Updated Alpha Prefix Reference List for Health Insurance Exchange information

The Alpha Prefix Reference List has been updated with information regarding Affordable Care Act compliant plans which are handled by a separate Provider Customer Service Unit and indicated on the Alpha Prefix Reference List as Health Insurance Exchange (HIX). Access the updates list online by going to anthem.com, and select Provider link in top center of page. Select Colorado/Nevada from drop down list and enter. From Provider Home tab, select the link titled “Contact Us (Escalation Contact List & Alpha Prefix List)”, and then the link titled “Alpha Prefix Reference List”.

Need to check the status of an authorization? Don’t call! Use Interactive Care Reviewer

Our ICR (Interactive Care Reviewer) tool continues to evolve, improving the precertification process. Now, it is easier to check on the details of a precertification. Instead of waiting on the phone, ordering and servicing physicians and facilities can make an inquiry to view information on any precertification previously submitted via phone, fax, ICR, or other online tool for any member covered by Anthem Blue Cross and Blue Shield, Anthem Blue Cross (California) or Blue Cross and Blue Shield of Georgia. Try it today!

You can access the inquiry functionality under Auth and Referral on the left navigation bar on www.Availity.com.

If your organization is NOT currently registered for Availity:

- 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 for registration status of your Tax ID.

If your organization is registered for Availity and just need access to inquiry:

- Your Primary Access Administrator can grant you access to Authorization and Referral Inquiry. Once you have access to Auth and Referral on Availity.com, click on Inquiry from the left navigation bar and you can start using our tool right away.

In addition, you can now submit both inpatient and outpatient pre-certifications online1. These are the most recent enhancements to our online precertification tool but not the last. Your Primary Access Administrator can give you access to Authorization and Referral Request to allow you to start utilizing ICR today!
Need Training?

To learn more about how you can streamline the precertification process by taking advantage of our ICR’s many features, register today by clicking here or go to https://www.livemeeting.com/irs/1100001891/Registration.aspx?pageName=83vbn5cyr00ngx4.

For questions regarding our ICR, please contact your local Provider Relations Representative. For questions on accessing our tool, call Availity Client Services at 800-AVAILITY (800-282-4548) or email questions to support@availity.com. Availity Client Services is available Monday-Friday, 8 a.m. to 7 p.m. ET (excluding holidays) to answer your registration questions.

1 Note: ICR is not currently available for Medicare Advantage, Medicaid, FEP, BlueCard®, and some National Account members; requests involving transplant services; or services administered by AIM Specialty HealthSM. For these requests, follow the same precertification process that you use today.

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Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.

The final Mental Health Parity Rule released

The federal government released the final Mental Health Parity Rule on November 13, 2013. This replaces the temporary rule from February 2010. As a result, Anthem Blue Cross and Blue Shield (Anthem) will apply this final rule to its new or renewing benefit plans, effective on or after July 1, 2014. The intent of the rule is to ensure that patient access to mental health or substance abuse services is the same access to medical services.

Note: The Affordable Care Act (ACA) or health care reform law expanded the mental health parity rule to affect small group and individual plans. Grandfathered small group are still exempt from the law and benefit plans (small group or individual) purchased under Medicare. For more on the rule please click here, or go to the following URL directly: http://www.hhs.gov/news/press/2013pres/11/20131108b.html.

PAP Device data required for ongoing Sleep Therapy Treatment requests

There is growing industry concern regarding patient compliance with PAP treatments used to treat obstructive sleep apnea (OSA). Poor compliance can lead to serious health issues and result in wasted dollars spent on equipment and supplies. For this reason, Anthem is introducing an enhancement to our sleep testing and treatment program, administered by AIM Specialty Health® (AIM), which will allow us to support your efforts to encourage patient compliance.

AIM Sleep Disorder Management Diagnostic and Treatment Guidelines provide that ongoing treatment is indicated only for patients who demonstrate compliance with therapy. In order to satisfy the medical necessity of ongoing treatment, demonstration of compliance is required every 90 days for the first year of therapy and annually thereafter. Beginning August 1, patient attestation of sleep therapy compliance will no longer be required to support a preauthorization request. Instead, AIM will be requiring DME device data to confirm compliance with therapy.

In order to facilitate the submission by your practice of DME device data, AIM has implemented a direct link with the following manufacturers who will automatically provide device usage information to AIM about a particular patient when you make a request for ongoing therapy.

- Philips
- Fisher and Paykel Healthcare

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

In Colorado: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Nevada: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
- ResMed

To take advantage of the convenience of these arrangements, you should register each patient in the appropriate DME manufacturers’ web-based software, per the training materials provided to you by each manufacturer. We also recommend that you perform periodic downloads of member device usage data before contacting AIM for review requests so that you can determine if the criteria for ongoing treatment are met.

For patients with devices manufactured by other companies, you will need to manually enter compliance data from their devices into the AIM system.

We are pleased that this enhancement to our sleep management program will:
- Help you more easily identify patients who may need help using their PAP equipment
- Promote more accurate clinical appropriateness determinations from actual compliance data
- Save you time by streamlining the approval process

For more information, please contact your Provider Relations representative.

**AIM Specialty Health expanded to the Federal Employee Program®**

Anthem is dedicated to meeting the evolving needs of our members. With consumers looking for tools to guide better health care decision making, we are pleased to announce that our Imaging Management Solution program has been expanded and will soon include the Federal Employee Program®, but not until August of 2014. Look for additional information and details about the program in the August provider newsletter.

**Infusion therapy choice: lower out-of-pocket expenses and convenience for members**

To promote member satisfaction and to help advance positive health care outcomes, we are working collaboratively with physicians regarding infusion therapy options available to our members. For our members who require infusion therapy services, out-of-pocket expenses, the place of infusion service, safety, time and convenience are contributing factors that can impact health care quality, value and member satisfaction.

Here’s how you can help. When possible, please consider and share with members the entire range of potential options available regarding infusion therapy. While the hospital is one option, please include alternative locations – such as office or home – when discussing/ordering infusion therapy for members who require these services. In addition, please inform members of any potential self-injection alternatives if appropriate, as members may prefer these convenient and lower-cost options. Referring members who require infusions therapy services to safe, lower-cost settings may result in significant savings in time and out-of-pocket expenses. Members will also appreciate the convenience and the flexibility.

Our members count on their physicians to provide comprehensive information so the members can make informed decisions about their health care choices. Members may have questions about alternate settings in which they can receive their intravenous infusions and costs associated with other aspects of their intravenous infusion therapy. To help members maximize their benefits, we may contact members and their physicians in the near future, informing them of opportunities for quality, lower-cost options for intravenous infusion services.

As always, you should refer members who require intravenous infusions to the location you deem appropriate. However, we encourage you to discuss with our members the options available to get their intravenous infusions safely and conveniently, at a lower out-of-pocket cost.
Update to Claims Processing Edits and Professional Reimbursement Policies

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

**Frequency**

The Frequency policy was updated to add additional rationale; “the Centers for Medicare & Medicaid Services’ (CMS’s) Medically Unlikely Edits (MUEs) designation, industry standards,” to the Description section. The code list was revised to be in numerical then alphabetical order by procedure code to make codes easier to find. Please review the full Frequency Editing policy for further information.

**Coding Tip/Reminder: Reporting Screening Diagnosis Codes**

We value preventive services and we encourage our members to seek appropriate care. It is very important for providers to use appropriate ICD-9 diagnosis coding guidelines when reporting preventive services, such as preventive “screening” mammograms and colonoscopies.

When non-screening ICD-9 diagnosis codes are submitted in the first diagnosis position on the claim form, claims can be processed incorrectly resulting in payments with higher cost shares for members. To help reduce claim adjustments for providers, we are recommending the following approach, which is based on information from the ICD-9-CM Official Guidelines for Coding and Reporting (http://www.cdc.gov/nchs/icd/9cm_addenda_guidelines.htm#guidelines).

To help summarize the portion of the guidelines that indicate what may be reported when a condition is encountered during a screening service we have included the helpful tip below.

When an individual presents to the office solely for the purpose of a screening mammogram or colonoscopy without any signs or symptoms of a disease, then a screening diagnosis code may be listed in the first diagnosis position on the claim form. In the event that a “condition” is discovered, during the course of the screening procedure, then the diagnosis code for the condition may be reported as a secondary diagnosis on the claim form.

The testing of a patient to rule out or confirm a suspected or possible diagnosis because the patient has some sign or symptom is a diagnostic not a screening test, even if the sign or symptom is discussed during a preventive visit. In these cases, the sign or symptom is used to explain the reason for the test. Example: Member goes to the provider’s office for a preventive exam. During the course of the exam they tell the provider they have been very fatigued. The provider orders a thyroid blood test with a diagnosis of fatigue rather than the preventive diagnosis code used for the preventive exam.

Reimbursement Policies and Clear Claim Connection are available on our secure provider portal, ProviderAccess

All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com, and select the Provider link in the top center of the page. Select Nevada from the drop down list, and enter. From the Provider Home page, go to the ProviderAccess Login (blue box on the left side of the page), and select Medical from the drop down list and click on the login button.

Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Professional Reimb & Admin Policies”. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select Continue. Select link titled “Anthem’s Professional Reimbursement & Administrative Policies – By Type”, then select the Reimbursement link, and next the Policy you would like to view.

Clear Claim Connection™ is our web-based editing tool from McKesson and includes an interface that will allow you to view the clinical rationale for ClaimsXten edits when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to
take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Follow the directions listed above to log into ProviderAccess. Once logged in, from the Claims tab, select the Clear Claim Connection link.

Health Care Reform Updates (including Health Insurance Exchange)

New Health Insurance Exchange article available online: Verify member grace period status electronically using Availity or EDI – May 2014

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance exchange may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance exchange, and all achieved articles, you can access them all online. Go to anthem.com, select the Provider link in the top center of the page. Select Nevada from the drop down list, and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange information.