Fall 2014 Provider Webinars – recorded versions now available online

Even if you missed one of our webinars, you still have the opportunity to listen to one of our recorded versions. The sessions included important updates and information to make it easier to do business with us. We split our webinar content into two portions; Part 1 (general content), and Part 2 (Provider Connectivity/Availity specific content). Decide which content portion most applies to you, and listen to Part 1, Part 2, or both! To access a recorded version, go to anthem.com and select the Provider link (top center of page). Next, select Nevada from the drop down list and enter. On the Provider Home page, select the Provider Seminars link under the Communications and Updates section. From the Provider Seminars landing page, select either the Part 1 or Part 2 recorded version; Fall 2014 Provider Webinar – Part 1 (General Content), recorded version or Fall 2014 Provider Webinar – Part 2 (Provider Connectivity/Availity content), recorded version.

2015 FEP Benefit information available online

To view the 2015 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to anthem.com/fep > select state > Coverage Options > Standard or Basic Option. Here you will find the Service Benefit Plan Brochure and Plan Benefit Summary information for year 2015. For questions please contact FEP Customer Service at 800-727-4060.

Important Postpartum Visit Reminder for OB/GYNs

As you may know, the National Committee for Quality Assurance (NCQA) specifies that the postpartum visit should be completed 21 to 56 days (3 to 8 weeks) after delivery. This visit is distinct from the C-section visit or incision check your patient may have had before that time.

The most current data shows that postpartum visits occur in a timely manner, overall. When a random sample of 2013 medical charts was reviewed, we found postpartum visits between 21 and 56 days in Nevada occurred 84% of the time among HMO plan members. The top 10% of health plans nationally have a compliance rate of least 91% among HMO members.

2013 Medical Chart Review Findings from a Sample of the Non-Compliant Women with a HMO plan in NV:

- 53% of patients had insufficient evidence of postpartum care, with a majority (70%) not documenting the date of the postpartum visit.
- 30% of women with a documented date were not seen in the appropriate timeframe:
  - 10% were seen before 21 days
  - 10% were seen between 56 and 63 days
  - 10% were seen one or more months after the 56th day
- 7% of the women had a caesarian section check only, without a postpartum visit.
What can you do?

- Make sure that every woman who delivers has a **postpartum visit scheduled between 21 and 56 days after delivery**. If possible, schedule the mother's postpartum visit upon or prior to hospital discharge. You may even be able to schedule it at the “last” prenatal visit, or two weeks prior to the expected delivery date. A study published in March 2011 found that postpartum follow-up rates were significantly higher (86.1% compared with 71.7%, P=.012) when a visit was scheduled prior to discharge (Tsai, Pai-Jong, et. Al. “Postpartum Follow-Up Rates Before and After the Post-Partum Follow-up Initiative at Queen Emma Clinic.” Hawaii Medical Journal. March 2011; 70(3): p 56-59).

- Specify the postpartum visit date on the claim and use the **Category II CPT Code 0503F** (indicating a postpartum visit) on the global delivery code with the delivery date. Using this supplemental tracking code would reduce the time and disruption to your office that the health plan would need to request to review patient charts for evidence of postpartum care.

- When you see a woman for their postpartum visit, remember to clearly **indicate the date, complete physical findings, and counseling/discussion points** in the patient’s chart. For your convenience, the “Quick Reference Guide for Clinicians” for Postpartum visits/counseling by the Association of Reproductive Health Professionals can be accessed by the following link: [https://www.arhp.org/uploadDocs/QRGPostpartumCounseling_Checklist_1.pdf](https://www.arhp.org/uploadDocs/QRGPostpartumCounseling_Checklist_1.pdf).

Please take less than 30 seconds to give us your feedback: [https://www.surveymonkey.com/r/8H3G8JF](https://www.surveymonkey.com/r/8H3G8JF)

**Pre-Payment Review Program**

Anthem Blue Cross and Blue Shield (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 has processes to review claims before and after the claim is processed to detect fraud, waste and abuse.

Beginning in December 2014, Anthem will include the following language in all Clinical Utilization Management Guidelines on the provider public portal about use of Clinical UM Guidelines for a variety of purposes. For example, Clinical UM Guidelines may be generally adopted for reviewing the medical necessity of services; used for provider education; and used for reviewing the medical necessity of services by a provider who has received notice about certain billing practices or claims, even if a guideline is not used for all providers delivering that service to Anthem’s members. The language states the following:

> Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline. Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

Please refer to your Provider Manual for further details on a new program to deter fraud, waste and abuse that is scheduled to be rolled out throughout 2015 for our commercial business and the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program (FEP).
Update to Claims Processing Edits and Professional Reimbursement Policies

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

Anesthesia Services

The Anesthesia policy received an annual review and has been updated to add the word “Services” to the name of the policy. Language that Anthem requires servicing modifiers QK, QX, and QY be listed in the first modifier field of the claim line when applicable, in order to apply the correct percentage amount, was also added. There are other wording changes for clarity with no change to policy position such as adding “post-operative” to the pain management section. Please refer to the full text of the policy for further information.

Coding Update Modifiers XE, XP, XS, and XU effective January 1, 2015

Effective January 1, 2015, CMS is adding four new HCPCS modifiers to selectively identify subsets of modifier 59 for Distinct Procedural Services as follows:

- **XE Separate Encounter:** a service that is distinct because it occurred during a separate encounter
- **XP Separate Practitioner:** a service that is distinct because it was performed by a different practitioner
- **XS Separate Structure:** a service that is distinct because it was performed on a separate organ/structure
- **XU Unusual Non–Overlapping Service:** the use of a service that is distinct because it does not overlap usual components of the main service

Beginning with claims for dates of service on or after January 1, 2015, Anthem will accept these new modifiers, collectively referred to as –X {EPSU} modifiers. We will apply edits to the –X {EPSU} modifiers equivalent to our modifier 59 edits with our first quarter 2015 update which is scheduled for February 16, 2015. Prior to the February update, these modifiers will be considered informational and will not be used to override an edit when a modifier 59 override would be appropriate.

Because these modifiers are more selective versions of modifier 59, they are not to be reported in conjunction with modifier 59. The –X {EPSU} modifiers are to be reported based on CPT instructions that state when another modifier is appropriate, it should be utilized rather than modifier 59. Modifier 59 will still be considered a valid modifier in the absence of a more descriptive modifier. The –X {EPSU} modifiers are not to be used with evaluation and management (E/M) services.

System Updates for 2015

As a reminder, our ClaimsXten editing software package will be updated quarterly in February, May, August and November of 2015. These upgrades will:

- reflect the addition of new and revised CPT/HCPCS codes and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (re-bundle) edits
- include assistant surgeon eligibility in accordance with the reimbursement policy
- include edits associated with other reimbursement policies including, but not limited to, preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)
Significant Edits, Customized Edits, Modifier 25 & 59 Rules and Additional Rules updates for 2014:
- We have updated our Significant Edits posting to reflect the 2014 analysis of claims data for significant code pair edits based on data for claims processed between May 1, 2014 and July 30, 2014. We will no longer be adding Significant Edit information to the Reimbursement Policies and this information will be removed from the reimbursement policies as they are updated in 2015.
- The Customized Edits, Modifier 25 and 59 Rules and Additional Rules documents will be removed as this information is included in the reimbursement policies.
- The Significant Edit information is available on our secure provider portal. Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the Significant Edit link.

HEDIS® 2014 Results Are In

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) data collection for 2014. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner, eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided.

Further information regarding documentation guidelines can be found on the HEDIS page on our public website. Go to anthem.com and select the Provider link (top center of page), select Nevada from the drop down list and enter. From the Provider Home page, select the Health and Wellness tab, then the Quality Improvement and Standards link, and finally select the appropriate link under the HEDIS Information heading. You will find reference documents entitled HEDIS 101 for Providers, HEDIS Physician Documentation Guidelines, and HEDIS Annual Calendar.

The table below shows comparison of some of our key measure rates to the Quality Compass® National Averages. Rates are in bold if improved from HEDIS 2013.

<table>
<thead>
<tr>
<th>Commercial HMO/POS Measures</th>
<th>HEDIS 2014 Rate (Percent)</th>
<th>Comparison to National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness of Care – Prevention and Screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>86.15</td>
<td>↑</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>71.25</td>
<td>↓</td>
</tr>
<tr>
<td>Childhood Immunization Status - DTAP</td>
<td>83.30</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status - IPV</td>
<td>95.20</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status - MMR</td>
<td>95.20</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status – HEP B</td>
<td>97.60</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status - VZV</td>
<td>92.90</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status - PCV</td>
<td>90.50</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status – HEP A</td>
<td>90.50</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status - ROTAVIRUS</td>
<td>85.70</td>
<td>↑</td>
</tr>
<tr>
<td>Childhood Immunization Status - INFLUENZA</td>
<td>52.40</td>
<td>↓</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>59.60</td>
<td>↓</td>
</tr>
<tr>
<td>Immunizations for Adolescents - MENINGITIS</td>
<td>43.60</td>
<td>↓</td>
</tr>
<tr>
<td>Immunizations for Adolescents – TDAP/TD</td>
<td>89.70</td>
<td>↑</td>
</tr>
<tr>
<td>Weight Assessment and Counseling – BMI TOTAL</td>
<td>53.30</td>
<td>↓</td>
</tr>
<tr>
<td>Weight Assessment and Counseling – Nutritional Counseling - TOTAL</td>
<td>49.40</td>
<td>↓</td>
</tr>
<tr>
<td>Weight Assessment and Counseling – Physical Activity- TOTAL</td>
<td>44.50</td>
<td>↓</td>
</tr>
<tr>
<td>Commercial HMO/POS Measures</td>
<td>HEDIS 2014 Rate (Percent)</td>
<td>Comparison to National Average</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-------------------------------</td>
</tr>
</tbody>
</table>

**Access / Availability of Care**

- Adults’ Access to Preventive/Ambulatory Health – TOTAL: 93.57 ↓
- Children & Adolescents’ Access to PCP (25 mos-6yrs): 89.34 ↓
- Children & Adolescents’ Access to PCP (7-11 yrs): 82.14 ↓
- Children & Adolescents’ Access to PCP (12-19 yrs): 82.50 ↓

**Effectiveness of Care – Respiratory Conditions**

- Antibiotic Treatment Adults w/ Acute Bronchitis: 25.58 ↓
- Appropriate Treatment Children w/ URI: 74.51 ↓

**Utilization & Relative Resource Use - Utilization**

- Adolescents Well-Care Visits: 23.76 ↓

**Effectiveness of Care – Diabetes**

- Comprehensive Diabetes Care – HbA1c Testing: 87.60 ↓
- Comprehensive Diabetes Care – Poor HbA1c Control (>9)*: 24.70 ↑
- Comprehensive Diabetes Care – Eye Exams: 45.40 ↓
- Comprehensive Diabetes Care – LDL-C Screening: 81.40 ↓
- Comprehensive Diabetes Care – LDL-C Controlled (LDL-C<100 mg/dL): 45.40 ↓
- Comprehensive Diabetes Care – Medical attention for nephropathy: 83.50 ↓
- Comprehensive Diabetes Care – Blood Pressure Control <140/90: 71.13 ↑

**Effectiveness of Care – Musculoskeletal**

- Use of Imaging Studies for Low Back Pain: 78.72 ↑

*lower rate is better

**Commercial PPO Measures**

<table>
<thead>
<tr>
<th>Effectiveness of Care – Prevention and Screening</th>
<th>Commercial PPO Measures</th>
<th>HEDIS 2014 Rate (Percent)</th>
<th>Comparison to National Average</th>
</tr>
</thead>
</table>
- Adult BMI Assessment | 3.60 | ↓ |
- Breast Cancer Screening | 63.67 | ↓ |
- Childhood Immunization Status – DTAP | 56.12 | ↓ |
- Childhood Immunization Status – IPV | 62.94 | ↓ |
- Childhood Immunization Status – MMR | 82.52 | ↓ |
- Childhood Immunization Status – HIB | 66.78 | ↓ |
- Childhood Immunization Status – HEP B | 39.16 | ↓ |
- Childhood Immunization Status – VZV | 81.29 | ↓ |
- Childhood Immunization Status – PCV | 55.42 | ↓ |
- Childhood Immunization Status – HEP A | 80.42 | ↑ |
- Childhood Immunization Status – ROTAVIRUS | 50.70 | ↓ |
- Childhood Immunization Status – INFLUENZA | 39.86 | ↓ |
- Childhood Immunization Status – COMBO 2 | 33.74 | ↓ |
- Colorectal Cancer Screening | 34.76 | ↓ |
- Immunizations for Adolescents – MENINGITIS | 42.41 | ↓ |
- Immunizations for Adolescents – TDAP/TD | 59.43 | ↓ |
- Weight Assessment and Counseling – BMI TOTAL | 1.19 | ↓ |
- Weight Assessment and Counseling – Nutrition Counseling TOTAL | 0.90 | ↓ |
- Weight Assessment and Counseling – Physical Activity TOTAL | 0.42 | ↓ |
### Commercial PPO Measures

<table>
<thead>
<tr>
<th>Effectiveness of Care – Prevention and Screening</th>
<th>HEDIS 2014 Rate (Percent)</th>
<th>Comparison to National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access / Availability of Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health – TOTAL</td>
<td>90.69</td>
<td>↓</td>
</tr>
<tr>
<td>Children’s &amp; Adolescents’ Access to PCP (25 mos-6 yrs)</td>
<td>83.69</td>
<td>↓</td>
</tr>
<tr>
<td>Children’s &amp; Adolescents’ Access to PCP (7-11 yrs)</td>
<td>81.37</td>
<td>↓</td>
</tr>
<tr>
<td>Children’s &amp; Adolescents’ Access to PCP (12-19 yrs)</td>
<td>78.31</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Effectiveness of Care – Respiratory Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Testing for Children w/ Pharyngitis</td>
<td>60.96</td>
<td>↓</td>
</tr>
<tr>
<td>Appropriate Treatment Children w/ URI</td>
<td>75.38</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Utilization &amp; Relative Resource Use - Utilization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Visits in the first 15 Months of Life (6+ visits)</td>
<td>66.94</td>
<td>↓</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>25.95</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Cardiovascular</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol Management – LDL-C Control &lt;100</td>
<td>29.38</td>
<td>↓</td>
</tr>
<tr>
<td>Persistence of Beta-Blocker Treatment after AMI</td>
<td>76.67</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – HbA1c Testing</td>
<td>81.35</td>
<td>↓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Poor HbA1c Control (&gt;9)*</td>
<td>69.54</td>
<td>↓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Eye Exams</td>
<td>31.52</td>
<td>↓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – LDL-C Screening</td>
<td>76.27</td>
<td>↓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Medical attention for nephropathy</td>
<td>75.18</td>
<td>↓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Blood Pressure Control &lt;140/80</td>
<td>0.45</td>
<td>↓</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care – Blood Pressure Control &lt;140/90</td>
<td>0.64</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Musculoskeletal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>76.55</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Effectiveness of Care – Behavioral Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Mgmt – Acute</td>
<td>56.39</td>
<td>↓</td>
</tr>
<tr>
<td>Antidepressant Medication Mgmt – Continuation</td>
<td>42.42</td>
<td>↓</td>
</tr>
<tr>
<td>FU Care Children’s ADHD Medication – Initiation</td>
<td>32.65</td>
<td>↓</td>
</tr>
<tr>
<td>FU Care Children’s ADHD Medication - Continuation</td>
<td>20.00</td>
<td>↓</td>
</tr>
</tbody>
</table>

*lower rate is better*

Although many scores remained below the national average in Nevada’s HMO plans, there were significant improvements in scores over last year. Increases were especially noted in Adult BMI (ABA), the control of blood pressure <140/90 in diabetics (CDC) and many childhood immunization (CIS) rates. The largest rate improvement was noted in a reduction in poor control of blood sugar [HbA1c test] within the diabetic population sample (CDC). The PPO plans also showed increases in multiple rates. Both lines of business had rates for the Use of Imaging Studies for Lower Back Pain (LBP) that were both improved from last year and also above the national average.

Although numerous rates improved, this year the PPO plans had the greatest number of decreases in rates. There are opportunities for improvement for the measures with the most significant decreases in rates, including Colorectal Cancer Screening (COL), use of antidepressant medication (AMM), follow up care for children on ADHD medication (ADD) and overall access/visits to PCPs by all ages (AAP and CAP).

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project, and to demonstrate the exceptional care that you have provided to our members.
In an effort to improve our scores, you and your office staff can help facilitate the HEDIS process improvement by:

- Responding to our requests for medical records within five days
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care in the patient’s medical record

Again, we thank you and your staff for demonstrating teamwork and partnership as we work together to improve the health of our members and your patients. We look forward to working with you next HEDIS season.

The source for data contained in this publication is Quality Compass® 2014 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2014 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA, CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Survey says... Patients see room for improvement with physician care

Every year, Anthem sends out the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to our PPO members. The survey gives Anthem members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. This same survey is used by all PPO plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

The following charts compare our results from 2013 with those in 2014. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem. These Quality Compass percentiles are derived from the scores of all other PPO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile. This is the level we encourage our network physicians to strive to achieve.

When you’re reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help ensure our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.

### 2014 Anthem – Nevada PPO

<p>| CAHPS® Adult Member Satisfaction Survey Results and NCQA Quality Compass Percentile Achieved |</p>
<table>
<thead>
<tr>
<th>NCQA Quality Compass Percentile Legend 6</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survey Question</strong></td>
<td>2013</td>
<td>2014</td>
<td>Trend 2013 vs. 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>74%</td>
<td>80%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>85%</td>
<td>78%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>71%</td>
<td>69%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Network Update is produced monthly by Anthem Blue Cross and Blue Shield.
Editor: Jackie Ferguson, 700 Broadway, Denver, CO 80273, E-mail: Jackie.Ferguson@anthem.com.

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

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.

### Getting Care Quickly

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Got appointment for check-up or routine care, as soon as needed</td>
<td>81%</td>
<td>88%</td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>83%</td>
<td>63%</td>
</tr>
</tbody>
</table>

### Doctor’s Communication with Patients

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>91%</td>
<td>96%</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>89%</td>
<td>90%</td>
</tr>
</tbody>
</table>

### Shared Decision Making

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor discussed reasons to take a medicine?</td>
<td>44%</td>
<td>40%</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you?</td>
<td>72%</td>
<td>66%</td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness?</td>
<td>70%</td>
<td>72%</td>
</tr>
</tbody>
</table>

### Continuity of Care

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>How often did your personal doctor seem informed about care you received from other health providers?</td>
<td>71%</td>
<td>NA</td>
</tr>
</tbody>
</table>

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding “Usually” or “Always.”
3 = % responding “A lot” or “Some”
4 = % responding “Yes”
5 = Percentile Definition – A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
DNA = Data Not Available
NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

*The source of data contained in this report is Quality Compass ® 2014 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

### Improving Your Patients’ Health Care Experience

Anthem is committed to working with our network physicians to make our members’ health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Simply log onto our website at anthem.com and follow this path: Providers > Select State > Enter > Communications > General Information > Guide to Improving the Patient Experience.

“This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California.”
Medicare Advantage Updates

Individual Medicare Advantage Membership moves to new claims processing system January 1, 2015

Starting January 1, 2015 Anthem will move Individual (non-group) Medicare Advantage members to a new claims processing system. Please review the following information so that you and your staff have the information you need to help ensure your claims are processed accurately and efficiently.

Group sponsored Medicare Advantage plan members are not affected by these changes. In most cases, this information will not apply to Anthem group sponsored Medicare Advantage members unless separately noted.

As of January 1, 2015, members with the following 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
- XDK
- XDT
- XGH
- XGK
- XKJ
- XVJ
- XVL
- YCG
- YGJ
- YGS
- YLR
- YLV
- YRA
- YRE
- YRU

- Pricing differences between individual and group sponsored Medicare Advantage members: Beginning January 1, 2015, providers may see differences in pricing between Medicare Advantage Individual and group sponsored member claims. The reasons for the potential differences are based on the following:
  - Claims for Medicare Advantage individual and group sponsored members will be processed on different platforms
  - Timing of Original Medicare pricing software updates may vary by platform.
  - Administration of claims edits and sequestration.

- Reimbursement policy changes: Highlights of the changes to the reimbursement policies can be found here. These changes are effective January 1, 2015. The complete set of policies is available here.

- On-demand patient records: Patient 360 is a read-only dashboard available through the Availity Web Portal to give you instant access to detailed information about Anthem individual Medicare Advantage members. By clicking on each tab in the 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

Patient 360 will be available January 1, 2015. For more information call 1-866-805-4589.

- Changes to sequestration reduction: Beginning January 1, 2015, we will change how we administer the sequestration reduction for Medicare Advantage claims processed on the new system.
  - Claims for individual members
o We will continue the existing reduction for contracted providers paid according to Medicare reimbursement methodologies.

o We will begin reducing payments to non-contracted providers.

o For both contracted and non-contracted providers, we will subtract the sequestration reduction from the final amount to be paid to the provider after the Medicare Advantage member cost share has been applied. So, the final amount to be paid to the provider is the plan allowance, minus any member cost-sharing, minus the sequestration reduction.

— Claims for group members

o We will continue the existing reduction for contracted providers paid according to Medicare reimbursement methodologies.

o Since group member claims are not migrating to the new claims processing system at this time, we will continue our current methodology for applying the sequestration reduction to the plan allowance.

— Please file two separate claims for members who have both an Anthem Medicare Advantage plan and other Anthem health benefits: If you treat an Anthem Medicare Advantage member who has Anthem Medicare Advantage coverage in addition to health benefits with another Anthem plan, you will have to file the claim with both plans separately. Please use the same electronic claims submission or address and P.O. Box you use today for Anthem claims filing.

— New Requirements effective January 1, 2015 For Individual Medicare Advantage Ambulance Anesthesia, Clinical Laboratory and Mammography Claims: Effective January 1, 2015, Anthem individual Medicare Advantage front-end claims editing will return claims billed without CMS required criteria to the provider who submitted the claim. These new front-end edits will include:

— Ambulance Claims billed without the Ambulance Pickup Location – Reference Medicare Claims Processing Manual, Chapter 15, Section 10.3 Point of Pickup

— Anesthesia Claims billed without an appropriate modifier – Reference Medicare Claims Processing Manual, Chapter 12, Section 50 K Anesthesia Claims Modifiers

— Anesthesia Claims billed with a unit-of-measure of “units”

— Clinical Laboratory claims billed without a Clinical Laboratory Improvement Amendment (CLIA) certification number in Box 23 on the CMS 1500

— Mammography claims billed without a mammography certification number in Box 23 on the CMS 1500

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

— Continue to use current phone number for 2015 precertifications: Individual Medicare Advantage members will be issued new ID cards effective January 1, 2015. The new cards will have a new Provider Service phone number. The new number on the ID cards will be used for all provider inquiries except precertification. For precertification, please continue to call the same numbers currently in place – as listed below. If you call the number on the back of the member’s card for Precertification, you will be directed back to the number below. To avoid this inconvenience, please note that the numbers below should be used for precertification requests throughout 2015. Phone: 866-797-9884, Fax: 800-959-1537

Submit all required clinical information at least three business days before the requested procedure to allow a thorough clinical analysis. For Institutional Admissions, all facilities must notify us within 24 hours or the next business day (whichever is earlier) after
admission. In an urgent or emergent situation, the above time frames will be waived. Please provide notice to the plan as soon as possible.

- **Continue to reach provider customer service by calling the number on the back of the member’s ID card.**
- **Continue to use the Availity Web Portal:** the Availity Web Portal can be accessed in the same manner as before and will continue to have information about both individual Medicare Advantage and group sponsored Medicare Advantage members.
- **Continue to use the same mailing address, Electronic Data Interchange gateway as you do today:** Claims and correspondence should continue to be submitted to same EDI gateway and the same Post Office Box address that you use today.

**New for 2015: Anthem introduces new benefit plans for Medicare Advantage Members**

Anthem also will introduce new benefits for our Medicare Advantage members and new types of Medicare Advantage plans. The information below highlights what’s new for 2015. For more details now and throughout 2015, please refer to [Important Medicare Advantage Updates](#) on your provider portal.

For a more detailed overview of 2015 changes in plan benefits, co-pays, service areas and more please see the 2015 Product Update for your state under [Important Medicare Advantage Updates](#).

**Referrals**

A referral may be required for Individual Medicare Advantage HMO members to see a specialist. In most situations, our individual Medicare Advantage HMO members may need to receive a referral from their Primary Care Physician before they can use specialists in the plan’s network. However, referrals from a PCP are not required for emergency care or urgently needed care. Certain routine care can be obtained without having an approval in advance from their PCP, such as routine women’s health care (breast exams, screening mammograms, Pap tests and pelvic exams) and routine dental and vision care. Providers are required to periodically review and comply with the latest Medicare Advantage Referral requirements found at [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider) on the document named: *Medicare Advantage Referral requirements*.

Please visit our [website](#) for more detailed product information or contact Provider Services at the number on the back of the member’s ID card. You can find Important Medicare Advantage Updates here. Contact your provider representative for participation details for our contracted plans.

**Precertification requirements updated for 2015**

Please refer to your provider agreement, provider manual and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at anthem.com for further information on existing precertification requirements and new precertification requirements for 2015.

Submit all required clinical information at least three business days before the requested procedure to allow a thorough clinical analysis. For Institutional Admissions, all facilities must notify us within 24 hours or the next business day (whichever is earlier) after admission. In an urgent or emergent situation, the above time frames will be waived. Please provide notice to the plan as soon as possible.

Precertifications can be obtained at the following phone or fax numbers for individual and group-sponsored Medicare Advantage plans: **Phone: 866-797-9884, Fax: 800-959-1537**

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

Y0071_14_21910_1 10/06/14
Y0071_14_21633_1 09/24/2014
Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance marketplace / affordable care act information may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance marketplace / affordable care act, and all achieved articles, 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 Marketplace / Affordable Care Act information.