Implementation of the Cancer Care Quality Program Prostate Cancer Treatment Pathways will be delayed until April 1, 2015

As we communicated to impacted providers in November 2014, the Cancer Care Quality Program would be expanded on February 1, 2015, to include the addition of Cancer Treatment Pathways for prostate cancer. The implementation of the Prostate Cancer Treatment Pathways has been delayed until April 1, 2015. As a reminder, the Cancer Care Quality Program* supports evidence-based care, benefits your patients and practice and can fit within your daily workflow. A provider website offers you all the tools and information you need to get started. To access, go to: www.cancercarequalityprogram.com

- Allows you to compare planned cancer treatment regimens against evidence-based clinical criteria
- Promotes Cancer Treatment Pathways that have been shown to be efficacious, lower in toxicity and cost-effective
- Gives details on an opportunity for enhanced reimbursement for value-based care

Please note: AIM is available to accept orders for clinical drug review; however, the Prostate Cancer Treatment Pathways will not be available until April 1, 2015.

*The program will be administered by AIM Specialty Health®.

UPDATE: Paper remittances no longer being mailed

In 2009, Anthem Blue Cross and Blue Shield (Anthem) discontinued mailing of paper remittances to providers who could access a secured PDF version of the complete paper remittance online through our secure provider portal, ProviderAccess. Remittances originally available online included Local and BlueCard members, but excluded Federal Employees Program® (FEP®) members.

Since FEP remittances were not available online, providers continued to receive paper remittances for these members in the mail.

We have recently identified that the paper remittances for FEP were shut-off inadvertently in mid-December. Some additional member types may also be amongst those impacted by this issue, but we believe it to be minimal. We sincerely apologize for any confusion and disruption this may have caused your organization.

We are in the process of implementing a long term fix to make these previously excluded remittance advices available online. This fix is tentatively targeted for our February release which should happen in mid-February. Once this fix has been successfully implemented, we will send out a communication to providers confirming that this information is available online.

As an interim solution until this information is available online, Providers seeking a copy of a remittance advice can contact Anthem. While not all of these remittances are for FEP members, we believe that the majority of them are isolated to this membership. Therefore, our FEP
Provider Customer Service unit will be facilitating these requests regardless of whether or not an FEP member is included on the remittance. If an FEP member is not included on the remittance, then the FEP Provider Customer Service unit will direct the provider to the appropriate area to supply the remittance advice per the provider’s request.

We would like to assure you that our Provider Customer Service areas have been educated about this interim solution and are trained to provide the remittance advice as outlined in this communication.

Requests for Remittance Advices, which are currently not available online through ProviderAccess, can be directed to Federal Employee Program Provider Customer Service – 800-727-4060.

Please include the following information with your request:

- Provider Name
- Provider Tax ID
- Provider NPI
- EFT number
- EFT amount
- Deposit date

Once these additional remittances are available online, accessing these remittances will be as easy as what is currently available for the Local and BlueCard members. Log into ProviderAccess, select the Claims tab, then select Remittance Advice Inquiry.

If you are currently registered for the Availity web portal, and you’ve already completed the Anthem Services Registration process, you may access the remittances and navigate from your Availity log in. Once logged into Availity, select My Payer Portals from the left side navigation menu, then Anthem Provider Portal, and select I Agree. Once routed into ProviderAccess, select the Claims tab, then Remittance Advice Inquiry.

ICD-10 Updates: Clinical Documentation Improvement

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

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

Updated Escalation Contact List

We have also updated our Escalation Contact List. This list will help outline the appropriate process for escalating an issue, if needed, to ensure you have the best provider experience possible and the quickest resolution to your issue. An updated Escalation Contact List is located online. Go to anthem.com, and select Provider link in lower right corner. Select 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 “Escalation Contact List”.

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.
Inovalon requests for 2015

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

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

We’ll continue to provide updates about the Inovalon engagement in upcoming editions for the Network Update.

Maternity-Related HEDIS Measures Frequently Asked Questions

In the December 2014 issue of Network Update, we discussed the HEDIS® measure related to postpartum care that should occur between 21 and 56 days after delivery and what you can do to improve your rates. A couple of questions arose around documenting the postpartum visit using the Category II CPT Code of 0503F for billing that we would like to clarify.

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

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

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

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

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

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

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

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

1. Timeliness of Prenatal Care as determined by the percentage of women receiving a prenatal visit within the first trimester or within 42 days of health plan enrollment. Using Category II CPT Code 0500F will signal the initial prenatal visit. The date of the initial prenatal visit should be included.

2. Frequency of On-going Prenatal Care as determined by the percentage of Medicaid deliveries that had the expected number of prenatal visits.

An additional HEDIS measure is under consideration to look at early elective deliveries among low risk patients.
Where does the information come from?

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

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

FEP® changes call in hours for UM/CM

The Federal Employee Program, Utilization and Case Management Department, is changing the hours of operation effective March 1, 2015. The new hours of operation will be 8:00 a.m. to 6:00 p.m. EST.

Update to Claims Processing Edits and Professional Reimbursement Policies

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

Assistant Surgeon Coding and Assistant Surgeon Services

The Assistant Surgeon Coding table has been updated to add the new Current Procedural Terminology (CPT®) and Health Care Common Procedure Coding System (HCPCS Level II) codes effective January 1, 2015 as well as updates to existing codes per policy methodology that are not eligible for reimbursement for assistant at surgery services reported with modifiers 80, 81, 82, or AS; CPT codes – 15956, 20604, 20606, 20611, 20697, 20983, 22510, 22511, 22512, 22514, 22515, 33270, 33271, 33272, 33273, 33946, 33947, 33948, 33949, 37191, 37192, 37193, 40525, 40654, 43180, 44381, 44384, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45346, 45347, 45349, 45350, 45351, 45393, 45398, 46601, 46607, 52441, 52442, 62302, 62303, 62304, 62305, 64486, 64487, 64488, 64489, and 93644; or HCPCs codes – G6018, G6019, G6020, G6022, G6023, G6024, G6025, G6027, G6028, 0377T, 0387T, and 0388T.

The following codes were deleted from CPT and have been removed from the Assistant Surgeon Coding table: 21800, 22520, 22521, 22522, 22523, 22524, 22525, 29020, 29025, 29715, 33961, 36469, 36822, 44383, 45339, 45345, 45355, 45383, 45387, 69400, 69401, 0226T, 0227T, 0319T, 0320T, 0321T, 0322T, 0323T, 0324T, and 0325T. The following CPT Codes are being removed from the denied list as they are allowed by the American College of Surgeons: 20101 and 21338.

In addition we have updated the effective date of the Assistant Surgeon Services policy to align with the effective date of the Assistant Surgeon Coding table.

Bundled Services and Supplies

Section 1 of the Bundled Services and Supplies policy effective January 1, 2015, has been updated to include the new 2015 codes not eligible for reimbursement (for commercial products only) mentioned in the January 2015 issue of Network Update. System editing for these CPT/HCPCS codes (listed again below) will begin with claims processed on or after February 16, 2015.

- G6030 – G6058 (drug screening)
- G0276 (blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial)
- G0472 (hepatitis C antibody screening for individual at high risk and other covered indication(s))
- G0473 (face-to-face behavioral counseling for obesity, group (2-10), 30 minutes)
- 99490 (chronic care management), 99497, and 99498 (advance care planning)
- 99497 – 99498 (Advance Care Planning service) – Advance Care Planning services
- 34839 (physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time)

For claims processed on or after February 16, 2015, Section 2 of the Bundled Services and Supplies policy has been updated to reflect that infusion supplies (such as HCPCS codes A4221, A4222, and E0781) are NOT eligible for separate reimbursement when reported with per diem home infusion therapy (HIT) service codes (such as HCPCS codes S5497-S5521, S9061, S9208-S9379, S9490-S9504, S9537-S9590) that include supplies or home therapy professional services. Modifiers will not override this edit; therefore, this information will be included in our Modifier 59 (Distinct Procedural Service) policy.

As reagent strips or tablets are included in the urinalysis tests reported with CPT codes 81000-81003, HCPCS code A4250 (urine tests, reagent strips or tablets (100 tablets or strips)) is not eligible for separate reimbursement when reported with one of these CPT codes. This information has been added to section 2 of the Bundled Services and Supplies policy effective for claims processed on or after February 16, 2015. Modifiers will not override this edit; therefore, this information is also included in our Modifier 59 (Distinct Procedural Service) policy.

Documentation Guidelines for Psychotherapy Services
A new policy effective February 1, 2015, Documentation Guidelines for Psychotherapy Services, outlines Anthem’s documentation guidelines for reporting psychotherapy services, and has been posted to the provider website.

Drug Screen Testing
The Drug Screen Testing policy has been updated to remove the word “qualitative” from the title. New 2015 HCPCS codes G6030-G6058 for drug screening have been added to the policy. As mentioned above, they will also be added to Section 1 of the Bundled Services and Supplies policy. (Please refer to CPT codes 80047-89398 for alternate coding).

Modifier 59 and XE, XP, XS, and XU (Distinct Procedural/Separate/Unusual Service)
The Modifier 59 (Distinct Procedural Services) policy title has been changed to Modifiers 59 and XE, XP, XS, and XU (Distinct Procedural/Separate/Unusual Service). This change reflects the addition of the new –X {EPSU} modifiers (XE, XP, XS and XU) to the policy. These new modifiers will function the same as modifier 59 effective with claims processed on or after February 16, 2015.

Modifier Rules
The Modifier Rules policy was updated to add the new –X {EPSU} Modifiers (XE, XP, XS, and XU) to the policy effective with claims processed on or after February 16, 2015.

Multiple and Bilateral Surgery Processing
The Multiple and Bilateral Surgery Processing policy was updated to add the new colonoscopy HCPCS codes G6024 and G6025 to the table. New CPT codes 45388, 45389, and 45390 fall into the CPT code range for colonoscopies; therefore, they are not listed individually in the code table. There are other minor wording changes for clarification of the endoscopy/arthroscopy step-down rule processes.

(3D) Three-Dimensional Radiology Services
The (3D) Three-Dimensional Radiology Services policy was updated to add new digital breast tomosynthesis (DBT) CPT codes 77601, 77602 and 77603 and HCPCS Level II code G0279 effective January 1, 2015 and additional information on DBT. Codes 77601, 77602, 77603 and G0279 will also be added to the Bundled Services and Supplies policy.
The following policy received an annual review with no substantive changes:

- Injection and Infusion Administration and Related Services and Supplies

**Coding Tip: Vaccine Administration and Skin Tests**

According to CPT Guidelines for Immunization Administration for Vaccines/Toxoids, it is stated to: “...report vaccine immunization codes, 90460, 90461, 90471-90474 in addition to the vaccine toxoid code(s) 90476-90749.” Therefore, vaccine administration codes should only be used to report the administration of vaccines and toxoids reported with codes that fall within the range of 90476-90749, and should not be reported for skin testing of bacterial, viral, or fungal extracts. (See the CPT Professional Edition Medicine Section—Immunization Administration for Vaccines/Toxoids.)

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

Please review the full policy for any changes referenced above for further information. All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com, 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 tool (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.

CPT® is a registered trademark of the American Medical Association
ClaimsXten® is a registered trademark of McKesson Information Solutions LLC
Clear Claim Connection™ is a registered trademark of McKesson Information Solutions LLC

**Non-participating lab referrals**

This is a reminder to ensure that you are referring Anthem members exclusively to participating labs. Not only does your Anthem agreement obligate you to refer to participating labs, but members will only receive their full benefits from participating providers.

Unfortunately, there are certain non-participating labs that are offering to waive or cap co-payments, coinsurance or deductibles to our members in order to increase their overall revenue. These practices undermine member benefits and may encourage over-utilization of services.

These billing practices have been illegal under the federal anti-kickback laws when used with federally-funded programs such as Medicaid and Medicare. Additionally, some benefit contracts explicitly exclude coverage for any out-of-network services for which the provider waives the additional out-of-pocket costs to members.

Anthem is contracted with Laboratory Corporation of America® ("LabCorp"). All lab work, including Pap tests and routine outpatient pathology, must be sent to LabCorp, with the exception of the procedures that can be performed in the Provider’s office or sent to LabCorp. (Please see our Laboratory Services section of our Provider Manual for a list of services that can be performed in the Provider’s office.)
For a listing of Anthem participating laboratories, please check our online directory. Go to anthem.com, select the Provider link in top center of the page. Select Nevada from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Find a Doctor”.

**HEDIS® 2015: Easy Submission of Commercial HEDIS Medical Records**

We want to make returning HEDIS medical records as easy as possible for your office. To return the time sensitive medical record documentation back to us in the recommended 5 day turnaround time, simply choose one of these options:

1. Upload to our secure portal. This is quick and easy. Logon www.submitrecords.com, enter the password: wphedis57 and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.

OR

2. Send a secure fax to 1-888-251-2985

OR

3. Mail to us via the US Postal Service to: Anthem Blue Cross and Blue Shield, 10897 S. River Front Parkway, Suite 110H, South Jordan, UT 84095-9984

We will begin requesting medical records in January and February via a phone call to your office followed by a fax. Contact information will be included with the fax should you have any questions. We thank you in advance for your support of HEDIS.

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

**HEDIS® 2015: Controlling High Blood Pressure Measure**

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

1. **The earliest documented date of hypertension (prior to July 1, 2014) found in your medical record.** This diagnosis date can be any time prior to July 1, 2014, but cannot be on July 1, 2014 or after. For example, the earliest documented date does not have to be in 2014 – it can be in 1998, 2000, 2005, and 2010 – **ANYTIME prior to July 1, 2014.** The diagnosis can be found on a dated history form, a problem list, or a progress note.

2. **Blood pressure (BP) reading(s) from the LAST TWO visits in 2014.** This does not have to be from a hypertension diagnosis; the last two blood pressure readings can be from any diagnosis in 2014. Please note – the blood pressure readings cannot be from the same date as the earliest documented hypertension date listed above, or from the same day as a major diagnostic or surgical procedure. Please include all BP readings for the last two visits documented in progress notes and/or vital signs flow sheets.

Only IF the following applies to the member do we need this requested documentation:

- Documentation of End Stage Renal Disease, renal dialysis or renal transplant with date of occurrence
- If the member was pregnant in 2014, provide documentation of pregnancy
- If the member had a non-acute inpatient admission during 2014 provide documentation

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

Avoid Second Fills of High-Risk Medications

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

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

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

If you receive a high-risk medication fax or report from us, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed at www.anthem.com/maprovidertoolkit.

Provider Requirements and Medicare Notices

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

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

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

Our audit findings show providers would benefit from focusing on the following elements required by CMS:

- NOMNC Notices:
  - Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
  - Include the beneficiaries Health Care Identification Number or Medical Record Number on page one
  - Include the specific type of services ending on page one
  - Include the Health Plans contact information on page two
  - Have the beneficiary or authorized representative sign and date page two at least two (2) days prior to the end of services
  - Retain a copy of the signed notice, both page one and page two.
IM Notices:
- Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
- Include the physician’s name on page one
- Have the beneficiary or authorized representative sign and date page one within 2 calendar days of the date of an inpatient hospital admission
- Call the authorized representative to deliver the IM when the beneficiary is unable to sign
- Deliver the IM, or copy of the IM again, no sooner than 2 calendar days before discharge
- Retain a copy of the signed notice, both page one and page two.
- To download the standardized IM/NOMNC Notices required by CMS, along with accompanying instructions, go to CMS website at www.cms.hhs.gov/bni or refer to the specific links below:

IM Notice: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Important Update: Quality Improvement Organizations (QIO’s) have changed. Make sure your Medicare notices have the correct QIO contact information. Please see http://www.qioprogram.org/contact to locate your QIO.

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

ICD-10-CM: ICD-9 vs. ICD-10 for Atrial Fibrillation and Flutter

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

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

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

<table>
<thead>
<tr>
<th>ICD-9 (Single code)</th>
<th>ICD-10 (Multiple specific codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>427.31 (Established or Paroxysmal)</td>
<td>I48.0 Paroxysmal</td>
</tr>
<tr>
<td>- Irregular, rapid atrial contractions</td>
<td>- Occurs periodically</td>
</tr>
<tr>
<td>Atrial Flutter</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>427.32</td>
<td>I48.1 Persistent</td>
</tr>
<tr>
<td>- Regular rapid atrial contractions</td>
<td>- Rapid contractions of the upper heart chamber</td>
</tr>
<tr>
<td></td>
<td>I48.2 Chronic</td>
</tr>
<tr>
<td></td>
<td>- Permanent atrial fibrillation</td>
</tr>
</tbody>
</table>
Atrial Flutter

- I48.3 Typical
  - Type I atrial flutter
- I48.4 Atypical
  - Type II atrial flutter

Unspecified atrial fibrillation and flutter

- I48.91 Unspecified atrial fibrillation
  - Type not specified
- I48.92 Unspecified atrial flutter
  - Type not specified

In future articles, we will continue to bring you helpful coding tips to assist you and your coding staff with the transition from ICD-9 to ICD-10.

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

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

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

Medicare Advantage HMO Referral Reminder – PCPs do not need to call Anthem to obtain a referral

Anthem values the role that primary care physicians play in helping to coordinate care for our Medicare Advantage HMO members. As such, we ask that you serve as their primary contact for referring them to other specialists or providers and that you document such referrals in individual member’s medical records.

To ensure the highest level of benefits and coordination of care for Anthem members and streamline the approval process for your office, it’s important that you refer members to in-network providers whenever possible. When you do, you will not need to contact the plan (Anthem) for preapproval of those referrals. Additionally, for in-network providers, members do not need a new referral simply because they are being seen in a new calendar year.

Referrals from a PCP are also 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.
Please visit our [website](#) for more detailed information on when pre-certifications are required or contact Provider Services at the number on the back of the member’s ID card. You can find Important Medicare Advantage Updates [here](#).

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Anthem Blue Cross and Blue Shield is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

**Reminder: clinical information required for Medicare Advantage members**

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

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

Please note that Anthem Medicare Advantage plans administer Medicare coverage for our Medicare Advantage members and follow Medicare guidelines. If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

Y0071_15_23063_I 01/06/2015

**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**.