Anthem Choice PPO (Pathway Tiered Network) utilizes Anthem’s standard PPO network as one of its tiered benefit level options

We have recently been made aware that some providers have incorrectly turned away members aligned with our Anthem Choice PPO (Pathway Tiered Network) thinking it was tied to our Pathway PPO network only, and the provider was not participating in that specific network.

As a reminder, Anthem Choice PPO (Pathway Tiered Network) utilizes the Pathway PPO network for Tier 1, and utilizes our standard PPO network for Tier 2. If a provider is not participating in Pathway PPO network, but they are participating in our standard PPO network, they can see the member under their Tier 2 – PPO benefit level. See below for a full overview.

In some instances, the network name as listed on the ID card will display “Pathway Tiered Network” in the network name field, and the plan name will include “Anthem Choice PPO”. But, for directory purposes, the network name will be listed as “Anthem Choice PPO (Pathway Tiered Network)”.

**Anthem Choice PPO (Pathway Tiered Network) Overview**

Anthem Choice PPO (Pathway Tiered Network) is a three tier PPO option:

- **Tier 1** – utilizes our Pathway PPO network:
  - Lower copays and highest benefit level.
  - Network includes:
    - Hospitals = 32, **excludes** St Rose Dominican Hospitals (Siena, San Martin, and DeLima)
    - PCPs = more than 654
    - Specialists = more than 2,946

- **Tier 2** – utilizes our standard PPO network:
  - Includes all other PPO providers **not already considered Pathway PPO**, at a reduced benefit level.
  - Network includes:
    - Hospitals = 3 in addition to Tier 1, **includes** St Rose Dominican Hospitals (Siena, San Martin, and DeLima)
    - PCPs = more than 739 in addition to Tier 1
    - Specialists = more than 2,120 in addition to Tier 1
o Tier 3 out of network:
  o All other providers not participating in Pathway PPO or our Standard PPO network, at a significantly reduced benefit level.

Identifying Members accessing the Anthem Choice PPO (Pathway Tiered Network):

<table>
<thead>
<tr>
<th>Network Name</th>
<th>Product type</th>
<th>Agreement needed for participation</th>
<th>Alpha Prefix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Choice PPO (Pathway tiered Network)</td>
<td>PPO</td>
<td>Tier 1 = Pathway PPO Tier 2 = all other PPO providers not already considered Pathway PPO (our Standard PPO)</td>
<td>YFX</td>
</tr>
</tbody>
</table>

Guidelines when a member can see another PCP if a different than the PCP is listed on the Member’s ID card

A Member can see a different PCP, other than the PCP listed on his/her ID card, as long as:

o The member stays within his/her designated network.
  – For example: If the member has a health plan aligned with our Pathway HMO network and he/she would like to see a PCP other than the one indicated on his/her ID card, he/she must see another PCP within the Pathway HMO network.

Note: The member can always contact Customer Service to change the PCP at any time, but the change may not be done retrospectively. Most changes will be on the first of the following month based on attribution to the provider.

New precertification requirements for certain cardiovascular services begins March 1, 2016

As a reminder, Anthem is expanding its cardiovascular program to require precertification for arterial ultrasound, cardiac catheterization, and percutaneous coronary intervention (PCI) beginning March 1, 2016. The program is managed by AIM Specialty Health® (AIM®), a separate company administering the program on behalf of Anthem.

Starting February 22, 2016, ordering physicians may submit a precertification request for the additional program requirements to AIM through the AIM ProviderPortal® at aimspecialtyhealth.com/goweb (available 24/7 to process orders in real-time), through the Availity Web Portal at availity.com, or by calling the AIM call center at 1-877-291-0366, Monday–Friday, 7:00 am–5:00 pm PT. Please note that Anthem FEP members are excluded from this program.

The clinical guidelines for arterial ultrasound, cardiac catheterization, and PCI outlining the clinical criteria for medical necessity are located on anthem.com.

Note: Duplex imaging (codes 93931, 93925, 93926, 93930, 93931) will only be reviewed retrospectively. The decision to perform this imaging is generally done while performing physiologic testing. The results of the physiologic testing are required in order to complete the review of duplex imaging. To initiate a retrospective review, please contact AIM or log on to the Provider Portal within 10 business days of the duplex imaging, but prior to submitting the claim.

For more information, please see the original notification regarding this change dated December 1, 2015: New pre-certification requirements and clinical guideline updates for certain cardiovascular services begins March 1, 2016 – December 1, 2015.
New precertification requirements for certain radiation therapy services begins March 1, 2016

As a reminder, on March 1, 2016, Anthem is expanding its Radiation Therapy Program to require precertification of:

- Image Guided Radiation Therapy (IGRT).
- Fractions (also referred to as units) for breast and bone metastases for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT).
- Special treatment procedure and special physics consult (CPT® codes 77470 and 77370) (e.g., total body irradiation, hemibody radiation, or endocavitary irradiation and special medical radiation physics consultation).

Starting February 22, 2016, ordering physicians may submit a precertification request for these additional requirements to AIM through the AIM ProviderPortalSM (available 24/7 to process orders in real-time), through the Availity Web Portal at availity.com, or by calling the AIM call center at 1-877-291-0366, Monday–Friday, 7:00 am–5:00 pm PT. Please note that Anthem FEP members are excluded from this program.

AIM will be hosting two webinars in February to provide additional information and clarification about the radiation therapy program enhancements. Attend one of the following webinars by phone or by clicking on the WebEx meeting link.

- Friday, February 19, 2016; 12:00 p.m. ET
  - Join WebEx meeting
    - Meeting number: 621 880 300
    - Meeting password: Anthem
  - Join by phone: 877-668-4490 or 408-792-6300
    - Access code: 621 880 300

- Friday, February 26, 2016; 2:00 p.m. ET
  - Join WebEx meeting
    - Meeting number: 629 387 251
    - Meeting password: Anthem
  - Join by phone: 877-668-4490 or 408-792-6300
    - Access code: 629 387 251

For more information, please see the original notification regarding this change dated December 1, 2015: New precertification requirements and clinical guideline updates for certain radiation therapy services begins March 1, 2016 – December 1, 2015.

Secure Web portal user profiles and HIPAA compliance reminder

As part of compliance with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and Anthem’s Information Security Policy, ProviderAccess users must NOT share User ID information on our secure site. Rather, please ensure that ALL individuals who access our secure portal have their own individual User ID registered under their names and with their own individual contact information.

In order to remain compliant with your contractual online, usage agreements, review your user lists at least quarterly to ensure all current employees have the access they need to use our secure Web portal and to disable the profiles of any individuals who are no longer employed. Please take a few moments to do this now.
Improving documentation of high blood pressure

Hypertension (HTN) is the most common condition seen in primary care practices and if managed well can reduce the burden of cardiovascular disease for a patient\(^1\). The Eighth Joint National Committee (JNC 8) guideline on the management of adult hypertension was released in 2014. The new changes recommend physicians treat to 150/90 mmHg in patients over age 60, and 140/90 for everybody else, including those patients who have diabetes.

Each year, health plans collect data from provider records to look at patients with hypertension to see if their blood pressure (BP) is under control. The National Committee for Quality Assurance (NCQA) made changes to the 2015 Healthcare Effectiveness Data and Information Set (HEDIS\(^\circ\)) to the Controlling High Blood Pressure (CBP) measure to align with the new JNC8 guidelines.

Improvements in documentation of the diagnosis and blood pressure can make a difference in whether CBP is considered compliant or not. The 2015 medical record review findings from provider offices that contributed to decreased scores included:

- **No Diagnosis confirmed**
  Diagnosis must be noted in the chart on or before 6/30 of the measurement year being reviewed.

- **Diagnosis confirmed, but either no BP was taken since diagnosis, or no BP was taken at all during the measurement year**

- **Diagnosis was listed as prehypertension**
  Prehypertension is not acceptable for confirming a diagnosis of HTN. Also, “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm Diagnosis.

- **BP documented as exactly 140/90**
  Blood pressure must be less than 140/90 mmHg unless your patient is 60-85 years of age and not a diabetic, then the blood pressure needs to be less than 150/90 mmHg.

- **BP out of control**
  Many times, there are no follow-up visits in the chart or additional BPs are not taken the same day as an elevated BP reading.

You can take the Journal of American Medical Association CME course to earn a maximum of 1 AMA PRA Category 1 Credit™ for the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JAMA. 2014;311(5):507-520). You can access the course and JNC8 guidelines at the following link: [http://jama.jamanetwork.com/article.aspx?articleid=1791497&tab=cme](http://jama.jamanetwork.com/article.aspx?articleid=1791497&tab=cme)

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


Important information about providing services to out-of-state Medicaid members

Beginning April 18, 2016, Anthem will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims. Additional information may require the provider to enroll in the member’s out-of-state Medicaid program, or provide missing Medicaid encounter data.
Enrolling in an out-of-state Medicaid program

At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Some state Medicaid programs require providers to enroll in a member’s state Medicaid program when services are performed for their members (Section 1902(kk)(7) of the Social Security Act, 42 CFR 455.410, and 42 CFR 455.440). If a provider submits a claim for a Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. Anthem will also send the provider a letter with information about how to enroll in the member’s state Medicaid program online.

Providers are encouraged to always verify member eligibility and benefits prior to performing services. This step will help determine if a member is enrolled in an out-of-state Medicaid program, and if provider enrollment is required. Whenever possible, the enrollment process should take place prior to submitting the claim to prevent delays in processing the claim. If the claim has been denied prior to enrollment, providers are advised to resubmit the claim for processing once enrollment is complete.

Medicaid encounter data

Encounter data includes records of health care services for which managed care organizations pay. In order to process a claim and apply appropriate benefits, providers are asked to submit all encounter data when billing for Medicaid services. The list below reflects fields that are needed and if not included can result in claim denial. The provider should submit the claim following the directions on the back of the member’s identification card.

If an out-of-state Medicaid claim is denied, Anthem will send a letter to indicate the encounter data needed. Upon return of this information, the claim will be reprocessed.

<table>
<thead>
<tr>
<th>Professional Encounter Data</th>
<th>Institutional Encounter Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual ambulance mileage</td>
<td>Occurrence code</td>
</tr>
<tr>
<td>Performing provider taxonomy code</td>
<td>Operating physician number and operating physician number qualifier</td>
</tr>
<tr>
<td>Billing provider address</td>
<td>Occurrence span code</td>
</tr>
<tr>
<td>Referring provider number and referring provider number qualifier</td>
<td></td>
</tr>
<tr>
<td>Billing provider middle initial</td>
<td>Occurrence date</td>
</tr>
<tr>
<td>Performing provider NPI</td>
<td>Performing provider taxonomy code</td>
</tr>
<tr>
<td>Provider NPI</td>
<td>Condition code</td>
</tr>
<tr>
<td>Service facility name</td>
<td>National drug code</td>
</tr>
<tr>
<td>Condition code</td>
<td>Occurrence from date</td>
</tr>
<tr>
<td>National drug code</td>
<td>Occurrence to date</td>
</tr>
<tr>
<td>Occurrence code</td>
<td>Referring provider number</td>
</tr>
<tr>
<td>Referring provider number</td>
<td>Value code</td>
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</table>

837 Field Name

<table>
<thead>
<tr>
<th>Claim Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional and professional</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification condition applies indicator and Condition indicator - early and periodic screening diagnosis and treatment (EPSDT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional and professional</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service facility name and location information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional</td>
</tr>
<tr>
<td>Ambulance transport information</td>
</tr>
<tr>
<td>-------------------------------</td>
</tr>
<tr>
<td>Ordering provider identifier and identification code qualifier</td>
</tr>
</tbody>
</table>

**Anthem to Discontinue Delivery of Multiple F Checks in the HIPAA 835 Payment Cycle**

Anthem will eliminate the use of the ‘F’ check number in the HIPAA 835 and combine ALL claims, paid and zero pay’ into a single 835 file for each payment cycle. This single 835 file will contain one check number. The 835 will report all finalized claim activity for that weekly payment cycle.

**Change:** The HIPAA 835 transaction file can contain both paid and rejected claims under the assigned check number. This is consistent with what is reported on the Provider voucher/EOP.

In the event that there is not a monetary payment, the 835 associated with the non-paid claims reported under that 835 will be grouped in a single file.

*Effective December 19, 2015, when the HIPAA 835 transaction file has all zero pay claims, there will not be a check/EFT number. The number mapped in TRN02 (check number field of the HIPAA 835 transaction) will be the vouchers FDSN (Financial Document Serial Number).*

- The FDSN will start with ‘V’ and be followed by up to 9 numbers (Example: V123456789).
- This number, minus the ‘V’ is located at the bottom right of the Provider voucher/EOP, under the page number. There is no change to the Provider voucher/EOP, or where the FDSN is located.

**Note:** Blue Exchange 835s will not be impacted by this change and will continue to produce single 835s for non-paid claims.

To view Provider Voucher examples, go to anthem.com/jedi, select Nevada, and enter. Select the Communications tab, then the Latest News link, then **Anthem to Discontinue Delivery of Multiple F Checks in the HIPAA 835 Payment Cycle – December 21, 2015.**

**Update to Claims Processing Edits and Professional Reimbursement Policies**

**Update to Commercial Claims Processing Edits and Reimbursement Policies**

On February 1, 2016, we will be updating ProviderAccess, our secure provider portal, with the following new and/or revised reimbursement policies.

**Bundled Services and Supplies**

Beginning with claims processed on or after February 22, 2016, Healthcare Common Procedure Coding Systems (HCPCS Level II) code C9257 for Avastin 0.25 mg will be eligible for reimbursement to professional providers who report their services on a CMS 1500 claim form as an exception to our always bundled edit for HCPCS “C” codes. Based on our policy, all other HCPCS “C” codes are not eligible for reimbursement when reported by professional providers.

For dates of service on or after January 1, 2016, services in the home or hospice setting identified by HCPCS codes G0151-G0164, G0299-G0300 and G9473-G9479 (effective January 1, 2016), Q5001-Q5002, and Q5009 will be added to our always bundled edit and will not be eligible for reimbursement when reported on a CMS 1500 claim form. This information will be reflected in Section 1 of our policy.
Please note that effective January 1, 2016, HCPCS has deleted codes G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter); therefore, we are removing these two codes from Section 1 of our policy.

**Durable Medical Equipment**

When durable medical equipment (DME) is rented by a patient, Anthem allows rental up to the purchase price or a maximum 10 month rental period, whichever comes first. When a patient was previously covered by another health insurance policy and such other policy covered a portion of the DME purchase price or rental period, we will apply the previous policy’s allowed amount or rental months to our current purchase allowance or 10 month rental period, whichever comes first, when the DME item is procured from the same DME provider. This information may be found under the “Purchase/Rent to Purchase” section of our policy dated February 1, 2016.

**Frequency Editing**

Beginning with claims processed on or after February 22, 2016 with dates of service on or after January 1, 2016 we will apply a frequency limit of one per date of service for new CPT code 0403T (Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day).

In addition, for claims processed on February 22, 2016 we will apply a frequency limit of 24 per 365 days to new CPT code 0403T. Please note that this edit will use claim lines processed in history that have previous, current, and subsequent dates of service to accumulate and apply this frequency limit.

For claims processed on or after February 22, 2016, we will be adding procedure codes to our one per date of service frequency limit edit. These are procedure codes that include in their description an indication that the code may be bilateral, or a particular code is designated by CMS as a bilateral service, or service is considered inherently bilateral. These codes should be reported with only one unit per date of service whether performed unilaterally or bilaterally. Anthem considers this edit to be correct coding.

In December, we advised that effective with dates of service on or after March 1, 2016 we would apply a limit of 400 units for J0585 (Botox, 1 unit) per date of service. Please note that we are updating the limit to allow 600 units per date of service.

In our recent provider notification on December 14, 2015 regarding HCPCS Drug Testing Codes Effective January 1, 2016, we advised that CMS will use new HCPCS “G” codes for “per day” presumptive (G0477-G0479) and definitive (G0480-G0483) drug testing. Beginning with dates of service on or after January 1, 2016, we accept these “G” code and will apply a frequency limit of 1 unit per date of service on HCPCS codes HCPCS codes G0477 – G0483. We will also apply a frequency limit of 18 units per 365 days on HCPCS definitive drug testing codes G0480 – G0483. This edit will use claim lines processed in history with prior, current, and subsequent dates of service to accumulate and apply this frequency limit.

**HCPCS Drug testing codes effective January 1, 2016:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td>Presumptive, per day, dip sticks, cups, cards, cartridges</td>
</tr>
<tr>
<td>G0478</td>
<td>Presumptive, per day, dip sticks, cups, cards, cartridges</td>
</tr>
<tr>
<td>G0479</td>
<td>Presumptive, per day, instrumented chemistry analyzers</td>
</tr>
<tr>
<td>G0480</td>
<td>Definitive, per day, 1 - 7 drug classes</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>G0481</td>
<td>Definitive, per day, 8 - 14 drug classes</td>
</tr>
<tr>
<td>G0482</td>
<td>Definitive, per day, 15 - 21 drug classes</td>
</tr>
<tr>
<td>G0483</td>
<td>Definitive, per day, 22 or more drug classes</td>
</tr>
</tbody>
</table>

**Modifier Rules**

When modifiers LT, RT, or 50 are reported with a CPT code that is inherently a bilateral procedure or includes “unilateral or bilateral" in the code description, Anthem does not consider this correct use of modifiers. Therefore, beginning with claims processed on or after February 22, 2016, codes considered bilateral or described as “unilateral or bilateral” will not be eligible for reimbursement when reported with modifiers LT, RT, or 50. This will eliminate incorrect reimbursement and retractions. This information is also included in our Multiple and Bilateral Surgery Processing reimbursement policy.

**Multiple and Bilateral Surgery Processing**

In our Multiple and Bilateral Surgery Processing reimbursement policy, we have updated the arthroscopic and endoscopic surgical procedures coding table to include new CPT code 43210 (esophagogastroduodenoscopy (EGD)). Claims processed on or after February 22, 2016 that includes 43210 and another EGD code identified in the table will be subject to the endoscopic reimbursement reduction for any subsequent procedures.

**Place of Service (Professional)**

Anthem considers the provision of any vaccine and the administration of such vaccines to be included under the facility’s reimbursement when the vaccines are provided in a facility setting. Therefore, beginning with claims processed on or after February 22, 2016 when a vaccine and the vaccine administration are reported by a professional provider with a facility setting place of service code, the vaccine and vaccine administration charges will not be eligible for separate reimbursement.

**Review of reimbursement policies**

The following professional reimbursement policies have been reviewed and include minor language revisions, but do not have changes to the policy position or criteria:

- *Documentation Guidelines for Psychotherapy Services*
- *Surgical Pathology for Prostate Needle Biopsy*

**Revised Coding Tip: Radiation Treatment Delivery and IGRT Professional Component**

In our December 2015 Network Update we advised in our coding tip for Radiation Treatment Delivery and IGRT that the professional component of CPT code 77387 (IGRT) would be eligible for separate reimbursement beginning with dates of service January 1, 2016 when reported with the treatment delivery codes based on the “Radiation Management and Treatment” table published in the CPT code book. We have made a decision to move this edit back to when 77387 became effective January 1, 2015. HCPCS code G6015 is also included in this edit.

**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 tout (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

**Commercial HEDIS® 2016 starts early February**

We will begin requesting medical records in February via a phone call to your office followed by a fax.

The fax will contain 1) a cover letter with contact information if you have any questions; 2) a Member list, which includes the member and HEDIS measure(s) they were selected for; and 3) an instruction sheet listing the details for each HEDIS measure. As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit [www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy).

HEDIS review is time sensitive, so please submit the requested medical records within five business days. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in the 3rd quarter provider newsletter.

To return the 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 to [www.submitrecords.com](http://www.submitrecords.com), enter the password: wphedisi57 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

Thank you in advance for your support of HEDIS.

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

**Clinical Practice and Preventive Health Guidelines available online**

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 anthem.com. Select the “Provider” link in the top center of the page. Select Nevada from the drop down list, and enter. Select the Health & Wellness tab, then the link title “Practice Guidelines”. You can then choose from Clinical Practice Guidelines, Preventive Health Guidelines, or Behavioral Health Clinical Practice Guidelines.

Pharmacy information available on anthem.com

Visit http://www.anthem.com/pharmacyinformation 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 certain drugs. 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 www.anthem.com, select Customer Support, select Nevada, Download Forms, Anthem Blue Cross and Blue Shield Drug Lists, and then choose Nevada Select Drug List.

Website links for the Federal Employee Program formulary Basic and Standard Options are Basic Option:
https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and Standard Option:
https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org │ Benefit Plans │ Brochures and Forms │ Medical Policies.

Medicare Advantage Updates

Anthem encourages care coordination for Medicare Advantage members with depression

Anthem encourages care coordination and continuity of care for members with a diagnosis of depression who have been admitted to a hospital. To enhance care coordination efforts Anthem behavioral health case coordinators will ensure that care plans are sent to the hospital, the member, the members’ primary care physician and/or the members’ behavioral health provider upon notice of an inpatient admission.

Additional support available for individual Medicare Advantage members with rare conditions

*Please note: The article below does not apply to providers with certain delegated risk agreements*

Anthem will be working with Accordant Health Services to provide targeted disease management services for our individual Medicare Advantage members with rare medical conditions, including:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- Crohn’s Disease
- Cystic Fibrosis
- Dermatomyositis
- Epilepsy
Members in your care who may benefit from additional outreach and information may receive letters, emails, or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention.

- If you feel that an individual Medicare Advantage member would benefit from this program, please have the member contact AccordantCare via phone or fax at 1-866-247-1150.

HIPPS codes required for SNF and HHA claims

As a reminder, all claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) received July 1, 2014 and after must contain a valid HIPPS code. This pertains to Contracted and Non-Contracted Providers. CMS requires Anthem to include this information on all processed claims data that we submit, regardless of the payment methodology. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including Medicare-Medicaid Plans. This does not apply to Dual Special Needs Plans (D-SNPs) or Medicare Supplement plans.

**SNFs**
- SNFs should bill the HIPPS code derived from the “Admission Assessment”.
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable Revenue Code (0022), the HIPPS code, 1 or more units, billed charges of 0.00 or one cent.

**HHAs**
- HHAs should bill the HIPPS code derived from the date of assessment.
- Bill the first line with the applicable Revenue Code (0023), the HIPPS code, date of the first covered visit, one or more units, billed charges of 0.00 or one cent.
- HHAs are not required to bill Treatment Authorization Codes.

If you currently have a contract with Anthem, the CMS mandated addition of the HIPPS code on your claim will not affect your contracted rate but is required to process your claim for payment.

57943WPPENMUB 12/16/2015

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 that providers 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.

For more information about compliance with the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Federal Clinical Compliance Department -- phone: 317-287-0196, fax: 877-261-2134, email: carol.bossingham@anthem.com.

Check Important Medicare Advantage Updates at anthem.com/medicareprovider for additional information.

Help ensure Anthem members have accurate information about your practice

Please keep Anthem apprised of any changes to street address, phone number, office hours or any other change that affects your availability to see existing Anthem Medicare Advantage members. In addition, Anthem also needs to know if you are accepting new patients or if you stop accepting new patients. This helps ensure that our Medicare Advantage members have accurate information about your practice.

Please review formulary changes to help members find best medication values

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes for 2016 include: tier changes, drug removals and new Prior Authorization and Quantity Limit requirements.

Our members will need your help to ensure they get their medications at the most affordable cost.

Please, encourage your patients to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications that will meet their needs at a lower cost.

Current and previous year Medicare Advantage formularies for plans sold directly to individuals are published at www.anthem.com/medicareprovider. An overview of plan changes for 2016, including notable formulary changes, can be found at www.anthem.com/medicareprovider under Important Medicare Advantage Updates. See the 2016 Medicare Advantage Plan Changes for your state dated October, 1, 2015.

Drug coverage provided to members of group-sponsored Medicare Advantage Plans and Part D Pharmacy Plans varies by employer or union. Patients who have group-sponsored Medicare Advantage or Part D Pharmacy coverage receive a new formulary booklet prior to the start of each calendar year that they can bring to their appointment with you.

Keep up with Medicare Advantage news
Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)

New Health Insurance Exchange Marketplace / Affordable Care Act Information article available online:

- Incentive opportunity for physicians treating patients with Anthem's Affordable Care Act (ACA) compliant plans purchased on or off the exchange (Nevada)

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 Insuranc Marketplace / Affordable Care Act information.