

Network Update

CENTRAL REGION

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Network Update is produced bi-monthly by Anthem Blue Cross and Blue Shield's Marketing Communications Department.

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Health Care Reform (including Health Insurance Exchange)

Updates and Notifications

Health Care Reform Updates and Notification and Health Insurance Exchange sections of our website

Please be sure to check the Health Care Reform Updates and Notifications and Health Insurance Exchange sections of our website regularly for new updates on health care reform and Health Insurance Exchanges, at www.anthem.com>Providers (select state)>Health Care Reform/Health Insurance Exchange.

Health Insurance Exchange

Please check this section often for updates on the networks that support Health Exchange products, how the Health Exchange works, who is affected, Plan names, how to identify members covered by a Health Exchange plan and much more.

The following article recently posted:

- [Access more information about three month grace period status electronically](#)

In addition, the following articles recently posted for [Indiana](#) and [Kentucky](#):

- *Important update about Anthem's 2015 ACA-compliant plans*
- *Member ID card update for 2015 ACA-compliant health plans*
- *Health Insurance Marketplace/ACA Quick Reference Guide*

Sign up to receive immediate notification of new information.

Network Update

Note that in addition to this newsletter and our website, we also use our email service, Network eUPDATE to communicate new information. If you are not yet signed up to receive Network eUPDATES, we encourage you to enroll now so you'll be sure to receive all information that we send about Exchanges. To [sign up](#), visit www.anthem.com > Providers (enter state)> Network eUPDATE.

Administrative Update

CAQH Proview is coming in February

The CAQH Universal Provider Datasource® (UPD) is trusted by more than 1.2 million healthcare providers as the premier resource for self-reporting personal and professional information to payers, hospitals, large provider groups and health systems. As the healthcare industry moves through some of the greatest changes in its history, CAQH is making significant improvements to UPD. **To reflect these improvements and enhanced functionality, CAQH is changing the name of this next generation UPD to CAQH ProView™.**

Scheduled to launch in February 2015, CAQH ProView will be faster and more intuitive to use. That means time savings for you.

Provider Benefits

CAQH has incorporated feedback from both provider and health plan focus groups into the development of CAQH ProView. A range of new features will make it easier for healthcare providers to make updates, reducing the time and resources necessary to submit accurate, timely data to organizations that require that information. Providers will be able to easily submit information through a more intuitive, profile-based design. CAQH ProView's time saving features include:

- Complete and attest to multiple state credentialing applications in *one* intelligent workflow design.
- Upload supporting documents directly into CAQH ProView to eliminate the need for manual submission and to improve the timeliness of completed applications.
- Review and approve Practice Manager information before data is imported.
- More focused prompts and real-time validation to protect against delays in data processing.
- Self-register with the system before a health plan initiates the application process.

CAQH ProView will continue to be available to providers free of charge. In addition, all completed UPD applications with current attestations will automatically migrate into CAQH ProView.

Practice Managers: Managing a group of providers or multiple sites?

CAQH ProView will simplify the data entry and upload process for Practice Managers. They will have the ability to maintain multiple practice locations and provider lists and to export select data to specific groups of providers. This improved Practice Manager Module will also feature a new 'bulk upload' option to allow large provider groups and hospitals the ability to submit files with pre-populated data, expediting completion of the providers' information. Additional time saving features of the CAQH ProView Practice Manager Module include:

- Export additional provider profile data.
- Access to detailed activity log and export history, as well as corresponding provider activity.
- Establish one main Practice Manager Module account with multiple users.

Prepare now. Verify your email address.

CAQH ProView will require an email address as the primary contact method for all providers. Please login to your UPD account today and confirm your email is correctly entered to stay informed about the steps you will need to take to prepare. To update your email address: Login to your UPD account; Click on “Edit Account;” Enter a valid email address; If applicable, Change your “Contact Method” from FAX to email.

Next Steps

Stay tuned for regular email communications updating you about the launch of CAQH ProView. To learn more, refer to this CAQH website. <http://www.caqh.org/ProView-Provider-Overview.php>

No-cost cultural competency training -- CME/CEU credits awarded

Your patients are becoming more racially, culturally and linguistically diverse. As such, there is an increased emphasis on cultural competence training for physicians, nurses, and other healthcare professionals who interact with these patients on a daily basis. Research shows that clinicians who are provided multicultural training are better able to serve these growing patient populations, and are more likely to improve patient satisfaction, adherence, and patient outcomes, as well as increase their market share from some of the nation’s fastest growing communities.

We are excited to offer providers the following two culturally and linguistically targeted e-learning courses: 1) *Viewpoints: Clinical Competence in a Globally Mobile World* and 2) *Language Access and the Law: Caring for the Limited English Proficient (LEP) Patient*. **These courses are offered to providers and appropriate office staff at no cost and provide AMA Category 1 CME/CEU credits.**

To learn more about how to register for and complete these free trainings, visit our course summaries web [page](#).

Inovalon requests for 2015

Just as in 2014, we have engaged Inovalon – an independent company that provides secure, clinical documentation services – to help us comply with provisions of the Affordable Care Act that require us to assess members’ relative health risk level. In the coming weeks and months, Inovalon will begin sending provider letters as part of a new risk adjustment cycle, asking for your help with completing health assessments for some of our members.

If you worked with Inovalon in 2014, many thanks for your help. This year will bring a new round of assessments. As always, if you have questions about the requests you receive, you can reach Inovalon directly at 1-877-448-8125.

ICD-10 updates: Clinical documentation improvement

Now is the time to focus on clinical documentation improvement (CDI). ICD-10 offers greater specificity than ICD-9, allowing documentation to be translated into an accurate and clear clinical picture. One of the best ways to prepare for the upcoming ICD-10 deadline is by improving your clinical documentation now. Visit your state’s ICD-10 webpage for additional information and resources on this topic.

IN - [Anthem’s ICD-10 webpage](#)

KY - [Anthem’s ICD-10 webpage](#)

MO - [Anthem’s ICD-10 webpage](#)

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OH - [Anthem's ICD-10 webpage](#)

WI - [Anthem's ICD-10 webpage](#)

Coming in April 2015! We will be launching a **free scenario-based coding practice tool** designed to give professional providers and their coders the opportunity to test their knowledge of the ICD-10 codes set by applying it to medical scenarios. Look for more details in the next edition of this newsletter.

New audit vendor

Effective January 1, 2015, Anthem added an additional audit vendor, Connolly, Inc., to conduct market diagnosis related group (DRG) audits for Anthem. For more information, see our Network [eUPDATE](#) at www.anthem.com>[Providers](#) (select state)>Network eUpdates.

Use the Provider Maintenance Form to update your information

We continually update our provider directories to help ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice – updating address and/or phone number, adding or deleting a physician from your practice, etc. -- please notify us by completing the Anthem Provider Maintenance [Form](#) at anthem.com. Thank you for your help and continued efforts to keep our records up to date.

FEP

Imaging cost and quality program will include FEP

Anthem is dedicated to meeting the evolving needs of our members. Beginning May 1, 2015, our Imaging Cost and Quality program, administered by AIM Specialty Health® (AIM), will include Federal Employee Program® (FEP) members for the following services:

- Computed Tomography (CT) - joints, spine, abdomen, pelvis
- Magnetic Resonance Imaging (MRI) - Joints, spine, abdomen, pelvis
- Nuclear Cardiology
- Positron Emission Tomography (PET)
- Stress Echocardiography (SE)
- Resting Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)

Providers should contact AIM to obtain an order number before scheduling or performing any elective outpatient imaging service. AIM will begin taking calls for FEP on April 20, 2015 for dates of service May 1, 2015 or after.

To submit your request for an FEP member, contact AIM Specialty Health® (AIM) via the **ProviderPortal** at www.aimspecialtyhealth.com/goweb. You may also contact AIM at the dedicated FEP line of business number at 866-789-0397, Monday-Friday 7:00 a.m. – 7:00 p.m. CST.

After clinical appropriateness of the outpatient and non-emergent radiology services* is confirmed and the choices are identified, AIM will make a proactive call to the member to aid in scheduling the service at a “best value” site. This helps guide our members to facilities offering high quality, affordable imaging services.

Note: For the following imaging services, Advanced Benefit Determinations are available by contacting FEP Utilization Management at 800-860-2156, or by fax 877-606-3807.

- Computed Tomography Angiography (CTA)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) Scans
- Nuclear Cardiology

**Services performed in conjunction with the emergency room services, inpatient hospitalization, or urgent-care facilities are excluded.*

Advanced benefit determination (ABD) process

Anthem would like to share information about our Advanced Benefit Determination (ABD) process for the Federal Employee Program® (FEP). This is a voluntary process offered to physicians and/or their representatives to prospectively submit a request for member-specific services to the Utilization Management staff for medical necessity review and benefit determinations. ABDs are assigned a Reference/Authorization number when the review determines the medical necessity criteria have been met and/or benefits are available. This Reference/Authorization number will be included in the top right hand corner of the letter sent to the provider. The letter includes direction for the provider regarding how to use the Reference/Authorization number for claims submission. If the ABD is approved, the provider can include the Reference/Authorization number on the post-service claim and the claim will be processed. This eliminates the need to submit the approval letter with each claim. The following paragraph is included in the approval letter:

“Note to Provider: To ensure efficient and timely payment of claims when submitted, please include the authorization number from this letter on your claim.”

New hours for UM/CM

The Federal Employee Program, Utilization and Case Management Department, is changing its hours of operation, effective March 1, 2015. The new hours of operation will be 8 am to 6 pm, EST.

Health Care Management

AIM clinical appropriateness guidelines for imaging

On May 4, 2015, the following changes to the AIM Specialty Health® (AIM) Clinical Appropriateness Guidelines for Radiology, Cardiology and Oncologic PET will become effective.

See below for a summary of these changes:

Head & neck appropriate use criteria

- Expansion of criteria for MRI and CT brain allowing for evaluation prior to discontinuation of antiepileptic medications when a patient has not had a prior MRI
- Expansion of existing criteria for MRI and CT brain for evaluation of sensorineural hearing loss
- Addition of new criteria for MRI, MRA, CT, and CTA brain for evaluation of tinnitus
- Addition of new criteria for MRI orbit, CT maxillofacial, and CT neck (soft tissue) for evaluation of osteonecrosis of the jaw

Chest appropriate use criteria

- Infectious and inflammatory criteria for CT chest are further differentiated at the condition level
- Addition of several new criteria for CT chest include bronchopleural fistula, complications of pneumonia and paraneoplastic syndrome with unknown primary tumor or origin

Abdomen & pelvis appropriate use criteria

- Addition of new criteria for MRI and CT abdomen for evaluation of iron deposition/overload in patients with hemochromatosis when they are candidates for chelation therapy
- Addition of new criteria for CTA abdomen and pelvis for evaluation of visceral artery aneurysms

Musculoskeletal appropriate use criteria

- Clarification of criteria for MRI and CT spine when evaluating cord compression
- Removal of criteria allowing CT cervical and thoracic spine evaluation for MS, myelopathy and spinal cord infarct (note: these are still available under MRI)
- Revision of criteria for MRI upper extremity evaluation of nonspecific upper extremity pain

Oncologic PET appropriate use criteria

- Enhancement of clinical criteria for thyroid cancer

Cardiology appropriate use criteria

- Addition of new criteria allowing stress echo and MPI evaluation of patients awaiting solid organ transplantation
- Clarification of criteria for stress echo and MPI evaluation of patients who have undergone percutaneous coronary intervention (PCI) greater than three years ago
- Clarification of criteria for stress echo, resting echo and MPI evaluation for cardiac arrhythmias redefining frequent premature ventricular contractions
- Modification of criteria for resting echo reevaluation of patients who have undergone implantation of a bioprosthetic valve to allow imaging seven years after the procedure and then annually thereafter

New Pediatric Guidelines

In addition to the changes above, AIM has developed a set of radiology guidelines that are specific to pediatric patients.

These guidelines include:

- Pediatric Abdomen & Pelvis
- Pediatric Chest
- Pediatric Head & Neck
- Pediatric Musculoskeletal
- Fetal MRI

The guidelines listed above bring together criteria from AIM's adult guidelines applicable to pediatrics with new criteria specific to pediatric patients.

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click [here](#) to access and download a copy of the current guidelines.

Y0071_15_22893_I 12/22/2014

Specialty pharmacy drug will require precert

Effective May 3, 2015, the following specialty drug will require precertification for members covered by Anthem local plans:

Note: For a complete listing of plans, please go online to www.anthem.com>Providers (select state)>Precertification Guidelines. For a complete listing of drugs and codes, including specialty pharmacy medications, please go online to www.Anthem.com > Provider Home Page >>Precertification> Specialty Pharmacy Precertification Drugs and Codes.

Medical Policy or Clinical Guideline Number	Medical Policy or Clinical Guideline Name	Drug Name(s)	Drug Code(s)
CG-DRUG-03	Beta Interferons or Glatiramer Acetate for Treatment of Multiple Sclerosis	Plegridy	J3490

To submit your precertification request for specialty pharmacy drugs, the preferred method is to go online to AIM Specialty Health via the Availity Web Portal. (For more information on how to access, see the article, "Important: Pre-service clinical review of specialty pharmacy drugs will transition to AIM," in the August 2014 [issue](#) of *Network Update*.) You also may use the [Specialty Pharmacy Clinical Data Submission](#) tools; they serve as guides to make sure that you have submitted all necessary information for Anthem to complete the review. (Note: Tools are not available for all specialty pharmacy data submissions.) You can find the tools at anthem.com>Providers (enter state)> Answers@Anthem >Precertification>Clinical Data Submission Tools> Specialty Pharmacy Clinical Data Submission Tool.

Note: In most cases, the changes do not apply to Blue Traditional®, National Accounts, Medicare Advantage (MA), or Federal Employee Program® (FEP). These accounts can generally be identified by the prefixes National: AN, GMP, NWM, GHP, GME, BXZ; Medicare: YRA, YRE, YRS, JWM, VZM, YRF. FEP: R.

New and revised clinical guidelines

The following clinical guidelines were reviewed on November 13, 2014 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Clinical Guideline Name & Number	MPTAC Outcome	Effective date
CG DRUG-38 Pemetrexed Disodium (Alimta®)	MPTAC approved new clinical UM guideline which reflects the following: <ul style="list-style-type: none"> Outlines the medically necessary and not medically necessary clinical indications for pemetrexed disodium in the treatment of oncologic conditions 	May 3, 2015
CG-DRUG-15 Gonadotropin Releasing Hormone (GnRH) Analogs	MPTAC approved revision of clinical UM guideline which reflects the following: <ul style="list-style-type: none"> Clarified that the treatment of clinically localized prostate cancer with intermediate or higher risk of recurrence is medically necessary as neoadjuvant therapy with radiation therapy or cryosurgery 	May 3, 2015

	<ul style="list-style-type: none"> Added 'Following radical prostatectomy as adjuvant therapy when lymph node metastases are present' as medically necessary indication Revised criteria to no longer consider 'In combination with antiandrogen (flutamide or bicalutamide) for locally confined stage T2b-T4 (stage B2-C) disease" as a medically necessary indication Removed separate medically necessary statement addressing treatment as neoadjuvant therapy with radiation or cryosurgery Updated Discussion and Reference sections 	
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Include reference numbers on fax cover sheets

As part of our continuing efforts to improve efficiencies in the Utilization Management (UM) process, we have identified an opportunity to expedite information received by fax: **Please include the reference number on fax cover sheets.** The reference number is provided on our fax communications or when a case is set up via phone.

By including the reference number on the fax cover sheet, we can more easily match new information with previously received material, resulting in timelier, more cost-efficient and streamlined communications.

As a reminder, please do NOT include protected health information (PHI) on fax coversheets.

Thank you for your assistance.

MCG guidelines to be updated May 3

Anthem will upgrade to 19th edition

Anthem's Utilization Management/Case Management departments will upgrade to the 19th edition of MCG, effective May 3, 2015. The following is a summary of some of the changes included in the MCG 19th edition:

- Goal Length of Stay (GLOS) changed for 5 Guidelines in the 19th edition of Inpatient & Surgical Care.

Guideline	MCG Guideline	19 th Edition GLOS	18 th Edition GLOS
Angina	M-40	Ambulatory or 1 Day	Ambulatory or 2Day
Laryngectomy Partial	S-790	2 days post-op	3 days post-op
Subarachnoid Hemorrhage, Nonsurgical Treatment	M-79	5 days	6 days
Thoracotomy with Biopsy or Miscellaneous Procedures by Video-Assisted Thoracic Surgery (VATS)	S-1082	Ambulatory or 2 days postoperative	Ambulatory or 1 day postoperative
Ureterotomy, Nontransurethral for Stone	S-1150	1 day postoperative	2 days postoperative

- Guideline Name Changes

The names of 34 guidelines were changed in the 19th edition of Inpatient & Surgical Care. With the exception of four guidelines, the names were changed by appending "Pediatrics" to the title to make it easier to differentiate these from adult versions of guidelines on the same condition. The exceptions include Apnea, Neonatal (Non-Preterm Infants); Knee Arthroplasty, Total; Prematurity (Greater Than 1000 Grams and Greater Than 28 Weeks' Gestation); and Prematurity, Extreme (Less Than 1000 Grams or Less Than 28 Weeks' Gestation).

Medicare

MA member identification prefixes for 2015

Anthem moved Individual (non-group) Medicare Advantage (MA) members to a single claims processing system Jan. 1, 2015. Member identification prefixes were updated as part of that transition. The 2015 member identification prefixes for individual MA plans are listed below.

Please file 2014 charges with the 2014 prefix and 2015 charges with the 2015 prefix to ensure claims are delivered to the appropriate claims system for processing.

2015 Individual MA plans

Prefix	State/Area	Plan Type	Plan Name	Provider and member service	CMS contract
XTH	KY	MA PPO	Anthem Medicare Preferred	1-855-690-7795	H5530
XPF	IN	MA PPO	Anthem Medicare Preferred	1-855-558-1438	H1607
VOC	OH	MA PPO	Anthem Medicare Preferred	1-855-690-7801	H5529
JRI	OH	MA HMO	Senior Advantage	1-855-690-7796	H3655
JWF	MO	MA PPO	Anthem Medicare Preferred (PPO)	1-855-690-7798	H1517
VOE	WI	MA PPO	Anthem Medicare Preferred (PPO)	1-855-690-7802	H4036
VOD	OH	MA RPPO	Blue Medicare Access (Regional PPO)	1-800-467-1199	R5941
XPG	IN	MA RPPO	Blue Medicare Access (Regional PPO)	1-800-467-1199	R5941
VOP	KY	MA RPPO	Blue Medicare Access (Regional PPO)	1-800-467-1199	R5941
ZRB	WI	MA HMO	Medicare Advantage HMO - WI	1-855-304-1774	H9525
VOK	IN	MA HMO	Med Adv HMO - Indiana	1-855-251-8827	H9954
VOH	MO	MA HMO	Med Adv HMO - Missouri	1-855-251-8826	H9886
XTG	KY	MA HMO	Senior Advantage	1-855-558-1439	H1849
XPS	KY	MA HMO/SNP	Anthem Dual Advantage (HMO SNP)	1-855-558-1439	H1849
JRG	OH	MA HMO/SNP	Anthem Dual Advantage (HMO SNP)	1-855-690-7796	H3655

VOT	WI	MA HMO/SNP	Anthem Dual Advantage (HMO SNP)	1-855-304-1774	H9525
JWO	MO	MA HMO/SNP	Anthem Dual Advantage (HMO SNP)	1-855-251-8826	H9886
XPK	IN	MA HMO/SNP	Anthem Dual Advantage (HMO SNP)	1-855-251-8827	H9954

Sample ID cards are available at the [Medicare Advantage public provider portal](#).

Group-sponsored MA plan members are not affected by these changes. Members with the following member identification prefixes on their member card will represent group sponsored business only and will remain on the current claims processing platform:

**JQF JWM VZM VZP WGK WSP
XGH XGK XKJ XVL YCG
YGJ YLV YRA YRE YRU**

Y0071_15_23123_I 01/09/2015

Reminder: Clinical information required for MA members

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our MA members. They rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential.

Please refer to your provider agreement and the [Medicare Advantage HMO & PPO Provider Guidebook](#) to ensure that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.

Please note that Anthem MA plans administer Medicare coverage for our MA members and follow Medicare guidelines. 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 request to allow for an appropriate decision to be made. 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 be made only when the documentation supports the service/item.

Y0071_15_23063_I 01/06/2015

Prior authorization required for members

This is a reminder that providers are required to request a prior authorization for individual and group-sponsored MA members for services that require prior authorization. Failure to obtain a prior authorization will result in an administrative

denial. The 2015 prior authorization requirements were posted to the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal on October 4, 2014.

Members cannot be balance billed for an administrative denial.

To obtain prior authorization or to verify member eligibility, benefits or account information, please call the telephone number listed on the member's plan membership card.

Please visit the [Provider Forms](#) section of the Anthem [Medicare Advantage Public Provider Portal](#) at www.anthem.com/medicareprovider to see the prior authorization list that is effective for 2015 as well as prior authorization requirements for 2014.

Y0071_14_22046_I 10/14/2014

SNF, long term acute care, inpatient rehab and facilities -- new precert fax number

When submitting precertification requests or additional clinical information for the services listed below, please use this fax number, **877-423-9972**.

- Skilled Nursing Facility (SNF)
- Long Term Acute Care (LTAC)
- Inpatient Rehabilitation
- Facility (acute and non-acute)

Please note, submitting requests for services not listed above may cause a delay in processing requests.

Y0071_14_22758_I 12/10/2014

Updated OrthoNet authorization phone and fax numbers

Medical necessity and professional service coding reviews

Anthem is collaborating with OrthoNet, LLC to conduct medical necessity reviews for physical therapy, occupational therapy and spine and back pain management for our individual MA members. Please note: Group-sponsored MA members are not affected.

What does this mean to you?

As previously published, effective January 1, 2015, the following services/treatment requests must be reviewed by OrthoNet for precertification:

- Outpatient Physical Therapy
- Outpatient Occupational Therapy
- Spine and Pain Management Procedures:
 - Epidurals
 - Facet Blocks
 - Pain Pumps
 - Neurostimulators
 - Spinal Fusion
 - Spinal Decompression
 - Vertebro/Kyphoplasty

In addition, OrthoNet will conduct post service prepayment coding review of professional services, including:

- Orthopedic Surgery
- Plastic Surgery
- Neurosurgery
- Sports Medicine
- Podiatry
- Hand Surgery
- Neurology
- Pain Management
- Psychiatry/ Physical Medicine and Rehabilitation (PM&R)
- ENT
- General Surgery
- Dermatology
- Cardiology
- Urology
- Percutaneous Coronary Intervention (PCI)

Precertifications can be obtained at the following phone or fax numbers:

Outpatient Physical and Occupational Therapy

Fax 1-844-340-6419

Phone 1-844-340-6418

Spine and Pain Management Procedures

Fax 1-844-788-4806

Phone 1-844-788-4805

A complete list of precertification requirements can be found at the [Provider Forms](#) section of the [Anthem Medicare Advantage Public Provider Portal \(www.anthem.com/medicareprovider\)](#).

Y0071_15_23119_I 01/09/2015

Routine physical exams covered in 2015

Anthem MA plans will continue to offer coverage for routine physicals in 2015 for individual and group-sponsored MA members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member's plan. Anthem MA plans also will continue to provide benefits for the following Medicare covered services:

- **Initial Preventive Physical Exam (IPPE)** also known as the "Welcome to Medicare Preventive Visit"

- Annual Wellness Visit (AWV)

The IPPE (preventive physical exam) and AWV (wellness visit) are not routine physical exams. Please refer to the chart below to ensure accurate coding for each type of exam.

The Welcome to Medicare Visit (IPPE) <ul style="list-style-type: none"> G0402 	The Annual Wellness Visit (AWV initial and subsequent) <ul style="list-style-type: none"> G0438 & G0439 	Routine Physicals/Preventive Medicine Services <ul style="list-style-type: none"> (99381-99397) Continued coverage in 2015 by Anthem MA Plans
G0402 Welcome to Medicare Visit/Initial Preventive Physical Exam: <ul style="list-style-type: none"> A preventive evaluation and management service; a face-to-face evaluation. This exam is a preventive physical exam and not a comprehensive physical checkup. This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a once in a lifetime benefit. 	G0438 Initial Annual Wellness Visit (AWV): <ul style="list-style-type: none"> Services limited to beneficiary during the Second year the patient is eligible for Medicare Part B. Only one first AWV per beneficiary per lifetime. Includes a personalized prevention plan of services; face-to-face visit. G0439 – Subsequent Annual Wellness Visit (AWV): One year after the patient’s Annual Wellness Visit. Once every 12 months. Includes a personalized prevention plan of services; face-to-face visit. This exam is a preventive physical exam and not a comprehensive physical checkup. <p>Note: The AWV is intended to build upon the previously established “Welcome to Medicare Visit” physical exam.</p>	99381-99397 – Preventive Medicine Services: <ul style="list-style-type: none"> The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient’s age, gender, and identified risk factors; face-to-face visit. “The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.” Includes clinical laboratory tests.

Ob/Gyn providers please note: A Pap test and pelvic exam for our MA members is covered annually *only* if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past three years. Otherwise a Pap test and pelvic exam is covered every two years for women at normal risk. These services should be filed as separate codes from the routine physical, if they are rendered.

MA member benefits are subject to change from year to year – please review 2015 benefits on the Medicare Advantage Providers page of the Anthem provider portal. Annual summaries of Medicare Advantage plan changes also can be found under [Important Medicare Advantage Updates](#). This will advise what coverage of what will and/or will not take place for routine physicals.

For further information or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member's identification card.

Law excludes coverage of some Part D drugs

Customer Service ready to help with members' questions

There are some drugs that are excluded from the majority of Medicare Part D coverage by law. These include prescription vitamins and minerals (except prenatal vitamins and fluoride preparations, non-prescription drugs (over-the-counter drugs) and drugs for:

- Anorexia, weight loss or weight gain (except to treat physical wasting caused by AIDS, cancer or other diseases)
- Fertility
- Cosmetic purposes or hair growth
- Relief of the symptoms of colds, like a cough and stuffy nose
- Erectile dysfunction
- Durable medical equipment

A few plans may cover the above as an Enhanced Benefit. This information is applicable to both individual and group-sponsored MA members. If there is a question of coverage, please have the member call their customer service line on the back of their benefit card.

\$0 co-pay medications available

New to Individual MAPD plans in 2015, select drugs will be available at a \$0 member co-pay for the following conditions:

- high blood pressure
- high cholesterol
- diabetes.

Medications include Glipizide, Lisinopril, Losartan, Metformin Hcl and Simvastatin.

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

Avoid second fills of high-risk medications

Anthem is required to monitor prescription activity for high-risk medications as defined by The Centers for Medicare and Medicaid Services (CMS) to improve patient safety.

To ensure providers are aware of any high-risk medications prescribed for our MA members, we fax a list of high-risk medication claims to providers each week.

Anthem also distributes a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication fax or report from us, please review it and help us support safe medication choices.

Note: Alternatives to high-risk medications are listed at www.anthem.com/maprovidertoolkit.

Network Update

Compounded drugs no longer a covered benefit for some

Effective January 1, 2015, compounds are no longer a covered benefit for individual MAPD and PDP plans. Members who had a compound prescription filled in the last six months of 2014 were notified of this coverage change via mail and/ or phone.

Please note that members of group sponsored MAPD and PDP plans will have coverage for only the Part D eligible drugs that are part of a compound.

If you believe the compounded medication you have prescribed is medically necessary, the patient may request an exception. The prescriber must provide a statement along with the exception request that explains the medical reasons for supporting the exception.

Provider requirements and Medicare notices

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

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

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

Our audit findings are shown below. They point to the elements required by CMS that providers would benefit from focusing in on.

NOMNC Notices

Deliver notice to Managed Medicare beneficiaries the way you do to *Traditional Medicare* beneficiaries:

- Include the beneficiaries Health Care Identification Number or Medical Record Number on page one
- Include the specific type of services ending on page one
- Include the Health Plans contact information on page two
- Have the beneficiary or authorized representative sign and date page two at least two (2) days prior to the end of services
- Retain a copy of the signed notice, both page one and page two.

IM Notices

Deliver notice to Managed Medicare beneficiaries the way you do to *Traditional Medicare* beneficiaries:

- Include the physician's name on page one

- Have the beneficiary or authorized representative sign and date page one within 2 calendar days of the date of an inpatient hospital admission
- Call the authorized representative to deliver the IM when the beneficiary is unable to sign
- Deliver the IM, or copy of the IM again, no sooner than 2 calendar days before discharge
- Retain a copy of the signed notice, both page one and page two.

To download the **standardized IM/NOMNC Notices required** by CMS, along with accompanying instructions, go to CMS website at www.cms.hhs.gov/bni or refer to the specific links below:

- **NOMNC Notice:** <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html>
- **IM Notice:** <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

IMPORTANT UPDATE: Quality Improvement Organizations (QIO's) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see <http://www.qioprogram.org/contact> to locate your QIO.

For more information on compliance with the Notice of Medicare Non Coverage or the Important Message from Medicare, contact Mary Heapes, RN, BSN in the Federal Clinical Compliance Department at (212) 476-2908.

ICD-9 vs ICD-10 for atrial fibrillation and flutter

In previous articles, we shared some basic information and recommendations to help identify how specific ICD-9 codes will be impacted by the implementation of ICD-10.

The diagnoses data we receive from providers is critical for helping meet the health care needs of our members and remain compliant with CMS regulatory requirements. The information below supports accurate and complete diagnoses reports and ensures the medical chart documentation for each encounter supports and validates the reported diagnoses codes. This helps avoid unnecessary and costly administrative revisions as a result of an audit.

This article focuses on atrial fibrillation and flutter. According to the ICD-10 codebook, atrial fibrillation and flutter are the most common abnormal heart rhythms (arrhythmia) presenting as irregular/regular, rapid beating (tachycardia) of the heart's upper chamber. The ICD-10 code set provides multiple codes that represent a progressive path (severity of illness) for atrial fibrillation, requiring more specificity for accurate code assignment. The table below demonstrates what terms need to be documented in ICD-10 to appropriately capture the type of atrial fibrillation and flutter.

ICD-9 (Single code)	ICD-10 (Multiple specific codes)
Atrial Fibrillation <ul style="list-style-type: none"> ○ 427.31 (Established or Paroxysmal) <ul style="list-style-type: none"> - Irregular, rapid atrial contractions Atrial Flutter <ul style="list-style-type: none"> ○ 427.32 <ul style="list-style-type: none"> - Regular rapid atrial contractions 	Atrial Fibrillation <ul style="list-style-type: none"> ○ I48.0 Paroxysmal <ul style="list-style-type: none"> - Occurs periodically ○ I48.1 Persistent <ul style="list-style-type: none"> - Rapid contractions of the upper heart chamber ○ I48.2 Chronic <ul style="list-style-type: none"> - Permanent atrial fibrillation Atrial Flutter <ul style="list-style-type: none"> ○ I48.3 Typical <ul style="list-style-type: none"> - Type I atrial flutter

	<ul style="list-style-type: none"> ● I48.4 Atypical <ul style="list-style-type: none"> – Type II atrial flutter <p>Unspecified atrial fibrillation and flutter</p> <ul style="list-style-type: none"> ● I48.91 Unspecified atrial fibrillation <ul style="list-style-type: none"> – Type not specified ● I48.92 Unspecified atrial flutter <ul style="list-style-type: none"> – Type not specified
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In future articles, we will continue to bring you helpful coding tips to assist you and your coding staff with the transition from ICD-9 to ICD-10.

CMS will **not** accept ICD-9 codes for dates of service beginning on Oct. 1, 2015. It will be critical to keep this in mind as all encounters/claims submitted with ICD-9 codes will reject beginning Oct. 1, 2015 resulting in delay or denial of payment. We all must be prepared to meet CMS guidelines.

To further assist you in your preparation we are providing the following references, helpful links and additional resources:

- The one-page [reference sheet](#) produced by AAPC shows how the code sets are organized, with easy color coding to help you find what you're looking for. It also has mnemonic tips (such as "C is for cancer" and "T is for toxicity") to help you remember where the new codes are located.
- [American Medical Association](#) physician resource page
- Centers for Medicare & Medicaid Services (CMS) [Provider Resources](#)
- [AAPC ICD-10 Implementation and Training Opportunities](#)

Training available for D-SNP plans offered in 2015

Anthem now offers Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs coordinate Medicare and Medicaid programs and provide enhanced member benefits.

Anthem is offering [an introduction to D-SNP plans](#), including claims submission, coding procedures and model of care information. Providers can access this information at [Important Medicare Advantage Updates](#).

Y0071_14_22638_I 11/21/2014

Individual MA membership enforces CLIA and ADI

Effective July 1, 2015, Anthem Individual MA will deny claims billed without CMS required criteria back to the provider who submitted the claim. The denials will include:

- Advanced Diagnostic Imaging (ADI) supplier not accredited for the service being billed
- Clinical Laboratory Improvement Amendment (CLIA) certification is missing or invalid, based on the laboratory code billed. CLIA certification should be billed in Box 23 on the claim form. Starting in March an *informational* message will be included on your remittance when you bill a laboratory code that requires certification reminding you that, effective July 1, claims will be denied when CLIA certification is not included.

Please ensure your billing staff is aware of these changes. If you have any questions, please contact the Provider Services number on the back of the member's ID card.

Y0071_14_22889_I_12/17/14

Reminder: PCPs do not need to call Anthem to obtain referral

This is a MA HMO referral reminder: To ensure the highest level of benefits and coordination of care for Anthem members and streamline the approval process for your office, it's important that you refer members to in-network providers whenever possible. When you do, you will not need to contact the plan (Anthem) for preapproval of those referrals. Additionally, for in-network providers, members do not need a new referral simply because they are being seen in a new calendar year. For more information, please see our Network [eUPDATE](#) at www.anthem.com>[Providers](#) (select state)>Network eUPDATES> *Medicare Advantage HMO Referral Reminder*.

Reminder: Individual MA membership moved to new claims system

Effective January 1, 2015, Anthem moved Individual (non-group) MA members to a new claims processing system. Please continue to check [Important Medicare Advantage Updates](#) on your [provider portal](#) for additional information.

Home health claims – please split dates of service for 2014 and 2015

Now that individual MA members (not group sponsored plan members) have moved to a new claims system, please split the date of services for your 2014 and 2015 services. This will help ensure your claims are processed accurately and efficiently.

Bill the dates of services using calendar year format. For example, if you are submitting a claim for dates of services 12/18/2014 -- 1/20/2015, submit a claim for:

- Dates of service 12/18/2014 thru 12/31/2014
- Dates of service 1/01/2015 thru 1/20/2015

One place of service per claim

MA providers should not submit claims with more than one place of service. Please submit separate claims for each place of service.

Pharmacy

Pharmacy information available at [anthem.com](http://www.anthem.com)

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

and pharmacy information for Health Plans offered on the Exchange Marketplace, go to Customer Support, select your state, Download Forms and choose "Select Drug List."

Quality

Easy submission of HEDIS® medical records

We want to make returning HEDIS medical records as easy as possible for you.

For commercial medical records requests:

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

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

We will begin requesting medical records in January via a phone call to your office followed by a fax. Contact information will be included with the fax should you have any questions.

The Federal Employee Program (FEP) will also be collecting medical records in 2015 for HEDIS. This is a separate request from the Commercial medical records request, and will also adhere to a five day turn around for submission. Submitting the medical records for an FEP request will be slightly different than the Commercial direction noted above.

For FEP medical records requests:

1. Providers will receive a phone call with the request for medical records followed by a fax with a list of members and instructions for submission.
2. Medical records may be submitted via fax with the phone number on the fax cover sheet received. Alternate methods of submission are mailing and electronic medical records, instructions will be included in the fax packet received.
3. Mail information to us via the U.S. Postal Service to:
MMR Services
General Dynamics Information Technology
One West Pennsylvania Ave,
Towson MD 21204

We thank you in advance for your support of HEDIS.

HEDIS 2015: Controlling high blood pressure

One of the HEDIS measures we are collecting this year includes **Controlling High Blood Pressure**. This measure is collected on members ages 18 to 85 with a diagnosis of hypertension. The following items are needed from the member's medical record:

1. **The earliest documented date of hypertension (prior to 7/1/14) found in your medical record.** This diagnosis date can be any time prior to 7/1/14, but cannot be on 7/1/14 or after. For example, the earliest documented date does not have to be in 2014 – it can be in 1998, 2000, 2005, or 2010 – **ANYTIME prior to 7/1/14**. The diagnosis can be found on a dated history form, a problem list, or a progress note.
2. **Blood pressure (BP) reading(s) from the LAST TWO visits in 2014.** This does not have to be from a hypertension diagnosis visit; the last two blood pressure readings can be from any visit in 2014. Please note – the blood pressure readings **cannot** be from the same date as the earliest documented hypertension date listed above, or from the same day as a major diagnostic or surgical procedure. Please include all BP readings for the last two visits documented in progress notes and/or vital signs flow sheets.
3. **Additional documentation** is requested only if the following applies to the member:
 - a. Documentation of End Stage Renal Disease, renal dialysis or renal transplant with date of occurrence
 - b. If the member was pregnant in 2014, provide documentation of pregnancy
 - c. If the member had a non-acute inpatient admission during 2014, provide documentation

Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures.

We look forward to working with you this HEDIS season and thank you in advance for your continued cooperation and support of HEDIS.

Maternity-related HEDIS measures: FAQs

In the December 2014 [issue](#) of this newsletter, we discussed the HEDIS measure related to postpartum care that should occur between 21 and 56 days after delivery and what you can do to improve your rates. We would like to clarify some questions that arose concerning documenting the postpartum visit using the Category II CPT Code of 0503F for billing.

How do I indicate a postpartum visit date and the Category II CPT Code on the global bill when the postpartum visit has not occurred yet?

There isn't a way to code for a service that has not occurred yet (i.e., the postpartum visit). You can simply report code 0503F when the actual postpartum visit is conducted.

What should you do if your patient does not return for the postpartum visit before 8 weeks, or not at all? In this case, how should the global delivery be billed?

You would need to bill the appropriate delivery only code (either 59409, 59514, 59612, 59620), plus the antepartum care only code (either 59425 or 59426).

When I submit a claim using the Category II CPT Code of 0503F with a date, why might the claim be denied for payment?

If you are paid for a global delivery code (59400, 59510, 59610, 59618), then you have already been paid for the postpartum care. It is included as an integral part of these codes. AMA CPT Category II codes are supplemental tracking codes only and are only used for administrative purposes. Anthem does not use them for reimbursement of health services. Using code 0503F signals that the postpartum visit was conducted, which allows for claim captures of postpartum data for HEDIS.

Besides postpartum care, what other maternity-related HEDIS measures is the National Commission for Quality Assurance (NCQA) concerned about?

In addition to the postpartum care measure looking at the percentage of women who have delivered a baby and received a postpartum care visit 21 to 56 days after delivery, there are 2 other HEDIS measures related to maternity care:

1. Timeliness of Prenatal Care as determined by the percentage of women receiving a prenatal visit within the first trimester or within 42 days of health plan enrollment. Using Category II cpt code 0500F will signal the initial prenatal visit. The date of the initial prenatal visit should be included.
2. Frequency of On-going Prenatal Care as determined by the percentage of Medicaid deliveries that had the expected number of prenatal visits.

Note: An additional HEDIS measure is under consideration to look at early elective deliveries among low risk patients.

Where does the information come from?

Patient information from a random sample about compliance with the maternity HEDIS measures is obtained from a combination of looking at claims and by looking at patient records. When looking at patient records, the review team is looking for documentation of pregnancy diagnosis, dates of service, delivery date, evidence of physical exam, and counseling/discussion points. When a supplemental tracking code (0503F for postpartum visit or 0500F for the initial prenatal visit) is used on a claim, less time and disruption to your office is required by the health plan to review patient charts for evidence of postpartum care.

Clinical practice & preventive health guidelines

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>Providers (enter state)> Health & Wellness> [Practice Guidelines](#).

Reimbursement

Facility BMI policy

As part of our ongoing commitment to share current administrative, billing, and reimbursement policies with you, we've posted a new Facility reimbursement policy titled "Documentation and Reporting Guidelines for the Diagnosis of Body Mass Index ≥ 40 ," that will become effective May 5, 2015. To view this policy, please follow the steps listed in the article, "View Anthem reimbursement policies," on page 24.

Revised professional reimbursement policies

Anthem in Indiana, Kentucky, Missouri, Ohio, and Wisconsin (individually referred to herein as the Health Plan) reviews its professional reimbursement policies annually to determine if any changes or revisions are required. Listed below are changes to the professional reimbursement policies to provide further clarification and detail.

Updates to policies

Changes to the following policies do not affect the outcome of the reimbursement for claims submitted. Examples of some changes include punctuation, grammatical edits, formatting, as well as insertions of AMA CPT Handbook terminology.

Reimbursement Policy	Effective Date
Surgical Pathology and Related Prostate Needle Biopsy	2/1/2015
Multiple Surgery and Bilateral Surgery Processing	2/1/2015
Injection & Infusions Admin and Related Services	2/1/2015

Updates to the Assistant Surgeon Coding table

We have updated our Assistant Surgeon Coding table with the new *Current Procedural Terminology* (CPT®) codes effective January 1, 2015 that are **not** eligible for reimbursement for assistant at surgery services reported with modifiers 80, 81, 82, or AS: 20604, 20606, 20611, 20983, 21811, 21812, 21813, 22510, 22511, 22512, 22513, 22514, 22515, 22858, 27279, 33270, 33271, 33272, 33273, 33946, 33947, 33948, 33949, 33951, 33952, 33953, 33954, 43180, 43181, 44381, 44384, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 44346, 44347, 44349, 44350, 45388, 45389, 45390, 45393, 45398, 46601, 46607, 52441, 52442, 62302, 62303, 62304, 62305, 64486, 64487, 64488, 64489, 93644, G6019, G6020, G6022, G6023, G6024, G6025, G6026, G6027, G6028, 0377T, 0387T, 0388T.

The following deleted codes have been removed from the Assistant Surgeon Coding table: 21800, 22520, 22521, 22522, 22523, 22524, 22525, 29020, 29025, 29715, 33961, 36469, 36822, 44383, 45339, 45345, 45355, 45383, 45387, 69400, 69401, 0226T, 0227T, 0319T, 0320T, 0321T, 0322T, 0323T, 0324T, 0325T.

In addition we have updated the effective date of our Assistant Surgeon Services policy to align with the effective date of our Assistant Surgeon Coding table. For more information, refer to the List of Payment Policy Indicators link under MyAnthemSM Provider and Administrative Support. To access, please follow the steps listed in the article, "View Anthem reimbursement policies," on page 24.

Revisions to Bundled Services and Supplies Policy

The following codes were included in Section 1 of our policy to reflect that these services were not eligible for reimbursement as of January 1, 2015:

- 77061, 77062, 77063, and G0279 (Digital breast tomosynthesis (DBT)); this information is also included in our Three-Dimensional (3D) Radiology Services Reimbursement Policy

In addition, we are adding HCPCS code G0431 and G0434 to our always bundled services edit, effective for dates of service on or after May 19, 2015. This information will be included in Section 1 of our policy.

We are continuing to review and add Healthcare Common Procedure Coding System (HCPCS Level II) "S" codes to our always bundled services edit. According to the Health Plan, unless there are specific, specialized contracts or criteria for a

provider to report their services using a HCPCS temporary “S” code, the Health Plan will consider “S” codes to be always bundled codes. Therefore, effective with dates of service on or after May 19, 2015 codes S0257, S1015, S1016, S3005, S4005, S4011, S4013, S4014, S4035, S4037, S8096, S8097, S8100, S8101, S9900, and S9901 will not be eligible for reimbursement. This information will be included in Section 1 of our policy.

Section 2 of our policy will be updated to reflect that supplies and/or professional services such as an IV pole (HCPCS code E0776), infusion supplies (A4221 and A4222) and/or home therapy professional services (S9810) will not be eligible for separate reimbursement when reported with a per diem home infusion therapy (HIT) (for example S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590) service that includes supplies or home therapy professional services. Modifiers will not override this edit; therefore, this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

In addition, adding to Section 2 of the policy HCPCS code A4250 (Urine test or reagent strips or tablets (100 tablets or strips)) will not be eligible for separate reimbursement when reported with CPT codes 81000-81003 (urinalysis). Modifiers will not override this edit therefore this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

For claims processed on or after February 1, 2015, Section 2 of our Bundled Services and Supplies Reimbursement Policy will be updated to reflect that when reported with electrical stimulator supplies (A4595) on the same date of service, electrodes (A4556) and lead wires (A4557) will not be eligible for separate reimbursement. Modifiers will not override this edit; therefore this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

New professional reimbursement policy

A new policy outlining our documentation guidelines for reporting psychotherapy services, titled Documentation Guidelines for Psychotherapy Services, became effective February 1, 2015. To review it, please follow the steps listed in the article, “View Anthem reimbursement policies,” on page 24.

2015 CPT/HCPCS code updates and reimbursement treatment

As a reminder, the following information was included in a Network eUPDATE which was distributed via email on December 23, 2014:

On January 1, 2015, the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) will be releasing new CPT® and HCPCS codes. Many codes released as part of their updates will be accepted by Anthem; however, the following new 2015 codes will not be eligible for reimbursement for our Commercial products only:

1. **Codes G6030 - G6058 (Definitive Drug Testing)** - Reimbursement will only be provided for the applicable new 2015 CPT codes.
2. **Code G0276 (Blinded procedure for lumbar stenosis, clinical trial)** - This code would only be payable for Medicare patients in their CED project.
3. **Code G0472 (Hepatitis C antibody screening for high risk)** - Reimbursement will only be provided for the applicable existing CPT code.
4. **Code G0473 (Group behavioral obesity counseling)** - Reimbursement will only be provided for the applicable existing CPT code.

5. **Code 99490 (Chronic Care Management service)** - Chronic care management services are an integral component of Anthem's value based payment innovation programs.
6. **Codes 99497 - 99498 (Advance Care Planning service)** - Advance Care Planning services are an integral component of Anthem's value based payment innovation programs.
7. **Code 34839 (Physician planning for endograft)** - Physician planning for surgery is an integral component of the surgical procedure.

If you have further questions, please contact your local Network Relations consultant.

View Anthem reimbursement policies

Anthem's reimbursement policies are available online at MyAnthem, which is accessible through the Availity Web Portal.* To view online reimbursement policies, you must be registered for access to Availity and MyAnthem functionality.

Non-Registered for Availity: To register for access to Availity, go to www.availity.com/providers/registration-details/.

Non-Registered MyAnthem: If your organization is not registered for MyAnthem, sign onto www.anthem.com, select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. If you do not have a MyAnthem user id and password, your organization's site administrator must register you as a new user and assign required Anthem-specific functionality. Note: Effective June 21, passwords are no longer generated.

Registered MyAnthem: If you are a registered MyAnthem user, sign onto www.availity.com, select "My Payer Portals," then choose "Anthem Provider Portal" to be navigated into MyAnthem without entering an additional log-in or password. Select the Administrative Support tab, then select the link labeled **Procedures for Professional Reimbursement** or **Procedures for Facility Reimbursement**.

*For more information, see "MyAnthem and the Availity Web Portal: Access both with one log-in" on page 7 of the June 2014 issue of [Network Update](#) and "[Logging into MyAnthem](#)" at www.anthem.com>Providers (enter state)>Answers@Anthem.