In this issue

Announcement
- New law requires coverage for autism

Coverage and clinical guideline update
- Coverage guideline updates effective April 1, 2012

Health care reform updates and notifications
- Updates on the Web
- Health Care Reform: What we’ve implemented and future changes

HIPAA 5010 update
- 5010 Readiness
  URGENT – 5010 compliance date January 1, 2012

ICD-10 update
- Transitioning to ICD-10: Key questions to ask

Business update
- New pre-service review requirements document posted at anthem.com
- Clinical practice and preventive health guidelines available on the Web
- Change with “Durable Do Not Resuscitate” regulations
- Survey says...Patients see room for improvement with physician care
- Alcohol and drug use – it’s a problem
- Working together to improve follow-up after mental health hospitalization

eBusiness
- Access patient information through Availity®; save time and money – register today
- It’s a new year; have you registered for the Network Rapid Update?

Network Update
A bi-monthly update for the health care professional community from Anthem Blue Cross and Blue Shield and its affiliated HMOs: Healthkeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc. Unless otherwise noted, the information in this newsletter pertains to all the aforementioned entities.

Provider Communications
2221 Edward Holland Drive
Richmond, VA 23230

The information in this newsletter is for informational purposes only and should not be construed as treatment protocols or required practice guidelines, diagnoses, treatment recommendations, or the provision of medical care services for our members and therefore is the responsibility of physicians and providers.

Anthem Blue Cross and Blue Shield of Virginia, Inc. is a trade name of Anthem Blue Cross and Blue Shield of Virginia, Inc. and its two affiliated companies, HealthKeepers, Inc. and Peninsula Health Care, Inc., which together are referred to as the “company,” “we,” “us,” or “our.” The company is an independent licensee of the Blue Cross Blue Shield Association. ♦ © 2011. All rights reserved. Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Important phone numbers

VAPENABSNL (01/12)
In this issue, continued

Medicaid information
- Formulary change for Anthem HealthKeepers Plus members – effective February 1, 2012 19
- DMAS expands Medicaid service area this month 20

Medicare information
- Anthem encourages your Medicare Advantage patients to get up-to-date on preventive care 21
- Medicare reports on osteoporosis management after bone fracture 22
- Pilot program promotes and measures medication adherence among Medicare members 23
- Formularies changing for 2012 Medicare Part D members 23

Pharmacy update
- Walgreens no longer a participating pharmacy in the Express Scripts network effective January 1, 2012 24
- Visit us on the Web for drug-related information 24

Bulletin board
- National accounts enroll with company 25
Announcement

New law requires coverage for autism

The 2011 Virginia General Assembly introduced a bill requiring health insurers to cover autism spectrum disorder for specified employer groups. Governor Robert McDonnell signed the bill, and the new law goes into effect for renewals for impacted employers beginning January 1, 2012.

Autism spectrum disorder (ASD) means any pervasive developmental disorder, including:

1. Autistic disorder
2. Asperger’s syndrome
3. Rett syndrome
4. Childhood disintegrative disorder, or
5. Pervasive developmental disorder – not otherwise specified

This definition is from the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Treatment

Treatment includes Applied Behavior Analysis (ABA), which is limited to $35,000 per member per year from age 2 through 6. Per the mandate, ABA must be provided or supervised by a board-certified behavior analyst, licensed by the Board of Medicine, and the prescribing practitioner is independent of the provider of the ABA. ABA will also have to be precertified to assure that all elements of treatment are compliant with the mandate. All ABA services should be billed using code H2027 – Psychoeducational service, per 15 minutes.

For children age 2 through 6 receiving speech, physical and occupational therapy, there are no limits placed on the number of visits for such therapy services for autism spectrum disorder. As announced in the November 2011 edition of Network Update, effective January 1, 2012, physical and occupational therapy for HealthKeepers members will no longer require precertification. PPO/POS members receiving physical or occupational therapy will need a specialty care review ( referral) on file. Speech therapy will continue to require precertification across HMO and PPO/POS products, and it remains highly recommended for PAR/PPO members.

If you have any questions about the Virginia autism mandate, please contact your Anthem network manager.
Coverage and clinical guideline update

Coverage guideline updates effective April 1, 2012

Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield (hereinafter “Anthem”) will implement the coverage guidelines below effective April 1, 2012. A brief summary of the changes for each guideline follows. The complete guidelines will be available for review on our website at www.anthem.com beginning January 11, 2012.

These coverage guidelines were among those approved at the Medical Policy & Technology Assessment Committee (MPTAC) meeting held on November 17, 2011. MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. The committee meets quarterly to review Anthem’s coverage and clinical UM guidelines. Voting membership includes:

- External physicians in clinical practices and participating in networks
- External physicians in academic practices and participating in networks
- Internal medical directors

Proton Beam Radiation Therapy (RAD.00015)

The coverage guideline Proton Beam Radiation Therapy (RAD.00015) was revised. Approved revisions of this guideline include the following:

- Clarification of the investigational statement addressing all conditions other than localized prostate cancer
- Revision of the medically necessary statement for localized prostate cancer
- Addition of brachytherapy as investigational in conjunction with proton beam radiation as dose escalation therapy for the treatment of localized prostate cancer
- Addition of an investigational statement addressing proton beam radiation therapy for the treatment of prostate cancer for all other indications not meeting the medically necessary criteria, including but not limited to salvage therapy for locally recurrent prostate cancer (such as post-prostatectomy)

Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty and Sacroplasty) (SURG.00067)

The medically necessary indications for percutaneous vertebroplasty and percutaneous kyphoplasty were revised. Percutaneous vertebroplasty or kyphoplasty of the cervical, lumbar or thoracic region is considered medically necessary after failure of standard medical therapy when any of the following criteria are met:

- Osteolytic vertebral metastasis including myeloma with severe back pain related to destruction of the vertebral body not involving the major part of the cortical bone, and chemotherapy and radiation therapy have failed to relieve symptoms; or
Vertebral hemangiomas with aggressive clinical signs (severe pain or nerve compression) or aggressive radiological signs, and radiation therapy has failed to relieve symptoms; or

Osteoporotic vertebral collapse or steroid induced vertebral fracture with persistent debilitating pain which has not responded to accepted standard medical therapy as documented in the medical records. Standard medical therapy may include initial bed rest with progressive activity, analgesics, physical therapy, bracing and exercises to correct postural deformity and increase muscle tone, salmon calcitonin, bisphosphonates and calcium supplementation; or

Painful vertebral eosinophilic granuloma with spinal instability

Sacroiliac Joint Fusion (SURG.00127)

This is a new coverage guideline addressing the proposed indications for sacroiliac joint fusion procedures for the treatment of chronic and intractable low back pain due to sacroiliac joint syndrome and other pain-related sacroiliac conditions. Sacroiliac joint fusion procedures, including but not limited to, minimally invasive and percutaneous sacroiliac joint fusion, are considered investigational for all indications.

The CPT codes associated with this new guideline are 27280 [arthodesis, sacroiliac joint (including obtaining graft)] and 27299 [unlisted procedure, pelvis or hip joint (when specified as arthrodesis of sacroiliac joint by minimally invasive or percutaneous approach)]. Note: This guideline does not address sacral fusion associated with severe traumatic injuries associated with pelvic ring fractures.

Brachytherapy for Oncologic Indications (RAD.00014)

The medically necessary criteria for the treatment of prostate cancer with brachytherapy were revised. Effective April 1, 2012, brachytherapy is considered medically necessary for prostate cancer that is clinically localized when one of the following criteria is met:

a) Individual with low risk of recurrence which is defined as tumor stage T1-T2a, low Gleason score ([GS] less than or equal to 6), serum PSA level below 10 ng/mL, and greater than or equal to 10-year expected survival and treatment involves:
   i. Permanent low dose rate [LDR] brachytherapy as monotherapy.

b) Individual with intermediate-risk of recurrence which is defined as tumor stage any T2b to T2c, or GS of 7, or PSA value of 10-20 ng/mL, and greater than or equal to 10-year expected survival and treatment involves one of the following:
   i. LDR brachytherapy in combination with EBRT; or
   ii. HDR brachytherapy in combination with EBRT.

c) Individual with high risk of recurrence which is defined as stage T3a or Gleason score 8-10, or PSA level greater than 20 ng/mL after definitive therapy and treatment involves one of the following:
   i. LDR brachytherapy in combination with EBRT; or
   ii. HDR brachytherapy in combination with EBRT.

Brachytherapy is considered investigational in individuals not meeting the above criteria.
Health care reform updates and notifications

Visit us on the Web at anthem.com for updates regarding health care reform. Once on anthem.com, select providers and then Virginia. Select the “Health Care Reform Updates and Notifications” link under Communications and Updates or click HERE.

Health Care Reform: What we’ve implemented and future changes

There is a lot to know when it comes to health care reform. That’s why we’ve created a summary with details about how we’ve implemented some of the most significant provisions impacting members and providers in 2010 and 2011. Except where indicated, these provisions were effective for members in non-grandfathered plans upon renewal on or after September 23, 2010. In some cases, we implemented provisions for grandfathered members as well, even though the provision did not require us to do so. Policy benefits vary based on grandfathered and non-grandfathered status, the size of the member’s group and other factors. In order to know how benefits apply to a specific policy, please continue to verify eligibility and benefits for all patients.
<table>
<thead>
<tr>
<th>Provision</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent coverage to age 26</td>
<td>For many plans, we implemented this provision early to avoid a coverage gap for spring 2010 graduates. Members with group plans were given the opportunity to enroll dependents younger than 26 at their first open enrollment after September 23, 2010. We implemented this provision for dependents to age 26 for most vision and dental plans as well, even though the health care reform law does not apply to these benefits.</td>
</tr>
<tr>
<td>No lifetime dollar limits/Restricted annual dollar limits on essential health benefits</td>
<td>We removed lifetime dollar limits from plans where required and provided a one-time, open enrollment period for members who had reached their lifetime maximum limit. We implemented the annual limits provision, removing annual dollar limits. In some limited cases, employers could apply to the government for a waiver of this requirement. In order to understand how benefits apply to a specific policy, please continue to verify eligibility and benefits for all patients.</td>
</tr>
<tr>
<td>No member cost share for in-network preventive care/Preventive services expansion</td>
<td>We expanded our standard preventive care list and updated non-grandfathered plans to cover these services with no member cost share. We also chose to include this coverage in some grandfathered plans.</td>
</tr>
<tr>
<td>Patient protections</td>
<td>This provision gave members more flexibility in choosing a primary care doctor and accessing OB-GYN services without a pre-authorization or referral. It also requires copayments and coinsurance for out-of-network emergency medical care received in an ER to not exceed those required for in-network emergency care. We decided to include these provisions in all plans, even though they were not required for grandfathered plans.</td>
</tr>
<tr>
<td>Pre-existing conditions</td>
<td>Beginning with renewals after September 23, 2010, we provide coverage for members under the age of 19, regardless of pre-existing conditions.</td>
</tr>
<tr>
<td>Spending account changes</td>
<td>Effective January 1, 2011, prescriptions are required for spending account reimbursement of over-the-counter drugs other than insulin.</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>If it was not already in place, we created a standard appeal process for members to comply with health care reform, including providing certain information to members, and allowing members to review their file and present evidence during the review. We’ve also coordinated external review for self-insured plans through three accredited independent review organizations. As we move forward, we will implement this review process for other plans as well.</td>
</tr>
</tbody>
</table>
| Revised appeals process and adverse benefit determinations | On July 1, 2011, we began including the following information on all Adverse Benefit Determinations [member explanation of benefits (EOBs), letters to the member, etc.], if not already included:  
  - Date of service  
  - Health care provider name  
  - Claim amount (if applicable)  
  - Statement that diagnosis code, treatment code and their meanings are available upon request  
  - Denial rationale (include a discussion of the decision)  
  - Any standards used when denying the claim (such as medical policies, etc.)  
  - The denial code and reason (this information is contained on the EOB)  
  - Description of the internal appeals and external review procedures  
  - Contact information for consumer assistance or Ombudsman program |
Looking ahead, there are still many parts of health care reform that will impact providers, members and the way we all work together. Here are some of the significant provisions which will be implemented through 2016. As we continue to navigate through the many upcoming phases of health care reform, we will share additional details about how these changes may impact the way we do business with you.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Details</th>
<th>Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revised appeals process and adverse benefit determinations</strong></td>
<td>Appeals process – bypass internal: Claimants will have the right to bypass internal appeals and go to external appeal or litigation if the insurer or plan fails to comply with the rule (exceptions for minor violations that are not reflective of a pattern or practice of noncompliance).</td>
<td>Next plan year on or after January 1, 2012</td>
</tr>
<tr>
<td></td>
<td>Language notifications: We will provide notices to certain members on how to request an adverse benefit determination in a language other than English.</td>
<td>Next plan year on or after July 1, 2012</td>
</tr>
<tr>
<td><strong>Women’s preventive services expanded</strong></td>
<td>Approved women’s preventive services will be added to the preventive care benefit to be covered at 100% with no patient cost sharing. We are unsure at this time if these services will be added at one time or upon renewal. More information will be provided as it is available.</td>
<td>August 1, 2012, or upon renewals starting August 1, 2012</td>
</tr>
<tr>
<td><strong>Pre-existing Conditions</strong></td>
<td>Pre-existing conditions will no longer apply to non-grandfathered plan members (over the age of 19).</td>
<td>January 2014</td>
</tr>
<tr>
<td><strong>Administrative simplification</strong></td>
<td>This provision requires the HHS Secretary to adopt and regularly update the standard, implementation, specifications and operating rules for electronic exchange and the use of health information for the purposes of financial and administrative transactions. Providers will need to continue to work with their clearinghouses to ensure that they are compliant with standards for electronic exchange.</td>
<td>January 2013 - 2016</td>
</tr>
<tr>
<td><strong>Health insurance exchanges</strong></td>
<td>States will begin to operate health insurance exchanges, which are envisioned to be marketplaces for individuals and some employer groups to obtain private health insurance. Employers will also be able to purchase coverage outside of the exchanges.</td>
<td>Expected to be set up before 2014</td>
</tr>
</tbody>
</table>
### Coverage for clinical trials

<table>
<thead>
<tr>
<th>Coverage for clinical trials</th>
<th>Non-grandfathered plans must include coverage of routine patient costs for clinical trials of life-threatening diseases.</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual mandate</td>
<td>All U.S. citizens and legal residents are required to have health care coverage. For citizens without health care coverage, a penalty will be phased in. Penalties are the greater of $95 per year in 2014, phasing in to $695 per year by 2016 or 1 percent of taxable income phasing in to 2.5 percent of taxable income by 2016. Some exemptions will be allowed for low-income individuals.</td>
<td>2014-2016</td>
</tr>
</tbody>
</table>

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**HIPAA 5010 update**

**5010 Readiness**

**URGENT – 5010 compliance date January 1, 2012**

Anthem Blue Cross and Blue Shield fully supports the Health Insurance Portability and Accountability Act’s (HIPAA) 5010 mandate and will be able to support HIPAA 5010 transaction transmission compliance by January 1, 2012. In addition, we expect that all EDI trading partners support the mandate and will be fully migrated to the 5010 standards by January 1, 2012. Any trading partner (provider, employer group, software vendor, billing service or clearinghouse) concerned in their ability to migrate to 5010 by the January 1 mandate should contact the EDI Trading Partner Migration team immediately to discuss contingency planning options to ensure continuity of processing and payment post-January 1, 2012, and establish a testing and transition plan for 5010.

You can reach us from 8 a.m. to 5 p.m. ET, Monday through Friday, toll free at 800-991-7259 or via e-mail at 5010EHTS@anthem.com.
ICD-10 update

Transitioning to ICD-10: Key questions to ask

If you have not begun preparing for ICD-10, it’s imperative that you begin preparations now. Below is a list of questions to help you.

- **How much do I know about ICD-10?** Start reviewing ICD-10 code set changes now to plan for upcoming changes. There are no special programs to translate ICD-9 codes to ICD-10. Know the changes to the codes that you primarily use in your practice, so you can develop plans for business, transition and training to address gaps.

- **Am I required to transition to ICD-10?** Are you considered an entity covered by the Health Insurance Portability and Accountability Act (HIPAA)? Visit resources such as CMS’s ICD-10 website to understand whether you are required to comply with ICD-10. Most providers will be “HIPAA-covered entities” but there are a few exceptions.

- **How will this affect my existing workflows and processes?** Assess necessary changes to your existing practice workflow and business processes based on your patient population. This could include your clinical documentation, encounter forms/superbills, practice management system, electronic health record system, contracts, and public health and quality reporting protocols. It is likely that wherever ICD-9 codes now appear, ICD-10 codes will take their place.

- **How are my business partners preparing for the ICD-10 transition?** Payers, clearinghouses and systems vendors are already working on ICD-10 transitions. Be proactive by reaching out to them to understand how they are becoming compliant. Also understand your obligations, limitations and opportunities during the ICD-10 transition. Do not assume your system vendors or clearinghouses will automatically translate ICD-9 codes to ICD-10 for you.

- **Is my ICD-10 plan comprehensive?** ICD-10 compliance means changes in how payers will process claims and authorizations. Understand the impact to your practice and plan accordingly. Budget for time and costs related to ICD-10 implementation, including expenses for system changes, resource materials and training. Also, be sure you understand the timelines for system installations from vendors and testing milestones with payers.

- **Will I have HIPAA 5010 implemented by the compliance date?** As you may know, 5010 is a prerequisite for ICD-10. So by preparing to become compliant with 5010 by the deadline of January 1, 1012, you are already on the road to ICD-10 compliance. Apply lessons from the 5010 efforts to your ICD-10 preparation. Many payers and vendors are taking similar testing and communications approaches for these mandates.

- **Who will need to be trained on ICD-10 and when?** Perform a thorough assessment to determine all staff members who will need training on how to handle ICD-10 codes, keeping in mind the potential procedure changes in coding, authorizations and billing, etc. Be sure to include physicians in your assessment, since complete and accurate...
documentation is critical to successful ICD-10 coding. Look for information about training courses offered in your area or those available online through professional associations.

Business update

New pre-service review requirements document posted at anthem.com

Anthem’s Utilization Management department performs two types of pre-service reviews as defined and determined by a member’s contract. As the name implies, the reviews are performed in advance of the service being rendered.

Pre-certifications include both inpatient and outpatient reviews and refer to those reviews that are required of a member’s contract. Pre-certifications remain separate from specialty care reviews (referrals) that only primary care physicians (PCPs) can request. Pre-certifications can be performed by PCPs or specialists.

Requirements for both review types have been re-combined into one document. Additionally, the new document, effective January 1, 2012, contains format revisions as well as substantive review changes. Please also note the “key” that describes which review type is required for each service.

Providers are encouraged to review the document online (see below) or access Point of Care – our secure, Web-based tool for network-participating providers in Virginia – to make inquiries for members under their specific member ID numbers, for most services. For more information concerning Point of Care, please contact your local Anthem provider network manager.

Accessing the revised pre-service review requirements online

To access the document that addresses pre-service review requirements, visit anthem.com. Select “Providers” and then “Virginia.” Next, select Utilization Management Review Requirements under the Answers @Anthem tab or use the link below.

Clinical practice and preventive health guidelines available on the Web

As part of our ongoing 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 the "Provider" home page at anthem.com> select Provider and Virginia> Health & Wellness> Practice Guidelines.

Change with “Durable Do Not Resuscitate” regulations

Effective July 21, 2011, the Virginia Department of Health made changes to the Durable Do Not Resuscitate (DDNR) regulations. The authorized DDNR Order has changed to a standardized, downloadable form. The use of this form is being encouraged for uniformity and can be honored by qualified health care personnel in any setting.

Patients in a qualified health care facility or in transport between health care facilities when attended by qualified health care personnel may use Other DNR Orders. Patients who are not within a qualified health care facility must have the authorized State DDNR form or alternate DDNR jewelry. This would include those patients at home.

Emergency Medical Services (EMS) providers do not need to see an original DDNR or Other DNR Order. The following types of DDNR Orders can be honored by EMS providers:

(1) The State DDNR form (old or new) can be honored at any time;

(2) Authorized Alternate DDNR jewelry can be honored at any time, but it must contain specified information;

(3) A verbal order from the physician;

(4) Other DNR Orders, when a patient is within a qualified health care facility or being transported between facilities.

The previous goldenrod-colored State DDNR form may still be honored no matter when it was dated, and physicians may still complete the forms until supplies are exhausted. Photocopies will be honored indefinitely.

For additional information, including a copy of the new DDNR form, fact sheet and revised regulations, see the Virginia Department of Public Health’s website at:

http://www.vdh.virginia.gov/oems/ddnr/
Survey says... Patients see room for improvement with physician care

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

The following charts compare results from 2010 with those in 2011. You’ll also see two other columns. One shows the 2011 percentile achieved comparing Anthem in Virginia’s network scores to scores from other HMO plans across the country. The other column references the 90th percentile score, which reflects the score achieved by plan networks that are the best in the country. This is the score we encourage our network physicians to strive to achieve.

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

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2010</th>
<th>2011</th>
<th>Percentile Achieved</th>
<th>90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rating of Physician</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of personal doctor</td>
<td>83%</td>
<td>83%</td>
<td>50th</td>
<td>87%</td>
</tr>
<tr>
<td>Rating of specialist seen most often</td>
<td>84%</td>
<td>82%</td>
<td>25th</td>
<td>87%</td>
</tr>
<tr>
<td>Rating of all health care provided in past 12 months</td>
<td>78%</td>
<td>74%</td>
<td>25th</td>
<td>82%</td>
</tr>
<tr>
<td><strong>Getting Care Quickly</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>93%</td>
<td>89%</td>
<td>50th</td>
<td>90%</td>
</tr>
<tr>
<td>Got appointment for non-urgent care as soon as needed</td>
<td>86%</td>
<td>88%</td>
<td>50th</td>
<td>92%</td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>62%</td>
<td>65%</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>
Doctor’s Communication with Patients

| How often personal doctor explained things understandably to you | 95% | 96% | 50th | 96% |
| How often personal doctor listened carefully to you | 93% | 94% | 25th | 97% |
| How often personal doctor showed respect for what you had to say | 95% | 94% | 10th | 97% |
| How often personal doctor spent enough time with you | 93% | 92% | 50th | 95% |

Shared Decision Making

| Doctor discussed pros and cons of each treatment choice? | 66% | 66% | 25th | 73% |
| Doctor asked you which treatment choice was best for you? | 51% | 54% | 25th | 63% |
| You and your doctor discussed ways to prevent illness? | 53% | 61% | 50th | 66% |

Continuity of Care

| How often did your personal doctor seem informed about care you received from other health providers? | 79% | 79% | 25th | 84% |

Alcohol and drug use – it’s a problem


The age group with the highest alcohol dependence rate was the 18 to 25 year olds across the nation. Overall, 22.4 million persons reported alcohol abuse in the National Survey. By state, Wisconsin had the highest rate with 10.1 percent and
Georgia had the lowest rate of 6 percent of alcohol use and abuse. Clearly, the problem with alcohol and drugs in our nation and particularly the younger population is not decreasing, and access to treatment is not readily available.

What does that mean to providers, especially in the nine states identified with highest rates of use? It is more likely you will be working with patients who use alcohol and drugs and who may abuse or become dependent upon them. According to the American Psychiatric Association (APA) Preferred Practice Guidelines, early physician diagnosis and intervention has been shown to be helpful in encouraging patients to examine and decrease their substance use and to reduce both the direct and indirect consequences. A simple and reliable assessment tool such as the Two-Item Conjoint Screening (TICS) can be easily administered during a office visit:

- **In the last year, have you ever drunk or used drugs more than you meant to?**
- **Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?**

For patients who have already been treated for alcohol or drug-related issues, such as alcohol detox, a follow-up office visit can be an opportunity to discuss the substance abuse problem, complete an updated clinical assessment and provide further clinical education. These visits can also reinforce the need for treatment or further the discussion with those patients who may be resistant.

For non-behavioral health providers, billing codes are now available for screening and brief intervention with patients you suspect may have problems with alcoholism or addiction. These billing codes are 99408 for 15-30 minutes and 99409 for greater than 30 minutes (“G” would preface CPT codes for Medicare billing). If you have any questions about these billing codes, please contact your Anthem network manager.

In conclusion, alcohol and drug addiction continue to present as a serious health problem. Screening and brief intervention should therefore be a routine part of medical care. It is a condition that responds to intervention and treatment which in turn can help the patient return to leading a full, healthy and productive life.

**Reference:**


*For further details, refer to the SAMHSA website:  [http://www.oas.samhsa.gov/2k5State](http://www.oas.samhsa.gov/2k5State)
Working together to improve follow-up after mental health hospitalization

Ensuring quality of care, coordination of care, medication management and scheduling prompt appointments for many patients can be challenging. We know the majority of our in-network providers excel at ensuring all patients are seen in a timely manner and providing quality behavioral health care. Toward that end, our shared goal is to ensure patients who have recently been psychiatrically hospitalized are seen within seven days of discharge. These efforts have been shown to dramatically decrease the likelihood of symptom relapse and subsequent re-hospitalization.

Our associates make a number of efforts to support timely follow-up care. Members routinely receive a follow-up call to make sure they have a scheduled appointment. If they do not have an appointment, staff will schedule an appointment as needed. We then contact providers in order to confirm that the appointment was kept and then follow up accordingly with the member.

By working together we are successfully improving our rates on timely follow-up care. Data gathered for a Behavioral Health quality improvement project in 2010 indicated that our goal for improvement in the number of members who were seen by a provider within seven days was exceeded by 3 percent. Similarly, our projected goal for successful telephonic contacts with members after discharge was also exceeded by 3 percent.

What are the goals set for 2012? Naturally, our goals are tailored to build upon success while striving for additional improvement in our rates for follow-up appointments. Working together, we will continue efforts such as:

- Supporting proactive discharge planning by hospitals
- Expanding our outbound calls to members
- Promoting linkage to outpatient treatment
- Providing educational materials on the importance of timely follow-up care and medication adherence

Visit the Virginia provider section of our website, anthem.com, for a provider toolkit that contains patient education materials and other information to help you. If you have a successful method or standard of practice to ensure patients who have been recently hospitalized have an appointment within seven days, please share those methods by sending an email to: Lauren.Sims@anthem.com.
Access patient information through Availity®; save time and money – register today

Providers can access information for Anthem members through Availity®, a multi-payer web portal. Using a single sign-on, providers are able to access multiple payers to check eligibility, benefits, claims and many other services offered by Availity.

Providers in Virginia can access the following information for Anthem and Blue Cross and Blue Shield members nationwide on the Availity site:

- Eligibility and benefits
- Claim status inquiries
- Clinical Messaging – clinical tips and reminders on patients’ medications and care gaps
- Availity® CareProfile® – a claims-based electronic medical record which provides up to 24 months of patient medical claims history from our system across all of a patient’s health providers, including labs, imaging centers and pharmacies.

Advantages of using Availity

- Single sign-on access to multiple payers (payers vary by state)
- Standard screen format for all health plans
- Ability to batch eligibility and benefits inquiry transactions across multiple payers and send all at once
- Reporting by user allows the Primary Access Administrator (PAA) to track work by associate
- Personalized training
- Utilization reporting (aggregate and user specific) for administrators in real time

Benefits for providers

- Easy to use
- Increases productivity for users who must check many payers’ information during the course of the day
- Fits easily into existing workflows
- Assists administrators in monitoring and managing utilization

Register today at www.availity.com

For more information, contact your Anthem network manager or call Availity Client Services toll free at 800-282-4548.

Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.
It’s a new year; have you registered for the Network Rapid Update?

In 2012, we’re continuing our registration efforts to enroll providers and their staff to receive our Network Rapid Update – our streamlined, e-mail communications tool. Get important “need-to-know” provider updates – delivered conveniently to your electronic inbox. We will only use the Network Rapid Update as the need arises to communicate urgent, critical or time-sensitive information that impacts you and how you do business with us.

If you haven’t yet registered and you’d like to receive the Network Rapid Update, you’ll need to provide us with an e-mail address where we can send these critical alerts. Only those providers who sign up will receive the Network Rapid Update via e-mail. (Please note if you’ve already enrolled for the Network Rapid Update, you do NOT need to register again.) To register your e-mail address with us, select the Network Rapid Update link on the Virginia provider home page of anthem.com or click HERE.

You may receive Web security alert/information questions. Simply answer yes to the security questions and complete the short registration form.

Medicaid information

Formulary change for Anthem HealthKeepers Plus members – effective February 1, 2012

ADHD medications for members 18 years or older will require prior authorization

Recently, our National Pharmacy and Therapeutics Committee reviewed and approved a new guideline for Attention Deficit Hyperactivity Disorder (ADHD) and Narcolepsy medications for Anthem HealthKeepers Plus (Medicaid/FAMIS) members. The committee recommended the change to enhance quality and appropriateness for the diagnosis and treatment of adults age 18 and over diagnosed with ADHD.

When a pharmacy attempts to fill a prescription for an ADHD medication on or after February 1, 2012, for an Anthem HealthKeepers Plus member 18 years of age or older, the claim will reject and be subject to the prior authorization process.
The following list represents the most commonly administered ADHD medications under our pharmacy benefit:

<table>
<thead>
<tr>
<th>dextroamphetamine and amphetamine:</th>
<th>methylphenidate:</th>
<th>lisdexamfetamine dimesylate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adderall/XR</td>
<td>Concerta</td>
<td>Daytrana</td>
</tr>
<tr>
<td>dextroamphetamine:</td>
<td>Metadate/CD/ER</td>
<td>lisdexamfetamine dimesylate</td>
</tr>
<tr>
<td>Dextedrine</td>
<td>Ritalin/LA/SR</td>
<td></td>
</tr>
<tr>
<td>Dextrostat</td>
<td>Methylin/ER</td>
<td></td>
</tr>
<tr>
<td>ProCentra</td>
<td>dexmethylphenidate:</td>
<td></td>
</tr>
<tr>
<td>methamphetamine:</td>
<td>Focalin/XR</td>
<td></td>
</tr>
<tr>
<td>Desoxyn</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you have any questions regarding these upcoming changes, please contact your Anthem network manager.

**DMAS expands Medicaid service area this month**

On January 1, 2012, the Department of Medical Assistance Services (DMAS) expands the Medicaid Managed Care (Medallion II) and Family Access to Medical Insurance Security (FAMIS) Plans to 24 additional cities/counties in Southwest Virginia. The expansion includes the following areas:

- Alleghany County
- Bath County
- Bedford County
- Botetourt County
- Craig County
- Floyd County
- Franklin County
- Giles County
- Henry County
- Highland County
- Montgomery County
- Patrick County
- Pulaski County
- Roanoke County
- Rockbridge County
- Wythe County
- City of Bedford
- City of Buena Vista
- City of Covington
Persons eligible for Medallion II or FAMIS in these locations who select HealthKeepers Inc. will be covered under Anthem HealthKeepers Plus – our Medallion II/FAMIS HMO product in Virginia. More than 40,000 new Medicaid members are eligible as a result of the expansion. Members impacted by the change will receive new HealthKeepers Inc. identification cards with member ID numbers beginning with YTD 865.

The provider network for the geographic areas listed above includes physicians, ancillary providers and hospitals participating in the Anthem HealthKeepers Plus network. Confidential access to benefits, eligibility and claim information for members enrolled in Anthem HealthKeepers Plus is available via Anthem Point of Care – Anthem’s secure, Web-based provider tool.

If you are a physician who serves this area, we encourage you to consider joining our network if you currently do not participate with Anthem. If you are interested in Anthem HealthKeepers Plus participation, please call 1-540-853-5077 to request additional information. Questions regarding benefits and coverage may be directed to Provider Services toll free at 1-800-901-0020.

**Medicare information**

**Anthem encourages your Medicare Advantage patients to get up-to-date on preventive care**

Anthem is committed to helping your Medicare Advantage patients stay up-to-date on preventive screenings:

- **Personalized checklist for preventive services** – Starting early in 2012, we will send members a healthy checklist. The checklist reminds them to ask you about preventive care and screenings they may need. Some reimbursable services may be completed by nurse practitioners and other non-MD providers.

- **Preventive service outreach calls** – Anthem will analyze claim records to identify members who still need preventive care or other services to manage chronic conditions, such as diabetes and hypertension.
  - The Clinical Quality Care Unit will call members to tell them about these services and to offer help scheduling an appointment.
  - A nurse or social worker will be available if members have questions about a health condition or community services and other assistance.
The following programs will help seniors get specific screenings and care for chronic diseases. Our Network Update will report dates and locations for these programs as they launch in 2012. (Please note that programs vary by region.)

If your patients participate in any of these programs, we will send the results of all screenings, lab tests and other assessments to you. The goal is to make it easier for your patients to stay up-to-date and to stay healthy.

- **Home lab kits** – Some members will be able to get in-home kits for colorectal cancer, blood sugar, and cholesterol screenings. We will send a letter to ask you first if you would like your patients to participate.

- **Home visits** – In some cases, we will set up a home visit. This can be very convenient for members who have transportation issues. The home visit can include a comprehensive health assessment to identify potential health issues.

- **Mammogram van** – The mobile mammogram will be performed in different locations in communities, such as community centers, hospital parking lot, etc. We will also call members who may need a mammogram and offer to make an appointment at a nearby clinic.

- **Glaucoma clinics** – To make it easier to get glaucoma screenings, Anthem will find eye care providers near members. We will help members who are not up-to-date on glaucoma screenings to make an appointment.

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**Medicare reports on osteoporosis management after bone fracture**

Once a woman has had a fracture, she has a four times greater risk of another fracture, reports the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

To monitor osteoporosis management, the National Committee for Quality Assurance reports to Medicare which of your female patients 67 years old or older has had a fracture and has had either bone mineral density testing or medication to treat or prevent osteoporosis within six months of the fracture.

Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the Journal of Rheumatology.
Pilot program promotes and measures medication adherence among Medicare members

In October 2011, Anthem began asking randomly selected Medicare members to participate in a medication adherence program. The pilot’s objective is to make it easier for patients to comply with medication regimens. The program is designed to help us understand consumer behavior and how to improve medication adherence among Medicare members.

Here’s how the program works: We send participants a device to help them remember to take their daily dosed medications. The package includes an educational letter, a free adherence aid, and a letter explaining the aid. Patients identified as non-adherent and taking medication for diabetes, high cholesterol or high blood pressure qualify to receive an adherence aid. (Non-compliance was defined as having a medication possession ratio, or MPR, of less than 80 percent.) Patients on a once-a-day or twice-a-day dose regime qualify to receive the Didit®. This reminder device attaches to the side of a prescription vial. The Didit helps patients track whether they have taken their medications.

We plan to review pilot outcomes at the end of the second quarter of 2012. So, stay posted. We will let you know if we decide to expand it to the entire Medicare population.

Formularies changing for 2012 Medicare Part D members

Some medications you have prescribed could be affected by recent formulary changes. As a result, your patients may request a prescription for a new, less expensive and/or equally therapeutic medication. Or, they may ask you for your help with medical necessity information for a prior authorization, or formulary or step therapy exceptions.

Please refer to your patient’s 2012 formulary for a complete list of available drugs. The formulary also notes tier levels and any requirements for coverage. If you need to immediately initiate a prior authorization, or a tiering, a formulary, or a step therapy exception request, please call 800-338-6180.

Thank you for reviewing these changes. We want to provide your patients with access to effective and affordable medications, so your help is much appreciated.
Pharmacy update

Walgreens no longer a participating pharmacy in the Express Scripts network effective January 1, 2012

Express Scripts, our pharmacy benefit vendor, contracts with retail pharmacies to provide affordable prescription drug services to members. Express Scripts had a contract with Walgreens, but Walgreens announced its intent to exit the Express Scripts pharmacy provider network as of December 31, 2011.

To ensure continuity of care, we recommended patients change pharmacies prior to December 31, 2011, rather than waiting until the end of the year. We communicated directly with patients to explain how they could easily move their prescriptions to another pharmacy. If members still have not moved their prescriptions, we would like to enlist your help so your patients experience minimal disruption.

Please take these steps to help ensure a smooth transition for your patients:

1) Make sure your office staff is aware that Express Scripts members have a choice to move their prescriptions.

2) Electronically prescribe for retail pharmacies other than Walgreens. If a prescription is for a maintenance medication, consider writing a 90-day prescription for home delivery from the Express Scripts PharmacySM.

3) If not prescribing electronically, provide patients with a paper prescription and advise them to fill it at another retail pharmacy in their network.

We appreciate your assistance in helping to ensure your patients experience minimal disruption as a result of this pharmacy change.

Visit us on the Web for drug-related information

Visit http://www.anthem.com/pharmacyinformation for more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and 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 using certain drugs. For state-sponsored business such as Medicaid (HealthKeepers Plus), visit SSB Pharmacy Information.
**Bulletin board**

**National accounts enroll with company**

Effective January 1, 2012, the following national accounts will enroll with us under our KeyCare and BlueCare plans:

- Wilson Trucking
- The William Carter Company

Please see the table below for pertinent information regarding these national accounts.

<table>
<thead>
<tr>
<th>Company</th>
<th>Effective Date</th>
<th>Alpha Prefix</th>
<th>Pre-certification Number</th>
<th>Customer Service Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The William Carter Company</td>
<td>1/1/2012</td>
<td>KeyCare: AKN, CDHP: AKZ, Indemnity: FEL, Other prefixes: TOT – Georgia (PPO), GCT – Georgia (CDHP)</td>
<td>855-405-3984</td>
<td>855-405-3984</td>
</tr>
</tbody>
</table>

The information in this publication is for informational purposes only and should not be construed as treatment protocols, required practice guidelines or product endorsement. Diagnosis, treatment recommendations, and the provision of medical care services for Anthem members and enrollees are the responsibility of providers and practitioners.