SOAP Notes/Health Assessments requested by Inovalon for 2016 calendar year must be submitted by February 10, 2017

IMPORTANT REMINDER: While the date of service must be from a visit in the 2016 calendar year, the SOAP note/Health Assessment can be submitted up until February 10, 2017.

Incentive opportunities available

We understand that completing these SOAP Note requests may take time. We are offering contracted providers the opportunity to increase reimbursement.

- **Electronic** SOAP Notes submitted via Inovalon’s ePASS® tool are eligible for $100 in addition to the office visit fee
- **Paper** SOAP Note submitted via Inovalon’s secure fax line at 1-866-682-6680 are eligible for $50 in addition to the office visit fee

Inovalon ePASS webinars offered

Webinars offered by Inovalon assist eligible providers in completing SOAP Notes/Health Assessments and utilizing the ePASS electronic tool. If you have not already done so, we encourage you to attend an upcoming session. All webinars take place on Wednesdays at 12 pm PT: January 25, February 1, and February 8

How to join (Note: Be sure to use the new contact information shown below.)

- **Teleconference:** Dial 1-888-757-2790 and enter access code: 351117.
- **WebEx:** Visit [https://inovalon.webex.com](https://inovalon.webex.com) and enter Meeting Number 740117402.

Once you join the call, live support is available at any time by dialing *0.

For more information on the outreach process or the ePASS tool, please reference our FAQs. Go to [anthem.com](http://anthem.com). Click **Menu**, and then under the **Support** heading select the **Providers** link. Choose **Nevada** from the drop down list, and click **Enter**. Select the **Provider Home** tab at the top of the page. Under the **Communications and Updates** heading, select Health Insurance Marketplace / Affordable Care Act Information, and then [Anthem engages Inovalon to conduct outreach efforts for our Exchange business: Frequently Asked Questions (Revised June 2015)](http://www.anthem.com). You may also contact Inovalon toll free at 1-877-448-8125.

To help easily identify members with Affordable Care Act plans, and the aligned networks, please see our [Affordable Care Act – Quick Reference Guide](http://www.anthem.com).

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Network Update is produced monthly by Anthem Blue Cross and Blue Shield.

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

In Colorado: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Nevada: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
Members managed by OrthoNet available online through Availity Web Portal

As previously communicated, Anthem Blue Cross and Blue Shield (Anthem) selected OrthoNet, LLC, to administer a physical and occupational therapy utilization management program in 2015.

The program requires that all outpatient and office based physical and occupational therapy services following the initial evaluation be authorized by OrthoNet. As indicated in previous communications, OrthoNet handles pre-certification requests for all Anthem members except: Medicare Advantage, Medicaid, Medicare supplement, Medicare Part D, Federal Employee Program® (FEP®), BlueCard, National Accounts, and certain self-funded and alternatively-funded groups. Members ages 6 and under are also excluded from participation in this program.

Providers are able to view members online through the Availity Web Portal, at Availity.com, to determine which members are administered under through OrthoNet.

- Log into Availity.com.
- From the Patient Registration tab, select Eligibility and Benefits (E&B) Inquiry
- Enter all required fields
  - Under Benefit / Service Type, select Physical Therapy, or Occupational Therapy

Sample screen shot below is utilizing Physical Therapy as the Benefit/Service Type. Note the OrthoNet message below including the phone number. If you see this message during your E&B inquiry, then please contact OrthoNet for authorization requests for this member. This message will not be displayed for members that are not administered by OrthoNet, saving you time to verify this information prior to submitting an authorization request through OrthoNet.
Reminder: ProviderAccess Web Portal Retirement Delayed

The decision has been made to postpone the ProviderAccess web portal retirement until second quarter 2017. We previously announced that Anthem was targeting January 2017 to retire ProviderAccess and transition all functionality to a single website, the Availity Web Portal.

Soon, Anthem will be introducing our new secure self-service tool on the Availity Web Portal where you can access all the important proprietary information and educational materials found on ProviderAccess today. After that tool is in place and you have had some time to get familiar with locating what you need, we will move forward with retiring ProviderAccess. More communication will follow as soon as we have determined the dates for these exciting changes.

Many tools on ProviderAccess have already been moved. If you are still going to ProviderAccess for Remittance Inquiry or the Professional Fee Schedule Inquiry tool (Contracted Pricing Tool), please start using these tools through Availity today. Currently, these tools are available in both systems, but after the retirement date, they will only be available through Availity.

Use the Interactive Care Reviewer via the Availity Web Portal to submit your requests for Behavioral Health services today!

Now with Interactive Care Reviewer (ICR), your practice can initiate precertification and prior authorization requests online more efficiently and conveniently for many Anthem members. Access ICR via the Availity Web Portal to experience a streamlined process to request inpatient and outpatient medical and behavioral health procedures for many of your patients covered by Anthem plans.

How does a provider gain access to our Interactive Care Reviewer (ICR)?

Access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select Register in the upper right hand corner of the page. If your organization already has access to Availity, your Availity Administrator can grant you access to Authorization and Referral Request for submission capability and Authorization and Referral Inquiry for inquiry capability. You can then find our tool under Patient Registration | Authorizations & Referrals then choose the Authorizations or Auth/Referral Inquiry option as appropriate.

Are there any specific services Behavioral Health practices can precert using ICR?

ICR can be used to submit or inquire on a precertification or prior authorization for many behavioral health services, including: Intensive Outpatient Program, Partial Hospital Program, Inpatient, Residential, Adaptive Behavioral Treatment (formerly known as ABA), and Transcranial Magnetic Stimulation.

Are there any services where an immediate decision can be obtained?

Yes! As of mid-January 2017, requests for Transcranial Magnetic Stimulation (TMS) are now eligible for an immediate decision when the completed attestation form within ICR is part of the submitted request.

Who can providers contact with questions?

For questions regarding our ICR, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Availity Client Services is available Monday-Friday, 8 am to 7 pm ET (excluding holidays) to answer your registration questions.

Here are just a few of the many benefits and efficiencies:

- Determine if a precertification or prior authorization is needed – For most requests, when you enter patient, service and provider details, you receive a message indicating whether or not review is required.
Member satisfaction with Behavioral Health outpatient services

Anthem conducts an annual satisfaction survey of our Member’s behavioral health outpatient service experience. The random survey is conducted based on receipt of claims. We have recently reviewed the 2016 survey experience results and wanted to share highlights with our network of behavioral health providers. The survey inquires about the member’s satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member’s various providers), prescriptions/medication management process (if applicable), financial and billing process, and their perceived clinical improvement. Our members are also asked to give an overall rating of his/her experience. The 2016 overall practitioner rating was 86.5% in NV based on the survey results.

We were pleased to see improvement in two areas of focus over the last year, prescriptions and coordination of care. Members responding to the survey indicated that conversations with their behavioral health prescribers were in depth and covered aspects, positive and negative, about taking the medication, along with alternative and supplemental treatments to address behavioral health issues. In addition, many respondents indicated that care was being coordinated among their providers, including medical. Care coordination and collaboration, particularly medical-behavioral integration, is a key area of our 2017 initiatives.

While we are pleased with our member’s experience with our participating provider network, and thank you for your network participation and the services you provide, there are areas of opportunity for improvement. These areas for improvement include:

Member’s Access to Behavioral Health Care

As a participating provider, please be reminded of Anthem’s expectation (based on NCQA definitions) of access to behavioral healthcare to help ensure our members have prompt access to behavioral health care:

- **Non-Life Threatening Emergency Needs – must be seen, or have appropriate coverage directing the Member, within 6 hours.** When the severity or nature of presenting symptoms is intolerable, but not life threatening to the member.

- **Urgent Needs – must be seen, or have appropriate coverage directing the Member, within 48 hours.** Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.

- **Routine office visit – must be within 10 business days.** Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.
We use several methods to monitor adherence to these standards. Monitoring is accomplished by a) assessing the availability of appointments via phone calls and surveys by our staff or designated vendor to the provider’s office; b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members. Anthem continues to look at gaps, barriers and alternative options to improve access to behavioral healthcare including telehealth services among network providers.

Members Held Harmless

As a participating provider in Anthem’s behavioral health provider network, a participating provider shall look solely to Anthem for compensation for covered services and under no circumstances shall render a bill or charge to any member except for applicable copayments, deductibles and coinsurance and for services that are not medically necessary or are otherwise not covered, provided that the Provider obtains the consent of the Member before providing such service. We recommend that consent be in writing and dated, in order to protect our members and providers from disputes.

In addition, Anthem also reminds our participating providers that Anthem members must be advised of missed or cancelled appointment policies at the onset of treatment. We also recommend that the advisement be acknowledged by the member in writing, and that acknowledgement is dated.

Thank you again for the services that you provide to our members.

Commercial HEDIS® 2017 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 your office can use to contact us if there are any questions; 2) a member list, which includes the member and HEDIS measure(s) the member was 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.

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, enter the password: wphediss57 and select the files to be uploaded. Once uploaded, you will receive a confirmation number to retain for your records.

2. **Send a secure fax:** 1-888-251-2985

3. **Mail to us via the US Postal Service to:**
   - Anthem Blue Cross and Blue Shield, 66 E. Wadsworth Park Drive, Suite 110H, Draper, UT 84020

Thank you in advance for your support of HEDIS.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
**Blood Pressure Monitor Benefits for Federal Employees**

The Blue Cross and Blue Shield (BCBS) Federal Employee Program® (FEP) and the American Medical Association (AMA) have come together in a collaborative effort to provide physicians with resources designed to improve health outcomes for patients with hypertension and suspected hypertension. This effort supports the goals of the Million Hearts® initiative.

Information can be found online covering self-measured blood pressure monitoring, a component of the Improving Health Outcomes: Blood Pressure Program developed by the AMA. The program is designed to help you and your office staff, engage your patients in the self-measurement of their own blood pressure. The Community Preventive Services Task Force found “there is strong evidence of effectiveness for these interventions when combined with additional support (i.e., patient counseling, education, or web-based support). The economic evidence indicates that self-measured blood pressure monitoring interventions are cost-effective when they are used with additional support or within team-based care.” ([http://www.thecommunityguide.org/cvd/RRSMBP.html](http://www.thecommunityguide.org/cvd/RRSMBP.html))

In support of this effort, FEP initiated a program to provide free blood pressure monitors* to FEP enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If your patient completes the Blue Health Assessment (BHA) and reports they have high blood pressure and you and your patient discuss home monitoring, your patient is eligible to receive a free blood pressure monitor. The BHA is a health-risk assessment and the first step in the FEP Wellness Incentive Program. In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle ([www.fepblue.org/bha](http://www.fepblue.org/bha)).

Information is available on anthem.com. Click Menu, and then under the Support heading select the Providers link. Choose Nevada from the drop down list and enter. Select the Health & Wellness tab at the top of the page, and click on Blood Pressure Information. You can also call FEP Customer Service at 800-727-4060 for additional information.

*The blood pressure monitors were selected by BCBS. The AMA does not endorse any particular brand or model of blood pressure monitor.

**Free provider training and CME credit – Moving toward equity in asthma care**

Did you know?

- Hispanics and African Americans with asthma are less likely to take daily controllers and are more likely to visit the emergency room and be hospitalized for asthma-related conditions than non-Hispanic Whites

- Asian Americans are more likely to die from asthma than non-Hispanic Whites

Anthem is committed to achieving health equity in asthma outcomes with diverse populations and now offers the free online experience, [Moving Toward Equity in Asthma Care](http://www.thebluecrossblue盾.org/resources/c facilitate-asthma-care), to support providers in delivering culturally appropriate asthma care to diverse patients.

Providers will receive 1.0 Continuing Medical Education (CME) credit upon successful completion of the course and easy access to additional resources about asthma disparities.

Key features of the course:

- Can be accessed from any mobile device, laptop, or desktop computer
- Interactive learning
- Bookmarking feature allows users to pause the course and resume it later
- Content is relevant for multiple diverse populations
- Focus on current disparities and what may contribute to them
To learn more about how providers and patients can work together to reduce asthma disparities, access this important training here.

Sources:


2 Office of Minority Health

This Enduring Material activity, Moving Toward Equity in Asthma, has been reviewed and is acceptable for up to 1.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 09/28/2016. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Hardware/Software Requirements – To access activities, users will need: A computer, tablet, or smartphone with an Internet connection. Microsoft Internet Explorer (9 or later); Google Chrome (38 or later); Safari (5 or later); Mozilla Firefox (32 or later).

Practitioners’ rights during the credentialing process

The credentialing process must be completed before a practitioner begins seeing enrollees and enters into a contractual relationship with a health care insurer or HMO. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application
- Correct erroneous information regarding a credentialing application
- Be notified of the status of credentialing or re-credentialing applications

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members’ claims.

Blue Physician Recognition and Physician Quality Measurement programs to sunset

In partnership with the Blue Cross Blue Shield Association (BCBSA), Anthem implemented two physician quality transparency programs for primary care physicians – Physician Quality Measurement (PQM) and Blue Physician Recognition (BPR) in 2012. Both programs have supported members in their health care decision-making through display of nationally-recognized physician performance measurements (PQM) and a logo (BPR) that identified physicians demonstrating a commitment to quality performance. Since their implementation, quality measurement and consumer transparency and engagement have evolved. Based on this and the analyses of these programs, BCBSA decided to sunset these programs and removed these displays from their National Doctor and Hospital Finder.

Anthem will remove this content from its website by April 23, 2017.

Update to Claims Processing Edits and Professional Reimbursement Policies

Update to Claims Processing Edits and Reimbursement Policies

On February 1, 2017, we will be updating our secure provider portal, ProviderAccess, with the following new and/or revised reimbursement policies.
The updates below identify if the article pertains to professional or facility provider billing.

**Bundled Services and Supplies – Professional**

The following Healthcare Common Procedure Coding System (HCPCS Level II) codes were effective January 1, 2017. Anthem considers these codes to be inclusive in the overall care of the patient and not eligible for separate reimbursement. Therefore, we are adding these new codes to our always bundled edit and they will be added to the Section 1 code list effective for claims processed on or after February 20, 2017. Modifiers will not override the edit.

- G0500 (moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports... patient age 5 years or older...)
- G0501 (resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)
- G0502 (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
- G0503 (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
- G0504 (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
- G0505 (Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home)
- G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service))
- G0507 (psychiatric collaborative care management)

The following HCPCS codes were effective January 1, 2017 for Medicaid services and will be added to our always bundled edit for claims processed on or after February 20, 2017 and will be added to the Section 1 code list. Modifiers will not override the edit.

- T1040 – Medicaid certified community behavioral health clinic services, per diem
- T1041 – Medicaid certified community behavioral health clinic services, per month

**Drug Screen Testing – Professional**

In our policy dated January 1, 2017, we have updated our policy to include new Current Procedural Terminology (CPT®) codes 80305, 80306, and 80307 (presumptive drug testing) that became effective January 1, 2017, which we will accept because HCPCS codes G0477, G0478, and G0479 (drug test(s), presumptive) have been deleted. In addition, we have added a new code HCPCS code G0659 for definitive drug testing, any number of drug classes. When G0480, G0481, G0482, or G0483 are reported with G0659, we consider this to be duplicate services and G0480, G0481, G0482, or G0483 will not be eligible for separate reimbursement. Modifiers will not override the edit. Please review the policy in its entirety.
Frequency Editing – Professional

We are updating our frequency limit for J1750 (injection, iron dextran (Infed), 50 mg) from 20 units per date of service to 40 units per date of service. This edit will be effective for claims processed on or after February 20, 2017 for dates of service on or after March 1, 2016.

For claims processed on or after February 20, 2017, we are adding frequency limits for the following HCPCS codes that were effective January 1, 2017:

- J7320 (hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 mg) will have a limit of 50 units per date of service
- J7322 (hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg) will have a limit of 48 units per date of service

Report HCPCS code C9257 for Avastin for Intravitreal Injection – Professional

Anthem will now accept HCPCS code C9257 (Injection, bevacizumab, 0.25 mg) for physician reporting of Avastin for intravitreal injection. Physicians should no longer report codes J3490, J3590, J9035, or J9999 for Avastin used in intravitreal injections.

Use of code C9257 will ensure that the appropriate reimbursement for this specific treatment is made. We have established a reimbursement allowance for code C9257, and, beginning with dates of service on or after March 1, 2017, we will allow a maximum of 5 units per injection per eye for a total of 10 units per date of service.

This reporting and reimbursement change impacts commercial Anthem members only.

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. Click Menu, and then under the Support heading select the Providers link. Choose 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. Please note: Any Cotiviti Healthcare edits will not be included in the Clear Claim Connection tool. These edits will be available by calling provider customer service at the number on the back of the member’s ID card.

CPT® is a registered trademark of the American Medical Association

ClaimsXten® is a registered trademark of McKesson Information Solutions LLC

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 online at anthem.com. Click Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. Select the Health & Wellness tab, then Practice Guidelines.

**Pharmacy information available on anthem.com**

Visit [http://www.anthem.com/pharmacyinformation](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 website 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](http://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](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf)
- **Standard Option:** [https://www.caremark.com/portal/asset/z6500_drug_list.pdf](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](http://www.fepblue.org) | Benefit Plans | Brochures and Forms | Medical Policies.

**Medicare Advantage Updates**

**Keep up with Medicare news**

Please continue to check [Important Medicare Advantage Updates](http://www.anthem.com/medicareprovider) at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Medicare risk adjustment and documentation guidance training offered
- Prior authorization requirements for intracardiac electrophysiological studies and catheter ablation
- December Reimbursement Policy Provider Bulletin

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**Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)**

**Preventive care services covered with no member cost-share (updated December 2016)**

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](http://www.anthem.com). Click Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. Select the Provider Home tab at the top of the page. Under the Communications and Updates heading, choose Health Care Reform Updates and Notifications or Health Insurance Marketplace / Affordable Care Act Information.