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Announcements

Anthem to implement Cancer Care Quality Program and precertification requirement for outpatient radiation therapy services – effective September 1

Soon, Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. will begin the process of notifying providers regarding two new initiatives we will implement on September 1, 2015:

1. Cancer Care Quality Program

2. Precertification Requirement for Outpatient Radiation Therapy Services

Cancer Care Quality Program initiative

We are pleased to announce the launch of the Cancer Care Quality Program (Program) beginning September 1, 2015. This innovative quality initiative is an evidence-based cancer treatment program that will enable you to compare planned cancer treatment regimens against evidence-based clinical criteria.

The Program also identifies certain evidence-based Cancer Treatment Pathways that have been shown to be efficacious, lower in toxicity and cost-effective. At launch, the Program will include Cancer Treatment Pathways for breast, lung, colorectal, lymphoma, chronic myelogenous leukemia, myeloma, melanoma, central nervous system, ovarian, prostate and pancreatic cancers. Additional Pathway regimens for other malignancies may be added later.

The Program also includes online tools to provide decision support to providers in selecting cancer treatment regimens that are consistent with current evidence and consensus guidelines. In addition, the Program includes Cancer Treatment Pathways based on medical evidence and best practices developed with leading cancer experts to support providers in identifying therapies that are highly effective and affordable for our members.

Anthem members impacted by the two new AIM initiatives effective September 1

The launch of the Cancer Care Quality Program and the precertification requirement for outpatient radiation therapy services applies to ALL Anthem members in your area. However, there are exceptions. Members enrolled in the following plans are NOT impacted:

- Blue Cross Blue Shield Service Benefit Plan also known as the Federal Employee Program® (FEP)
- BlueCard® (except for members with health plans issued or administered by the following Anthem Affiliates: Anthem Blue Cross and Blue Shield in Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, or Wisconsin; Blue Cross and Blue Shield of Georgia; Empire Blue Cross Blue Shield in New York; and Anthem Blue Cross in California)
- Medicare Advantage plans
- Anthem HealthKeepers Plus/FAMIS plans (Medicaid)

Please note that other lines of our business may adopt the AIM programs as well. Separate notification of these implementations will occur later as appropriate.
AIM Specialty Health® (AIM), a separate company, will administer the Program on behalf of Anthem in Virginia. AIM is a nationally recognized leader in specialty benefits management and will also begin managing the diagnostic imaging and sleep management program on behalf of Anthem and HealthKeepers, Inc. effective July 1, 2015. In addition, AIM collaborates with payers to help improve health care quality and manage costs for some of today’s complex tests and treatments, promoting patient care that’s appropriate, safe and affordable.

Complete details regarding the Cancer Care Quality Program are included in a letter we are sending to certain providers. Visit the Cancer Care Quality Program website at www.cancercarequalityprogram.com to learn more about this quality initiative.

Precertification for outpatient radiation therapy services initiative

With our second initiative, also effective September 1, 2015, Anthem and HealthKeepers, Inc. will require precertification of certain non-emergency, outpatient radiation therapy services through AIM Specialty Health. For treatment plans that are scheduled to begin on or after September 1, 2015, all providers must contact AIM for precertification for the following non-emergency, outpatient radiation therapy modalities:

- Intensity Modulated Radiation Therapy (IMRT)
- Proton Beam Radiation Therapy
- Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiotherapy (SBRT)
- Brachytherapy

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through Anthem in Virginia’s inpatient precertification process. Members currently undergoing treatment on September 1, 2015, will not be impacted.

Note: Radiation therapy providers are strongly encouraged to verify that an order number has been obtained before initiating scheduling and performing services.

Beginning August 24, 2015, providers will be able to contact AIM through the ProviderPortal or the AIM Call Center.

Pre-notification for three-dimensional (3D) conformal radiation therapy

While not subject to precertification requirements, Anthem in Virginia is requesting that ordering providers contact AIM to review 3D conformal therapy requests. Notification and requested clinical information for 3D conformal requests is voluntary. Clinical review will be performed to confirm appropriateness and to ensure the ordering physician is aware of alternative treatments where applicable. Once clinical review is completed, a confirmation/tracking number will be issued. Servicing providers’ claims will not be denied as a result of the pre-notification process.

Required information for radiation therapy requests

Please use the checklist below as a guide to help ensure you have all the information necessary for a radiation therapy request:

- Member’s identification number, name, date of birth, and health plan
• Ordering physician information (name, location)
• Radiation therapy provider information (name, location)
• Treatment Modality being requested (for example, IMRT, SBRT, SRS)
• Cancer type and stage
• Goal (curative, palliative)
• Body Part
• Patient age, height, weight and gender
• Total dose, fractions, and dose per fraction
• Clinical symptoms/indications (intensity/duration)

Based on clinical criteria, AIM will either issue an order number or forward the case to a nurse or physician for review. The AIM physician reviewer may contact the ordering physician to discuss the case in greater detail. Ordering physicians may also contact AIM’s physician reviewer at any time during the prior authorization or notification process.

Upon approval, AIM will provide the ordering physician with an order number which will be valid for 90 days from the treatment start date. **It is important to note that issuance of an order number is not a guarantee of payment.** When submitted, the claim will be processed in accordance with the terms of the member’s health benefit plan.

**Note:** Retrospective requests received more than two business days after the date of service will not be considered.

As with the Cancer Care Quality Program, we are notifying providers of details regarding this initiative in a letter as well. If you have further questions, please contact your network manager.

**AIM Specialty Health® to conduct webinars beginning June 9**

Anthem and AIM are working together to host a number of webinars to address the AIM initiatives. We want to help ensure a smooth transition for our provider community.

With the first session beginning June 9, the webinars will share information needed for obtaining an order number from AIM before scheduling any elective outpatient advanced diagnostic imaging procedures and other need-to-know information impacting your office or facility. Several webinars will be offered – so please consider attending one that’s convenient for you. Select this [LINK](#) for the schedule at the end of this edition.
Business update

Virginia imaging and sleep management programs

In a special edition of our provider newsletter Network Update in May, we announced that Anthem Blue Cross and Blue Shield in Virginia will be delegating the management of outpatient advanced diagnostic imaging services and sleep testing and treatment services to AIM Specialty Health® (AIM). A separate company, AIM Specialty Health is a leading specialty benefits management company with more than 20 years of experience and a growing presence in the management of radiology, cardiology, oncology, sleep medicine, and specialty drugs.

The AIM programs will become effective beginning with procedures scheduled on or after July 1, 2015. All providers within our service areas of Virginia will be required to obtain an order number from AIM before scheduling any elective outpatient procedures included in the program.

The management programs will apply evidence-based clinical guidelines and Anthem’s coverage guidelines for certain elective, outpatient advanced imaging and sleep services as follows:

- Imaging services – CT, MRI, Nuclear Cardiology, PET, and Echocardiography exams
- Sleep services – Home sleep test (HST); In-lab sleep study (PSG); Titration study; Initial treatment order (APAP, CPAP, BPAP); and Ongoing Treatment Order (APAP, CPAP, BPAP)

A full list of the CPT® and HCPCS codes included under this program can be found on our website at www.anthem.com. The list may be updated from time to time to reflect changes published by the American Medical Association in the CPT and HCPCS Manual.

AIM online registration

Also in the May 2015 edition, we included information on AIM’s online registration requirements for professional and facility providers.

On May 15, 2015, we began collecting information about the imaging capabilities of all Anthem in Virginia contracted providers who provide the technical component of imaging services (Computed Tomography CT/CTA, Magnetic Resonance Imaging MRI/MRA, Nuclear Cardiology, and Positron Emission Tomography PET). The data you provide will become an important part of the information available to ordering physicians and members.

AIM’s online registration tool, OptiNet®, will collect modality-specific data on imaging providers in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment, and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

The provider registration is available online at www.aimspecialtyhealth.com/goweb. Simply select “Anthem BCBS VA” from the drop down menu. Only those providers who have completed the provider registration will be able to view their information.
online. Site information became available for review online starting March 15, 2015. All facilities need to complete their registration to have their site included in the online directory. If you have questions or need help completing the registration, please call AIM Customer Service toll free at 1-800-252-2021.

May 2015 SPECIAL EDITION

To view the May 2015 SPECIAL EDITION of the Network Update in its entirety including frequently asked questions about the new AIM rollout, visit the Virginia provider section of anthem.com for our provider newsletters or select this LINK. If you prefer, please contact your network manager if you have questions about the new AIM process.

Accessing AIM via Availity

Users can view AIM information using one of Anthem’s Web-based provider tools – Availity. Providers can navigate to the AIM Specialty Health site via the Availity Web Portal at www.availity.com. Once a provider has logged into Availity, the AIM Specialty Health link is under Auths and Referrals on the left navigation menu of the Availity Web Portal.

IMPORTANT NOTE: The primary access administrator (PAA) for the organization must grant each user the role of “authorization and referral request” in order for users to view AIM link and have access to AIM information.

Date correction: AIM to begin taking calls on June 22, 2015

With the transition to AIM Specialty Health®, providers can contact AIM to request order numbers by phone or online beginning June 22, 2015. Please note that the May 2015 SPECIAL EDITION of the Network Update erroneously included a date of June 15, 2015. The correct date is June 22 as noted here. We apologize for any inconvenience this misprint may have caused.

Here is the AIM contact information to request order numbers effective June 22, 2015:

Call AIM toll free at 1-866-789-0158 (weekdays, 8 a.m. to 5 p.m. ET)

Use AIM’s ProviderPortalSM at www.providerportal.com. If you already use AIM’s Web portal, there is no need to register again. If you are new to AIM, please register at www.aimspecialtyhealth.com/goweb.

Precertification requirements for ground ambulance

In this edition of the Network Update, we are sharing information around precertification requirements when billing for ground ambulance services. You’ll find a link to the coverage guideline online at anthem.com, a list of non-emergent services and destinations requiring precertification, and information required.
Looking for the guideline for non-emergent ground ambulance on anthem.com?

Ambulance Services: Ground; Non-Emergent (CG-ANC-06) is located at the link below on:
http://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalguidelines/va/f1/s0/t0/pw_037245.htm&na=coverageguidelines_va&rootLevel=0&label=Overview

What non-emergent services and destinations require precertification?

All Anthem HealthKeepers products require authorization for non-emergent transports. A pre-determination can be requested for our PPO products. The following destinations must have the appropriate modifiers for billing:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN</td>
<td>Physician’s Office to skilled nursing facility (SNF)</td>
</tr>
<tr>
<td>NP</td>
<td>SNF to Physician’s Office</td>
</tr>
<tr>
<td>HP</td>
<td>Hospital to Physician’s Office</td>
</tr>
<tr>
<td>HR</td>
<td>Hospital to Residence</td>
</tr>
<tr>
<td>HE</td>
<td>Hospital to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)</td>
</tr>
<tr>
<td>PR</td>
<td>Physician’s Office to Residence</td>
</tr>
<tr>
<td>RP</td>
<td>Residence to Physician’s Office</td>
</tr>
<tr>
<td>JR</td>
<td>Non-Hospital based dialysis facility to Residence</td>
</tr>
<tr>
<td>RJ</td>
<td>Residence to Non-Hospital based dialysis facility</td>
</tr>
<tr>
<td>EP</td>
<td>Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility) to Physician’s Office</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or service expected to be denied as not reasonable and necessary</td>
</tr>
</tbody>
</table>

What information is required?

1. The ambulance must have the necessary equipment and supplies to address the needs of the individual; and

2. The individual’s condition must be such that any other form of transportation would be medically contraindicated; and
3. Either of the following circumstances exists:

   a. Transportation to or from one hospital or medical facility to another hospital or medical facility, skilled nursing
      facility, or free-standing dialysis center in order to obtain medically necessary diagnostic or therapeutic services
      is required (for example magnetic resonance imaging, computed tomography scan, acute interventional cardiology,
      intensive care unit [ICU] services [including neonatal ICU], Cobalt therapy, etc.) provided such services are
      unavailable at the facility where the individual initially resides; or

   b. Transfer from an acute care facility to an individual's home or a skilled nursing facility is required.

The use of non-emergency ground ambulance services is considered **not medically necessary** when:

1. The criteria and circumstances above have not been met; or

2. The services are primarily for the convenience of the individual or the

3. The services are for a transfer of a deceased individual to a funeral home, morgue, or hospital, when the individual
   was pronounced dead at the scene.

**How do providers access member eligibility and benefits to determine if precertification is required?**

Eligibility and benefits can be verified by calling the number on the back of the member's identification card. Service
precertification is based on member's benefit plan/eligibility at the time the service is reviewed/approved. Benefit plans vary
widely and are subject to change based on the contract effective dates. The provider is responsible for verification of member
eligibility and covered benefits. Except in the case of an emergency, failure to obtain precertification for HealthKeepers
products prior to rendering the designated services will result in denial of reimbursement.

**How can providers check the status of a precertification request?**

Providers can check on the status of a precertification request through Virginia's Point of Care Web-based provider tool.
Please note that providers must access Point of Care using the single sign-on feature through Availity – another of Anthem’s
online provider tools. If preferred, providers can call us toll free at 1-800-533-1120.

**REMINDER: Filing claims for air ambulance services for Blue Cross and Blue Shield patients**

In a letter dated March 2015, Anthem Blue Cross and Blue Shield notified all our network-participating, air ambulance
providers of a new claims filing requirement from the Blue Cross and Blue Shield Association (BCBSA) that would take effect
on April 19, 2015. As a reminder, we are including the information we shared in March in this edition of the Network Update
for easy reference.

Generally, as a health care provider, you should file claims for your Blue Cross and Blue Shield patients to the local Blue
Plan. However, there are unique circumstances when claims filing directions will differ based on the type of service rendered.
To that point, effective April 19, 2015, Anthem implemented air ambulance claim filing requirements that reflect a BCBSA mandate.

The BCBSA requirements stipulate that claims for air ambulance services must be filed to the Blue Plan in whose Exclusive Service Area (ESA) the point of pick-up zip code is located.

Note: If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Effective April 19, 2015, air ambulance providers should follow the air ambulance claim filing requirements listed in the chart below. This will avoid your claims rejecting because Anthem is not the correct Plan to process.

<table>
<thead>
<tr>
<th>Service Rendered</th>
<th>How to file (required fields)</th>
<th>Where to file</th>
<th>Example</th>
</tr>
</thead>
</table>
| Air Ambulance Services | **Point of Pickup ZIP Code:**  
  - Populate item 23 on CMS 1500 Health Insurance Claim Form, with the five-digit ZIP code of the point of pickup
    - For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.
  - Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the five-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.
    - Form Locators (FL) 39-41
    - Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.
    - Value: Five-digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
    - For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional. | File the claim to the Plan in whose service area the point of pickup ZIP code is located.*  
  *BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. | The point of pick up ZIP code is in Plan A service area.  
The claim must be filed to Plan A, based on the point of pickup ZIP code. |
1. The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.

2. Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1-800-676-BLUE.

3. Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Anthem network manager.

4. Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.

5. Providers who wish to establish Trading Partner Agreements with other Plans should contact the Plans directly if they are not currently billing through a clearinghouse. Clearinghouses can assist providers with setting up access for electronically billing other Plans. In order to avoid claims rejections, these providers should set up Trading Partner agreements with Plans with whom they don't currently contract.
   a. Our contracted ancillary providers can call the EDI HelpDesk at 1-800-470-9630, or go to http://www.anthem.com/edi to request assistance with submitting to other Anthem Plans in Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, Ohio, Virginia and Wisconsin; Anthem Blue Cross in California; Empire Blue Cross Blue Shield in New York; and Blue Cross and Blue Shield of Georgia.

6. If you have any questions about where to file your claim, please contact provider customer service at the phone number on the back of the member ID card.

7. Members enrolled in the Blue Cross Blue Shield Service Benefit Plan also known as the Federal Employee Program (FEP) are NOT impacted.

**Medical records associated with BlueCard® claims**

In an ongoing effort to receive and address medical records in a timely manner, Anthem Blue Cross and Blue Shield in Virginia will implement a new process for medical records associated with BlueCard (out-of-area) claims. This new process helps eliminate duplicate requests and streamline the review process by routing the records as quickly as possible.

Beginning June 2015, Anthem will add bar codes to BlueCard letters requesting medical records. The bar code on the letter helps ensure that returned records are attached directly to the open claim requesting the information.

*For this automated process to work, the bar-coded letter MUST be returned with the records.* Without the bar-coded letter, the process reverts to a manual procedure which may result in duplicate requests and delays. Please note that providers may continue to receive some requests for medical records without a bar code. *When the bar code is present,*
please put the letter on top and return it with the medical records to help ensure the records are appropriately handled.

In this new process, Anthem will send two written requests for medical records. If we do not receive the medical record(s) after the first letter, we send a second letter after 20 days.

Providers who receive a request for medical records may mail or fax the clinical information to Anthem. Again, to ensure the quickest turnaround time, the letter – with or without a bar code – must be included with the requested medical records. Please return these medical records to Anthem – with Anthem's letter on top – to the address specified in the letter. Or, if you prefer, you can fax the medical records to 1-855-607-0514.

Fraud, waste and abuse detection

Anthem recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse and is committed to protecting and preserving the integrity and availability of health care resources for our members, clients and business partners. Anthem accordingly maintains a program – led by Anthem's Special Investigations Unit (SIU) – to help combat fraud, waste and abuse in the health care industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans.

Pre-payment review

One method Anthem utilizes to help detect fraud, waste and abuse is through pre-payment review. Through a variety of means, certain providers of health care or certain claims submitted by providers may come to Anthem’s attention for some reason or behavior that might be identified as unusual, or which indicates the provider is an outlier with respect to his/her/its peers. One such method is through computer algorithms that are designed to identify a provider whose billing practices or other factors indicate conduct that is unusual or outside the norm of his/her/its peers.

Once such an unusual claim is identified or a provider is identified as an outlier, further investigation is conducted by SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual claim. If the investigation results in a determination that the provider’s actions may involve fraud, waste or abuse, the provider is notified and given an opportunity to respond.

If, despite the provider’s response, we continue to believe the provider’s actions involve fraud, waste or abuse or some other inappropriate activity, the provider is notified he/she/it is being placed on pre-payment review. This means that the provider will be required to provide medical records with each claim submitted so that we will be able to review them compared to the services being billed. Failure to submit medical records to Anthem in accordance with this provision may result in a denial of a claim under review. The provider will be given the opportunity to request a discussion of his/her/its pre-payment review status. Under this program, we may review coding and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of claims submitted by the provider, even if those guidelines are not used for all providers delivering services to Plan’s members.

The provider will remain subject to the pre-payment review process until we are satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from our provider network.
Finally, providers are prohibited from billing covered individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other billing issue or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of the applicable provider agreement and state law. Providers also may appeal such determination in accordance with applicable grievance procedures.

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. From there, select “Provider” and Virginia> then Health & Wellness> Practice Guidelines.

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

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/va/f2/s2/t0/pw_a035223.htm&state=va&rootLevel=1&label=Practice%20Guidelines

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.
Coverage and clinical guideline update

Coverage guideline for advanced lipoprotein testing effective November 1, 2015

Advanced lipoprotein testing (Lab.00031) is considered investigational and not medically necessary for cardiovascular disease (CVD) risk assessment and management. Therefore, for dates of service effective November 1, 2015, claims submitted with these codes will be denied.

Advanced lipoprotein testing includes any test that is not included in a basic lipid panel. A basic lipid panel consists of:

- Total cholesterol levels (TC)
- Low-density lipoprotein cholesterol (LDL-C)
- Triglycerides (TG) and
- High-density lipoprotein cholesterol (HDL-C) levels

The following are some examples of tests that fall into the advanced lipoprotein testing category:

1. Apolipoprotein A-I (apoAI)
2. Apolipoprotein B (apoB)
3. Apolipoprotein E (apoE)
4. Intermediate density lipoproteins (IDL)
5. Lipoprotein(a) (Lp(a)) enzyme immunoassay
6. Lipoprotein-associated phospholipase A2 (Lp-PLA2)
7. Small density lipoproteins.

Without a clear link to a therapeutic decision and improved clinical outcomes, testing is not recommended by national guidelines and experts in the field. Similarly for the other advanced lipoprotein tests, the usefulness of testing is not yet clear and further clinical trials are needed.

Codes that will not be reimbursed include:

82172: Apolipoprotein, each
83695: Lipoprotein (a)
83698: Lipoprotein-associated phospholipase A2 (Lp-PLA2)

83700: Lipoprotein, blood; electrophoretic separation and quantitation

83701: Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)

83704: Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (e.g., by nuclear magnetic resonance spectroscopy)

The services addressed in this coverage guideline will require authorization for all of our HealthKeepers products with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage and the Medicare-Medicaid Plan (Duals Demonstration). A pre-determination can be requested for our PPO products.

ICD-10 update

ICD-10 precertification begins June 1 for dates of service on or after October 1, 2015

Starting June 1, 2015, Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. will begin accepting and processing precertification requests containing ICD-10 codes for services scheduled on or after October 1, 2015, the mandated ICD-10 compliance date. It is important to note that you must continue to use ICD-9 codes to pre-authorize services scheduled through September 30, 2015. Some precertification requests may span the compliance date of October 1, 2015. The code set of the precertification will vary depending on the scenario. The following chart will help you determine what code set to use for your precertification requests.

A printable version of this chart is available at anthem.com on our Virginia provider home page – just select this LINK.
<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Begins</th>
<th>Ends</th>
<th>Precertification</th>
<th>Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Admission begins on or after October 1, 2015</td>
<td>Discharge on or after October 1, 2015</td>
<td>Precertification must be requested with ICD-10 codes.</td>
<td>Claim for services rendered on or after October 1, 2015, must be billed with ICD-10 codes.</td>
</tr>
<tr>
<td>Inpatient with unknown discharge date</td>
<td>Admission begins before October 1, 2015</td>
<td>Unknown at the time of admission, then discharge occurs on or after October 1, 2015</td>
<td>Precertification must be requested with ICD-9 codes. This precertification will be valid for the entire admission.</td>
<td>The code set used on the claim will be based on the discharge date, so the entire claim must be billed with ICD-10 codes.</td>
</tr>
<tr>
<td>Inpatient with known discharge date</td>
<td>Admission begins before October 1, 2015</td>
<td>Known discharge on or after October 1, 2015</td>
<td>Precertification should be requested with ICD-10 codes.</td>
<td>The code set used on the claim will be based on the discharge date, so the entire claim must be billed with ICD-10 codes.</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Service on or after October 1, 2015</td>
<td>Not applicable</td>
<td>Precertification should be requested with ICD-10 codes.</td>
<td>Claim must be filed with ICD-10 codes.</td>
</tr>
<tr>
<td>Long-term Outpatient Services (such as Physical Therapy, Radiation Therapy, Chemotherapy, etc.)</td>
<td>Services begin before October 1, 2015</td>
<td>Services end on or after October 1, 2015</td>
<td>Precertification obtained in ICD-9 will be valid for services rendered on or after October 1, 2015.</td>
<td>The claims for these services need to be separated and filed with the correct code set for the date(s) of service. Claims with both codes sets, or mixed claims, will not be accepted.</td>
</tr>
</tbody>
</table>

**ICD-10 updates online at anthem.com**

We encourage you to visit us online at anthem.com and view our ICD-10 webpage for information about claims processing with ICD-10, tools available and much more. Visit [Anthem’s ICD-10 webpage](#) for these resources.
**Health care reform (including health insurance exchange)**

**Important Notice: Anthem to discontinue mailing paper remittances to all ERA registered providers beginning October 1, 2015**

In May 2014, Anthem Blue Cross and Blue Shield began notifications to providers about the Health Insurance Portability and Accountability Act’s (HIPAA) Administrative Simplification requirements to discontinue the mailing of paper remittances for providers registered for electronic remittance advices (ERA). **In support of these requirements, Anthem will discontinue the mailing of paper remittances to all providers currently registered for ERA beginning October 1, 2015.**

As previously communicated, in-network providers can continue to conveniently access copies of paper remittances online via the Availity Web Portal. (In-network providers in Virginia can access paper remittances from Point of Care using the single-sign on feature via the Availity Web Portal.) **If you are an ERA registered provider, please ensure you have completed the steps to access copies of your paper remittances online via Availity immediately.** Read instructions to access your remittances online via Availity [HERE](#).

Please note, providers may continue to receive some remittances by mail up to four weeks after October 1, 2015, to allow for the delivery of paper remittances already in queue.

To manage the mailing of paper remits, go to the [online paper remittance election form](#).

**Medical chart reviews begin July for members with plans on or off the exchange**

Each year, Anthem Blue Cross and Blue Shield requests your assistance in our retrospective medical chart review programs. We continue to request members’ medical records to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS).

In July 2015, we will continue our chart review program for **those members who have purchased our individual and small group health insurance plans on or off the Health Insurance Marketplace** (commonly referred to as the exchange). This particular effort is part of Anthem’s compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual or small group health plans on or off the exchange. The members’ medical record documentation helps support this data requirement.

**Anthem engages Inovalon to conduct medical chart reviews for our exchange members**

To assist with our ongoing medical chart review program for members enrolled in our individual and small group exchange plans, Anthem is again collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon’s Web-based workflows help reduce time and improve efficiency and...
costs associated with record retrieval, coding and document management. Anthem is working with Inovalon in retrieving and reviewing our members’ medical records.

Inovalon is using the following methods of collecting medical record information:

- Scanned or faxed medical records that providers’ offices send to Inovalon
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider’s EHR system

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the providers’ offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within 30 days.

In cases where Inovalon is requesting more than six medical records to review, an Inovalon reviewer calls the provider’s office and arranges a time convenient to visit the office onsite to collect the appropriate information. Before the onsite visit, Inovalon mails or faxes the provider’s office a letter to confirm the upcoming visit. The Inovalon medical record review personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, an automated, medical record data retrieval occurs through the provider’s EHR system. Upon receiving the provider group’s one-time authorization, Inovalon’s systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this partnership is to both improve the medical record data extraction experience for Anthem’s network-participating hospitals, clinics and physician offices. Anthem and Inovalon are working together to identify facilities and providers’ offices for engagement.

Appropriate coding helps provide comprehensive picture of patients’ health and services provided

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. When members visit your practice or office, we encourage you to document ALL of the members’ health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.

By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping Anthem meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.

Reminder about ICD-9 CM coding

As you are aware, the ICD-9 CM coding system, (and soon ICD-10 coding which is scheduled to implement October 1, 2015), serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, Anthem uses ICD-9 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

Network Update

June 2015
We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.

- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider’s overall management or treatment of that patient in the remaining positions.

- Always assign the ICD-9 code to the highest level of specificity, using four- or five-position codes as appropriate.

Reminder about completing SOAP Notes

The SOAP Note – the standardized documentation format of a medical record – stands for Subjective, Objective, Assessment, and Plan. SOAP Notes are used with the Inovalon outreach efforts and are meant to be a supplement to providers’ usual documentation process. When submitting information to Inovalon, providers have the option of completing SOAP Notes electronically using Inovalon’s ePASS® Web-based tool or using a paper format. Here are some tips for completing SOAP Notes that we hope you find helpful.

- The exam date for the patient must match the exam date on the completed SOAP Note

- A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note

- The provider signature date should be the actual date the SOAP Note is signed

- All “mandatory” fields on the paper SOAP Note must be completed

- The exam date must occur between March 1, 2015, and December 31, 2015, for this benefit year

Inovalon continues outreach efforts on Anthem’s behalf to help identify members needing care

At Anthem Blue Cross and Blue Shield, we are working to update health documentation for our members in the individual and small group markets who have purchased our health insurance plans on and off the exchange. Working with our providers, we engaged Inovalon to contact our members and encourage in-office visits with their physicians. Therefore, as a physician, you may receive letters throughout the year from Inovalon on our behalf. Inovalon began contacting providers and members in January 2014. In 2015, we are continuing these efforts and want to help ensure you and your office staff members are aware of these ongoing outreach efforts Inovalon is conducting on our behalf.

It is important to note that this is a voluntary program developed to encourage members to seek treatment for any conditions that may be identified during the assessment. The goal is to identify or help close gaps in care. We appreciate your cooperation should Inovalon contact your office or facility.

In the event our members do not visit their physicians, Inovalon also offers the option of a personal health visit that a medical professional from Inovalon conducts in members’ homes. The member may also opt to visit a retail clinic or other Inovalon location. We’ll continue to provide updates about the Inovalon engagement in upcoming editions of the Network Update.

If you have questions about the Inovalon effort and this ongoing outreach effort, we’ve compiled a list of questions and responses for your reference on our website HERE.
All “mandatory” fields on the paper SOAP Note must be completed to be eligible for incentive payment.

Incentives are only paid once for each patient for whom a health assessment was requested.

For additional information about SOAP notes, incentives, the medical record review process or the outreach effort, please refer to the frequently asked questions document available on our website HERE.

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

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.

eBusiness

Receive e-mail notifications via our Network eUPDATE

Our provider newsletter, Network Update, is our primary source for providing important information to health care providers and professionals. Network Update is published bi-monthly and is posted to our website on the Virginia provider section of anthem.com for easy 24/7 access.

Note that in addition to this newsletter and our website, we also use our e-mail service – Network eUPDATE – to communicate new information. If you are not yet signed up to receive Network eUPDATEs, we encourage you to enroll now so you’ll be sure to receive all information we will be sending about the Health Insurance Marketplace or commonly called exchanges and other pertinent topics.

Reminder notifications sent via e-mail

When you sign up, you’ll not only receive an e-mail reminder for each newsletter posted online, you’ll also be notified of other late breaking news and important information you’ll need when providing services and filing claims for our members. It’s easy to sign up – just select Virginia and access the provider home page. There, you’ll find a link to register for our Network eUPDATE.
Medicaid information

ICD-10 precertifications to begin in June for members enrolled in Anthem HealthKeepers Plus/FAMIS plans

Earlier in this edition of the Network Update in the section called “ICD-10 update,” we announced that effective June 1, 2015, Anthem and HealthKeepers, Inc. will begin accepting and processing precertification requests containing ICD-10 codes for services scheduled on or after October 1, 2015. October 1 is the mandated ICD-10 compliance date. This notice also applies to claims and precertification requests for members enrolled in our Anthem HealthKeepers Plus/FAMIS (Medicaid) plans. For the complete details, please see page 15 of this newsletter or select this LINK.

Distinct procedural service coding update for Medicaid

On January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) established four new HCPCS modifiers to define subsets of the “-59” modifier used to define a distinct procedural service. Currently, the “-59” modifier is used when a code for a service which would usually be bundled is being considered separate and distinct from another service.

CMS has defined four new HCPCS modifiers to selectively identify subsets of distinct procedural services (-59 modifier). These modifiers, collectively referred to as “-X{EPSU}” modifiers, are as follows:

- XE Separate Encounter – A service that is distinct because it occurred during a separate encounter
- XP Separate Practitioner – A service that is distinct because it was performed by a different practitioner
- XS Separate Structure – A service that is distinct because it was performed on a separate organ/structure
- XU Unusual Non-Overlapping Service – The use of a service that is distinct because it does not overlap usual components of the main service

For Anthem HealthKeepers Plus members, HealthKeepers, Inc. will begin accepting CMS Modifiers for distinct procedural services. We will continue to recognize the “-59” modifier; however, CPT instructions state that the “-59” modifier should not be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the “-59” modifier; it would be incorrect to include both modifiers on the same line.
Anthem will be accepting the –X{EPSU} modifiers prior to the National Corrective Coding Initiative (NCCI) edits update. We will require the use of selective modifiers in lieu of the general “-59” when the –X{EPSU} modifiers provide more clarity for the service/procedure performed.

If you have questions about distinct procedural service, please contact Provider Services at 1-800-901-0020.

**Body mass index and obesity: Coding tips and claims documentation**

**Obesity related services**

Obesity related services help address unhealthy weight. HealthKeepers, Inc. covers a range of services for Anthem HealthKeepers Plus members to prevent and reduce obesity, including body mass index (BMI) screening, education and counseling about nutrition and physical activity, prescription drugs, and surgery. Health care providers should conduct height, weight and nutrition assessments as part of all well-child visits and adult annual checkups. If primary care providers counsel patients regarding obesity, there are procedure codes that can be billed to report the services for reimbursement. Providers should ensure the correct diagnosis and BMI codes are billed that correlate to obesity to support the counseling. For questions about benefit levels and available coverage, contact our Provider Services team at 1-800-901-0020.

**Claims documentation and coding**

Obesity codes are located in the Endocrine, Nutritional and Metabolic Diseases chapter of ICD-9-CM. The codes are to be applied when documentation supports a clinical diagnosis from physician documentation.

| ICD-9 Codes for Reporting Weight-related Clinical Diagnoses |
|-----------------|------------------|
| Code            | Description      |
| 278.00          | Obesity unspecified |
| 278.01          | Morbid obesity   |
| 278.02          | Overweight       |

A coding instructional note listed with category 278.0 states to code BMI using codes V85.0-V85.54. Assign both the clinical diagnosis and the BMI code on your claim. ICD-9 Coding Guidelines define morbid obesity as BMI greater than 40 for adults.

**AHA Coding Clinic advice**

Per American Hospital Association (AHA) Coding Clinic 2010, Q2, BMI itself may be retrieved from nonphysician documentation such as a dietician. However, the clinical diagnosis must come from physician documentation. Per AHA Coding Clinic 2011, Q3, individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the BMI code meets the requirement for clinical significance when obesity is documented.
Obesity and BMI coding in ICD-10

Document the type (for example, morbid, obese or overweight) and cause of obesity for ICD-10 (such as excess calories, drugs, etc.).

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E66.3</td>
<td>Overweight</td>
</tr>
<tr>
<td>E66.8</td>
<td>Obesity, other causes</td>
</tr>
<tr>
<td>E66.9</td>
<td>Obesity, unspecified</td>
</tr>
<tr>
<td>E66.01</td>
<td>Morbid obesity, due to excess calories</td>
</tr>
<tr>
<td>E66.09</td>
<td>Other obesity due to excess calories</td>
</tr>
<tr>
<td>Z68</td>
<td>Body mass index</td>
</tr>
</tbody>
</table>

Procedure code 99420 – Administration and interpretation

HealthKeepers, Inc. reminds providers that procedure code 99420, health risk assessment, does not get paid separately if the health assessment is part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Procedure code 99420 covers Anthem HealthKeepers Plus member newborns, from birth until the child reaches 2 years of age, with a maximum of four assessments. This procedure code also covers pregnant women throughout their pregnancy, plus 60 days post-partum, also with a maximum of four assessments.

For additional information about code 99420, contact Provider Services at 1-800-901-0020.

Updated clinical practice guidelines now available online

Updated clinical practice guidelines (CPG) are now available on the Anthem HealthKeepers Plus self-service website. These evidence-based guidelines were reviewed and approved by our Enterprise Clinical Quality Committee and Preventive Health Guidelines Work Group, a group of specialists and external practitioners. The guidelines include direct links to the source documents for reference.

For a printed copy of the CPGs, call Provider Services at 1-800-901-0020.
The disease management centralized care unit (DMCCU) is based on a system of coordinated care management interventions and communications designed to assist physicians and others in managing members with chronic conditions. Through our programs, Anthem HealthKeepers Plus members receive care management and education provided by a team of highly qualified disease management professionals operating under a holistic model of care. Our programs are based on national CPGs from recognized sources.

### DMCCU programs

- Asthma
- Bipolar disorder
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Coronary artery disease
- Diabetes
- HIV/AIDS
- Hypertension
- Major depressive disorder
- Obesity
- Schizophrenia
- Substance use disorder

All Anthem HealthKeepers Plus members diagnosed with any of these DMCCU program conditions are eligible for disease management services. Anthem HealthKeepers Plus members are identified through a number of sources, including continuous case finding, welcome calls, and referrals. Our care managers are licensed nurses and social workers who work collaboratively with you for input on the development of care plans.

Anthem HealthKeepers Plus members who are identified for participation in DMCCU programs are assessed and risk-stratified based on the severity of their conditions. Once enrolled in a program, members are provided with continuous education on self-management concepts, which include primary prevention, behavior modification, and compliance and surveillance, as well as case and care management. DMCCU staff also helps to connect members with local resources for additional support services.

### Provider feedback

Program evaluation, outcome measurement, and process improvement are built into all the DMCCU programs. Provider feedback occurs monthly or as needed for patients enrolled in disease management programs, annually for provider adherence to guidelines, and as needed for patient status and progress.

### How to refer a member

We encourage you to refer any members you feel may benefit from additional education and care management support. You can reach our team, Monday through Friday, from 8:30 a.m. to 8:30 p.m. Eastern time at 1-888-830-4300 or through Provider Services at 1-800-901-0020. Confidential voice mail is available 24 hours a day.

More information about DMCCU programs is available on the provider self-service website, by visiting the Disease Management Centralized Care Unit (DMCCU) page. Printed copies of information located on the website can be obtained by contacting DMCCU. Members can obtain information about our programs from their member handbook.

If you have questions about DMCCU programs, contact your local Provider Relations representative or call Provider Services at 1-800-901-0020.
Intensive behavioral dietary counseling

As of July 1, 2014, HealthKeepers, Inc. implemented the 2014-2015 Department of Medical Assistance Services (DMAS) Medallion 3.0 contract which affects members enrolled in Anthem HealthKeepers Plus for Medicaid.

The DMAS Medallion 3.0 contract with HealthKeepers, Inc. has carved out services for intensive behavioral dietary counseling. Services for intensive behavioral dietary counseling for adults with Medicaid benefits who have hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease are currently only available for Medicaid Works.

If you have questions or need additional information about behavioral dietary counseling, contact Magellan at 1-800-424-4046 for questions about coverage and eligibility.

Medicaid-Medicare plan update

This section of the newsletter addresses information on the Medicare-Medicaid Plan or MMP. Members are enrolled in both Medicaid and Medicare under the Commonwealth Coordinated Care Plan, also known as the Duals Demonstration (“Demonstration”) Program.

Distinct procedural service coding update

In the “Medicaid” section of this edition of the Network Update, we share a notice about updates to distinct procedural service codes. It is important to note that the information presented about the updates also applies to providers in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan. Please refer to the full article on page 21 or select this LINK about the distinct procedural service coding updates. If you have additional questions, contact MMP Customer Care toll free at 1-855-817-5788.
Medicare information

New CLIA and ADI requirements for individual Medicare Advantage plans – effective July 1

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 is not accredited for the service it is 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. February’s Network Update erroneously stated that an informational message will be included starting on your March remittance when you bill a laboratory code that requires certification. This message was not included on your March remittance. However, the message will appear on your remittance in the coming months.

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

Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 and older. 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.

Anthem asks that providers encourage women 67 to 85 who have had a fracture or may be a risk for a fracture to have a Bone Mineral Density screening or be placed on osteoporosis medication if appropriate.

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.
DMARDs help prevent long-term disability

The American College of Rheumatology recommends that persons with rheumatoid arthritis (RA) are prescribed a Disease Modifying Anti-Rheumatic Drug (DMARD) to prevent long-term disability and damage. To help ensure your Medicare Advantage RA patients have these important prescriptions, we will review medical and pharmacy claims looking for members who have a RA diagnosis and do not appear to have a claim for a DMARD. Providers who have members with a diagnosis of RA and not on a DMARD may receive a monthly fax reminder. Please be sure to use the correct diagnosis codes for RA and be careful not to use a RA code for ruling out RA, osteoarthritis and joint pain.

Encourage Medicare Advantage members to control high blood pressure

According the Centers for Disease Control and Prevention, almost one in three American adults has high blood pressure but only about half have their blood pressure under control. Anthem joins you in encouraging our Medicare Advantage members to know and control their blood pressure to lower their risk of heart attack, heart disease, stroke and kidney disease.

House Call Program: Available at no out-of-pocket cost to Medicare Advantage members

The House Call Program is a voluntary program that we offer at no out-of-pocket cost to our individual Medicare Advantage members. It gives our members the opportunity to receive non-invasive health services and a health evaluation in the comfort of their own home from a licensed and credentialed clinician.

We are offering the House Call program to help support the care our members currently receive. Through this program:

- The visiting clinician is able to collect information that helps us identify patients who may benefit from case management programs.
- Our members’ physicians can use the evaluation forms to match health care needs with the appropriate level of care.
- Anthem is able to meet our annual obligation to report all required diagnoses to the Centers for Medicare & Medicaid Services (CMS) for each member for the purpose of risk adjustment.

We kick off the program by mailing a letter and a program brochure to our members. The mailer is then followed by a phone call from a contracted vendor to schedule an appointment with one of its clinicians for an hour-long visit.

During the visit, the clinician uses a health evaluation form to document all medical conditions that exist on the date of the visit. We will send a summary of the evaluation to the member’s physician identified during the house call visit. We will make
full copies of the completed forms available to the members’ physicians to include in their records per request. We also will provide copies of the forms to members at their request. In addition, based on the outcome of the health evaluation, Anthem may conduct post-visit outreach with a member’s physician and may make a case management referral.

Providers may request a copy of member evaluations by emailing housecallprogram-external@anthem.com or calling toll free 1-844-227-0154.

Follow CMS guidelines for Medicare Advantage Part B immunizations claims filing

Anthem follows the Centers for Medicare & Medicaid Services’ Medicare Part B Immunization Billing guidelines. Please use the following forms when filing flu, pneumonia or Hepatitis B claims for Anthem individual and group-sponsored Medicare Advantage members.

- Professional claims should be filed on the CMS-1500 form with the appropriate Current Procedural Terminology code and/or Health Care Procedural Code for the vaccine and administration.

- Institutional claims should be filed on the UB-04 form with the appropriate revenue codes

  Revenue Codes (except Rural Health Clinics and Federally Qualified Health Centers):

  - 0636 – vaccine (and CPT or HCPC)
  - 0771 – administration (and HCPC)

  Rural Health Clinics and Federally Qualified Health Clinics – 052X revenue code series

Please refer to page three of the Medicare Part B Immunization Billing Guide for specifics on institutional billing.

ICD-10-CM: Human immunodeficiency virus (HIV) status

We continue to provide basic coding and documentation tips to help with the transition to ICD-10-CM code set that will be implemented October 1, 2015.

The documentation needs to state the condition to the highest degree of specificity. For example, documentation needs to specify a patient’s Human Immunodeficiency Virus (HIV) status.

Only confirmed cases of HIV are to be coded (this is an exception to hospital inpatient guidelines). Code assignment is based on the provider’s diagnostic statement that the patient is HIV positive or has an HIV-related illness; confirmation does not need to be documented with positive serology or culture of HIV. Asymptomatic HIV status is used for reporting a patient diagnosed with HIV status without having had an opportunistic infection. Once a patient has had an HIV-related illness or condition, it is to be coded as HIV disease thereafter. The code for HIV disease is synonymous with the terms acquired
immune deficiency syndrome (AIDS), AIDS-related complex (ARC), and symptomatic HIV infection. There is a note to use additional code(s) to identify all manifestations of HIV and/or HIV-2 infection for HIV disease.

The table below reflects the crosswalk from ICD-9 to ICD-10.

<table>
<thead>
<tr>
<th>ICD-9 Code(s)</th>
<th>ICD-10 Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V08- Asymptomatic human immunodeficiency virus (HIV) infection status</td>
<td>Z21- Asymptomatic human immunodeficiency virus [HIV] infection status</td>
</tr>
<tr>
<td>079.53- Human immunodeficiency virus, type 2 (HIV 2), in conditions classified elsewhere and of unspecified site</td>
<td>B97.35- Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere</td>
</tr>
</tbody>
</table>

To further assist in preparation for ICD-10, please see the following resources:

- Centers for Medicare & Medicaid Services (CMS): [Provider Resources](#)
- American Academy of Professional Coders: [AAPC ICD-10 Resources](#)
- World Health Organization: [WHO ICD-10 Training](#)

Medicare Advantage precertification requirements and reimbursement policies available on our provider portal

Network physicians are required to obtain precertification for specified services for Medicare Advantage members. For the member to receive maximum benefits, the health plan must authorize or precertify the covered services prior to being rendered. Additional information on 2015 Medicare Advantage precertification requirements can be found [here](#).

For Anthem Medicare Advantage reimbursement policy updates, please see [Important Medicare Advantage Updates](#). To review our complete set of reimbursement policies, select [Medicare Advantage Reimbursement Policies](#). Our reimbursement policies apply to participating providers who serve Individual Anthem Medicare Advantage business unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

Reminder: Individual Medicare Advantage membership moved to 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](#) for additional information.
Failure to pre-certify an admission or provide notice of emergent inpatient admission will result in administrative denial effective May 1, 2015

Network physicians and facilities are required to obtain precertification for specified services for individual and group-sponsored Medicare Advantage members, including an admission to any inpatient facility. For the member to receive maximum benefits, the health plan must authorize or pre-certify the covered services prior to being rendered.

As previously communicated, please notify Anthem as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

Effective May 1, 2015, if the required precertification is not obtained within the specified timeframe, the claim will be administratively denied due to failure to notify Anthem of the admission. The provider will not receive payment for the service. Providers cannot bill the member for these denied services.

If you do not notify us within the required time frame, you may file an appeal. As part of the appeal, the provider must demonstrate that he or she did notify Anthem or attempted to notify Anthem and that the service is medically necessary.

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at www.anthem.com for further information on existing precertification requirements.

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

Precertifications for Anthem individual Medicare Advantage members also can be initiated via the Availity Web portal at www.Availity.com. To access this new functionality, go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site that includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the precertification look-up tool.

Please visit www.anthem.com/medicareprovider to learn more about this online provider self-service tool.
Pharmacy update

Notice of post-service review for specialty drugs

Beginning July 1, 2015, Anthem Blue Cross and Blue Shield will begin a new process to verify the accuracy of information received on the pre-service notifications for select specialty drugs. Specialty Pharmacy claims may be audited post-payment. Medical records will be requested in order to validate the claim. Examples of specialty drugs:

- Botox
- Remicade
- Synagis
- IVIG
- Erythropoietin
- Synvisc
- HGH

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.”
AIM webinars offered beginning June 9

As we noted on page 3 of this edition of the Network Update, Anthem is working with AIM Specialty Health® (AIM) to host several webinars. We are working together to help make the transition a smooth one for our provider community with the rollout of the AIM initiatives in Virginia. There’s no need to register for the webinars – just mark your calendars to attend one of the online sessions beginning this month.

**Webinar attendees must have Internet and simultaneous telephone access.**

**WebEx Dial-in Information**

Toll-free, Call-in Number (All Sessions): 1-877-668-4490 (United States/Canada)

Access Code: 622 591 175

Password (if prompted): aim

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<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>ONLINE LINK</th>
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<tbody>
<tr>
<td>Tuesday, June 9, 2015</td>
<td>10 a.m.-11 a.m. ET</td>
<td>[Join WebEx meeting]</td>
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<td>Tuesday, June 9, 2015</td>
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<td>Thursday, June 11, 2015</td>
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<td>Tuesday, June 23, 2015</td>
<td>10 a.m.-11 a.m. ET</td>
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<td>2 p.m.-3 p.m. ET</td>
<td>[Join WebEx meeting]</td>
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Anthem medical office webinar scheduled for August 19 – register soon

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, LPC, 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, LPC, LFMT, CNS, CNM, DDS, OD, or OTHER: _________

Location of main office in Virginia: __________________________________________________

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 work stations, we must have SEPARATE registration forms with each individual’s e-mail address.

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

- [ ] 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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