Anthem BlueCross BlueShield

Working together to improve the health of our members.

April 2015

Network Update

CENTRAL REGION

In this issue

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

anthem.com

CE0415
IN, KY, MO, OH, WI

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.

The following articles were recently posted:

- Updated contact information for ERA and EFT registration - February 2015
- Claim adjustments for members reaching out-of-pocket maximums -- February 2015
- Preventive care services covered with no member cost-share (updated 2/12/15)

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 was recently posted:

- Integrated Care Model for plans purchased on the Health Insurance Marketplace benefits patients and physicians

Administrative Update

New Ohio networks

Notice of Other/Separate provider network/programs and provider panels

In response to a request from customers to offer a tiered niche option, effective July 1, 2015, Anthem will offer a new group tiered product in the local Ohio marketplace. Note: This tiered-designed product will not be available in all Ohio markets.

Although Anthem's Blue Access® network is being utilized in part for this PPO product design, certain modifiers such as "OH I" and "OH II" will be appended to the Blue Access network name for benefit design and/or local market identification purposes to differentiate these new provider networks (i.e., "Blue Access®-OH I" and "Blue Access®-OH II"). Anthem will be communicating directly with providers concerning participation in the new networks.

Thank you for your continued support of our Anthem members, and please contact your network consultant should you have any questions.

Fraud, waste and abuse detection

Anthem recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse and is committed to protecting and preserving the integrity and availability of health care resources for our members, clients, and business partners. Anthem accordingly maintains a program, led by Anthem's Special Investigations Unit (SIU), to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans.

Pre-payment review

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

Once such an unusual Claim is identified or a Provider is identified as an outlier, further investigation is conducted by SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual Claim. If the investigation results in a determination that the Provider's actions may involve fraud, waste or abuse, the Provider is notified and given an opportunity to respond.

If, despite the Provider's response, we continue to believe the Provider's actions involve fraud, waste or abuse or some other inappropriate activity, the Provider is notified he/she/it is being placed on pre-payment review. This means that the Provider will be required to provide medical records with each Claim submitted so that we will be able to review them compared to the services being billed. Failure to submit medical records to Anthem in accordance with this provision may result in a denial of a Claim under review. The Provider will be given the opportunity to request a discussion of his/her/its pre-payment review status. Under this program, we may review coding and other billing issues. In addition, we may use one or more clinical

utilization management guidelines in the review of claims submitted by the Provider, even if those guidelines are not used for all Providers delivering services to Plan's members.

The Provider will remain subject to the pre-payment review process until we are satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the Provider could face corrective measures, up to and including termination from our Provider network.

Finally, Providers are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other billing issue or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable provider agreement and state law. Providers also may appeal such determination in accordance with applicable grievance procedures.

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.

Missing a 1099 IRS form?

Use the following link -- www.1099dept@anthem.com for information.

Or call 1-888-246-4893.

Claims

ICD-10 Updates: Free coding practice tool, end-to-end testing results

Visit our ICD-10 Updates webpage* for the above resources, as well as our latest information on ICD-10.

Free Coding Practice Tool Available to Code Medical Scenarios in ICD-10: Starting in April, we are offering a free scenario-based coding practice tool designed to give physicians and their coders the opportunity to test their knowledge of the ICD-10 codes set by applying it to medical scenarios. These customized scenarios are based on provider type and specialty, so you can practice using codes relevant to you. ***Registration is required.*** This tool will be available until September 2015.

End-to-End Testing Results: In 2014, we conducted extensive end-to-end claims testing with facility providers, professional providers and clearinghouses. Visit our ICD-10 webpage* to learn about the insights we gained during the testing. We've also included a list of clearinghouses we've successfully tested with.

* ICD-10 webpage by state: IN - **Anthem's ICD-10 webpage**, KY - **Anthem's ICD-10 webpage**, MO - **Anthem's ICD-10 webpage**, OH - **Anthem's ICD-10 webpage**, WI - **Anthem's ICD-10 webpage**

Reminder: Billing for "Incident to" services

This is a reminder that "Incident to" services rendered and billed under the supervising provider must meet the Anthem definition of medically necessary and be otherwise covered services. For more details, please see our Network eUPDATE here.

eBusiness

Availity to launch new eligibility and benefits functionality

During the 2nd quarter 2015, watch for upcoming changes to the Availity Web Portal, including the launch of new eligibility and benefits (E&B) functionality and features. These changes will make finding E&B easier and faster for you. Here's a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes user's most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus only information relevant to that member is displayed.
Menu by benefit type	Located under the 'Coverage and Benefits' tab, this interactive list includes key coverage elements and only shows information that is returned from the payer.
Organization-wide view of E&B transactions	Users can see transactions by other users within their organization (shared history). This means less duplication of work.
Organization drop down menu	Users responsible for more than one organization can switch organizations while staying on the same page, resulting in a convenient, streamlined workflow.
Payer section	Includes value-added services on one page so that users can access value-added services, such as patient care summary, from the same page.

Availity will offer training to learn more about these time-saving features. Details will be shared soon.

Reminder: Access your Anthem remittances via Availity

Are you accessing your Anthem paper remittances online through the Availity Web Portal? If not, take the following steps now to begin accessing your paper remittances online.

If your organization is NOT currently registered for the Availity Web Portal:

- The designated administrator for your organization should go to **www.availity.com**.
- Click on *Get Started* under Register now for the Availity Web Portal, and then complete the online registration wizard.
- The administrator will receive an e-mail from Availity with a temporary password and next steps.

Not sure if your organization is registered?
Call Availity Client Services at 800-AVAILITY (800-282-4548) for registration status of your Tax ID.

Once registered on Availity, complete the Anthem Services Registration within the Availity Web Portal:
This registration process grants Availity users who are set up with an Anthem Health Plan User ID to access paper remittances on MyAnthem through the Availity Web Portal by using a single sign on feature.

- On Availity, from the left navigation menu, select *My Account* | then *Anthem Services Registration*.
- Select the user's organization (if applicable).
- Select *Non-Registered Users.*
- From the *Non-Registered Users* list, locate your user and type in their Anthem Health Plan User ID; repeat this step for additional registrations.
- Click Register.
- Log out and log back into Availity in order for the new access to take effect.

Important Note: The user's first and last name must exactly match what is registered in the Anthem system. If an exact match is not made, the registration will be rejected.

Take the following steps to update the user's name in Availity:

- From the Availity menu, select *Account Administration* | then *Maintain User.*
- Locate the user and type in the changes.

Don't know your Anthem Health Plan User ID?
You may call the Anthem eBusiness Helpdesk at 1-866-755-2680 to obtain this information or you may send an email to Central.eProvider.Rep@Anthem.com. (Be sure to include your TIN, state, and phone number so that your inquiry can be directed to the most appropriate area.)

How does a user receive an Anthem Health Plan User ID?
Your organization's Site Administrator for the MyAnthem provider portal will need to register a user* for the MyAnthem web portal in order to issue an Anthem Health Plan User ID. Once the Anthem Health Plan User ID has been issued to a user, the Anthem Services Registration described in Step 1 can be completed. **The Site Administrator should take the following steps to register users for the MyAnthem web portal:**

- Log into Availity | select *My Payer Portals*| select *Anthem Provider Portal* then click on "I Agree" to link out to MyAnthem.
- Select *Manage My Users.*
- From *Manage My Users*, select ADD then complete the required fields and assign the role *View Remit* to the user.
- Click Submit and you will then automatically receive the Anthem Health Plan User ID for the user.

Note: Remit access can be given to an existing user by following the steps above and then choosing a user to EDIT instead of choosing ADD.

*Only network providers who participate with Anthem can register for MyAnthem.

Access your Paper Remittances through the Availity Web Portal:
Users can now follow the steps below to access your organization's paper remittances:

- Log into Availity at www.availity.com.
- Click *My Payer Portals* | then *Anthem Provider Portal* then click on "I Agree" to link out to MyAnthem You are now logged directly into the MyAnthem Provider Home page.
- Select *Online Provider Inquiry* to access the link for Remittance Inquiry.

One last step:
Once you have completed the registration to obtain your online "paper" remittances through the Availity Web Portal and no longer require the delivery of paper remittances by mail, you can discontinue the mailing of paper remittances by completing the online form.

Is Training Available?
Availity offers a variety of ongoing training options, including live and on-demand webinars, online demonstrations, local workshops, comprehensive help topics, tip sheets and more. For a full list of learning options, log in to the Availity portal and click *Free Training* at the top of any page.

Have Questions?

- *If you do not know your Anthem Health Plan User ID:* Call Anthem eBusiness Helpdesk @ 1-866-755-2680 or send an email to Central.eProvider.Rep@Anthem.com. (Be sure to include your TIN, state, and phone number so that your inquiry can be directed to the most appropriate area.)
- *For questions regarding MyAnthem user registration:* Send an email to Central.eProvider.Rep@Anthem.com.
- *For questions regarding Availity's Anthem Services Registration:* Call Availity Client Services toll free at 1-800-282-4548.

Federal Employee Program (FEP)

FEP medical policy

The FEP Medical Policy Manual may viewed online, go to www.anthem.com>Providers (select state)>Medical Policies and Clinical UM Guidelines>Federal Employee Program, or you can also go to www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies. Here providers can review specific medical policies that pertain to the Blue Cross and Blue Shield Service Benefit Plan, also known as FEP. The policies contained in the FEP Medical Policy Manual are developed to assist in administering plan benefits and do not constitute medical advice. They are not intended to replace or substitute for the independent medical judgment of a practitioner or other health care professional in the treatment of an individual member. The Blue Cross and Blue Shield Association does not intend by the FEP Medical Policy Manual, or by any particular medical policy, to recommend, advocate, encourage or discourage any particular medical technologies. Medical decisions relative to medical technologies are to be made strictly by members/patients in consultation with their health care providers. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that FEP covers (or pays for) this service or supply for a particular member.

Health Care Management

Medical policy update

The following Anthem medical polices were reviewed on February 5, 2015 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on July 15, 2015:

DRUG.00072 Alpha-1 Proteinase Inhibitor Therapy
This new medical policy addresses indications for the use of alpha-1 proteinase inhibitors as therapy for individuals with a deficiency of alpha-1 antitrypsin (AAT).

DRUG.00073 Rilonacept (Arcalyst®)
This new medical policy addresses the U.S. Food and Drug Administration (FDA) approved indications for rilonacept (Arcalyst) an interleukin-1 (IL-1) inhibitor drug which is indicated for the treatment of cryopyrin-associated periodic syndromes (CAPS), including Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS).

DRUG.00074 Alemtuzumab (Lemtrada™)
This new medical policy addresses the use of alemtuzumzab (Lemtrada), which is a humanized monoclonal antibody directed at CD52 (a protein on the surface of immune cells) used for the treatment of multiple sclerosis (MS).

MED.00115 Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
This new medical policy addresses the use of a wireless implantable hemodynamic system for ambulatory monitoring of heart failure.

MED.00116 Near-Infrared Spectroscopy Brain Screening for Hematoma Detection
This new medical policy addresses the use of near-infrared spectroscopy (NIRS) for the screening and detection of brain hematoma and intracranial bleeding.

GENE.00010 Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status
This medical policy was revised to address genotype testing for genetic polymorphisms to determine drug-metabolizer status for individuals initiating therapy with simprevir plus sofosbuvir, opiods, and narcotics.

To view online, go to www.anthem.com>Providers (select state)>Medical Policies and Clinical UM Guidelines.

Specialty pharmacy drugs will require precert

A new clinical guideline, outlining the medically necessary and not medically necessary clinical indications for pegasparagase and asparaginase Erwinia chrysanthemi, will be implemented for the following specialty drugs. Effective July 2, 2015, the following drugs will require precertification for members covered by Anthem local plans:

Medical Policy or Clinical Guideline Number	Medical Policy or Clinical Guideline Name	Drug Name(s)	Drug Code(s)
CG-DRUG-42	Asparagine Specific Enzymes (Asparaginase)	Erwinaze, Asparaginase, Oncaspar	J9019 J9020 J9266

Effective July 15, 2015, the following specialty drugs will require precertification for members covered by Anthem local plans:

Medical Policy or Clinical Guideline Number	Medical Policy or Clinical Guideline Name	Drug Name(s)	Drug Code(s)
DRUG.00073	Rilonacept (Arcalyst®)	Arcalyst	J2793
DRUG.00074	Alemtuzumab (Lemtrada™)	Lemtrada	J3490, J3590

Effective July 15, 2015, the following specialty drugs, currently on the precertification list, will be reviewed using a new medical policy:

Medical Policy or Clinical Guideline Number	Medical Policy or Clinical Guideline Name	Drug Name(s)	Drug Code(s)
DRUG.00072	Alpha-1 Proteinase Inhibitor Therapy	Aralast, Aralast NP, Prolastin, Prolastin-C Glassia	J0256, J0257

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, which help you make sure that all necessary information has been submitted so that Anthem can complete the review. You can find the tools at www.anthem.com>Providers (enter state)> Precertification>Commercial Specialty Pharmacy Clinical Data Submission Tools. (Note: Tools are not available for all specialty pharmacy data submissions.)

For additional information on Anthem precertification requirements for specialty pharmacy drugs, please see Specialty Pharmacy Precertification Drugs and Codes and Precertification Guidelines at www.anthem.com>Providers (enter state).

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.

AIM to review pre-service requests – revised date

Important: Revised transition date of pre-service clinical review of specialty pharmacy drugs
As you may recall, you were previously notified in the August 2014 issue of *Network Update* that the pre-service clinical review of specialty pharmacy drugs would transition from Anthem to AIM in September 2014. However, this transition was ultimately delayed. **Please be advised that the pre-service clinical review of specialty pharmacy drugs that fall under the medical benefit will now transition to AIM, effective May 1, 2015.** You may submit an online request for pre-service clinical review, or call AIM directly.

Internet requests
Online pre-service clinical review will be available via **Provider**Portal℠, AIM's web-based application. **Provider**Portal is available twenty-four hours a day, seven days a week. It is fully interactive, processing requests in real-time using clinical criteria. To access, go to www.providerportal.com.

Telephone requests
Submit requests for pre-service clinical review via telephone. Call AIM toll-free at 800-554-0580, Monday -- Friday, 8 am – 8 pm EST to request pre-service review.

Once the transition occurs, Anthem's phone prompts will be changed to include a Specialty Pharmacy prompt that will automatically route the caller to AIM for pre-service clinical reviews.

* Note: Except as indicated below, this transition does not apply to National accounts, Federal Employee Program (FEP), Medicare Supplement plans, Medicare Advantage HMO and PPO plans and Medicaid.

Please note that, on behalf of Anthem, AIM already reviews pre-service requests for certain specialty pharmacy oncology drugs for the Cancer Care Quality Program. Oncologists and hematologists are encouraged to continue to submit cancer treatment regimens to AIM for review. (See more information on the Cancer Care Quality Program here.)

Codes added to CG-MED-38 and CG-REHAB-08

Anthem Utilization Management has updated the coding of the Clinical Guidelines. As a result, effective July 2, 2015, the following codes will be added to CG-MED-38 and CG-REHAB-08:

Medical Policy or Clinical Guideline	Name	Code(s) added to Medical Policy or Clinical Guideline
CG-MED-38	Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer	Added Diagnosis V10.87 for codes related to thyroid cancer treatment
CG-REHAB-08	Private Duty Nursing in the Home Setting	Added Nursing Codes T1030 and T1031

Medicare

Precert required for four new Part B injectables

Anthem added the following four new injectable drugs to the 2015 Medicare Advantage (MA) list of Part B Injectables / Infusibles requiring precertification. **As of March 1, 2015, providers must call for prior authorization of these drugs.**

1. Benlysta (belimumab) for treatment of lupus (SLE) (J0490): Drugs billed with NOC HCPCS J code (J3490)
2. Iluvien (fluocinolone acetonide injection): for treatment of diabetic macular edema (DME) (unlisted, no J code established at this time)
3. Lemtrada (alemtuzumab injection): for treatment of relapsing forms of multiple sclerosis (MS) (unlisted, no J code established at this time)
4. Opdivo (nivolumab) for treatment of unresectable or metastatic melanoma (unlisted, no J code established at this time)

Please note: For drugs currently billed under the Not Otherwise Classified J code (J3490), the plan's denial will be for the drug and not the HCPCS. This applies to all Medicare Advantage Group Sponsored and Individual Medicare Advantage plans.

To contact the plan for prior authorization of these services: call **866-797-9884 Option 5,** fax to **866-959-1537,** or send an email to **maspecialtypharm@anthem.com**.

As a reminder, MA providers were previously notified of this in the Medicare Advantage Outreach and Education Bulletin dated February 17, 2015; it can be found under "Important Medicare Advantage Updates" on the public Medicare Advantage provider website.

Members encouraged to stay up-to-date on preventive care

Anthem is committed to helping your Medicare Advantage (MA) patients maintain good health habits and stay up-to-date on preventive screenings. We encourage you to check in with your senior patients about the following issues to help ensure they are monitoring their own health and receiving needed care.

Physical Health/Monitor Physical Activity

- Discuss and encourage the importance and benefits of exercise
- Discuss applicable exercise options
- Discuss any problems/pain members are having with accomplishing daily activities

Mental Health

- Discuss overall mental health and if physical and emotional health is affected
- Discuss feelings of anxiety, blues, depression
- Discuss members' overall energy level

Bladder Control

- Assess whether the member has had any leaking of urine
- Advise the member of bladder treatment options such as bladder training, exercises, medication and surgery

Breast Cancer Screening

- Women 50-74 need to have a mammogram at least every 24 months

ACIP updates Pneumococcal Vaccine Policy

Anthem would like to make you aware that the Advisory Committee on Immunization Practices (ACIP) has changed its policy regarding pneumococcal vaccines for persons over the age of 65.

Effective September 19, 2014, Anthem covers:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

ClaimCheck upgraded for individual Medicare Advantage members

Anthem will complete two upgrades to ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in the Version 55 upgrade will become effective **July 2015**. The changes included in the Version 56 upgrade will be effective in **August 2015**.

Anthem uses an auditing software product from McKesson to reinforce compliance with standard code edits and rules. ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being

Anthem uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to industry standards.

ClaimCheck is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes.

Anthem uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- Diagnosis to procedure mismatch
- Upcoded services
- Fragmented billing of pre- and postoperative care

Other procedures and categories reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Procedures billed with inappropriate modifiers

The information above is applicable to claims for individual Medicare Advantage members only. It is not applicable to group-sponsored Medicare Advantage claims.

CMS weighs monitoring statin use among diabetics

Endocrinologists and primary care providers (PCPs) please note: In November of 2013 the ACC/AHA released new guidelines for the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults. One major focus in this recommendation is reducing the risk of atherosclerotic cardiovascular disease (ASCVD) in persons with diabetes who are 40-75 years of age. According to the ACC/AHA guideline, "Moderate-intensity statin therapy should be initiated or continued for adults 40-75 years of age with diabetes mellitus," and "High-intensity statin therapy is reasonable for adults 40-75 years of age with diabetes mellitus with a ≥7.5% estimated 10-year ASCVD risk unless contraindicated." *

To align practice standards, the Pharmacy Quality Alliance (PQA) has developed a measure to support the ACC/AHA guidelines. The measure is labeled "Statin Use in Persons with Diabetes," and calculates the percentage of patients ages 40-75 years who received a medication for diabetes and also received a statin medication during the measurement period. The Center for Medicare and Medicaid Services (CMS) is closely following this measure and is evaluating the addition of this measure as a future Medicare Part D health plan rating.

Please consider initiating statin therapy in patients who fit these criteria in conjunction with the recommendations from 2013 ACC/AHA Guidelines for the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. The 2013 ACC/AHA Guidelines for the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults can be found at: http://circ.ahajournals.org/content/129/25_suppl_2/S1

*Formulary moderate-intensity statin therapies include atorvastatin 10-20 mg, Crestor 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg; while formulary high-intensity statins include atorvastatin 40-80 mg and Crestor 20-

40 mg. Simvastatin currently costs our members $0 to $5 (varies by plan) for a 30-day fill at a preferred pharmacy. This would be the least expensive option for them.

OrthoNet to conduct post-service prepay medical necessity reviews

Appropriate care is the key to achieving the best outcomes for our MA members. To help reach that goal, Anthem is collaborating with OrthoNet to help ensure that invasive cardiac procedures are reasonable and necessary for the diagnosis and/or treatment of coronary artery disease.

Effective April 1, 2015, Anthem contracted with OrthoNet to conduct post-service prepay medical necessity reviews of selected cardiac procedures, including reviews of facility and professional Cardiac Catheterizations and Percutaneous Coronary Interventions (PCIs). These reviews will apply to individual Anthem MA members.

Providers who submit claims for these services for individual Anthem MA members after the effective date may receive a request for records and related digital images. The process for submitting records and related images will be streamlined by providing you with a HIPAA-compliant, secure internet portal for uploading the needed information. Instructions for completing this process will be included with the request.

A board-certified cardiologist will review the records and images to determine if the services were reasonable and necessary to diagnose and/or treat the patient. Should you receive a medical record request, Anthem would appreciate your timely compliance.

OrthoNet will use Medicare national coverage determinations, local coverage determinations, Anthem's medical policies, and clinical utilization management guidelines to determine medical necessity of the requested therapies. You may access these coverage determinations, medical policies and clinical guidelines here.

If you have questions about this communication or need assistance with any other item, contact OrthoNet at **844-278-5477** (phone) or **844-876-4924** (fax).

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

As a reminder, MA providers were previously notified of this in the Medicare Advantage Outreach and Education Bulletin dated February 28, 2015; it can be found under "Important Medicare Advantage Updates" on the public Medicare Advantage provider website.

Y0071_15_23430_I 02/04/2015

Precert requests and information available via Availity

Precertifications for Anthem individual MA members can be initiated via the Availity web portal at www.Availty.com. To access this functionality, go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well, via the Precertification look-up tool. Please visit www.anthem.com/medicareprovider to learn more.

Find medical record information through Patient360

Patient360 is a read-only dashboard available online that gives you instant access to detailed individual MA member information. By clicking on each tab in the Patient360 dashboard, you can drill down to specific items in a patient's medical record:

- Demographic information – member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries – emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details – status, assigned diagnoses and services rendered
- Authorization details – status, assigned diagnoses and assigned services
- Pharmacy information – prescription history, prescriber, pharmacy and quantity
- Care management-related activities – assessment, care plans and care goals

MA reimbursement policy changes posted online

Anthem MA published Medicare Advantage Reimbursement Policy Changes in the October 2014 issue of *Network Update* and posted the information under "Important Medicare Advantage Updates" in August 2014. Anthem has updated and expanded this initial communication to help address any questions you may have. To view this communication, please click here.

CPGs assist with chronic condition management

Clinical Practice Guidelines (CPGs) are resources to assist providers and members in the management of chronic medical conditions. They are reviewed by board-certified practitioners and distributed to network providers to reduce unnecessary variation in care. Anthem CPGs are located online at www.anthem.com>Providers (enter state)>Health &Wellness>Practice Guidelines.

ICD-10-CM: Breathe Easy with these Coding Tips for COPD

In ICD-9, COPD code 496 is not to be used with any code from categories 491 (chronic bronchitis), 492 (emphysema), or 493 (asthma). In ICD-10, code category J44 encompasses asthma and bronchitis associated with COPD. Code category J44 includes other COPD, asthma with COPD, chronic asthmatic (obstructive) bronchitis, chronic bronchitis with airways obstruction, chronic bronchitis with emphysema, chronic emphysematous bronchitis, chronic obstructive asthma, chronic obstructive bronchitis and chronic obstructive tracheobronchitis. Furthermore, in ICD-10 there is a note to use an additional code to identify exposure to environmental tobacco smoke (Z77.22), history of tobacco use (Z87.891), occupational exposure to environmental tobacco smoke (Z57.31), tobacco dependence (F17.-), or tobacco use (Z72.0).

The table below reflects the crosswalk from ICD-9 to ICD-10.

ICD-9 (COPD documented with a more specific respiratory condition fell under multiple code categories)	**ICD-10** (COPD documented with a more specific respiratory condition falls under one code category)
• 491.2-, Obstructive chronic bronchitis • 493.2-, Chronic obstructive asthma • 496, COPD	• J44.-, Other chronic obstructive pulmonary disease – Code also type of asthma, if applicable (J45.-)

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.

As a reminder, claims/encounters with dates of service October 1, 2015 and later must be submitted with ICD-10 codes. CMS will reject those submitted with ICD-9 codes resulting in delay or denial of payment. We must all be prepared to meet CMS guidelines.

Y0071_15_23499_I 02/12/2015

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.

Y0071_14_22758_I 12/10/2014

Pharmacy

Pharmacy information available at 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

Update to the Cancer Care Quality Program

Attention Oncologists, Hematologists and Urologists
As a reminder, Anthem launched the Cancer Care Quality Program ("Program"), a quality initiative, on July 1, 2014. The Program provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways ("Pathways"). Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM, a separate company.

To help ensure the Cancer Treatment Pathways remain consistent with current evidence and consensus guidelines, they will be reviewed quarterly or more frequently as needed. When it is necessary to make a change to existing Pathways where a specific Pathway treatment regimen moves from "on Pathway" to "off Pathway," Anthem will provide 30 days' notice of the change to physicians in *Network Update*, our online provider newsletter. After the effective date of the change, physicians

will no longer be eligible to receive enhanced reimbursement for the S codes once the number of months specified in any previous notification and instructions issued to the physician by AIM via the AIM **Provider**Portal or AIM Call Center has expired. Any new requests will need to be on Pathway to be eligible for enhanced reimbursement.

ConditionCare program benefits patients and physicians

Anthem members have additional resources available to help them better manage chronic conditions. The ConditionCare program is designed to help participants' improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

Engagement methods vary by risk level but can include:

- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Coaches and other health professionals.

Physician benefits:

- **Save time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient's progress in the program.

The goal of our nurse coaches is to encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Please visit Anthem's website to find more information about the program, such as program guidelines, educational materials and other resources. Go to www.anthem>Providers (select state) > Health and Wellness > ConditionCare**.** Also on our website is the Patient Referral Form, which you can use to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call **877-681-6694**. Our nurses are available Monday-Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 5:30 p.m.

Please note that we also have a care management program specifically for members with health plans purchased on the Health Insurance Marketplace (also called the exchange). More information is available in the article entitled "Integrated Care Model for plans purchased on the Health Insurance Marketplace Benefits Patients and Physicians."

HEDIS 2015: Colorectal cancer screening

One of the HEDIS measures we are collecting this year is Colorectal Cancer Screening. This measure is collected to ensure that our members between the ages of 50 and 75 have been screened appropriately for colorectal cancer. The following items are needed from the member's medical record:

1. Documentation must indicate the date that the member had one of the following screenings:
    a. **Colonoscopy** – Completed within the last 10 years (1/1/05- 12/31/14)
    b. **Flexible Sigmoidoscopy** - Completed within the last 5 years (1/1/10 – 12/31/2014)
    c. **Fecal Occult Blood Test (FOBT)** – ALL tests that were completed in 2014. There are two types of FOBT tests: guaiac (gFOBT stool card with 3 samples) and immunochemical (iFOBT– sometimes referred to as FIT-1 sample). Depending on the type of FOBT test, a certain number of samples are required, so please send all tests.

A result is NOT required if the documentation is clearly part of the "Medical History" section of the record. If this is not clear, the result or finding must also be present to ensure that the screening was performed and not merely ordered. Hemoccult tests taken during a routine rectal exam do not count towards this screening measure.

2. Documentation of a history of one of the following at any time through December 31, 2014:
    a. Colorectal cancer
    b. Total colectomy

We have found that evidence of colorectal cancer screening is not always found in the same part of every medical record. We encourage your staff to check the History & Physical, Consultation Reports, Procedure List, Progress Notes and Lab Sections of the chart for the required documentation before indicating that a screening was not completed. Please submit any documentation that is found to serve as evidence of screening.

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.

KY, MO, WI: Quality and cost program to expand

Anthem previously has implemented an integrated management program to help members compare facility costs on imaging and sleep services. The program is administered in partnership with AIM.

On May 1, 2015, this program will expand for some of your patients to include the following surgical procedures:

- Colonoscopy- screening, biopsy, and lesion removal
- Endoscopy – Upper GI with Biopsy
- Arthroscopic ACL Repair
- Knee Arthroscopy with Cartilage Repair
- Shoulder Arthroscopy
- Shoulder Arthroscopy with Rotator Cuff Repair

Program components

- *Provider notification:* You may contact AIM when your patient requires one of the surgical procedures listed above. Both ordering and servicing providers may contact AIM.
- *Provider/patient transparency*: Once AIM is notified, surgical facility cost information will be shared with you and your patient to help select a lower-cost option. This enhancement is available for fully-insured members. Cost information is based on Anthem's historical paid claims data for the various services in scope. This data is updated twice per year.

You may contact AIM in one of two ways:

- Online through **Provider**Portal at *www.aimspecialtyhealth.com/goweb.*
- Via telephone at (800) 554-0580 or by using the number displayed on the back of the member ID card.

Claims will not be denied for failure to inform AIM. Members will not be denied access to services if they do not choose a lower-cost option. Our goal is simply to provide members with information to make informed choices about their health care.

If you have any questions about this information, please contact your local Network Relations consultant.

Note: Medicaid, Medicare Advantage, Healthy Indiana, and FEP members are not included in this program.

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

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. Please see the following changes to the professional reimbursement policies:

- **Updates for punctuation, grammatical edits, formatting, etc.** 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
Lab and Venipuncture	04/01/2015
Global Services	04/01/2015
Sleep Studies	04/01/2015
Urgent Care	04/01/2015

Moderate Sedation	04/01/2015
Three Dimensional (3D) Radiology Services	01/01/2015
Bundled Services and Supplies	05/19/2015

- **Policy title change:** Effective May 19, 2015 the "Qualitative Drug Screen" policy title will be changed to "Drug Screen Testing" and will include information on coding updates. In addition, as communicated in the article, "Bundled Services and Supplies," published in the February 2015 issue of *Network Update*, the Health Plan considers G0431 and G0434 to be always bundled services and not eligible for reimbursement. Anthem will accept the definitive drug testing codes 80150-80377 in place of G0431 and G0434.

- **Codes added to Bundled Services and Supplies Policy:** The following changes are effective with dates of service on or after July 1, 2015:
  - 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 providers 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 July 1, 2015, codes S4028, S8415, S9098 and S9110 will not be eligible for reimbursement. This information will be included in Section 1 of our policy.
  - In addition, we are adding HCPCS code 98961 and 98962 to our always bundled services edit, effective for dates of service on or after July 1, 2015. This information will be included in Section 1 of our policy.

Coding tip: Adaptive BH follow-up assessments 0360T-0363T

Based on CPT's description for CPT codes, the following services are to be reported based on the time that the patient is face-to-face with one or more technician(s); however, *only the time of one technician is counted and reported.*

- 0360T-0361T (Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first and each additional 30 minutes of technician time, face-to-face with the patient) and
- 0362T-0363T (Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first and each additional 30 minutes of technician(s) time, face-to-face with the patient).

If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code.

In addition, the Health Plan follows CPT's "Time-Rule for Face-to-Face Technician Time" guidelines that a unit of time is attained when the mid-point is passed and that the time reported is for a single day and is not cumulative over a longer period of time.

View Anthem reimbursement policies

Anthem's reimbursement policies are available online at MyAnthem; access via the Availity Web Portal.* (Note: 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 for 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 for 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.

Medicaid Notifications

KY, WI: ClaimCheck Versions 55 & 56 upgrades

The following article applies to Anthem Blue Cross and Blue Shield Medicaid (KY) and Anthem Blue Cross and Blue Shield (WI).

Earlier in this edition of the *Network Update*, we provided a short notice about upgrades to ClaimCheck. Please refer to the full article on page 11 about the ClaimCheck upgrades.

If you have questions about the upgrades, contact your local Provider Relations representative or call our Provider Services team at **1-855-558-1443**.

ICD-10 coded prior authorizations

The following article applies to Anthem Blue Cross and Blue Shield Medicaid (KY) and Anthem Blue Cross and Blue Shield (WI).

The transition from ICD-9 to ICD-10 goes into effect on **October 1, 2015**. Anthem will begin accepting ICD-10 coded authorizations beginning **June 1, 2015,** for authorization requests with dates of service for **October 1, 2015,** or later. Authorization requests for dates of service prior to **October 1, 2015,** will continue to be coded using ICD-9.

Preparing to transition to ICD-10
To help ensure you are ready, here are some additional things to remember:

- Make sure your practice management system and/or billing system is ICD-10 ready. Talk with your vendor about the support and services you might need to be compliant for ICD-10.
- There is no need to memorize all of the new ICD-10 diagnoses. If you are not an inpatient facility, you only need to be concerned with the most common medical conditions your practice treats today, and understand how ICD-10 impacts them.
- If you rarely see a patient with a particular ailment, there is no need to memorize the code or convert the code to the ICD-10 equivalent diagnosis code on your paper super bill, or on your problem list in your electronic medical record.

- If your practice treats a wide range of medical conditions, just identify which ICD-10 diagnosis codes are most widely used. This would be helpful for providers in family practice, pediatric medicine, or internal medicine.

CMS offers the "*Road to ICD-10"* – a comprehensive online tool where you can explore common codes, primers for clinical documentation, clinical scenarios, and additional resources associated by specialty. Visit www.roadto10.org to find information for:

- Family Practice
- Pediatrics
- OB/GYN
- Cardiology
- Orthopedics
- Internal Medicine
- Other specialties

Did you know you also have the opportunity to earn continuing medical education (CME) credits while preparing for ICD-10? CMS, through Medscape Education, has released two ICD-10 video lectures and an expert article providing practical guidance for the ICD-10 transition. The video lectures are specifically for physicians, while the article covers more general topics for all health care providers. CME credits are available to physicians who complete the modules, and anyone who completes them can receive a certificate of completion. The modules are free and can be found on the CMS website.

ICD-10 efforts and our Medicaid business: In the Claims section of this edition of the *Network Update*, we share information regarding our ongoing efforts to help ensure our internal systems will comply with the upcoming ICD-10 requirements set to implement in October 2015. As these efforts also impact our Medicaid business, you may wish to refer to the article, ICD-10 Updates, on page 4 for details about a free coding practice tool, end-to-end testing results and a link to other resources.

Reimbursement for professional vision services

The following article applies to Anthem Blue Cross and Blue Shield Medicaid (KY).

Anthem utilizes the diagnosis code to properly process vision claims. Through our claims review analysis, we have identified several claims that have been processed incorrectly. When a claim is billed with a routine diagnosis code, regardless of the CPT/HCPCS code, the claim should be submitted to our vision vendor, eyeQuest. If billing a medical diagnosis code, then the claim should be submitted to Anthem.

There may be instances where the ophthalmologist will want to bill both a medical and routine diagnosis. If a claim is truly medical, it should not be billed with a routine diagnosis.

Example:

- Diabetes and myopia, both routine diagnoses, should be billed to eyeQuest.
- Diabetic retinopathy, a specific medical disease, should be billed to Anthem.

We will begin pulling claims for dates of service from January 1, 2014, to present to review for reprocessing. Providers will begin to see these corrections on future remits.

Providers will not need to resubmit claims as they will be identified during our rework process.

If you have questions about reimbursement for professional vision services, please contact your Provider Relations representative or the Provider Services team at 1-855-661-2028.

OrthoNet implementation date change

The following article applies to Anthem Blue Cross and Blue Shield Medicaid (KY).

As previously communicated, Anthem is collaborating with OrthoNet, LLC to implement a medical necessity review program for musculoskeletal providers. The implementation date for this program has changed and the program **will not be implemented on May 1, 2015**, as previously communicated.

An implementation date will be communicated to providers when it becomes available. This date will impact treatment requests for the following services to be reviewed by OrthoNet for prior authorization:

- Speech, physical and occupational therapy
- Back pain management
- Spine management

For additional information about the implementation date change, please contact your Provider Relations representative or call our Provider Services team at 1-855-661-2028.