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**Network Update**

A bi-monthly update for the health care professional community from Anthem Blue Cross and Blue Shield and its affiliate Healthkeepers, Inc. Unless otherwise noted, the information in this newsletter pertains to all the aforementioned entities.

Provider Communications
2221 Edward Holland Drive
Richmond, VA 23230

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Announcements

Important information regarding 2015 CPT/HCPCS code updates and reimbursement treatment – Commercial products only

On January 1, 2015, the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) released new CPT® and HCPCS codes. Many codes released as part of the updates are accepted by Anthem. However, the following new 2015 codes are NOT eligible for reimbursement for our commercial products only:

1. **Codes G6030 - G6058 (Definitive Drug Testing)** – Reimbursement will only be provided for the applicable new 2015 CPT codes.

2. **Code G0276 (Blinded procedure for lumbar stenosis, clinical trial)** – This code would only be payable for Medicare patients in the Coverage with Evidence Development (CED) project.

3. **Code G0472 (Hepatitis C antibody screening for high risk)** – Reimbursement will only be provided for the applicable existing CPT code.

4. **Code G0473 (Group behavioral obesity counseling)** – Reimbursement will only be provided for the applicable existing CPT code.

5. **Code 99490 (Chronic Care Management service)** – Chronic care management services are an integral component of Anthem's value-based payment innovation programs.

6. **Codes 99497 - 99498 (Advance Care Planning service)** – Advance Care Planning services are an integral component of Anthem's value-based payment innovation programs.

7. **Code 34839 (Physician planning for endograft)** – Physician planning for surgery is an integral component of the surgical procedure.

Inovalon requests for 2015

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

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

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

Anthem’s 2015 webinars get under way in February

We are excited to announce our 2015 webinars that begin later this month. For your convenience, we offer these informative, hourly sessions online to eliminate travel time and help minimize disruptions to your office or practice. Please see the schedule and registration form at the end of this edition to sign up today for a webinar that’s convenient for you.

Network Update

February 2015
Coverage and clinical guideline update

Coverage guidelines effective May 1, 2015

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective May 1, 2015. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage and the Medicare-Medicaid Plan (Dual Integration product). Furthermore, the guidelines were among those recently approved at the quarterly Medical Policy and Technology Assessment Committee meeting held on November 13, 2014.

The following six guidelines are addressed in this edition of the Network Update:

- Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices (DME.00011)
- Static Progressive Stretch (SPS) and Patient Actuated Serial Stretch (PASS) Devices (DME.00038)
- Percutaneous Neurolysis for Chronic Neck and Back Pain (SURG.00066)
- Antihemophilic Factors and Clotting Factors (DRUG.00066)
- Powered Robotic Lower Body Exoskeleton Devices (OR-PR.00006)
- Surgery for Clinically Severe Obesity (SURG.00024)

SPECIAL NOTE

The services addressed in ALL the coverage guidelines presented in this section (pages 4 through 7) will require authorization for all of our HealthKeepers products. A pre-determination can be requested for our PPO products.
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<td><strong>Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices (DME.00011)</strong></td>
<td>This revised coverage guideline addresses auricular electrostimulation, H-wave stimulation, interferential stimulation therapy, microcurrent electrical nerve stimulation, pulsed electrical stimulation, percutaneous neuromodulation therapy, supraorbital transcutaneous neurostimulation, and sympathetic therapies. The revisions to the coverage guideline include the addition of supraorbital transcutaneous neurostimulation as investigational for all indications including, but not limited to, prophylactic treatment of episodic migraine headaches. Currently, there is no specific CPT or HCPCS code(s) for supraorbital transcutaneous neurostimulation. E1399, durable medical equipment, miscellaneous, is listed to represent this device.</td>
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<td><strong>Static Progressive Stretch (SPS) and Patient Actuated Serial Stretch (PASS) Devices (DME.00038)</strong></td>
<td>This new coverage guideline addresses static progressive stretch (bidirectional static progressive stretch) and patient-actuated serial stretch devices as a means of treating joint stiffness and contracture. Static progressive stretch (SPS) and patient-actuated serial stretch (PASS) devices are considered to be investigational. The HCPCS codes associated with this new coverage guideline are E1399, E1801, E1806, E1811, E1816, E1818, E1821, E1831, and E1841.</td>
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<td><strong>Percutaneous Neurolysis for Chronic Neck and Back Pain (SURG.00066)</strong></td>
<td>This revised coverage guideline addresses the use of percutaneous surgical procedures for the destruction of nerves in individuals with chronic neck and back pain. Revisions to this coverage guideline include the addition of cooled radiofrequency as investigational for the treatment of chronic back pain, including but not limited to facet or sacroiliac (SI) joint pain. The CPT codes listed in this revised coverage guideline are 64633, 64634, 64635, 64636, 64999 and 64640.</td>
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<td>Antihemophilic Factors and Clotting Factors (DRUG.00066)</td>
<td>This new coverage guideline outlines the medically necessary and investigational criteria for select hemophilia and clotting factor replacement products. Products addressed in this coverage guideline include:</td>
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<td>- Alphanate® (Grifols Biologicals Inc., Los Angeles, CA)</td>
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<td>- Alphanine® SD (Grifols Biologicals Inc., Los Angeles, CA)</td>
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<td>- Bebulin® (Baxter Healthcare Corporation, Westlake Village, CA)</td>
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<td>- BeneFix® (Wyeth Pharmaceuticals Inc., Philadelphia, PA)</td>
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<td>- Rixubis™ (Baxter Healthcare Corp., Westlake Village, CA)</td>
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<td>- Xyntha® (Wyeth Pharmaceuticals, Inc., Philadelphia, PA)</td>
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<td>- Xyntha® Solufuse™ (Wyeth Pharmaceuticals, Inc., Philadelphia, PA)</td>
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<td>The HCPCS codes listed in this new coverage guideline are J7198, J7189, J7190, J7185, J7192, J7191, J7183, J7186, J7187, J7193, J7194, C9133, J7195, C9134, J7180, and J7178.</td>
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| Powered Robotic Lower Body Exoskeleton Devices (OR-PR.00006) | This new coverage guideline addresses the use of powered, robotic lower body exoskeleton devices that may be utilized in the rehabilitation or daily use of individuals with neurological disorders that affect an individual’s ability to ambulate without assistance.  

The use of a powered, robotic lower body exoskeleton device is considered investigational under all circumstances, including but not limited to the following:  

- To enable individuals with spinal cord injury to perform ambulatory functions; OR  
- To assist in the rehabilitation of individuals with spinal cord injury; OR  
- To assist in the rehabilitation of individuals with traumatic brain injury.  

Currently, there is no specific CPT or HCPCS code(s) for powered, robotic lower body exoskeleton devices. L2999, lower extremity orthosis, not otherwise specified is listed on this new coverage guideline to represent these devices. |

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| Surgery for Clinically Severe Obesity (SURG.00024)   | This revised coverage guideline addresses surgical procedures for the treatment of clinically severe obesity.  

Revisions to this coverage guideline include the addition of medical necessity criteria requiring the serial documentation of an individual’s active participation in a non-surgical weight reduction regimen for at least six continuous months prior to surgery to enable both behavioral changes and adequate assessment of anticipated postoperative dietary maintenance.  

CPT codes listed in this coverage guideline are 00797, 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, 43632, 43659, and 43999. |

These new and revised coverage guidelines are available for review on our website at [www.anthem.com](http://www.anthem.com).
Enhancements to AIM Clinical Appropriateness Guidelines for advanced imaging – effective May

On May 4, 2015, the following changes to our Clinical Appropriateness Guidelines for Radiology, Cardiology, and Oncologic PET will become effective.

A summary of these changes is presented below.

Head and neck appropriate use criteria

- Expansion of criteria for MRI and CT brain allowing for evaluation prior to discontinuation of antiepileptic medications when a patient has not had a prior MRI
- Expansion of existing criteria for MRI and CT brain for evaluation of sensorineural hearing loss
- Addition of new criteria for MRI, MRA, CT, and CTA brain for evaluation of tinnitus
- Addition of new criteria for MRI orbit, CT maxillofacial, and CT neck (soft tissue) for evaluation of osteonecrosis of the jaw

Chest appropriate use criteria

- Infectious and inflammatory criteria for CT chest are further differentiated at the condition level
- Addition of several new criteria for CT chest include bronchopleural fistula, complications of pneumonia, and paraneoplastic syndrome with unknown primary tumor or origin

Abdomen and pelvis appropriate use criteria

- Addition of new criteria for MRI and CT abdomen for evaluation of iron deposition/overload in patients with hemochromatosis when they are candidates for chelation therapy
- Addition of new criteria for CTA abdomen and pelvis for evaluation of visceral artery aneurysms
Musculoskeletal appropriate use criteria

- Clarification of criteria for MRI and CT spine when evaluating cord compression
- Removal of criteria allowing CT cervical and thoracic spine evaluation for MS, myelopathy, and spinal cord infarct (note: these are still available under MRI)
- Revision of criteria for MRI upper extremity evaluation of nonspecific upper extremity pain

Oncologic PET appropriate use criteria

- Enhancement of clinical criteria for thyroid cancer

Cardiology appropriate use criteria

- Addition of new criteria allowing stress echo and MPI evaluation of patients awaiting solid organ transplantation
- Clarification of criteria for stress echo and MPI evaluation of patients who have undergone percutaneous coronary intervention (PCI) greater than three years ago
- Clarification of criteria for stress echo, resting echo, and MPI evaluation for cardiac arrhythmias redefining frequent premature ventricular contractions
- Modification of criteria for resting echo reevaluation of patients who have undergone implantation of a bioprosthetic valve to allow imaging seven years after the procedure and then annually thereafter

New pediatric guidelines

- In addition to the changes above, AIM has developed a set of radiology guidelines that are specific to pediatric patients. These guidelines include:
  - Pediatric Abdomen and Pelvis
  - Pediatric Chest
  - Pediatric Head and Neck
  - Pediatric Musculoskeletal
  - Fetal MRI
- The guidelines listed above bring together criteria from AIM’s adult guidelines applicable to pediatrics with new criteria specific to pediatric patients

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via e-mail at aim.guidelines@aimspecialtyhealth.com. Click here to access and download a copy of the current guidelines.
**Reminder: No copayment required for wellness and preventive care benefits for most Anthem plans**

Many members enrolled in plans offered by Anthem and our affiliate HealthKeepers, Inc. frequently report they are being asked for a copayment for wellness and preventive care services. Members in most Anthem plans pay no copayment for the following services:

- **Routine Wellness:** Annual check-up, routine screenings, immunizations, lab and X-ray services.
- **Preventive Care (one each per plan year):** Gynecological exam, Pap test, mammography screening, prostate exam, PSA test and colorectal cancer screenings including colonoscopies.

As always, providers should check eligibility and benefits for Anthem members seeking care by using our online provider tool – Availity.

*Avality, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.*

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

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

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

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

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

- Documentation of End Stage Renal Disease, renal dialysis or renal transplant with date of occurrence
- If the member was pregnant in 2014, provide documentation of pregnancy
- If the member had a non-acute inpatient admission during 2014 provide documentation
Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures.

We look forward to working with you this HEDIS season, and thank you in advance for your continued cooperation and support of HEDIS.

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

**HEDIS® 2015: Easy submission of commercial HEDIS medical records**

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

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

   **OR**

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

   **OR**

3. Mail information to us via the **U.S. Postal Service** to:

   Anthem Blue Cross and Blue Shield  
   10897 S. River Front Parkway, Suite 110H  
   South Jordan, UT  84095-9984

We began requesting medical records in January via phone calls to providers' offices followed by a communication via fax. Contact information is included with the fax should you have any questions. We thank you in advance for your support of HEDIS.

For information about submissions of HEDIS medical records for members enrolled in the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program (FEP), please see the “FEP update” section on page 20 in this edition of the *Network Update*. 
Maternity-related HEDIS® measures frequently asked questions

In our December 2014 Network Update, we presented the HEDIS measure related to postpartum care that should occur between 21 and 56 days after delivery and what you can do to help improve your rates. A few questions arose regarding the documentation of the postpartum visit using the Category II CPT Code of 0503F for billing. We hope you find the following explanations helpful.

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

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

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

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

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

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

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

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

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

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

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

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

Providers asked to include reference numbers on fax cover sheets to Anthem's UM area

As part of our continuing efforts to improve efficiencies in the Utilization Management (UM) process, we have identified an opportunity to expedite information received by fax. Asking providers to include the reference number on fax cover sheets is one such opportunity. This will make it easier to match new information with previously received material. It will benefit the provider and member by providing timelier, cost-efficient and more streamlined communications.

Action needed:

- Please include the reference number on the fax coversheet on all future correspondence.
  - The reference number is provided on our fax communications or when a case is set up via phone.

- As a reminder, do NOT include protected health information (PHI) on fax coversheets.

Thank you for your assistance.

Reminder: Health Diagnostic Laboratory leaves lab network

Effective February 1, 2015, Health Diagnostic Laboratory, Inc. is no longer participating in Anthem’s laboratory network. For a complete list of network-participating laboratory providers, please visit [www.anthem.com](http://www.anthem.com) and use our provider finder tool (“Find a Doctor”). Or if you prefer, you can call the customer service number on the back of the member’s ID card.
Improving your patients’ health care experience

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

Simply log onto our website at www.anthem.com and follow this path: Providers>Select State>Enter>Health & Wellness>Guide to Improving the Patient Experience.

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

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®) survey to our HealthKeepers/POS members. The survey gives Anthem members an opportunity to share their perceptions of the quality of care and services provided by our 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 our results from 2013 with those in 2014. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem in Virginia. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile. This is the level we encourage our network physicians to strive to achieve.

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

<table>
<thead>
<tr>
<th>Percentile</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survey Question</strong></td>
<td>2013</td>
<td>2014</td>
<td>Trend 2013 vs. 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rating of Physician</strong></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>84%</td>
<td>83%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>84%</td>
<td>83%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>78%</td>
<td>80%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Getting Care Quickly</strong></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>87%</td>
<td>88%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for check-up or routine care as soon as needed</td>
<td>84%</td>
<td>89%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got help or advice needed when calling doctor after regular office hours</td>
<td>71%</td>
<td>77%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor’s Communication with Patients</strong></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>96%</td>
<td>96%</td>
<td>=</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>94%</td>
<td>93%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>96%</td>
<td>94%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>94%</td>
<td>90%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shared Decision Making</strong></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons to take a medicine?</td>
<td>45%</td>
<td>44%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons not to take a medicine?</td>
<td>25%</td>
<td>20%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you?</td>
<td>72%</td>
<td>75%</td>
<td>↑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness?</td>
<td>73%</td>
<td>73%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Continuity of Care</strong></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did your personal doctor seem informed about care you received from other health providers?</td>
<td>81%</td>
<td>74%</td>
<td>↓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

**Clinical practice and preventive health guidelines available on the Web**

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 the "Provider" home page at [www.anthem.com](http://www.anthem.com). From there, select “Provider” and Virginia> then Health & Wellness> Practice Guidelines.

Or, for Anthem HealthKeepers Plus (Medicaid/FAMIS), select the following link:


**Misrouted protected health information**

As a reminder, providers and facilities are required to review all member information received from Anthem Blue Cross and Blue Shield to help ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Anthem provider services area to report receipt of misrouted PHI.
Facility update

Guidelines for hospital laboratory billing – Effective March 1

Effective March 1, 2015, if a facility has an independent lab agreement in place with Anthem, any lab-only services billed by the facility on a UB04 claim form will be denied back to the facility for proper billing on a CMS-1500 claim form as outlined in the lab agreement with Anthem. This includes specimens collected from the member in the physician's office and sent to the hospital for testing, or if the PAR/PPO covered member receives lab-only services in an outpatient department of the facility.

Lab Billing

Anthem or HealthKeepers, Inc. may contract with a limited number of laboratory service providers to provide outpatient lab and reference lab services to our covered individuals. Covered individuals should be directed to a participating lab provider for services. In some cases, the facility may bill for the lab services directly as outlined below in Acute Care Facility Setting (Hospital).

Laboratory services must be billed to Anthem by the provider of service. This means that laboratory services provided in the provider's office should continue to be billed by the provider. However, services provided by an outside laboratory must be billed directly to Anthem by the laboratory. For purposes of this Agreement, an outside laboratory must be a reference laboratory or a laboratory in which the referring provider or provider group has no financial or ownership interest, and which accepts samples for review from all providers. If an outside laboratory references a lab service to a subcontracted provider, the outside laboratory that initially received the order is required to bill for the service.

Outlined below are some examples of how lab services may be handled.

Acute Care Facility Setting (Hospital)

LAB SERVICES for HealthKeepers members

When specimens are collected from HealthKeepers covered individuals in a community physician's office and sent to the hospital lab for testing, or if the HealthKeepers covered individual receives lab-only services in the outpatient department of the hospital (not in conjunction with an inpatient, outpatient or emergency room service such as pre-admission testing), the hospital should bill HealthKeepers, Inc. directly and will only be reimbursed if the hospital has an authorization to provide the service. An authorization will only be granted when there is clinical justification that the service cannot be provided by our designated laboratory. If the hospital does not have an authorization for the service, the lab charges will be denied and the HealthKeepers covered individual must be held harmless.

Pre-admission testing can be performed by either an in-network lab provider or the hospital lab. Pre-admission testing by the hospital lab must be pre-authorized to the hospital in order for the hospital to receive reimbursement.
LAB SERVICES for PAR/PPO members

When specimens are collected from PAR/PPO covered individuals in a community physician’s office and sent to the hospital for testing, or if the PAR/PPO covered individual receives lab-only services in the outpatient department of the hospital, the service should be billed under an independent lab agreement using the CMS-1500 claim form. Lab-only services billed on a UB-04 claim form will be denied. If the hospital does not have an independent lab agreement, the services will not be reimbursed and the covered individual must be held harmless.

Physicians who provide clinical lab or pathology services to hospital inpatients or outpatients shall only be reimbursed for the professional component fee allowance (when the code has a separate professional component RVU assigned based on CMS guidelines). There will be no reimbursement to the physician for the technical component only, or the complete service. Such reimbursement has been included in the payment to the hospital.

When the hospital chooses to send a lab specimen to an outside lab provider to perform a test, the hospital is responsible for billing Anthem for the services and reimbursing the lab provider directly for the services.

Ambulatory Surgery Center (ASC)

When an HealthKeepers covered individual receives services at an ASC that is either an outpatient department of a hospital, or billed through a hospital tax identification number, then the ASC can either send the specimen to the designated lab provider or bill HealthKeepers, Inc. for the global or technical portion of the services. If the ASC bills only the technical portion of the services, then the professional portion of the services can be billed by a participating pathologist. Pre-admission testing can be performed by either an in-network lab provider or the hospital lab. Pre-admission testing by the hospital lab must be pre-authorized to the hospital in order for the hospital to receive reimbursement.

When a HealthKeepers covered individual receives services at an ASC that is “freestanding” (is separate and apart from the hospital) and bills to Anthem under a unique tax identification number, the ASC can:

- Send the specimen to the designate lab provider for processing;
- Bill HealthKeepers, Inc. for the global service; [or]
- Bill HealthKeepers, Inc. for the technical portion (a participating pathologist can bill for the professional portion)

The ASC can send the specimen to a hospital or other lab provider; however, the ASC is responsible for billing the technical portion of the service directly to Anthem (a participating pathologist can bill for the professional portion). The ASC is responsible for reimbursing the hospital or lab provider for the services. Any services for HealthKeepers members billed directly to HealthKeepers, Inc. from the hospital or non-designated lab provider will be denied, unless pre-authorized.

Pre-admission testing can be performed by the hospital lab, but it must be pre-authorized to the hospital in order to be paid.
Behavioral health update

Reminder: New partial day and intensive outpatient billing guidelines

As we shared with you in the June 2014 edition of the Network Update, Anthem updated several billing processes and guidelines to comply with requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA). Effective July 1, 2014, the changes accommodate the new coverage criteria for behavioral health treatment and services.

As a reminder, we are including a summary of this information again in this edition of the Network Update. These changes apply to both partial day substance abuse facilities as well as professional providers. Professional providers should submit their partial day services using the appropriate outpatient mental health service codes. This will allow our claims systems to apply the appropriate outpatient mental health benefit.

Effective July 1, 2014, partial day and intensive outpatient covered services must be billed on a UB-04 claim form as an outpatient service using bill type 131 and the revenue codes specific to the services as listed below. This service cannot be billed as an inpatient for any services with an admit date on or after July 1, 2014. Any claims submitted for admit dates of July 1 and after that are not submitted as an outpatient claim will be returned to the provider. For admit dates prior to July 1, bill the claim as you currently do. For professional providers, please submit your claims for partial day and intensive outpatient covered services using a CMS-1500 claim form with the appropriate outpatient mental health service code(s).

In addition, intensive outpatient mental health services will now be a covered benefit for our members. Please contact your provider representative for information to participate in this network.

ICD-10 update

ICD-10 updates: Clinical documentation improvement

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

Coming in April 2015

We will be launching a free scenario-based coding practice tool designed to give professional providers and their coders the opportunity to test their knowledge of the ICD-10 codes set by applying it to medical scenarios. Look for more details in the next edition of our Network Update provider newsletter.
Health care reform (including Health insurance exchange)

Refer to anthem.com for information about health care reform and the exchange

We continue to post information on our dedicated Web pages regarding health care reform and the health plans HealthKeepers, Inc. is offering on and off the exchange. Click either of these Web pages Health Care Reform or Health Insurance Exchange for more information, and refer back to these pages often.

For 2015, we have posted updated information regarding our plans members purchase on and off the exchange. Here are some links that may be of interest to you.


Important Update About Anthem’s 2015 ACA-Compliant Health Plans -- January 2015

Member ID Card Update for 2015 ACA-Compliant Health Plans – January 2015

Virginia Benefit Guides for Plans Purchased On and Off the Exchange – January 2015

FEP update

Submission of HEDIS® medical records for FEP members in 2015

Earlier in this edition of the Network Update, we shared information regarding 2015 HEDIS efforts for medical records for our commercial lines of business. The Federal Employee Program (FEP) will also be collecting medical records in 2015 for HEDIS.

It is important to that this is a SEPARATE request from the commercial medical records request and will also adhere to a five-day turn around for submission. Submitting the medical records for an FEP request will be slightly different than that of the commercial directions noted on page 11 in this edition of the Network Update.

For FEP medical records requests:

1. Providers will receive a phone call with the request for medical records followed by a fax with a list of members and instructions for submission.
2. Medical records may be submitted via fax with the phone number on the fax cover sheet received. Alternate methods of submission are mailing and electronic medical records. Instructions will be included in the fax packet received.

Mail information to us via the **U.S. Postal Service** to:

- MMR Services
- General Dynamics Information Technology
- One West Pennsylvania Avenue
- Towson, MD 21204

Thank you for your assistance with this HEDIS effort.

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

### FEP's advanced benefit determination process

Anthem Blue Cross and Blue Shield Federal Employee Program® (FEP) would like to share information about our advanced benefit determination (ABD) process. This is a voluntary process offered to physicians and/or their representatives to prospectively submit a request for member-specific services to the Utilization Management staff for medical necessity review and benefit determinations.

ABDs are assigned a reference/authorization number when the review determines the medical necessity criteria have been met and/or benefits are available. This reference/authorization number will be included in the top right hand corner of the letter sent to the provider. The letter includes direction for the provider regarding how to use the reference/authorization number for claims submission. If the ABD is approved, the provider can include the reference/authorization number on the post-service claim and the claim will be processed. This eliminates the need for the provider to submit the approval letter with each claim. The following statement is included in the approval letter:

> "Note to Provider: To ensure efficient and timely payment of claims when submitted, please include the authorization number from this letter on your claim."

### FEP changes call-in hours for UM/CM

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

Reimbursement policy reminders

To view additional information for policies in this edition of the Network Update and all Anthem HealthKeepers Plus reimbursement policies, visit www.anthem.com/vamedicaiddoc.

Modifier 22: Increased Procedural Service
(Policy 07-020, originally effective January 1, 2014)

HealthKeepers, Inc. allows reimbursement for procedure codes appended with Modifier 22 when the procedure or service provided is greater than what is usually required for the listed procedure code.

Prepayment reviews are performed to support the use of Modifier 22. If medical review of the documentation submitted with the claim supports Modifier 22, reimbursement is based on 120 percent of the fee schedule or contracted/negotiated rate for the procedure appended with Modifier 22.

In addition, if the documentation does not support the use of Modifier 22 or there is no documentation submitted with the claim, reimbursement will not exceed 100 percent of the fee schedule or contracted/negotiated rate of the procedure.

Reminder: Modifier 22 is appropriate to use only with surgery, radiology, pathology, laboratory and medicine procedure codes with a global period of 0, 10 or 90 days.

For additional reimbursement information and/or non-reimbursable services, refer to the Modifier 22 Reimbursement Policy at www.anthem.com/vamedicaiddoc.

Split-Care Surgical Modifiers
(Policy 11-005, originally effective January 1, 2014)

Reimbursement of surgical codes appended with “split-care modifiers,” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 70 percent
- Modifier 55 (postoperative management only): 20 percent
- Modifier 56 (preoperative management only): 10 percent

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member’s care.
Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

**Reminder: We have changed the way you must bill for services rendered by a CRNA**

Based on feedback received from the provider community, HealthKeepers, Inc. has adjusted our billing practices for our anesthesia providers. We have changed the way we want you to bill for services rendered by a certified registered nurse anesthetist (CRNA).

When the provider bills for a CRNA employed and medically directed or supervised by the provider for operative anesthesia covered services, the provider must report both services on separate claim lines using the appropriate modifiers (QK or QY for the anesthesiologist services and QX for the CRNA services).

Each line should be billed identically, with the exception of the modifier, and include the total charge for that modifier. Anthem HealthKeepers Plus’ reimbursement for some claims will be 50 percent of the Anthem HealthKeepers Plus rate for both the claim line with modifier QK or QY and the claim line with modifier QX; however, some claims may process with the line reporting the QK or QY receiving 100 percent of the reimbursement and the line with the QX being denied. Either way, the claim processes will result in 100 percent of the contractual Medicaid HMO Allowance.

When the provider bills only for supervision or medical direction of a CRNA who is not employed by provider, the provider should report services with the appropriate modifier (QK or QY) and anesthesia reimbursement will be 50 percent of the Medicaid HMO Allowance.

**Applicable Modifiers Required for all Anesthesia Claims**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Description</th>
<th>Who Performed the Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by anesthesiologist</td>
<td>Anesthesiologist</td>
<td>100%</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than four concurrent anesthesia procedures</td>
<td>Anesthesiologist</td>
<td>100% up to 3 base units</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
<td>Anesthesiologist</td>
<td>50%</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>CRNA</td>
<td>50%</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
<td>Anesthesiologist</td>
<td>50%</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
<td>CRNA</td>
<td>100%</td>
</tr>
</tbody>
</table>
We ask that you begin billing the two claim lines as described above inclusive of appropriate modifiers, for services rendered on and after January 1, 2015.

If you have questions, contact our Provider Services team at 1-800-901-0020.

View the provider agreement attachment, here.

Vaccine billing procedures for Anthem HealthKeepers Plus (Medicaid) and FAMIS

There are differences between how vaccine administrations and serums are reimbursed for our FAMIS and Medicaid members.

For Medicaid members, providers will be reimbursed one rate per serum, not per component of the serum. Providers will only be reimbursed for the administration fee. This payment will appear under the serum code line of the claim.

For FAMIS members, providers will be reimbursed for both the administration fee and the serum. Providers will be reimbursed at not less than 100 percent of Virginia Department of Medical Assistance Services (DMAS).

**Anthem HealthKeepers Plus (Medicaid)**

The vaccine product is provided by Virginia Vaccines for Children (VVFC) for Medicaid members.

**Immunization Administration:**

- Do **not** use codes 90460-90461 or 90471-90474 to bill the administration and vaccine serum(s) components administered (this is optional).

- Do use the appropriate serum codes **90476-90749** to bill for administration of the vaccine products provided to you by the state for free under VVFC program.

- Payment will be made for only the administration of the vaccine on the serum codes, and our system will record the actual vaccine product administered.

**Anthem HealthKeepers Plus (FAMIS)**

The vaccine product is **not** provided by VVFC for FAMIS members.
Immunization Administration:

- Do bill 90460 on one claim line when counseling is provided. The total number of units should equal the number of injections administered (includes first vaccine component) on that date of service.

- Do bill 90461 on one claim line when counseling is provided. The total number of units should equal the number of remaining components contained in the injection(s) administered.

- Do bill 90471-90474 on one claim line with one unit for single or combined vaccine/toxoid as follows:
  - 90471 – immunization administered percutaneous, intradermal, subcutaneous or intramuscular; one vaccine
  - 90472 – each additional vaccine administered percutaneous, intradermal, subcutaneous or intramuscular
  - 90473 – immunization administered intranasal or oral route; one vaccine
  - 90474 – each additional immunization administered intranasal or oral route

Vaccine/toxoid product:

- Bill codes 90476-90749 for the vaccine product (serum) administered.

- Payment will be made for the vaccine product(s) administered and the administration of the injections based on contractual benefits.

For additional information, contact our Provider Services team at 1-800-901-0020.

Provider reconsideration, claims payment appeal and corrected claims information and process

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
<th>Contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims Payment Reconsideration Requests</td>
<td>When there is a question regarding the outcome of a claim not related to a request for additional authorized days or services,* providers may request a reconsideration verbally by calling the Provider Service Unit or by submitting an Anthem 151 Claim Information/Adjustment Request form. Examples of reconsiderations include: Claim processing errors A response to additional information requested to perfect a claim</td>
<td>Reconsiderations will not be considered if received 12 or more months after the claim adjudication date/date of the explanation of payment (EOP). HealthKeepers, Inc. will respond to all reconsideration requests within 60 calendar days. Verbal Reconsideration: To submit a verbal reconsideration, call the Provider Service Unit at 1-800-901-0020.</td>
</tr>
<tr>
<td>(First Level Appeal)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NOTES:

A request to review a finalized claim denied as not medically necessary or experimental/investigational will not be considered if submitted verbally through the Provider Service Unit or sent on an Anthem 151 Claim Information/Adjustment Request form. These should be submitted as medical necessity appeals.

A request to review a finalized claim that may require additional authorized days or services should be submitted as a Claims Payment Appeal (see below).

Corrected claims are finalized claims that the provider may need to adjust through the inclusion of additional information. These should be submitted as Corrected Claims (see below).

Hours of operation are 8 a.m. to 6 p.m., Monday through Friday, Eastern time (ET).

**Written Reconsideration:**
To submit a written reconsideration, use a blank Anthem 151 Claim Information/Adjustment Request form, which is available online at www.anthem.com.

1. Select Providers.
2. Select VA.
3. Select Answers at Anthem.
4. Select Provider Forms.

Complete the form, attach any necessary information and mail it to the address below:

HealthKeepers, Inc. Reconsiderations
P.O. Box 62404
Virginia Beach, VA 23466-2404

**Electronic Reconsideration:**
To file a claims reconsideration through Availity, Go to availity.com.

1. Select Claims Management/ Claims Status Inquiry
2. Fill in required fields (for complete detail on claims inquiry, search claim inquiry within Availity Help.
3. Navigate to the claims detail page
4. Go to the bottom of the claims detail and click on the link Request an appeal for this claim.
5. Click I Agree.
6. If the claim appeal is submitted within 1 year from the Date of EOP, the appeal submission will be treated as a Reconsideration.
7. The provider can attach a 151 Reconsideration Form, but it is not required.
8. If the submission is within one year of the Date of EOP, and the provider wishes for HealthKeepers, Inc. to treat the submission as an official Appeal, the provider should note that the submission should be treated as an Appeal and not a Reconsideration in
**Claims Payment Appeal (Second Level Appeal)**

A claims payment appeal may be requested when a provider:

1. Does not agree with the determination of a reconsideration
2. Is requesting additional days or services to be authorized for a paid claim

A claims payment appeal may be submitted in one of two ways:

- **In writing**
- **Via our provider website**

To ensure a timely and appropriate resolution of your appeal, we recommend that you:

- Include the word **APPEAL** in bold in your request.
- Include, if available, the patient's name, identification number, date(s) of service, claim number(s) and our case number.
- Provide the specific reason(s) for the appeal. It is important for you to explain each claim you wish to appeal exactly and why you feel we should reconsider your claim. Giving a generic reason for the appeal will make it difficult for us to respond timely and appropriately.
- Include all relevant information, such as medical records or other supporting documentation, regardless of whether it was considered at the time the initial decision was made.

**NOTE:**

If your claim appeal is denied, or you receive reduced reimbursement through the appeal process, you have exhausted your appeal rights with HealthKeepers, Inc. However, you can request an appeal of the denied or reduced reimbursement to the Department of Medical Assistance Services (DMAS). Before appealing to DMAS, you must first exhaust all of HealthKeepers, Inc.

An appeal request must be received within 15 months of the date of service or 180 calendar days of the date you are notified of HealthKeepers, Inc.'s adverse coverage decision, whichever is later.

HealthKeepers, Inc. will respond to all claims payment appeal requests within 60 calendar days.

**Written appeal:**

Mail written appeal requests to:

HealthKeepers, Inc.

Payment Appeals Unit
P.O. Box 61599
Virginia Beach, VA 23466-1599

**Electronic appeal:**

To file a claims payment appeal through Availity, go to **availity.com**.

- Select **Claims Management/ Claims Status Inquiry**
- Fill in required fields (for complete detail on claims inquiry, search **claim inquiry** within Availity Help).
- Navigate to the claims detail page
- Go to the bottom of the claims detail and click on the link **Request an appeal for this claim**.
- Click **I Agree**.

For additional assistance, please call our Provider Service Unit at **1-800-901-0020** from 8 a.m. to 6 p.m., Monday through Friday, EST.
appeal processes. All provider appeals to DMAS must be submitted in writing within 30 days of the last date of denial by HealthKeepers, Inc. to:

DMAS Appeals Division
600 E. Broad Street – 11th Floor
Richmond, VA 23219.

Corrected Claims

If there is a need to modify a paid/finalized claim, which paid according to the information originally submitted, the corrections must be submitted on the applicable claim form.

A claim is considered a corrected claim when there are any data changes from the original submission.

Requests for claims corrections cannot be submitted on an Anthem 151 Claim Information/Adjustment Request form.

Corrected claims may be submitted in one of two ways:
- Mailed on the proper claim form
- Submitted via our provider website

Corrected claims must be received within 12 months of the adjudication of the original claim/date of the EOP.

**Written Corrected Claim:**
Mail written corrected claims to:
HealthKeepers, Inc.
P.O. Box 62404
Virginia Beach, VA 23466-2404

**Electronic Corrected Claim:**
To file a corrected claim through Availity, go to availity.com.
- Select Claims Management/Professional Claim or Facility Claim
- Fill in required fields (for complete detail, search submitting claims within Availity Help.)

For additional assistance, please call our Provider Service Unit at 1-800-901-0020, 8 a.m. to 6 p.m., Monday through Friday, ET.
Coverage changes for incontinence quantity limits

Effective December 1, 2014, quantity limits changed for certain incontinence supplies provided by durable medical equipment providers.

Diapers, briefs and pads

The following HCPCS incontinence codes have changed in quantity benefit:

- The new standard benefit limit is 180 diapers/liners per month. A4520, A4554, T4521-T453 and T4541-T4543
- Reusable diapers/liners new standard benefit limit is 24 per year. T4536, T4537, T4539 and T4540

All services will require authorization for quantities outside of those specified within this communication.

Claims for services rendered without prior authorization will be denied.

Example: when billing revenue code HCPCS/CPT* A4520 if more than 180 diapers are needed prior authorization will be required. Any quantity less than the plan amount will not require prior authorization.

HealthKeepers, Inc. does not reimburse for incontinence briefs or incontinence under pads for children younger than age 3 under the Anthem HealthKeepers Plus plan.

We appreciate the care and service you give to Anthem HealthKeepers Plus members. If you have questions about this notification or need assistance, please contact our Provider Services Unit at 1-800-901-0020 (TTY 1-800-855-2880) from 8 a.m. to 6 p.m. Eastern time, Monday through Friday.

*HCPCS and CPT codes above are examples. Use the visit code that best defines the service rendered. Please refer to your provider agreement for specific series of revenue codes included for payment.
Coverage changes for catheter quantity limits and grouping

Effective December 1, 2014, quantity limits changed for certain external, indwelling and intermittent catheters provided by durable medical equipment providers.

Catheter benefit groupings and limits

The following catheter codes have new limits:

- External catheters are limited to 36 per month (grouped) without prior authorization A4326 and A4349*
- Indwelling catheters are limited to three per month (grouped) without prior authorization A4338, A4340, A4344, and A4346*
- Intermittent catheters are limited to 180 per month (grouped) without prior authorization A4351-A4353*

All services will require authorization for quantities greater than those specified within this communication. Claims for services rendered without prior authorization will be denied.

As always, we appreciate the care you provide to Anthem HealthKeepers Plus members. If you have questions about this notification or need assistance, please contact our Provider Services Unit at 1-800-901-0020 (TTY 1-800-855-2880) from 8 a.m. to 6 p.m. Eastern time, Monday through Friday.

*HCPCS and CPT codes above are examples. Use the visit code that best defines the service rendered. Please refer to your provider agreement for specific series of revenue codes included for payment.

Medicare information

Individual Medicare Advantage membership has moved to a new claims system

Effective January 1, 2015, Anthem moved Individual (non-group) Medicare Advantage members to a new claims processing system. Please continue to check Important Medicare Advantage Updates on your provider portal regarding reimbursement policies and other information.
Home health claims – Please split dates of service for 2014 and 2015

Effective January 1, 2015, claims for individual Medicare Advantage members (not group sponsored plan members) moved to a new claims system. Please review the following information to help ensure your claims are processed accurately and efficiently. To expedite the processing of your claims, please split the date of services for your 2014 and 2015 services.

When billing for your Home Health services please bill the dates of services using calendar year format.

Example:

- Actual Dates of Services 12/18/2014 thru 01/20/2015
- Submit a claim for:
  - Dates of Service 12/18/2014 thru 12/31/2014
  - Dates of Service 01/01/2015 thru 01/20/2015

Please submit no more than one place of service per claim

Medicare Advantage providers should not submit claims with more than one place of service. Please submit separate claims for each place of service.

Routine physical exams are covered in 2015

Anthem Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2015 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member’s plan.

Anthem Medicare Advantage plans also will continue to provide benefits for the following Medicare covered services:

- Initial Preventive Physical Exam (IPPE) also known as the “Welcome to Medicare Preventive Visit”
- Annual Wellness Visit (AWV)

The IPPE (preventive physical exam) and AWV (wellness visit) are NOT a routine physical exam. Please refer to the chart on the next page to ensure accurate coding for each type of exam.
<table>
<thead>
<tr>
<th>The Welcome to Medicare Visit (IPPE) G0402</th>
<th>The Annual Wellness Visit (AWV initial and subsequent) G0438 &amp; G0439</th>
<th>Routine Physicals/Preventive Medicine Services (99381-99397)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G0402 Welcome to Medicare Visit/Initial Preventive Physical Exam:</strong> A preventive evaluation and management service; a face-to-face evaluation. This exam is a preventive physical exam and <strong>not a comprehensive physical checkup.</strong> This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a <strong>once in a lifetime benefit.</strong></td>
<td><strong>G0438 Initial Annual Wellness Visit (AWV):</strong> Services limited to beneficiary during the <strong>Second</strong> year the patient is eligible for Medicare Part B. <strong>Only one first AWV per beneficiary per lifetime.</strong> Includes a personalized prevention plan of services; face-to-face visit.</td>
<td><strong>99381-99397 – Preventive Medicine Services:</strong> The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient's age, gender, and identified risk factors; face-to-face visit. “The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.” Includes clinical laboratory tests.</td>
</tr>
<tr>
<td><strong>G0439 – Subsequent Annual Wellness Visit (AWV):</strong> One year after the patient's Annual Wellness Visit. Once every 12 months. Includes a personalized prevention plan of services; face-to-face visit. This exam is a preventive physical exam and <strong>not a comprehensive physical checkup.</strong></td>
<td><strong>NOTE:</strong> The AWV is intended to build upon the previously established &quot;Welcome to Medicare Visit&quot; physical exam.</td>
<td></td>
</tr>
<tr>
<td>OB/GYN providers please note: A Pap test and pelvic exam for our Medicare Advantage members is covered annually only if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past three years. Otherwise a Pap test and pelvic exam is covered every two years for women at normal risk. These services should be filed as separate codes from the routine physical, if they are rendered. Medicare Advantage member benefits are subject to change from year to year – please review 2015 benefits on the Medicare Advantage Providers page of the Anthem provider portal. Annual summaries of Medicare Advantage plan changes also can be found under Important Medicare Advantage Updates. This will advise what coverage of what will and/or will not take place for routine physicals. For further information or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member’s identification card.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Network Update

February 2015 32 of 42
Law excludes coverage of some Part D drugs; Customer service ready to help with members’ questions

There are some drugs that are excluded from the majority of Medicare Part D coverage by law. These include:

- **Drugs for:**
  - Anorexia, weight loss or weight gain (except to treat physical wasting caused by AIDS, cancer or other diseases)
  - Fertility
  - Cosmetic purposes or hair growth
  - Relief of the symptoms of colds, like a cough and stuffy nose
  - Erectile dysfunction
  - Durable medical equipment

- **Prescription vitamins and minerals** (except prenatal vitamins and fluoride preparations)

- **Non-prescription drugs** (over-the-counter drugs)

A few plans may cover the above as an Enhanced Benefit. This information is applicable to both individual and group-sponsored Medicare Advantage members. If there is a question of coverage, please have members call their customer service line on the back of their benefit card.

New 2015 precertification fax number for skilled nursing, long-term acute care, inpatient rehab and facilities

Effective January 1, 2015, we have a separate fax number for providers and acute and non-acute facilities to use. The phone number is:

**877-744-2319**

The new fax number should only be used when submitting precertification requests or additional clinical information for the following services – skilled nursing facility (SNF), long term acute care (LTAC), inpatient rehabilitation and acute and non-acute facilities. Please note submitting requests for services not listed above may cause a delay in processing requests.

Y0071_14_22758_I 12/10/2014
Avoid second fills of high-risk medications

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

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

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

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

Compounded drugs no longer a covered benefit for individual MAPD and PDP plans

Effective Jan. 1, 2015, compounds are no longer a covered benefit for individual Medicare Advantage Prescription Drug (MAPD) plans and prescription drug plans (PDP). Members who had a compound prescription filled in the last six months of 2014 were notified of this coverage change via mail and/or phone.

Please note that members of group sponsored MAPD and PDP plans will have coverage for only the Part D eligible drugs that are part of a compound.

If you believe the compounded medication you have prescribed is medically necessary, the patient may request an exception. The prescriber must provide a statement along with the exception request that explains the medical reasons for supporting the exception.

Provider requirements and Medicare notices

The Centers for Medicare & Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two (2) days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.
Additionally, CMS requires providers to deliver the **Important Message from Medicare About Your Rights (IM)** notice to every Medicare beneficiary within 2 calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than 2 calendar days before discharge.

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

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

- **NOMNC Notices:**
  - Deliver notice to *Managed Medicare* beneficiaries the way you do to *Traditional Medicare* beneficiaries
  - Include the beneficiaries Health Care Identification Number or Medical Record Number on page one
  - Include the specific type of services ending on page one
  - Include the Health Plans contact information on page two
  - Have the beneficiary or authorized representative sign and date page two at least two (2) days prior to the end of services
  - Retain a copy of the signed notice, both page one and page two.

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


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

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

**ICD-10-CM:** **ICD-9 vs. ICD-10 for atrial fibrillation and flutter**

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

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

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

The table on the next page demonstrates what terms need to be documented in ICD-10 to appropriately capture the type of atrial fibrillation and flutter.
<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Single code)</td>
<td>(Multiple specific codes)</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>• 427.31 (Established or Paroxysmal)</td>
<td>• I48.0 Paroxysmal</td>
</tr>
<tr>
<td>● Irregular, rapid atrial contractions</td>
<td>● Occurs periodically</td>
</tr>
<tr>
<td>Atrial Flutter</td>
<td>• I48.1 Persistent</td>
</tr>
<tr>
<td>• 427.32</td>
<td>● Rapid contractions of the upper heart chamber</td>
</tr>
<tr>
<td>● Regular rapid atrial contractions</td>
<td>• I48.2 Chronic</td>
</tr>
<tr>
<td></td>
<td>● Permanent atrial fibrillation</td>
</tr>
<tr>
<td></td>
<td>Atrial Flutter</td>
</tr>
<tr>
<td></td>
<td>• I48.3 Typical</td>
</tr>
<tr>
<td></td>
<td>● Type I atrial flutter</td>
</tr>
<tr>
<td></td>
<td>• I48.4 Atypical</td>
</tr>
<tr>
<td></td>
<td>● Type II atrial flutter</td>
</tr>
<tr>
<td></td>
<td>Unspecified atrial fibrillation and flutter</td>
</tr>
<tr>
<td></td>
<td>• I48.91 Unspecified atrial fibrillation</td>
</tr>
<tr>
<td></td>
<td>● Type not specified</td>
</tr>
<tr>
<td></td>
<td>• I48.92 Unspecified atrial flutter</td>
</tr>
<tr>
<td></td>
<td>● Type not specified</td>
</tr>
</tbody>
</table>

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

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

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

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

Y0071_14_22638_1 11/21/2014
Prior authorization required for members

Anthem Blue Cross and Blue Shield wants to remind providers that they are required to request a prior authorization for individual and group-sponsored Medicare Advantage members for services that require prior authorization. Failure to obtain a prior authorization will result in an administrative denial. The 2015 prior authorization requirements were posted to the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal October 4, 2014.

Members cannot be balance billed for an administrative denial.

To obtain prior authorization or to verify member eligibility, benefits or account information, please call the telephone number listed on the member's plan membership card.

Please visit the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal at http://www.anthem.com/medicareprovider to see the prior authorization list that is effective for 2015 as well as prior authorization requirements for 2014.

Reminder: Clinical information required for Medicare Advantage members

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

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

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

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

- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.
Medicare Advantage member identification prefixes updated for 2015

Anthem moved Individual (non-group) Medicare Advantage members to a single claims processing system January 1, 2015. Member identification prefixes were updated as part of that transition. The 2015 member identification prefixes for individual Medicare Advantage plans are listed below.

Please file 2014 charges with the 2014 prefix and 2015 charges with the 2015 prefix to help ensure claims are delivered to the appropriate claims system for processing.

2015 Individual Medicare Advantage plans

<table>
<thead>
<tr>
<th>Prefix</th>
<th>State/Area</th>
<th>Plan Type</th>
<th>Plan Name</th>
<th>Provider and member</th>
<th>CMS contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOA</td>
<td>Central - Virginia</td>
<td>MA PPO</td>
<td>Anthem Medicare Preferred</td>
<td>1-866-827-9866</td>
<td>H4909</td>
</tr>
</tbody>
</table>

Sample ID cards for are available at the [Medicare Advantage public provider portal](#).

Group-sponsored Medicare Advantage plan members are not affected by these changes. Members with the following member identification prefixes on their member card will represent group sponsored business only and will remain on the current claims processing platform:

JQF JWM VZM WGP XGH XGK XKJ XVL YGJ YLV YRE

OrthoNet authorization phone and fax numbers updated; Use for medical necessity reviews and professional service coding reviews

Anthem is collaborating with OrthoNet, LLC to conduct medical necessity reviews for physical therapy, occupational therapy and spine and back pain management for our individual Medicare Advantage members. Group-sponsored members are NOT impacted.

What does this mean to you?

As previously published, effective January 1, 2015, the following services/treatment requests must be reviewed by OrthoNet for precertification.

- Outpatient Physical therapy
- Outpatient Occupational therapy
Spine and Back Pain Management procedures:

- Epidurals
- Facet Blocks
- Pain Pumps
- Neurostimulators
- Spinal Fusion
- Spinal Decompression
- Vertebro/Kyphoplasty

In addition, OrthoNet will conduct post-service prepayment coding review of professional services for our individual and group-sponsored Medicare Advantage members, including:

- Orthopedic Surgery
- Plastic Surgery
- Neurosurgery
- Sports Medicine
- Podiatry
- Hand Surgery
- Neurology
- Pain Management
- Psychiatry/Physical Medicine and Rehabilitation (PM&R)
- ENT
- General Surgery
- Dermatology
- Cardiology
- Urology
- Percutaneous Coronary Intervention (PCI)

Precertifications can be obtained at the following phone or fax numbers:

**Outpatient Physical and Occupational Therapy**
Fax 1-844-340-6419
Phone 1-844-340-6418

**Spine and Back Pain Management procedures**
Fax 1-844-788-4806
Phone 1-844-788-4805

A complete list of precertification requirements can be found at the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal (www.anthem.com/medicareprovider).

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

Y0071_15_23119_I 01/09/2015
Individual Medicare Advantage membership enforces CLIA and ADI beginning July 1, 2015

Effective **July 1, 2015**, Anthem Individual Medicare Advantage will deny claims billed without CMS required criteria back to the provider who submitted the claim. The denials will include:

- Advanced Diagnostic Imaging (ADI) supplier not accredited for the service being billing
- Clinical Laboratory Improvement Amendment (CLIA) certification is missing or invalid, based on the laboratory code billed. CLIA certification should be billed in Box 23 on the claim form. Starting in March, an informational message will be included on your remittance when you bill a laboratory code that requires certification reminding you effective July 1 claims will be denied when CLIA certification is not included.

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

Y0071_14_22889_I_12/17/14

Pharmacy update

Pharmacy information available on anthem.com

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 using certain drugs, visit:


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). For Anthem HealthKeepers Plus (Medicaid), visit SSB Pharmacy Information.

To locate the “Marketplace Select Formulary” and pharmacy information for health plans offered on the Health Insurance Marketplace (also called the exchange), go to Customer Support, select your state, Download Forms and choose “Select Drug List.”

Network Update

February 2015
Due to subject matter content, these webinars will be made available only to "professional providers", defined as Anthem network-participating providers and their staffs who submit claims using the 837P or CMS-1500 format, and who have the following medical credentials: MD, DO, DC, DPM, LCSW, LCP, LFMT, CNS, CNM, plus DDS, DMD & OD (non-routine medical services only).

WEBINAR ATTENDEES MUST HAVE INTERNET AND SIMULTANEOUS TELEPHONE ACCESS. THE BELOW INFORMATION IS REQUIRED IN ORDER TO RECEIVE OUR WEBINAR CONNECTIVITY INFORMATION:

**Provider Request for Anthem Webinar Invitation**

Provider/Practice Name: ____________________________________________________________

Medical Specialty: ___________________________ Your Provider Type(s) (circle):

MD, DO, DC, DPM, LCSW, LCP, LFMT, CNS, CNM, DDS, OD, or OTHER: _________

Location of main office in VA: ________________________________________________________

NPI #: ___________________________ Tax ID #: ___________________________

* Attendee Name: _________________________________________________________________

* E-mail Address: __________________________________________________________________

Phone #: ___________________________ Fax #: ___________________________

**Important Note:** If multiple attendees will be viewing the webinar and listening together as a group via a single computer and phone line, we only need one e-mail address; however, if multiple attendees will each be viewing and listening from their own workstations, we must have SEPARATE registration forms with each individual's e-mail address.

Please mark which 2015 Webinar(s) you wish to attend:

- [ ] Wednesday, February 25 (10:30 a.m.-11:30 a.m.) – First Quarter Anthem Updates
- [ ] Wednesday, May 20 (10:30 a.m.-11:30 a.m.) – Second Quarter Anthem Updates
- [ ] Wednesday, August 19 (10:30 a.m.-11:30 a.m.) – Third Quarter Anthem Updates
- [ ] Wednesday, November 18 (10:30 a.m.-11:30 a.m.) – Fourth Quarter Anthem Updates

**Please complete form and fax it to (804) 354-2979**

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