Intranasal flu vaccine will not be covered for upcoming flu season

To help to ensure that members receive access to effective flu vaccines, Anthem will not be covering intranasal influenza vaccination in the upcoming 2016-2017 flu season (pending finalization of the ACIP recommendation). Anthem will continue to support reimbursement for all other influenza immunizations recommended by ACIP.

Updated Escalation Contact List

The Escalation Contact List has been updated. Access the updated list online by going 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”.

Updated Alpha Prefix Reference List

The Alpha Prefix Reference List has been updated. Access the updated list online by going 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 “Alpha Prefix Reference List”.

Is your Availity Web Portal access up to date?

Anthem Blue Cross and Blue Shield (Anthem) continues to transition tools to the Availity Web Portal offering ease of use, broad functionality and breadth of services. So make sure that your access is up to date so you can get the information you need.

Here are some highlights of what is available now:

- Eligibility
- Claims Inquiry
- Claims Submission
- Secure Messaging
- Remittance Inquiry – coming soon
- Research Procedure Code Edits
- Online Provider Maintenance Form (Access only available to Administrators)
- Fee Schedule (Professional)
Find Remittances (when available), Research Procedure Code Edits (Clear Claim Connection) and the Fee Schedule under the new Payer Spaces link. Fee Schedule tool is found under the Applications tab, and the Research Procedure Code Edits (Clear Claim Connection) tool is found under the Resources tab.

See something you can’t access, but you need it?

Contact your organization’s administrator to request the role you need. To determine who your organization’s administrator is, select “Who controls my access” from your account drop down box located in the upper right corner of the Availity Web Portal’s top menu bar.

Do you have all of your tax IDs registered on the Availity Web Portal?

If not, now is the time to register. Your organization’s administrator can add additional tax ids by selecting Maintain Organization from the Admin Dashboard.

Use the Interactive Care Reviewer (ICR) to submit and check the precertification status for many of your Anthem patients today!

When you use ICR to initiate a request for precertification of some inpatient and outpatient procedures,* you may receive an immediate authorization decision. More information about this exciting feature is available 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 Interactive Care Reviewer (Submit inpatient and outpatient precertification requests online). Finally, click on the Provider Information link.

Need to check the status of an authorization? No need to call or fax!

Also use ICR to inquire on a previously submitted case and find out right away what is the status of the precertification request. Ordering and servicing physicians, and facilities can inquire to find information on a precertification previously submitted via phone, fax, ICR or other online tool.

Plus, check out one of ICRs newer features: You can find decision letters associated with your precertification requests. The letters are viewable and printable.

Attend one of our upcoming webinars and learn about the features that will help you to optimize your ICR experience! Register now – Follow the navigation instructions listed above to our Interactive Care Reviewer webpage, and go to the link which states “To learn more about ICR, register for a FREE webinar here.”

*Excludes: Medicare Advantage, Medicaid, Federal Employee Program® (FEP), BlueCard® and some National Account members
Requests involving transplant services
Services administered by AIM Specialty Health
Services administered by OrthoNet LLC (Indiana, Kentucky, Missouri, Ohio, Wisconsin, California, Colorado and Nevada)

For the above requests, follow the same precertification process that you use today.

Anthem implements Pharmacy Home program

In April, 2016, Anthem implemented the Pharmacy Home program to help improve patient safety through enhanced coordination and to reduce the misuse and abuse of prescription drugs, as set forth in the Certificate of Coverage. The Pharmacy Home program applies to all Anthem health plans.
Members with an increased safety risk are identified for the Pharmacy Home program when a retrospective drug utilization review (DUR) indicates a member has one of the following claim scenarios within a 90 day period:

- Filled five or more controlled-substance prescriptions, or 20 or more prescriptions not limited to controlled substances
- Visited three or more health care providers for controlled substance prescriptions, or 10 or more providers not limited to controlled substances
- Filled controlled substances at three or more pharmacies, or 10 or more pharmacies not limited to controlled substances

Members will be mailed a letter advising them that they meet one of the above criteria. If the member’s claim activity does not change over the following 60 days, the member will be mailed an enrollment letter requesting them to select a single pharmacy location to fill all of their medications for a period of one year. The use of a single pharmacy will help improve the member’s coordination of care and reduce the potential risk for prescription abuse or misuse.

If one of your patients is identified for the Pharmacy Home program, you will receive a letter. This notification can help you assist with medication reconciliation. Medication reconciliation includes reviewing the medications your patient is taking to look for possible duplication of therapy to help ensure they are not at risk for negative drug interactions or possible prescription abuse or misuse.

If you have additional questions regarding the Pharmacy Home program, please feel free to contact us at rxhomeprogram@anthem.com, or fax: (855) 212-1249.

**Behavioral Health Appointment Access**

Your contract with Anthem requires that your practice provide timely access to care for our members. We will conduct daytime telephonic access studies to assess how well practices are meeting this provision, and your practice may receive a call from North American Testing Organization, a vendor in California working on Anthem’s behalf. To be compliant, please verify that your staff is familiar with Anthem’s timelines as outlined below.

Anthem performs the annual assessment of Behavioral Health (BH) prescribers and non-prescribers.

Note that Anthem may use prescribing nurse practitioners for availability, if they are in the scope of credentialing, as licensed independent practitioners. These same professionals will be included in the access assessment.

<table>
<thead>
<tr>
<th>BH Appointment Type</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td>24/7 access</td>
</tr>
<tr>
<td></td>
<td>Immediate access at a facility, ER, 911 or Crisis Center, as appropriate.</td>
</tr>
<tr>
<td>Non-life threatening Emergent appointment</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Members under acute distress, whose ability to conduct themselves for their own safety, or the safety of others, may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Situation has the potential to escalate into an emergency without clinical intervention.</td>
<td>Patient can be seen in the office by their BH Practitioner, another participating Practitioner in the practice or a covering Practitioner; or Patient directed to 911, ER or 24 hour crisis services, as appropriate.</td>
</tr>
<tr>
<td>Urgent Care appointment</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Non-emergent care with significant psychological distress</td>
<td>Patient can be seen in the office by their BH Practitioner,</td>
</tr>
</tbody>
</table>
and symptoms. Calls are urgent when the severity or nature of presenting symptoms is intolerable, but not life threatening to the member. another participating Practitioner in the practice or a covering Practitioner; or
- Patient directed to 911, ER or 24 hour crisis services, as appropriate.

<table>
<thead>
<tr>
<th>Routine initial appointment</th>
<th>Within 7 calendar days</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient non-urgent appointment.</td>
<td>New patient can be seen in the office by a BH Practitioner within the timeframe. (After the intake assessment.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine follow-up appointment</th>
<th>Within 30 calendar days</th>
</tr>
</thead>
<tbody>
<tr>
<td>New or existing patient</td>
<td>Patient can be seen in the office by their BH Practitioner, another participating Practitioner in the practice or a covering Practitioner within the timeframe.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>After Hours Urgent Access</th>
<th>24X7 phone access</th>
</tr>
</thead>
</table>
| Contacting BH Practitioners for emergency and urgent instructions. | - Recording or live person refers patient to ER / 911 / 24-hour crisis services; 
- Caller is directed to contact a BH professional (via cell, pager, beeper, transfer system) or get a call back for instructions or consultation. |

Anthem uses several methods to monitor adherence to these standards, including a) assessing the availability of appointments via phone calls and surveys by our designated vendor to the provider’s office; b) analysis of member complaint data; and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members.

Is your practice compliant?

**HEDIS Spotlight: Antibiotic Use**

Antibiotic stewardship has been identified as a national priority. The first known superbug, or bacterial infection that is resistant to antibiotics of last resort, was recently discovered in the United States. The Center for Disease Control (CDC) estimates that drug resistant bacteria cause two million illnesses and 23,000 deaths annually.

Studies indicate that up to 50% of antibiotic use is either unnecessary or inappropriate across all types of health care settings (Dellit, Timothy H., et al. “Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship.” *Clinical Infectious Diseases*. January 15, 2007; 44: p 159-177.).

Misuse occurs for a variety of reasons including the use of antibiotics when they aren’t needed or clinically indicated; continuing treatment when it is no longer needed; the wrong dose of the antibiotic; the use of a broad-spectrum antibiotic to treat a susceptible agent; and, the use of the wrong antibiotic to treat the infection. In 2011, a national survey found that 60% of infectious disease physicians had seen a pan-resistant, untreatable infection in the last year (Spellberg, Brad and David N. Gilbert. “The Future of Antibiotics and Resistance: A

Inappropriate antibiotic use adversely impacts patients and society and is leading to a pandemic of antimicrobial resistance.

To further underscore the focus on prescribing and using antibiotics appropriately, the National Committee for Quality Assurance (NCQA) has identified three Health Effectiveness Data and Information Set (HEDIS) measures around antibiotic use:

- **Children (2 to 18 years) who present with Pharyngitis who are first given a group A streptococcus (strep) test and then appropriately receive an antibiotic.**
- **Children (3 months to 18 years) with a diagnosis of Upper Respiratory Infection who are not given an antibiotic prescription.**
- **Adults with a diagnosis of Acute Bronchitis who are not given an antibiotic prescription.**

The ratings for each of these metrics are determined by claims data only. And, it only takes one time of an antibiotic being inappropriately prescribed (and filled) in the one year measurement period to lower the scores.

**Things that might help you**

In an effort to help slow the emergence of antibiotic resistant bacteria and prevent the spread of antibiotic resistant infections, please commit to:

- **Avoid prescribing antibiotics inappropriately:** Write a prescription for symptom relief instead of an antibiotic and educate patients on comfort measures that may work without antibiotics.
- **Communicate with patients:** Discuss realistic expectations for recovery time, explain that antibiotics do not significantly reduce the duration of symptoms, and that unnecessary use of antibiotics may cause adverse effects that lead to antibiotic resistance.
- **Test for bacterial infections:** If a child presents with a sore throat, do a strep test and prescribe accordingly. Don’t send a script home with the patient “just in case,” but rather offer to call it in if the test comes back positive.
- **Code claims correctly and accurately:** If your patient has comorbidities, bacterial infections, or competing diagnoses, the standard codes for adults with acute bronchitis (AAB) and upper respiratory infection (URI) may not be applicable. Ensure proper documentation is in the medical record and use correct diagnosis and procedure codes on claim/encounter.

**Here are some Resources** that might help you and your patients:

- Anthem one-minute video: [www.anthem.com/cold](http://www.anthem.com/cold)
- Choosing Wisely—[www.choosingwisely.org](http://www.choosingwisely.org):
  - 5 Patient Questions to ask Before Taking Antibiotics and Antibiotics: When you Need them and When you Don't in English and
  - Antibiotics: When you Need them and When you Don't in Spanish
- AWARE program materials—[Physician-Patient Resources in English and Spanish](http://www.anthem.com/cold)
- CDC “Get Smart about Antibiotics”—[Patient and Provider Materials and References including Clinical Guidelines](http://www.anthem.com/cold)
- National Quality Forum Antibiotic Stewardship in Acute Care: A Practical Playbook
- CDC Core Elements of Hospital Antibiotic Stewardship Programs

**August 2016**

Colorado

Network Update is produced monthly by Anthem Blue Cross and Blue Shield.

Editor: Jackie Ferguson, 700 Broadway, Denver, CO 80273, E-mail: Jackie.Ferguson@anthem.com.

The content of this update is for informational purposes only and should not be construed as treatment protocols or required practice guidelines, nor should anything herein be construed as legal advice. Readers are strongly advised to consult their own legal counsel as necessary. Diagnoses, treatment recommendations and the provision of health care services for Anthem Blue Cross and Blue Shield members are the responsibility of physicians and providers.
Update to Claims Processing Edits and Professional Reimbursement Policies

Update to Claims Processing Edits and Reimbursement Policies

On August 1, 2016, we will be updating Anthem’s secure Provider Portal, ProviderAccess, with the following new and/or revised reimbursement policies.

The updates below identify if the article pertains to professional or facility provider billing.

Frequency Editing – Professional
Taking guidance from CMS’s MUEs, we are adding a limit of 4 units per date of service for CPT code 86160 (complement; antigen, each component) when reported by the same provider for the same patient. This limit will be applied to claims processed on or after August 22, 2016. Modifiers will not override this frequency limit.

Laboratory and Venipuncture Services and Modifier Rules – Professional
In our policies dated August 22, 2016, we are removing information that modifier 91 (repeat clinical diagnostic laboratory test) will override frequency limits for drug screen testing. Our Frequency Editing reimbursement policy currently documents that modifiers will not override frequency limits identified in the policy including, but not limited to, drug screen testing.

Modifiers 59 and XE, XP, XS, & XU (Distinct Procedural/Separate/Unusual Service) – Professional
For claims processed on or after August 22, 2016, we are updating language under the “Exceptions” section of our policy to reflect that when the denial of a code is supported by CPT parenthetical language that indicates a code is not reportable “with” specific other code(s) (e.g., do not report xxxxx with yyyyy...), modifiers will not override the denial.

Coding Tip: Low Dose Computed Tomography Lung Cancer Screening – Professional
In January 2016, CMS published HCPCS code G0297 for low dose computed tomography (LDCT) lung cancer screening as a replacement for the temporary “S” code S8032 (low dose computed tomography for lung cancer screening). Because of the development of HCPCS code G0297, which we have been accepting for dates of service on or after January 1, 2016, we are adding temporary “S” code S8032 to our always bundled edit for claims with dates of service on or after August 22, 2016.

Durable Medical Equipment and Modifier Rules – Professional
Healthcare Common Procedure Coding Systems (HCPCS Level II) modifier EX was developed by the Centers of Medicare & Medicaid Services (CMS) to allow suppliers to bill Medicare for purchased only DMEPOS items that are furnished to expatriate beneficiaries (those patients whose residence is outside the United States) while the beneficiary was in the United States. By attaching the EX modifier to DMEPOS codes, the supplier is attesting that the patient is an expatriate beneficiary and that the DMEPOS was delivered/furnished while the patient was present in the U.S., and all other billing criteria has been met. For claims processed on or after August 22, 2016, our claims systems will accept modifier EX when appended to all lines for submitted expatriate beneficiary DME claims.

Modifiers BP (patient has been informed of the purchase and rental options and has elected to purchase the item) and BR (patient has been informed of the purchase and rental options and has elected to rent the item) have also been added to our policies.

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 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.

CPT® is a registered trademark of the American Medical Association

ClaimsXten® is a registered trademark of McKesson Information Solutions LLC

**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 **www.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](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](http://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**.

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](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf) and **Standard Option:** [https://www.caremark.com/portal/asset/z6500_drug_list.pdf](https://www.caremark.com/portal/asset/z6500_drug_list.pdf). This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at [www.fepblue.org](http://www.fepblue.org) | Benefit Plans | Brochures and Forms | Medical Policies.
Medicare Advantage Updates

Medicare Supplement members to receive new ID cards

All Anthem Medicare Supplement Individual members will receive new member ID cards beginning November 1, 2016. Please obtain a copy of the new member ID cards to file claims for dates of service November 1, 2016 and beyond. Medicare will be notified of these changes for Anthem Medicare Crossover claim purposes. If you need to submit a claim that is not reflected as a Medicare Crossover claim, please use the correct member ID number beginning November 1, 2016. Please ask our members to present their most current ID cards each time they receive services – especially on or after November 1. This helps ensure appropriate claims routing and processing. Provider offices should carefully review member ID numbers when filing claims.

Payments will be processed daily.

All individual Medicare Supplement members will have a new group ID number and new member ID number on their new member ID cards. Further information can be found in the spotlight section of the provider home page and at the Answers @ Anthem tab at the top of the Anthem provider home page.

59277MUPENMUB 03/17/2016

Improve Medicare Advantage members’ medication adherence with 90-day prescriptions

To help improve medication adherence among Anthem individual and group-sponsored Medicare Advantage members, Anthem will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. 90-day prescriptions help improve the adherence of our Medicare Advantage members by having them travel to their pharmacy less often. When medically appropriate, we request that you convert the member’s prescription to a 90-day supply to improve patient adherence and outcomes without compromising the quality of care. Please note that we do not intend to transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.

Alendronate added to the $0 copay tier for 2016 for Medicare Advantage members

Individual MAPD plans in 2016 have added alendronate for osteoporosis to the $0 copay tier and continue to offer select drugs at a $0 member copay for the following conditions: high blood pressure, high cholesterol and diabetes. The 2016 medication list includes: alendronate, glipizide, lisinopril, losartan, metformin, simvastatin, benazepril, enalapril, enalapril-hctz, lisinopril-hctz, glimepiride, glipizide ER, losartan-hctz, metformin ER, atorvastatin, lovastatin and pravastatin.

Group-sponsored plans continue to offer the Select Generics benefit, which offers $0 copay for select generic drugs.

Anthem offers in-home Bone Mineral Density (BMD) testing

Anthem is working with a vendor to conduct in-home bone mineral density (BMD) testing.

Individual and group-sponsored female Medicare Advantage members age 67-85 who have claims that indicate a bone fracture and are not on an osteoporosis medication and/or have not had a BMD scan in the last 24 months receive a letter about osteoporosis. Through the letter and subsequent phone calls, these members are offered the opportunity to have an in-home screening. The screening takes about 10 minutes. The resulting T-Score is faxed to the attributed primary care provider (PCP). If the vendor cannot reach the member, a registered nurse may follow up with the PCP to request assistance with scheduling a BMD appointment for the member or inquire about medication therapy for the member.
Program helps members with rheumatoid arthritis that may be missing important medications

According to the American College of Rheumatology, Disease Modifying Anti-Rheumatic Drugs can help prevent long term disability and damage to persons with Rheumatoid Arthritis. If you see an individual or group-sponsored Medicare Advantage member who has been diagnosed with Rheumatoid Arthritis and that member has not received or filled a prescription for a DMARD, Anthem will send you a fax with that member’s contact information and a request to help ensure that the member has this important medication. A registered nurse also may follow up with the physician or the member to assist with appointments or prescriptions as needed.

Clinical cumulative morphine equivalent dosing point-of-sale edit effective January 1, 2017

Beginning January 1, 2017, most Medicare Advantage plans will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale. This MEq dosing edit will identify members taking a cumulative dose that exceeds the daily dose that Anthem sets. This is a patient safety edit intended to reduce the risk from high dose opioid use. There is a higher risk for overdose when exceeding the set MEq dosing limit. The claim(s) will reject at the point of sale and require a prior authorization review if the cumulative dosing is over the set daily limit. Certain members may be excluded from the edit, such as members with cancer. The edit supports the CMS guidance mandating that Medicare plans implement a cumulative dosing edit. Anthem anticipates that this edit will impact a fairly high number of claims.

Please check your contract prior to rendering supplemental benefits

Our Medicare Advantage HMO and PPO Plans may include supplemental benefits. Supplemental benefits are items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the Plan in addition to what Medicare covers. Please refer to each plan’s benefit materials to locate any supplemental benefit coverage. Most supplemental benefits are required to be rendered by providers within the vendor network associated with that supplemental benefit or they are considered non-covered benefits.

Providers contracted with the vendor network associated with that supplemental benefit must bill that vendor directly.

Providers not contracted with the vendor network to render such a benefit, please note you will only reimbursed or able to bill a member if:

- For an HMO member, you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member’s MA plan. This will ensure that the member will receive a notice of denial of medical coverage and accompanying appeal rights. As per the Medicare Advantage HMO and PPO Provider Guidebook CMS has stated that the use of an Advanced Beneficiary Notice or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

- For a PPO member, you notify the member up front you are not contracted for the Supplemental Benefit and therefore, out of network cost share will apply.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

Complying with Medical Record documentation requests

As outlined in the Medicare Advantage HMO and PPO Provider Guidebook the facility, treating physician, clinician or supplier must comply with all requests for documentation from the Plan. Providers are responsible for providing any and all related medical records, answer questions from health plan representatives or furnish any necessary information when requested. Information must be submitted in a timely manner, be complete and legible, as well as identify the provider and date of service. Records can be requested by the Plan for reviews such as:

- Compliance with Medicare laws, audits and record retention requirements

August 2016
Provider medical record audits/reviews
- Precertification requests
- Medicare appeals

Additional information can also be located in your provider contract. Please remember that your performance in submitting records impact you as well as our members in some situations. Provider compliance with requests will also be monitored.

**Medicare notices and provider requirements**

The Centers for Medicare and Medicaid Services (CMS) require providers to notify every Medicare beneficiary of their discharge appeal rights using the Notice of Medicare Non-Coverage (NOMNC) for skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities, and the Important Message from Medicare About Your Rights (IM) for inpatient hospitals.

Download IM and NOMNC notices and instructions from the CMS website:

**IMPORTANT REMINDER:** Make sure the Medicare notices have the correct Beneficiary and Family Centered Care (BFCC) Quality Improvement Organization (QIO) contact information. Locate your QIO at [http://www.qioprogram.org/contact](http://www.qioprogram.org/contact).

For more information about CMS guidelines for delivery and retention of the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Clinical Compliance Department -- phone: 317-287-0196, fax: 877-261-2134, email: carol.bossingham@anthem.com.

**Please use Medicare billing guidelines when filing preventive service claims for Anthem Medicare Advantage members**

Please use the same billing guidelines as set forth by Medicare for preventive service claims when filing claims for Anthem individual and group-sponsored Medicare Advantage members.

This applies to both professional and institutional billing.

- Professional claims should be filed on the CMS 1500 form with the appropriate Current Procedural Terminology (CPT) code and/or Health Care Procedural Code (HCPC) for the preventive service. The required primary and/or secondary diagnosis must also be listed with the appropriate CPT and/or HCPC.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes. The Medicare Preventive Services Chart does not list revenue codes. Please be sure to follow UB04 billing guidelines.

Examples:

Revenue Codes (except Rural Health Clinics and Federally Qualified Health Centers):
- 0636 – vaccine (and CPT or HCPC)
- 0771 – administration (and HCPC)

Rural Health Clinics and Federally Qualified Health Clinics – 052X revenue code series

Please refer to the [Medicare Preventive Services Chart](https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS-QuickReferenceChart-1TextOnly.pdf) for specifics on billing.
Please follow home health billing instructions

All claims from home health agencies (HHAs) must follow CMS billing instructions. These billing instructions pertain to providers contracted to Medicare pricing and non-contracted providers.

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.

Keep up with Medicare news

Please continue to check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Member Incentive for Annual Routine Physical
- Medicare Advantage reimbursement policies
- 2016 Diabetic Supply Coverage for Individual Medicare Advantage Members
- Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning Feb. 1, 2016
- Contact Medicare Part B Specialty Pharmacy before Injections, Infusion Drug Prior Authorization Expire

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

Please check out these recent postings to the Health Insurance Exchange Marketplace / Affordable Care Act information page:

- New webinar schedule for ePASS and SOAP Notes overview; incentives offered – July 2016

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.