this is the same as the ProviderAccess User ID. Once the Anthem Services Registration process is completed; when a User conducts a Claims Inquiry transaction, the User will then be able to choose the Secure Provider Messaging link by at the bottom of the Claims Detail page.

For more details on completing the Anthem Services Registration process:

Go to anthem.com. Select the Provider link (top center of the page), then select Colorado from the drop down list, and click Enter. From the Provider Home page, look for the link titled ProviderAccess Migration to the Availity Web Portal, then select the link titled Anthem Services Registration Instructions.

Now is the time to make the move to the Availity Web Portal's new eligibility and benefits

Existing Eligibility and Benefits tool to be retired August 15, 2015

The older version of the eligibility and benefits tool on the Availity Web Portal will be retiring August 15, 2015, so start using the new version today.

Enhanced features on the new eligibility and benefits redesigned experience include:

- A request page that lets you submit multiple patient inquiries without having to wait for results from each search.
- A workflow-friendly results list that shows your most recent results – for up to 24 hours. Review your results without having to run a new inquiry.
- A results page that shows only information that’s relevant to the patient’s plan. Details are always available through an interactive list of key coverage elements.

If you haven’t made the switch to the new eligibility and benefits tool already, do it today! It’s easy to get started. We think that you’ll be pleased at the new experience waiting for you!

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.

BRCA testing alternatives

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

* Some Plans may restrict BRCA testing to specific labs in network. Please refer to online directory for more details by Plan. Check benefit plan information for coverage terms and conditions.

For a complete listing of Providers and Facilities, please check our online directory. Go to anthem.com, select the Provider link in top center of the page. Select Colorado from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Find a Doctor”.

Note: When searching for laboratory, pathology, or radiology services, under the field “I am looking for a:” select Lab/Pathology/Radiology; and then under the field “Who specializes in:” select Laboratories, Pathology, or Radiology.

HEDIS® 2015: Provider Incentive Winners Announced!

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

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

Fax/Mail Drawing
- Castle Rock Family Physicians
- Centennial Family Health Center - Ordway
- John D McLaughlin II MD PC - Aurora
- Bariatric & Lifestyle Medicine of Fort Collins
- Colorado Springs Internal Medicine

Above and Beyond
- Mary Hendrix RN - Lakewood
- Arkansas Valley Regional Medical Center – La Junta

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

We look forward to working with you next HEDIS season!

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Anthem will discontinue mailing paper remittances to all ERA registered providers beginning October 1, 2015

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

Providers can continue to conveniently access copies of their “paper” remittances online via ProviderAccess® or the Availity Web Portal. If you are an ERA registered provider, please ensure you have completed the steps to access copies of your paper remittances online immediately. Read instructions to access copies of your paper remittances online via ProviderAccess® or the Availity Web Portal. 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, under the Self-Service and Support section, select the link titled “Remittance Advices – Access Online in ProviderAccess, via the Availity Web Portal”.

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

Update to Claims Processing Edits and Professional Reimbursement Policies

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

(3D) Three-Dimensional Radiology

For dates of service on or after August 17, 2015, codes for digital breast tomosynthesis (DBT) will be removed from our bundled services edit. Therefore, Current Procedural Terminology (CPT®) codes 77061, 77062, and 77063, and Healthcare Common Procedure Coding System (HCPCS Level II) code G0279 are being removed from the (3D) Three-Dimensional Radiology reimbursement policy.

Bundled Services and Supplies

HCPCS code Q9977 (compounded drugs, not otherwise classified) is a new code effective July 1, 2015 that Anthem considers to be an always bundled service. Therefore, claims processed on or after August 17, 2015 with dates of service on and after July 1, 2015, Q9977 will not be eligible for reimbursement. This information will be added to Section 1 of the Bundled Services and Supplies reimbursement policy.

Beginning with dates of service on or after April 1, 2015, ClaimsXten removed their incidental edit for CPT code 43235 (esophagogastroduodenoscopy (EGD), flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)) when reported with CPT codes 43770 – 43775 (laparoscopy, surgical, gastric restrictive procedures). However, when an EGD is done pre- or post-gastric restrictive procedures, Anthem considers the EGD to be an integral part of the primary procedure and not eligible for separate reimbursement.

Therefore, beginning with claims processed on or after August 17, 2015, Anthem will again apply the bundled services incidental edit for CPT code 43235 (EGD) when reported with CPT codes 43770 – 43775 (gastric restrictive procedures). This information will be documented in Section 2 of the Bundled Services and Supplies reimbursement policy.
For claims processed on or after August 17, 2015, HCPCS code S8262 (mandibular orthopedic repositioning device, each) will be added to the always bundled service edit and will not be eligible for reimbursement. This edit is based on correct coding and will be documented in Section 1 of the Bundled Services and Supplies reimbursement policy.

Bundled Services and Supplies and Modifiers 59 and XE, XP, XS, & XU

For claims processed on or after August 17, 2015, CPT code 36000 (introduction of needle or intracatheter, vein) will not be eligible for separate reimbursement when reported with CPT codes 96360, 96365, 96374-96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450 or 96542 (injection and infusion services). Per CPT, the IV start is not reported separately from the IV therapy service. Modifiers will not override this edit; therefore, this information is included in the Modifiers 59 and XE, XP, XS, & XU reimbursement policy.

For dates of service on or after August 17, 2015, codes for digital breast tomosynthesis (DBT) will be removed from the bundled services edit. Therefore, CPT codes 77061, 77062, and 77063, and HCPCS code G0279 in Section 1, and code pair information associated with DBT in Section 2, are being removed from the Bundled Services and Supplies reimbursement policy. DBT information will also be removed from the Modifiers 59 and XE, XP, XS, & XU reimbursement policy.

Frequency Editing

For claims processed on or after August 17, 2015, Anthem is implementing a frequency limit of 1 per date of service for the following Definitive Drug Testing CPT codes: 80320, 80323, 80338, 80345, 80348, 80349, 80353 – 80360, 80365 – 80368, 80371 – 80374, and 83992. 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.

Based on prescribing information, effective for claims processed on or after August 17, 2015, Anthem is adding a frequency limit for the following prescription drug:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Frequency Limit</th>
<th>Rationale</th>
<th>Effective for claims processed on or after:</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7307</td>
<td>Etonogestrel (contraceptive) implant system (Nexplanon or Implanon)</td>
<td>1 unit per date of service</td>
<td>Based on prescribing information</td>
<td>August 17, 2015</td>
</tr>
</tbody>
</table>

The Frequency Editing reimbursement policy will be updated to reflect this change.

Global Surgery

As documented in the Global Surgery reimbursement policy, Anthem considers local infiltration, anesthetic blocks, or topical anesthesia to be part of the global surgical package; therefore, for claims processed on or after August 17, 2015 HCPCS codes J2001 (injection, lidocaine HC1 for intravenous infusion, 10 mg) will not be eligible for separate reimbursement when reported with a surgical procedure.

Laboratory and Venipuncture Services

The Laboratory and Venipuncture Services reimbursement policy will be updated to document the following information regarding current editing.

- HCPCS code G0471 (collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency), is eligible for separate reimbursement when reported on the same date of service as a laboratory service.
o CPT code 80076 (hepatic function panel) is being added to the list of laboratory panels identified in the “Description” section of the policy.

o When two providers submit the same lab test code, only the first claim processed and approved will be eligible for reimbursement. Subsequent claims processed will be denied, even when one provider reports a global procedure code and a different provider reports the same procedure code with a professional component (26) or a technical component (TC) modifier appended to the code.

o Other minor wording changes with no change to the policy criteria were also added.

Modifiers 59 and XE, XP, XS, & XU

Per CPT introductory guidelines for definitive drug testing, “Drug classes may contain one or more codes based on the number of analytes. For example, an analysis in which five or more amphetamines and/or amphetamine metabolites would be reported with CPT code 80326. The CPT code is based on the number of reported analytes and not the capacity of the analysis.” Based on these guidelines, definitive drug testing CPT codes within the same drug classes, reported more than once per date of service, are considered mutually exclusive and not eligible for separate reimbursement; therefore, beginning with claims processed on or after August 17, 2015, modifiers will not override the mutually exclusive edits. Please refer to the Modifiers 59 and XE, XP, XS, & XU reimbursement policy for CPT code information.

Prolonged Services

Beginning with claims processed on or after August 17, 2015, Anthem is adding the diagnosis of post-traumatic stress disorder, ICD-9 (309.81) and ICD-10 (F43.10-F43.12, effective for dates of service on or after October 1, 2015) to the list of diagnoses that will allow separate reimbursement for prolonged services CPT codes 99354 and 99355.

Coding Tip for Modifiers 25 and 57

According to Coding with Modifiers, Grider, Deborah, 4th edition ©2011, “Modifier 57 should not be used with E/M services during the global period for minor procedures (0-10 global days) unless the purpose of the visit was a decision for major surgery”. Therefore, Anthem requires modifier 57 only be reported when the evaluation and management service is for the initial decision for surgery made on the day before or the same day as a major surgical procedure with a 90-day global period.

Coding with Modifiers also states: “For most payers, modifier 25 is to be used when the decision is made on the same day to perform a minor surgical procedure with a global period of 0 to 10 days”. Therefore, modifier 25 should be reported when the E/M service is for a separately identifiable E/M by the same provider on the same day as a minor procedure with 0 or 10 global days. Please see the Evaluation and Management Services and Related Modifiers -25 & -57 reimbursement policy for further information.

Coding Tip for Site Specific Modifiers

When procedures allow for an anatomical site specific modifier including, but not limited to, LT, RT, E1-4, FA and F1-F9, TA and T1-T9; the anatomical site specific modifier should be reported (when appropriate), on ALL associated procedure codes submitted for the same date of service.

Currently, Anthem’s claim editing system assumes different anatomical sites when only one procedure code on the claim has a site specific modifier. Effective with claims processed on or after August 17, 2015, Anthem will assume the same anatomical site when an edit exists between two codes, and only one code has a site specific modifier. This change may result in denied services based on the same anatomical site assumption.
Examples:

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Claim Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>20600</td>
<td>(no modifier)</td>
<td>assume same site</td>
</tr>
<tr>
<td>20604</td>
<td>(no modifier)</td>
<td>assume same site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incidental NCCI denial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allows</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Claim Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>20600</td>
<td>F1</td>
<td>Allows at 50% per multiple surgery reduction (MSR) guidelines</td>
</tr>
<tr>
<td>20604</td>
<td>(no modifier)</td>
<td>assume different site</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allows at 100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier</th>
<th>Claim Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>20600</td>
<td>F1</td>
<td>Incidental NCCI denial</td>
</tr>
<tr>
<td>20604</td>
<td>(no modifier)</td>
<td>(Same site (F1) assumed)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allows</td>
</tr>
</tbody>
</table>

Coding Tip for reporting Imaging Guidance with Intensity Modulated Radiation Treatment (IMRT)

Effective January 1, 2015, the American Medical Association (AMA) with input from the American Society for Therapeutic Radiology and Oncology (ASTRO) released the following new CPT codes for Intensity Modulated Radiation Treatment delivery (IMRT) services.

- 77385 – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
- 77387 – Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

With the release of the new CPT codes, ASTRO also released the following coding guidance:

The nomenclature for the new IMRT delivery CPT codes (77385 and 77386) includes the following language: “includes guidance and tracking, when performed”.

The technical component of the image guidance and tracking (IGRT) part of the procedure is now packaged into the IMRT delivery CPT codes 77385 and 77386, and is not reported or allowed separately. Consequently, the total component for CPT code 77387 is not separately reimbursed with CPT codes 77385 and/or 77386.

When guidance and tracking (IGRT) are performed, the professional component of the guidance and tracking CPT code 77387 is allowed and reported by appending modifier -26 to the CPT code (77387-26-59).
Because the professional services modifier -26 is not an “override” modifier, the separately identifiable service “override” modifier -59 is also required by Anthem’s editing system to override the edit that bundles the global and technical components of CPT code 77387 into CPT codes 77385 and 77386.

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 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 Connection™ 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.

Updates to Anthem’s Find a Doctor tool

The Find a Doctor tool at anthem.com is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans.

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

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

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

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

Attention Oncologists, Hematologists and Urologists

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

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

New Cancer Treatment Pathways added to the Program include:

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

Cancer Treatment Pathways removed* from the Program include:

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

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

The following regimens continue as a Cancer Treatment Pathway, but the following changes apply:

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

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

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

Redesigned explanation of benefits (EOB) easier to read

Starting later this fall, Anthem members living in Colorado who purchased through the Exchange will begin receiving a new explanation of benefits (EOB) that is easier to read and understand. Members will be able to compare the information included in the EOB with the information in providers’ bills, to make sure that Anthem paid the right amount for the right service. It also shows members what they owe the provider.

The new EOB gives members a complete picture of the services rendered, how they were paid for and how those payments work with their...
health plan, what was covered, what was paid and what’s owed.

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

**Non-participating lab referrals**

This is a reminder to ensure that you are referring Anthem members exclusively to participating labs. Not only does your Anthem agreement obligate you to refer to participating labs where available, but members will only receive their full benefits from participating providers. As a result, referring your patient and our member to a non-participating lab may expose them to a greater financial responsibility.

Unfortunately, there are certain non-participating labs that are offering to waive or cap co-payments, coinsurance or deductibles to our members in order to increase their overall revenue. These practices undermine member benefits and may encourage over-utilization of services.

These billing practices are also questionable in their legality. Such a practice may present violations under state or federal anti-kickback laws, and may constitute the abuse of health insurance under the Colorado criminal code.

For a listing of Anthem participating laboratories, please check our online directory. Go to anthem.com, select the Provider link in top center of the page. Select Colorado from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Find a Doctor”.

Note: When searching for laboratory, pathology, or radiology services, under the field “I am looking for a:” select Lab/Pathology/Radiology; and then under the field “Who specializes in:” select Laboratories, Pathology, or Radiology.

**LabCorp is our exclusive lab provider and offers a Single Source Solution to your testing needs:**

LabCorp is capable of providing services that range from routine testing, such as basic blood counts and cholesterol tests, to highly complex diagnosing of genetic conditions, cancers, and other rare diseases. LabCorp has specialized laboratories which cover the following areas of testing:

- Allergy Program
- Cancer Testing
- Cardiovascular Disease
- Companion Diagnostics
- Dermatology
- Diabetes
- DNA Testing
- Endocrine Disorders
- Esoteric Coagulation
- Gastroenterology
- Genetic Testing
- Genetic Counseling
- Genomics
- HLA Lab for National Marrow Donor Program
- Hematopathology
- Infectious Disease
- Immunology
- Liver Disease
- Kidney Disease
- Medical Drug Monitoring
- Molecular Diagnostics
- Newborn Screening
- Pain Management
- Pathology Expertise w/range of Subspecialties
- Pharmacogenomics
- Preimplantation Genetic Diagnosis
- Reproductive Health
- Obstetrics/Gynecology
- Oncology
- Toxicology
- Whole Exome Sequencing
- Virology
- Women’s Health
- Urology

Note: This relationship with LabCorp does not affect network hospital-based lab service providers, contracted pathologists, or contracted independent laboratories.
Medicare Advantage Updates

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

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

HIPPS codes required for all Skilled Nursing and Home Health Providers

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

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

Appeals information for participating Medicare Advantage providers

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

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

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

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

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

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

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

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

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

When the tetanus vaccine is given for treatment of an illness or injury, the provider must bill CPT code 90703 with the diagnosis range 800.00 to 897.99 for payment under the member’s Part B medical benefits.

For more information on where a provider can submit bills for the shingles or tetanus vaccine, go to: http://www.anthem.com/shared/noapplication/f2/s2/t1/pw_e229050.pdf?refer=ahpmedprovider.

Labs: Anthem Medicare Advantage plans accept G Codes for definitive drug testing

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

Medicare Supplement Plan N ID cards have a new look

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

The identification card previously indicated “Office Visit $20 copay” or “Office Visit $20.”

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

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Facilities: failure to pre-certify an admission or provide notice of emergent inpatient admission, results in administrative denial

Facilities and network physicians are required to obtain pre-certification for specified services for individual and group-sponsored Medicare Advantage members, including an admission to any inpatient facility. For the member to receive maximum benefits, the health plan must
authorize or pre-certify the covered services prior to being rendered. As previously communicated, please notify Anthem as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

Effective May 1, 2015, if a facility does not obtain the required pre-certification within the specified timeframe, the claim will be administratively denied due to failure to notify Anthem of the admission. The facility will not receive payment for the service. Facilities cannot bill the member for these denied admissions.

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

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook, and the Medicare Advantage Precertification Guidelines (which can be found online), for further information on existing pre-certification requirements. 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 Medical Policy, UM Guidelines and Precertification Requirements tool (blue box on the left side of the page), and select enter, and then click Pre-Certification / Pre-Authorization Requirements (Medicare Advantage).

To obtain pre-certification or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card. Pre-certifications for Anthem individual Medicare Advantage members can also be initiated via the Availity web portal at www.Availity.com. To access this new functionality, go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Pre-certification site which includes the pre-certification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find pre-certification requirements there as well via the Pre-certification look-up tool.

Please visit www.anthem.com/medicareprovider to learn more about this online provider self-service tool.

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

Colonoscopy Billing Reminder: Preventive vs. Diagnostic

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

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

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

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

- In the instance that an individual presents for treatment due to signs or symptoms to rule out or confirm a suspected diagnosis, such an encounter should be considered a diagnostic exam, not a screening exam. In such a situation, the modifier PT should not be used and the sign or symptom should be used to explain the reason for the test.

**New Health Care Reform article available online:** [Anthem will discontinue mailing paper remittances to all ERA registered providers beginning October 1, 2015 – July 2015](#)

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](#).