New Member Identification Prefixes coming in 2018

The Blue Cross and Blue Shield Association (BCBSA) assigns member ID prefixes for all Blue Cross and Blue Shield-branded Plans – Anthem Blue Cross and Blue Shield (Anthem) Plans as well as non-Anthem Plans. There are a limited number of unused three-character, alpha-only prefixes remaining, and they are expected to be exhausted in the 2nd or 3rd quarter of 2018. When that happens, the BCBSA will begin assigning prefixes that contain a combination of letters and numbers, or alpha-numeric prefixes.

What does this mean to you?
- It will be even more important to ask your patients for their most recent identification (ID) card.
- When submitting claims, enter the identification number exactly as it appears on the member’s ID card.
- Check your EDI Software now to make sure it can accept alpha-numeric prefixes.
- Check any internal documents you may have and update any references of “alpha prefix” to “prefix”.

Note: Current three-character, alpha-only prefixes will not be affected by this change. Current prefixes will still be valid once the new alpha-numeric prefixes are issued, unless there is another need to change or remove a prefix currently in use.

We’ll send you reminders of this upcoming change in future issues of Network Update.

Important Announcement: Risk Adjustment Data Validation Audit

The Centers for Medicare & Medicaid Services (CMS) is conducting a Risk Adjustment Data Validation (RADV) Audit beginning June 2017 through January 2018. This audit is in accordance with provisions of the Affordable Care Act (ACA) and its risk adjustment data validation standards.

For this audit, CMS will select a statistically valid sample of Anthem’s enrollees/members enrolled in an ACA plan members purchased on or off the Health Insurance Marketplace (also referred to as the exchange). Provider(s) whose patients during the benefit year 2016 selected for this audit will receive request(s) and must provide copies of medical record(s)/chart(s) within the specified timeframe on the request letter. This audit is to verify that diagnosis codes reported to CMS are accurate, properly documented, and coded with accurate levels of specificity.

In the event your patient(s) are selected for this RADV audit, Anthem is working with Altegra Health – an independent company that provides secure, clinical documentation services – to assist us in requesting and collecting the needed medical records and signature attestations (if applicable) on our behalf. We appreciate your assistance and patience during this process. Altegra is a business partner of Anthem and can provide a copy of the business associate agreement upon request.
Representatives from Anthem may also reach out to your site for more information and/or clarification as necessary in addition to Altegra’s efforts. In addition, you may also receive medical record requests from the Blue Cross Blue Shield Association (BCBSA) contracted vendor Verscend for services rendered outside of the Control/Home Plan’s service area.

Be advised that Anthems not requesting copies of “psychotherapy notes” as defined by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, psychotherapy notes are defined as “notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical record. However, any data excluded from the definition of psychotherapy notes must be provided where applicable and pursuant to this request.

If you have any questions/concerns, please send them via email to RiskAudit@anthem.com.

Upcoming Re-Credentialing Event? Re-attest to your CAQH ProView profile today

Anthem uses the CAQH ProView® system to gather and coordinate the information needed for credentialing. If you are due for an upcoming re-credentialing event and have not accessed CAQH ProView recently, please take a moment to login to CAQH ProView, update your data profile and re-attest to your information.

Re-attestation is due every 120 days, and it is very important to keep your data profile accurate and current so that Anthem can complete the credentialing process without requiring additional outreach to you.

Below are frequently asked questions regarding the CAQH ProView system.

What is CAQH ProView?
CAQH ProView is an online provider data-collection solution. It streamlines provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital and other healthcare organization.

CAQH ProView enables physicians and other healthcare professionals in all 50 states and the District of Columbia to enter information free-of-charge into a secure central database and authorize healthcare organizations to access that information. CAQH ProView eliminates redundant paperwork and reduces administrative burden.

Does it cost anything to use CAQH ProView?
There is no cost for physicians and other healthcare providers to use CAQH ProView.

How do providers access CAQH ProView?
Providers can register online at https://proview.caqh.org/, or will receive registration instructions once Anthem notifies CAQH that the provider needs to access the database. Once registered, use the CAQH Provider ID and password to access CAQH ProView.

How do physicians and other healthcare professionals complete the CAQH ProView data collection process?
Completing the online form requires five steps:

1. Register with CAQH ProView.
2. Complete the online application and review the data.
3. Authorize access to the information.
4. Verify the data and/or attest to it.
5. Upload and submit supporting documents.

**Why should providers respond to CAQH re-attestation notices?**

After providers complete their CAQH ProView applications, CAQH will notify them every four months to re-attest that all information is still correct and complete. This enables a provider’s contracted participating organizations to access CAQH ProView profile information based on their different re-credentialing cycles.

**Who can I contact for help or if I have any questions about CAQH ProView?**

Contact the CAQH Help Desk. **Providers:** [Log in to CAQH ProView](https://proview.caqh.org/PR/) (or go directly to URL: https://proview.caqh.org/PR/) and select the chat icon at the top of any page or call: 888-599-1771. Help Desk hours are: Monday – Thursday: 7:00am – 9:00pm (ET), Friday: 7:00am – 7:00pm (ET).

**Credentialing News**

As previously advised, Anthem will be credentialing additional practitioner and health delivery organization (HDO) provider types who are contracted with Anthem. Please respond with the information requested when you are contacted by Anthem’s credentialing department.

For additional details on all practitioner and HDO provider types requiring credentialing, please reference the Credentialing section of our Provider and Facility Manual. Go to [anthem.com](https://www.anthem.com). Select **Menu**, and under the Support heading select the Providers link. Choose Colorado from the drop down list, and press **Enter**. From the **Provider Home** page, under the Communications and Updates heading, select the Provider Manual link.

**Interactive Care Reviewer (ICR) training opportunities**

**Are you aware of the training opportunities available to you and your staff for Interactive Care Reviewer (ICR), Anthem’s online pre-certification tool?**

Physicians and facilities can use the ICR to submit online Medical and Behavioral Health outpatient and inpatient pre-certification and prior authorization requests for many members* covered by Anthem health plans. Also, ordering and servicing physicians and facilities can use the inquiry feature to find information on their organization’s requests.

**If you are you a new user attend one of our FREE upcoming monthly webinars, and get a jump start on navigating the ICR tool.**

After you attend the webinar you will be able to:

- Describe the benefits of using ICR
- Be familiar with the products and services available for authorization via ICR
- Access ICR through the Availity Web Portal
- Create a pre-certification or prior authorization request
- Inquire on a previously submitted authorization
Register for a webinar

Select the following link to register for an ICR webinar today: Interactive Care Reviewer Webinar Registration, or go directly to URL: https://antheminc.webex.com/antheminc/onstage/g.php?PRID=9f3d602ce452c042e4e60b0441a0bd1c

*Note: ICR may not be available for Federal Employee Program®, BlueCard®, and some National Account members: requests involving transplant services; or services administered by AIM Specialty Health®. For these requests, follow the same precertification process that you use today.

835 Electronic Remittance Advices for Cashless Payments versus Zero Paid

Anthem subscribers may seek services from a health care provider that is also their employer. The employer is a self-funded, administrative services only (ASO) group contracted by Anthem. For this type of arrangement, cashless payments apply as these self-funded employer groups pay themselves for the claim services incurred by their employees with no exchange of monies from the payer, Anthem.

On the 835 ERA, cashless payment is further defined by the Claim Adjustment Reason Code (CARC) of 139; Contracted funding agreement – Subscriber is employed by the provider of services. Review of the entire 835 ERA must be done to also account for when claims are zero paid due to uncovered services, exhaustion of benefits, or member liability.

<table>
<thead>
<tr>
<th>835 Example – Subscriber paid $20 copayment</th>
<th>835 Example – $59.12 towards coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLP<em>999999999</em>1<em>246</em>0<em>20</em>12<em>CLAIMNO1</em>11*1~</td>
<td>CLP<em>999999000</em>1<em>1075</em>0<em>59.12</em>15<em>CLAIMNO2</em>13*1~</td>
</tr>
<tr>
<td>SVC<em>HC</em>99214<em>246</em>0~</td>
<td>AMT<em>AU</em>591.25~</td>
</tr>
<tr>
<td>DTM<em>472</em>20160531~</td>
<td>SVC<em>NU</em>09211075<em>0</em>1~</td>
</tr>
<tr>
<td>CAS<em>PR</em>3*20~</td>
<td>DTM<em>472</em>20170119~</td>
</tr>
<tr>
<td>CAS<em>CO</em>45<em>126.65</em>139*99.35~</td>
<td>CAS<em>CO</em>139<em>532.13</em>45*483.75~</td>
</tr>
<tr>
<td>REF<em>6R</em>1234567~</td>
<td>CAS<em>PR</em>2*59.12~</td>
</tr>
<tr>
<td>AMT<em>B6</em>119.35~</td>
<td>AMT<em>B6</em>591.25~</td>
</tr>
<tr>
<td>Claims Paid Amount $0</td>
<td>Claims Paid Amount $0</td>
</tr>
<tr>
<td>Total Charged Amount $246</td>
<td>Total Charged Amount $1075</td>
</tr>
<tr>
<td>Copayment $20 CAS PR 3</td>
<td>Copayment $59.12 CAS PR 2</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Coinsurance $59.12</td>
</tr>
<tr>
<td>Contractual write Amount $126.55 CO 45</td>
<td>Contractual write Amount $483.75 CO 45</td>
</tr>
<tr>
<td>Amount we would have paid $99.35 CO 139</td>
<td>Amount we would have paid $532.13 CO 139</td>
</tr>
<tr>
<td>Total $246.00</td>
<td>Total $1075</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>835 Example – $242.96 towards coinsurance</th>
<th>835 Example – $110 towards deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLP<em>999123000</em>1<em>242.96</em>15<em>CLAIMNO3</em>11*1~</td>
<td>CLP<em>999123000</em>1<em>200</em>0<em>110</em>15<em>CLAIMNO4</em>13*1~</td>
</tr>
<tr>
<td>CAS<em>CO</em>139*2186.62~</td>
<td>CAS<em>CO</em>45*90~</td>
</tr>
<tr>
<td>CAS<em>PR</em>2*242.96~</td>
<td>CAS<em>PR</em>1*1110</td>
</tr>
<tr>
<td>AMT<em>AU</em>242.96~</td>
<td>AMT<em>B6</em>1110~</td>
</tr>
<tr>
<td>Claims Paid Amount $0</td>
<td>Claims Paid Amount $0</td>
</tr>
<tr>
<td>Total Charged Amount $2429.58</td>
<td>Total Charged Amount $200</td>
</tr>
<tr>
<td>Copayment</td>
<td>Copayment $110 CAS PR 1</td>
</tr>
<tr>
<td>Coinsurance $242.96 CAS PR 2</td>
<td>Coinsurance $110</td>
</tr>
<tr>
<td>Deductible</td>
<td>Deductible $90</td>
</tr>
<tr>
<td>Contractual write Amount $2186.62 CO 139</td>
<td>Contractual write Amount $90</td>
</tr>
<tr>
<td>Amount we would have paid $2186.62 CO 139</td>
<td>Amount we would have paid $110 CO 1110</td>
</tr>
<tr>
<td>Total $2429.58</td>
<td>Total $200</td>
</tr>
</tbody>
</table>
Changes for Mid-June 2017
Currently, employee claim payments are combined with non-employee claims in a single 835 from Application Sender’s Code NASCO (GS02). Changes are scheduled for mid-June to report cashless payments into a separate B835 identified by the BPR01, BPR02, BPR04 and TRN02:

<table>
<thead>
<tr>
<th>Transaction Handling Code (BPR01)</th>
<th>must = H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monetary (Check) Amount (BPR02)</td>
<td>must = 0 (zero)</td>
</tr>
<tr>
<td>Payment Method Code (BPR04)</td>
<td>must = NON</td>
</tr>
<tr>
<td>Check/EFT Number TRN02</td>
<td>Begins with ‘V’ or ‘F’</td>
</tr>
</tbody>
</table>

If you have questions specific to 835s, please contact your local E-Solutions Help Desk at (800) 470-9630 or via email at e-solutions.support@anthem.com.

Anthem E-Solutions Service Desk supports EDI direct submitters
At Anthem, our knowledgeable and experienced E-Solutions Service Desk associates are available to assist if you directly submit and receive electronic data interchange (EDI) transactions. Note: If you use a clearinghouse, please use existing procedures in place for EDI questions and/or concerns.

<table>
<thead>
<tr>
<th>E-Solutions EDI Website</th>
<th><a href="http://www.anthem.com/edi">www.anthem.com/edi</a></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Note: Website includes Live Chat option</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-Solutions EDI Service Desk Hours</th>
<th>Service Desk is open in all time zones 8-4:30pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Solutions EDI Service Desk Contact Information</td>
<td>Phone: (800)470-9630</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:E-solutions.support@anthem.com">E-solutions.support@anthem.com</a></td>
</tr>
</tbody>
</table>

For us to assist you as quickly as possible, please provide the following:

- ERA Inquiries/ Follow-up – Trading Partner/Submitter ID, REQ number if available
- Electronic Remittance Advice (ERA) only requests – Link under the register tab on EDI webpage – [ERA registration E-Form](#)
- Submitted claim information – Trading Partner/Submitter ID, Member ID and Date of Service
- Submitted file information – Trading Partner/Submitter ID, Control number and File Submission Date
- Requested research follow-up – Trading Partner/Submitter, the File Control number or ticket number provided by service desk if available
- Claim receipt verification – Trading Partner/Submitter ID, Tax ID and Check Information
- Batch claim status and benefit inquiry – Trading Partner/Submitter ID and File Submission Date
- To register for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA), or Electronic Funds Transfer (EFT) only – Please visit [www.caqh.org/solutions/enrollhub](http://www.caqh.org/solutions/enrollhub)
- For established Electronic Funds Transactions (EFT) – Please contact EDI at the toll free number or support mailbox

**Live Chat Option**
We also offer a Live Chat option located on the EDI web page at [www.anthem.com/edi](http://www.anthem.com/edi). Please be prepared to provide the following required components for Live Chat:

- Trading Partner/Submitter ID
- Region
- Name


Diabetic Retinal Eye Exam

National guidelines and the National Committee of Quality Assurance (NCQA) recognize the importance of screening people with diabetes annually for diabetic retinopathy through its inclusion in one of the Comprehensive Diabetes Care (CDC) measures. Similarly, Anthem has included retinal eye exams (either by dilation or photograph) for people with diabetes as one of the measures on the Enhanced Personal Health Care scorecard.

What can you do to improve compliance rates?

- Talk to your patients with diabetes about the importance of getting an annual comprehensive eye exam including dilation. Since the retinal eye exam (DRE) is recommended by evidenced based clinical guidelines as a medically necessary part of a diabetic care plan, a member’s medical benefits will cover the exam, subject to his or her share of the cost including co-pays and deductibles. A diabetic eye exam does NOT require vision benefits, as it is part of the medical benefit package. Patients should call Member Services on the back of their identification card for clarification around benefits.

- If you are a primary care doctor or endocrinologist, refer your patients with diabetes to an in-network ophthalmologist or optometrist, if they aren’t already connected with an eye doctor. Follow-up with their eye doctor, as you would any other specialist.

- If you are an eye doctor, follow-up and provide the patient’s test results to their primary care doctor and/or endocrinologist.

- Keep clear documentation in the patient’s medical record:
  - Clearly document referrals, eye exam, and lab results.
  - Document the date of the most recent diabetic eye exam with results and name of vision provider.
  - Obtain and include a copy of diabetic eye exams performed by an optometrist or ophthalmologist.

- Use the following medical procedure codes to document diabetic eye exams.

<table>
<thead>
<tr>
<th>Service</th>
<th>Claim Submission Method</th>
<th>CPT codes</th>
<th>HCPCS Codes</th>
<th>CPT Category II Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Procedures</td>
<td>Anthem Medical</td>
<td>67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228</td>
<td>S0620, S0621, S3000 – Diabetic indicator; retinal eye exam, dilated, bi-lateral</td>
<td>2022F, 2024F, 2026F, 3072F – Low Risk for Retinopathy (no evidence of retinopathy in the prior year)</td>
</tr>
<tr>
<td>Evaluation and Management Codes (by an Optometrist or Ophthalmologist Only)</td>
<td>Anthem Medical</td>
<td>92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Updated Escalation Contact List

The Escalation Contact List has been updated. Access the updated list online. Please go to anthem.com. Select Menu, and under the Support heading, select Providers. Choose Colorado from the drop down list, and Enter. Select the Provider Home tab at the top of the page. Under the Self Service and Support heading, choose Contact Us (Escalation Contact List & Alpha Prefix List), and then Escalation Contact List.

Updated Alpha Prefix Reference List

The Alpha Prefix Reference List has been updated. Access the updated list online. Please go to anthem.com. Select Menu, and under the Support heading, select Providers. Choose Colorado from the drop down list, and Enter. Select the Provider Home tab at the top of the page. Under the Self Service and Support heading, choose Contact Us (Escalation Contact List & Alpha Prefix List), and then Alpha Prefix Reference List.

Update to Claims Processing Edits and Reimbursement Policies

Update to Claims Processing Edits and Reimbursement Policies

On June 1, 2017, we will be updating our 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.

Review of reimbursement policies – Professional

The following professional reimbursement policies received a review and may have word changes or clarifications, however they do not have significant changes to the policy position or criteria:

- Documentation & Reporting for Psychotherapy Services
- E/M Services and Related Modifiers -25 & -57
- Modifier 22

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. Select Menu, and under the Support heading, select Providers. Choose 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 select 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. Please note: Any Cotiviti Healthcare edits will not be included in the Clear Claim Connection tool. These edits will be available by calling provider customer service at the number on the back of the member’s ID card.

CPT® is a registered trademark of the American Medical Association

ClaimsXten® is a registered trademark of McKesson Information Solutions LLC

June 2017 Colorado
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 anthem.com. Select Menu, and under the Care heading, choose Search Medications. Under the Select Drug Lists heading, choose Colorado Select Drug List (Searchable) | PDF.

Website links for the Federal Employee Program formulary Basic and Standard Options are Basic Option: https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and Standard Option: https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated regularly as needed.

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

Medicare Advantage Updates

Home Health Services for Medicare Advantage Individual Members to Require Prior Authorization

Effective September 1, 2017, Anthem will require prior authorization of home health services for our individual Medicare Advantage members, including:

- Skilled Nursing
- Home Health Aide
- Therapies (Physical Therapy, Occupational Therapy and Speech Therapy)
- Medical Social Worker

Only the following Member ID Card alpha prefixes are included in this requirement: VAP, VAT

Beginning August 21, 2017, prior authorizations for dates of service September 1, 2017 and after can be obtained via fax, phone, or portal:

- Fax: 1-844-834-2908
- Phone: 1-844-411-9622
- Portal: https://portal.mynexuscare.com/

NOTE: This will be in effect for new requests for Home Health services starting on or after September 1, 2017. Any care that has begun prior to September 1, 2017 will not be subject to this requirement. If home health care services need to be extended past September 1, 2017, please contact myNEXUS to request a prior authorization to be extended.

Prior authorizations will be reviewed and approved by myNEXUS. myNEXUS health professionals will work directly with home health providers to review the member’s progress, ensure complete discharge plans are in place and that any medications needed after discharge are prescribed for the member.

By working closely with the home health provider, myNEXUS will help ensure that our Medicare Advantage members who will benefit from more time in a home health setting receive the services and screenings they need during their home health stay.
In addition, members who are ready to go home early can do so, equipped with a complete discharge plan and prescriptions for any medications they may need at home.

Additional communication will be coming out soon, with information on the myNEXUS prior authorization program, including a Welcome letter and an invitation to Orientation and training sessions.

A list of frequently asked questions and answers will be available at https://www.mynexuscare.com/anthem/ later this month.

To verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member’s identification card.

**No copay benefit for diabetes retinal exam and HbA1c testing effective January 1, 2017**

Effective January 1, 2017, no copay is required for HbA1c testing for individual and some group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual dilated retinal exam at no out-of-pocket cost.

The annual retinal exam claim must include a line for measurement code 2022F to report the use of dilation during the exam for no copay to apply.

This is not applicable to Anthem Special Needs Plans or Anthem MediBlue Coordination Plus plans. Some group-sponsored plans may require a member copayment or coinsurance for these services.

66669MUPENMUB 5/09/2017

**Tips for submitting Medicare Advantage corrected claims**

When submitting a corrected claim, clearly identify the claim is a correction to an original bill. Additional details for submitting corrected medical electronic CMS-1500 claims, paper CMS-1500 claims and facility UB-04 electronic or paper claims can be found here, or by going directly to URL: https://www11.anthem.com/shared/noapplication/f0/s0/t0/pw_g311570.pdf?refer=ahpmedprovider.

**HCPCS codes allow for payment for coordinating behavioral health services**

Anthem would like to remind Medicare Advantage providers of the collaborative care, case management and cognitive assessment HCPCS codes that became effective January 1, 2017. The Centers for Medicare & Medicaid Services (CMS) approved these codes for services provided under the Psychiatric Collaborative Care Model, which supports integration of behavioral health care into primary care treatment.

These codes allow payment for the efforts to coordinate and integrate behavioral health care services by primary care providers, including key services of care management for patients receiving behavioral health treatment and psychiatric consultation to primary care treatment teams. For a list of the collaborative care codes introduced in 2017, please see Important Medicare Advantage Updates at www.anthem.com/medicareprovider.

**Use code 1111F to receive reimbursement for post-discharge medication reconciliation**

Medication Reconciliation once the patient is discharged plays an important role in preventing adverse drug events. This should be done within 30 days of discharge from an acute or non-acute inpatient stay. Later this year, Anthem will reimburse providers who conduct medication reconciliation within 30 days of an inpatient hospital discharge for individual and group-sponsored Medicare Advantage members and submit the claim using the CPT Category II code 1111F. Medication reconciliation must be completed by the prescribing practitioner, registered nurse or clinical pharmacist and noted by one of these professionals on the outpatient medical record. The effective
Imaging services providers must complete OptiNet assessments to avoid line-item denials

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM’s online registration tool, OptiNet. OptiNet will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retropertoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET), and echocardiograph imaging services. Areas of assessment include facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

These data will be used to calculate site scores for providers who render imaging services for our individual Medicare Advantage members.

All participating providers who provide imaging services, including X-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. All facility diagnostic imaging services are excluded from line item denials at this time. Although there is no reimbursement impact at this time, Anthem continues to encourage facility network providers to submit imaging services data for the AIM Specialty Health initiative.

If you have already completed an OptiNet assessment, please ensure that you keep your registration up to date. Expiring data could lead to a negative impact in your modality scores.

Keep up with Medicare news

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

- Prior authorization requirement change for Part B drug; Herceptin
- Prior authorization requirement change for Part B drug; Bavencio
- Prior authorization requirement change for Part B drug; Spinraza
- Prior authorization requirements for continuous interstitial glucose monitoring
- Risk adjustment and documentation guidance training offered
- Retrospective medical record review program launches

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 Menu, and under the Support heading, select Providers. Choose Colorado from the drop down list, and Enter. Select the Provider Home tab at the top of the page. Under the Communications and Updates heading, choose Health Care Reform Updates and Notifications or Health Insurance Exchange Marketplace / Affordable Care Act information.