Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Working together to improve the health of our members.

August 2015

Network Update

VIRGINIA

In this issue

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

anthem.com

Important phone numbers

VAPENABSNL (08/15)

In this issue, continued

Page

Announcements

Updates to Anthem's Find a Doctor tool

The Find a Doctor tool at Anthem Blue Cross and Blue Shield is used by consumers, members, brokers and providers to identify in-network physicians and other health care providers supporting member health plans.

Beginning this fall, you'll notice some updates to our Find a Doctor tool that will make it even easier to search for providers. These changes include:

- An updated screen layout with cues to encourage members to login for the most accurate results, or search as a guest by selecting a plan to find in-network physicians and hospitals.
- Guided assistance asking a short set of questions to personalize and narrow the plan selection list.
- Quick search links for users familiar with the state and plan they are searching.
- More prominent placement of the Provider Name search option to help users determine if a physician is in-network after selecting a plan.

We believe these updates will help improve the online experience for consumers, members, brokers and providers when using the Find a Doctor tool.

Anthem's medical office webinar scheduled for August 19

We invite you to attend our webinar on Wednesday, August 19. The session will address any Anthem updates for the third quarter. Please see pages 36 and 37 in this edition of the *Network Update* for a registration form and further details.

Webinar: August 19 – Registration Form

Onsite seminar offered

We are also offering an onsite medical office seminar that will take place on September 16. See page 38 for details.

Onsite Seminar: September 16 – Registration Form

AIM alerts

(Information regarding Anthem's implementation of AIM Specialty Health® initiatives)

IMPORTANT UPDATE: Provider searches on the AIM Specialty Health® online portal

Anthem's implementation of the AIM Specialty Health's management of outpatient advanced diagnostic imaging services and sleep testing took place July 1. As with the transition to any new business process or system, there are often challenges. There have been some issues with properly identifying the participation status of servicing providers for the AIM call center and also for our Anthem providers when using the AIM portal.

We have been working with AIM to determine the best way to prevent participating provider groups from being identified as non-participating. Group names are typically not used for claims processing, so they are not being loaded into the AIM system. When AIM or an ordering provider tries to search for a group name, it will not be found.

If the actual servicing provider is known, we suggest that you search for that provider. If unknown, search for any individual provider within the servicing group. Any participating provider who is appropriate for the service being requested in the group will do.

Ordering providers can expedite the AIM authorization process by identifying an individual provider within the servicing practice who can be used for the authorization in advance of requesting the authorization. To get this information, the ordering provider can call the imaging location and ask for a list of participating providers; look up the imaging center online and identify individual providers; or call an Anthem network manager for assistance.

When providers try to use the AIM portal and cannot find the group they are looking for, they should then search for a specific provider at that location. Providers can then use that name/record to create the authorization.

REMINDER: Anthem on course to implement Cancer Care Quality Program September 1

Recently, Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. began the process of notifying oncologists, hematologists and urologists regarding the implementation of our Cancer Care Quality Program that launches on September 1, 2015. This innovative quality initiative is an evidence-based cancer treatment program that will enable these physicians to compare planned cancer treatment regimens against evidence-based clinical criteria. AIM Specialty Health® (AIM), a separate company, will administer the Program on behalf of Anthem in Virginia.

The Cancer Care Quality 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.

Complete details regarding the Cancer Care Quality Program are included in a letter we sent to oncologists, hematologists and urologists. If interested in learning more about the Cancer Care Quality Program, please visit www.cancercarequalityprogram.com .

REMINDER: Precertification requirement for outpatient radiation therapy services effective September 1

Beginning 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 *Provider*Portal℠ 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)

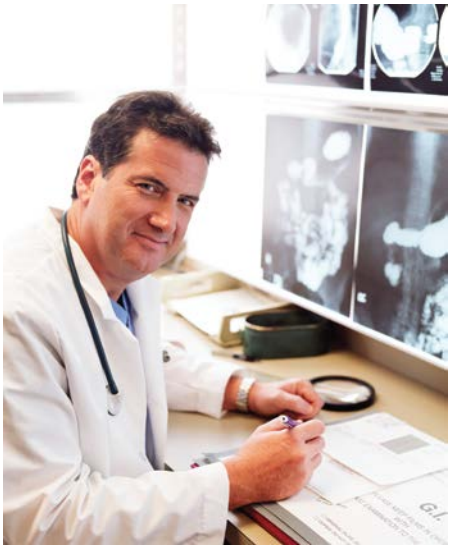
Based on clinical criteria, AIM will either issue an order number or forward the case to a nurse or physician for review. The AIM physician reviewer may contact the ordering physician to discuss the case in greater detail. Ordering physicians may also contact AIM's physician reviewer at any time during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

If you have further questions about the new precertification requirements, please contact your network manager.

REMINDER: Virginia imaging and sleep management programs



On July 1, 2015, Anthem Blue Cross and Blue Shield in Virginia began delegating the management of outpatient advanced diagnostic imaging services and sleep testing and treatment services to AIM Specialty Health® (AIM) – a separate company with specialty benefits management expertise. AIM has a growing presence in the management of radiology, cardiology, oncology, sleep medicine, and specialty drugs.

The AIM programs became effective beginning with procedures scheduled on or after July 1, 2015. As a reminder, 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 via OptiNet® is required for professional and facility providers

In May 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®, and 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. In addition for more details about OptiNet registration, please see our May 2015 SPECIAL EDITION of the *Network Update* at this LINK.

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.

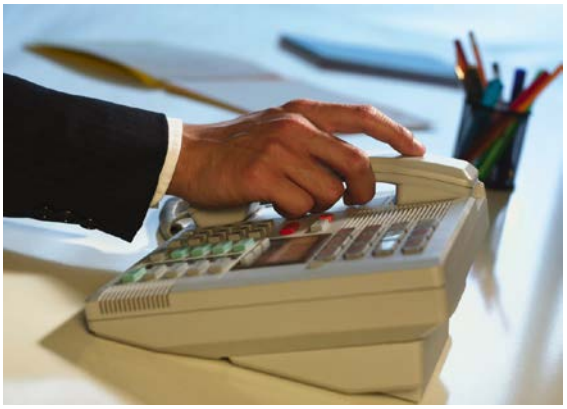
IMPORTANT NOTE: The primary access administrator (PAA) for the organization must grant each user the role of **"authorization and referral request"** in order for users to view the AIM link and have access to AIM information.

AIM's contact information

With the transition to AIM Specialty Health®, providers can contact AIM to request order numbers by phone or online.

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

Use AIM's *ProviderPortal*℠ 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.



SPECIAL NOTE

The services addressed in ALL the coverage guidelines presented in this section (pages 9 through 11) will require authorization for all of our products offered by HealthKeepers, Inc. with the exception of Anthem HealthKeepers Plus (Medicaid). Other exceptions are Medicare Advantage and the Medicare-Medicaid Plan (Dual Integration product).

A pre-determination can be requested for our PPO products.

Coverage and clinical guideline update

Coverage guidelines effective November 1, 2015

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage and clinical UM guidelines effective November 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 May 7, 2015.

The following coverage guidelines are presented in this edition of the *Network Update*:

- Gene Expression Profiling of Melanomas (GENE.00023)
- Positron Emission Tomography (PET) and PET/CT Fusion (RAD.00002)
- Peripheral Nerve Block for Treatment of Neuropathic Pain (SURG.00140)
- White Blood Cell Growth Factors (CG-DRUG-16)
- Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot) (CG-DRUG-45)
- Fundus Photography (CG-MED-47)
- Surgical Interventions for Scoliosis and Spinal Deformity (CG-SURG-47)

Gene Expression Profiling of Melanomas (GENE.00023)

The scope of this coverage guideline has been expanded to include cutaneous melanomas. Gene expression profiling of cutaneous melanoma is considered to be investigational.

Currently, there is not a specific CPT or HCPCS code for gene expression profiling for cutaneous melanoma, CPT codes 81599, unlisted multianalyte assay with algorithmic analysis and 84999, unlisted chemistry procedure are listed to represent this service.

Positron Emission Tomography (PET) and PET/CT Fusion (RAD.00002)

This coverage guideline was revised to consider PET scanning of the prostate using C-11 choline radiotracer or any other radiopharmaceutical (such as FDG-PET) as

investigational for all applications, including but not limited to, initial staging, confirming of the diagnosis, and restaging or monitoring for recurrence of prostate cancer.

CPT and HCPCS codes associated with this revised coverage guideline are 78811, 78812, 78813, 78814, 78815, 78816, and G0235.

Peripheral Nerve Block for Treatment of Neuropathic Pain (SURG.00140)

This new coverage guideline addresses the use of peripheral nerve blocks for the treatment of peripheral neuropathy.

Peripheral nerve blocks are considered to be investigational for management of neuropathic pain, including but not limited to treatment of any of the following:

- Chemotherapy-induced peripheral neuropathy (CIPN);
- Chronic nonmalignant pain;
- Peripheral neuropathy (for example, diabetic neuropathy, HIV-related neuropathies, etc.);
- Trauma induced neuropathy.

The CPT codes associated with this coverage guideline are 64415, 64417, 64447, and 64450.

White Blood Cell Growth Factors (CG-DRUG-16)

This clinical UM guideline addresses the medical necessity for white blood cell growth factors, also known as colony stimulating factors (CSF) which are administered to enhance recovery of blood-related functions in neutropenia including febrile neutropenia.

Effective November 1, 2015, HCPCS codes J1442, J1446, J2505, J2820, S9537, and Q5101 will be subject to review based on the position statements in the clinical UM guideline.

Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot) (CG-DRUG-45)

This new clinical UM guideline outlines the medical necessity criteria for octreotide acetate. Both Sandostatin® and Sandostatin® LAR Depot are somatostatin analogues, an acetate salt of a long-acting cyclic octapeptide with pharmacologic properties mimicking those of the natural hormone somatostatin.

The HCPCS codes associated with this clinical UM guideline are J2353 and J2354. Effective November 1, 2015, both J2353 and J2354 will be subject to review based on the position statements in the clinical UM guideline.

Fundus Photography (CG-MED-47)

This clinical UM guideline outlines the medical necessity criteria for the use of fundus photography. Fundus photography uses a retinal camera to photograph regions of the vitreous, retina, choroid, and optic nerve to document abnormalities related to disease processes affecting the eye or to follow the progress of the disease in response to therapy.

Effective November 1, 2015, CPT codes 92250 and 0380T will be subject to review based on the position statements in the clinical UM guideline.

Surgical Interventions for Scoliosis and Spinal Deformity (CG-SURG-47)

This new clinical UM guideline outlines the medically necessary indications for surgical interventions for the treatment of scoliosis and spinal deformity to include spinal fusion, osteotomy, vertebrectomy and associated instrumentation procedures.

The CPT codes associated with this clinical UM guideline are 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22842, 22843, 22844, 22845, 22846, 22847, 22849

All of these coverage and clinical UM guidelines addressed in this section are available for review on our website at www.anthem.com.

Specialty pharmacy infusions

Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. recognize that most patients prefer to receive their infusions in their physician's office, infusion center or at home through home infusion therapy. This is more comfortable for the member, results in lower member financial responsibility and, in many cases, is a clinically appropriate setting. There may be other circumstances where a patient's medical situation requires that he or she receive infusions in a hospital facility. To that end, **effective November 1, 2015,** the setting for specialty pharmacy infusions will be reviewed for appropriate clinical setting.

A Clinical UM Guideline in is development to be effective November 1, 2015. More details regarding the Clinical UM Guideline will be forthcoming in a future edition of the *Network Update.*

Business update

Anthem implements HealthKeepers reimbursement for DOC inmates – effective July 1, 2015

At the request of the Virginia Department of Corrections (DOC), Anthem implemented Anthem HealthKeepers reimbursement for DOC inmates effective July 1, 2015. As of July 1, 2015, providers will be reimbursed at Anthem HealthKeepers rates for covered DOC inmates.

This change only impacts covered inmates of the DOC – not inmates of regional or local (Sheriffs') jails. All other policies and procedures related to the covered inmates of the Department of Corrections will remain the same.

Please call Anthem's customer service area toll free at 1-877-332-8198 if you have questions.

BlueCard® claims filing

The BlueCard® program enables members to obtain health care services while traveling or living in another Blue Cross and Blue Shield (BCBS) company's service area. The program links health care providers with all BCBS companies across the nation through a single electronic network for claims processing and reimbursement. Please refer to the BlueCard Claims Filing brochure available from the "Answers@Anthem" tab on the Virginia provider section of our website at anthem.com. The brochure provides helpful information regarding alpha prefixes and other details when filing BlueCard claims. Additionally, BlueCard claims information can be found in the Provider Office Manual section of your Anthem contract.

BRCA testing alternatives

Public awareness of genetic testing continues to grow. In response, more labs are providing this type of testing. For example, did you know that the number of labs offering the BRCA test has increased significantly and Anthem* now contracts with multiple labs for this service? This gives you and most of your patients* greater choice in BRCA testing and an opportunity to compare costs and potentially save money. The following are some additional network options now available:

- Ambry Genetics
- BioReference
- Counsyl

- LabCorp
- Quest

* Some Plans may restrict BRCA testing to specific labs in network. For all Anthem HealthKeepers and Anthem HealthKeepers Plus plans (Medicaid/FAMIS), LabCorp (and its subsidiaries Dianon Systems, Litholink and Med Tox) is the only participating lab provider for outpatient laboratory testing. Please refer to ProviderFinder for more detail by Plan. Check benefit plan information for coverage terms and conditions.

CMS-1500 Claim Form version 08/05 for paper claims no longer accepted effective October 1

Effective October 1, 2015, Anthem Blue Cross and Blue Shield (Anthem) will no longer accept the old CMS-1500 Claim Form version 08/05 for paper claims.

Paper claims will only be accepted on the CMS-1500 Claim Form version 02/12.

Any paper claims received on or after October 1, 2015, using the old CMS-1500 Claim Form version 08/05 will be rejected. This applies to claims that may have been submitted prior to the October 1 effective date, but Anthem has not received by the October 1 effective date.

Anthem began accepting the CMS-1500 Claim Form version 02/12 in January 2014. We suggest that you transition to using the updated CMS-1500 Claim Form version 02/12 now, if you have not already done so.

For information on how to complete the updated CMS-1500 Claim Form version 02/12, follow the guidelines set forth by the National Uniform Claim Committee (NUCC). Please visit the NUCC website at www.nucc.org for helpful resources such as a list of changes between the 08/05 and 02/12 claim form versions and the 1500 instruction manual.

HEDIS® 2015: Provider incentive winners announced

We have completed the 2015 HEDIS data collection for our Anthem PPO and Anthem HealthKeepers plans and want to thank all of the physicians, health care professionals and their staffs who assisted us. Your partnership in this process allows us to achieve the best HEDIS results possible.

This is the fourth year for our incentive program to acknowledge some of our providers who either responded in a timely manner or went “above and beyond” to help make our HEDIS data collection successful. Any practices that responded within five business days of our initial request or who made a special effort by taking additional steps to help us with data collection were entered in a drawing to receive a gift. In the event an office was not able to accept a tangible gift, a special written recognition was given.

We are pleased to announce our incentive winners as follows:

Dumfries Health Center (Dumfries, Virginia)

Chantilly Family Medicine (Chantilly, Virginia)

Capital Family Practice (Fairfax, Virginia)

EVMS Ghent Family Medicine (Norfolk, Virginia)

Aaron Figler, M.D. (Woodbridge, Virginia)

Glenside Medical Associates (Richmond, Virginia)

Patient First (Richmond, Virginia)

Jackson River Family Practice (Low Moor, Virginia)

Virginia Women's Center Inc. (Richmond, Virginia)

Virginia Commonwealth University Health System/ Medical College of Virginia Hospitals and Physicians (Richmond, Virginia)

Thanks again to all of the health care professionals and their staffs for assisting us in collecting HEDIS data. Our HEDIS results reflect the excellent care you provide your patients – our members. An overview of our HEDIS rates will be published in the *Network Update* provider newsletter in the fourth quarter. In addition, more information on HEDIS can be found by visiting the Virginia provider section of our website at www.anthem.com. Once on our website, select the provider tab and then Virginia. Next, select Health & Wellness > Quality Improvement and Standards > HEDIS Information.

We look forward to working with you next HEDIS season.

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

Facility footnotes

Attention Facilities: Proper billing guidelines for Body Mass Index

In this edition of the *Network Update*, we are sharing guidelines for facilities/institutional providers regarding the appropriate billing of Body Mass Index (BMI). BMI is an approved diagnosis which may be reported as a secondary clinical condition. BMI may be recorded in a medical record by any physician or other qualified health care provider who provides care to the patient.

The International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM), or International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM), Official Guidelines for Coding and Reporting, Section III, states that "For reporting purposes the definition for 'other diagnoses' is interpreted as additional clinical conditions that affect patient care in terms of requiring:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring."

This policy documents the Health Plan's documentation and reporting guidelines for the diagnosis of Body Mass Index.

The following criteria shall be met to support additional reimbursement in conjunction with the diagnosis coding of BMI ≥40.

1. BMI ≥40 is reported as a secondary diagnosis.
2. The BMI ≥40 must be documented in the medical record by the physician, or by a clinician (e.g., a nutritionist or nurse).
3. There must also be a clinical diagnosis or condition documented by the physician that corresponds to the BMI ≥40 and thereby explains its significance.
4. The physician medical record documentation or the hospital medical record documentation must demonstrate that the presence of the BMI ≥40 lead to substantially increased hospital resource use because of the need for such services as intensive monitoring, expensive and technically complex services, extensive care requiring a greater number of caregivers, or extended length of hospital stay. When there is insufficient documentation to support the above criteria, services for such diagnosis shall be ineligible for reimbursement. The diagnosis shall not be considered in the grouping to the DRG, if applicable.

ICD-9-CM	Description	ICD-10-CM	Description
V85.41	Body Mass Index 40.0-44.9, adult	Z68.41	Body Mass Index 40.0-44.9, adult
V85.42	Body Mass Index 45.0-49.9, adult	Z68.42	Body Mass Index 45.0-49.9, adult
V85.43	Body Mass Index 50.0-59.9, adult	Z68.43	Body Mass Index 50.0-59.9, adult
V85.44	Body Mass Index 60.0-69.9, adult	Z68.44	Body Mass Index 60.0-69.9, adult
V85.45	Body Mass Index 70 and over, adult	Z68.45	Body Mass Index 70 and over, adult
V85.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age	Z68.53	Body Mass Index, pediatric, 85th percentile to less than 95th percentile for age
V85.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age	Z68.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age

National Uniform Billing Committee UB-04 code change

The National Uniform Billing Committee (NUBC) previously implemented a change to require an admission date be submitted on specific outpatient institutional claim type of bills such as 837I electronic and UB-04 paper claims. Anthem will enforce this rule beginning October 1, 2015.

- Admission Date Required – Type of Bills (TOB): 12X, 22X, 32X, 34X, 81X and 82X

Type of Bill Descriptions:

CODE	DESCRIPTION
12x	Hospital Inpatient Part B
22x	SNF Inpatient Part B
32x	Home Health
34x	Home Health (Part B Only)
81x	Nonhospital based hospice
82x	Hospital based hospice

Please make sure all billing staffs are aware of this change. These changes impact claims for members who are enrolled in our PPO, Anthem HealthKeepers and Medicare Advantage health plans. In addition, the changes also impact claims for the following members:

- Those enrolled in the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP).
- Those who purchased individual and small group health plans on or off the Health Insurance Marketplace (also called the exchange).

Please note that members enrolled in Anthem HealthKeepers Plus (Medicaid/FAMIS) are NOT impacted.

ICD-10 update

ICD-10 Updates: No delay yet; ICD-10 on track for implementation October 1

It's August 2015, and though there is some proposed legislation suggesting another ICD-10 delay; however, nothing so far has moved the compliance date of October 1, 2015. So, contrary to prior years, it's really looking like ICD-10 will happen in about two months.

Are you ready?

Prior delays may have slowed, or even stopped, your implementation plans. If you fall in this category, you may have much work to do in a short period of time. However, if you move quickly, a successful ICD-10 implementation can still happen for your practice before the deadline of October 1, 2015.

Here are some suggestions:

Need a plan to get started? CMS's Road to 10 provides a complete roadmap for small and medium practices to follow to get you to your ICD-10 destination by October 1.

Need to practice using ICD-10-CM codes? Coders with some training can take advantage of the free scenario-based coding practice tool Anthem is offering (accessed through Anthem's ICD-10 webpage). The coding tool is designed to give physicians and coders an opportunity to apply their knowledge of the ICD-10 code set to various medical scenarios.

Want to work on improving your clinical documentation? CMS is offering Interactive Case Studies designed to help you understand key ICD-10 documentation concepts. The case studies include sample clinical scenarios, short quizzes on related coding concepts and documentation tips. New scenarios are added weekly.

Check our ICD-10 Updates – Resources webpage for more suggested resources that can help you prepare for ICD-10.

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)

Colonoscopy billing reminder – Preventive vs. diagnostic

The Affordable Care Act (ACA) requires nongrandfathered health plans to cover outlined preventive care and screenings without member cost sharing when the services are rendered by an in-network provider and/or facility. Colorectal cancer screenings are included as a covered preventive care service under these guidelines.

Since colonoscopies are rendered for both screening and diagnostic purposes, it is very important for providers to use appropriate ICD-9 diagnosis coding guidelines (or ICD-10 coding guidelines, once implemented) when reporting colonoscopies. When inappropriate ICD-9 diagnosis codes are submitted on claims, it can result in incorrect provider payment and/or incorrect member cost sharing.

To reduce claim adjustments and your corresponding refunds to members, we recommend the following approach when coding a colonoscopy claim.

- In a situation where an individual presents for treatment solely for the purpose of a screening exam, without any signs or symptoms of a disease, then such a procedure should be considered a screening. The appropriate use of screening diagnosis codes and procedure codes is valuable in promoting appropriate adjudication of the claim.
- In a circumstance where an individual presents for a screening exam (without signs or symptoms), and an issue is encountered during that preventive exam, then such a circumstance would warrant the use of the PT modifier. The procedure and diagnosis codes that would typically be used in such an instance may not clearly demonstrate that the service began as a screening procedure but had to be converted to a diagnostic procedure due to a pathologic finding (such as polyp, tumor, bleeding) encountered during that preventive exam.
- In the instance that an individual presents for treatment due to signs or symptoms to rule out or confirm a suspected diagnosis, such an encounter should be considered a diagnostic exam, not a screening exam. In such a situation, the modifier PT should not be used.

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

Anthem launches digital magazine featuring tested resources for all people touched by cancer

Stronger Together – a new digital magazine featuring tested resources available at no charge for all people touched by cancer.

Stronger Together is a new digital magazine featuring resources available at no charge for all people touched by cancer. Anthem's Community Health Initiatives department worked with leading national organizations* to make these resources available to providers, patients/survivors, caregivers, workplace managers and employees.

Stronger Together addresses the needs of primary care providers and specialists seeking tested resources for themselves and all patients regardless of health plan.

"The resources can be used by people with cancer and caregivers to support their journey through treatment and survivorship, as well as those who play a crucial role in their health and well-being" said Jennifer Hausman, public health program director, Community Health Initiatives.

We hope you will share Stronger Together with your patients and colleagues.

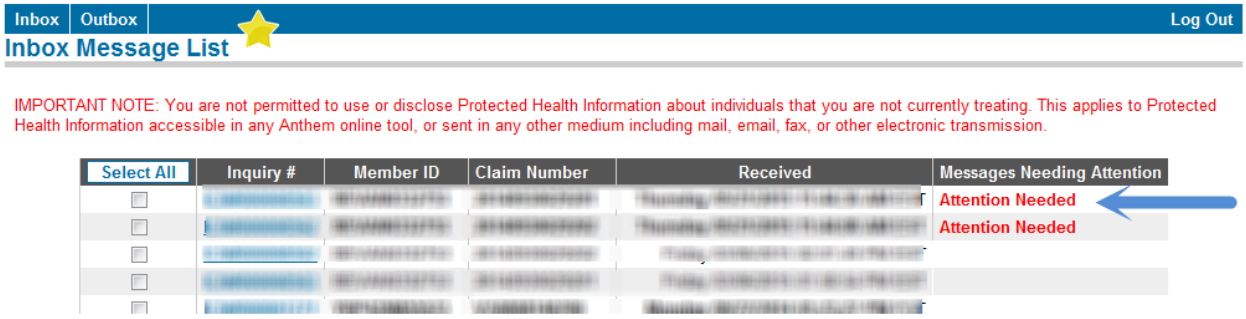
* Anthem Foundation, Cancer and Careers, CancerCare, Cancer Support Community, Caregiver Action Network, Genentech, Indiana University, Michigan State University, National Coalition for Cancer Survivorship, Oncology Nursing Society, Pfizer, SEDL an affiliate of American Institutes for Research, Takeda Oncology, UCLA Cancer Survivorship Center, and US Business Leadership Network.

Provider Secure Messaging enhancements on Availity

If you are a current user of Secure Messaging, a feature available from the Claim Status Detail page on the Availity Web Portal that replaces the electronic Claim Information/Adjustment Request 151 Form, please take note of recent upgrades.

Anthem can now send you follow-up messages on your claim inquiry. These may share pertinent detail or request additional specific information. You will know if Anthem has sent you a new message because a new column, titled "*Messages Needing Attention*," has been added to your inbox. In this column, if you have a new message, you will see "*Attention Needed*."

If you use Secure Messaging, check your inbox periodically for this indicator. It will look like this:



Also, when you view your message, look for a new option, "Download Secure Message," which is located to the right of the message. Use Download Secure Message to save or print the content of the entire message. This eliminates the need for multiple print screens in order to capture the message detail – helping to save you time with administrative tasks.

Anthem to discontinue mailing paper remittances to all ERA-registered providers

In support of the Health Insurance Portability and Accountability Act's (HIPAA) Administrative Simplification requirements, Anthem Blue Cross and Blue Shield will discontinue mailing paper remittances to all providers currently registered for electronic remittance advices (ERA) effective October 1, 2015. You will not be impacted by this change if you have already taken action to manage your paper remittances.

Have you taken steps to prepare? If no, we recommend that you do so soon. It's easy to access your online remittances through the Availity Web Portal. As an ERA-registered provider, your Availity primary access administrator (PAA) must complete the steps outlined below to allow access to online remittances through Availity immediately.

Where to start

- Each user needs an individual Availity Web Portal ID and Password and his or her own unique Point of Care provider portal login ID, also known as Point of Care Health Plan User ID.
- Anthem Services Registration, located on the Availity Web Portal, needs to be completed to link the Point of Care Health Plan User ID and the Availity User ID.

Step 1 – Complete the Anthem Services Registration within the Availity Web Portal

This registration process grants Availity users who are set up with a Point of Care Health Plan User ID the ability to access paper remittances on Point of Care through the Availity Web Portal – by using a single, sign-on feature.

The Availity PAA for your organization needs to complete the Anthem Services Registration for users. If the PAA has previously completed this step, proceed to step 2.

- On Availity, from the left navigation menu, select My Account | then Anthem Services Registration.
- Select the user's organization (if applicable).
- Select Non-Registered Users.
- From the Non-Registered Users list, locate your user and type in the Point of Care Health Plan User ID; repeat this step for additional registrations.
- Click Register.
- Log out and log back into Availity in order for the new access to take effect.

Important Note: The user's first and last name must exactly match what is registered in Point of Care. If an exact match is not made, the registration will be rejected.

The PAA can take the following steps to update the user's name in Availity:

- From the Availity menu, select Account Administration | then Maintain User.
- Locate the user and type in the changes.

How does a user receive an Anthem Health Plan User ID?

Your organization's Point of Care Administrator for the Point of Care provider portal will need to register a user for the Point of Care Web portal in order to issue a Point of Care Health Plan User ID. Once the Point of Care Health Plan User ID has been issued to a user, the Anthem Services Registration described in Step 1 can be completed.

The Point of Care Administrator should take the following steps to register users for the Point of Care web portal:

- Log into Availity at www.availity.com

- Click My Payer Portals | then select Anthem Point of Care|; then select “I Agree” to link out to Point of Care.
- From Point of Care, select the Administration Tab |the select Administer Users to add a user.
- The new user will be sent an email containing an activation code and a link.
- The user should click the link and use the activation code to register for Point of Care and create a Point of Care Health Plan user ID.
- The user gives his or her new Point of Care Health Plan user ID to the PAA to register on the Availity Web Portal. The Point of Care Administrator can also retrieve a user’s Point of Care Health Plan user ID by selecting Active Health Plan User ID from the Point of Care Administration Tab.

Note: Only network providers who participate with Anthem Blue Cross and Blue Shield can register for Point of Care.

Step 2 – Access your Paper Remittances on Point of Care through the Availity Web Portal

Users can now follow the steps below to access your organization’s paper remittances:

- Log into Availity at www.availity.com
- Click My Payer Portals | then Anthem Point of Care|; then click on “I Agree” to link out to Point of Care. You are now logged directly into Point of Care.
- From the Point of Care Home page, select Reports|; then Payment Vouchers to access your paper remittances.

Is Training Available?

Availity offers a variety of ongoing training options, including live and on-demand webinars, online demonstrations, local workshops, comprehensive help topics, tip sheets and more. For a full list of learning options, login to the Availity portal and click *Free Training* at the top of any page.

Have Questions?

If you do not know your Point of Care Health Plan User ID:
Call Anthem Anthem’s eBusiness Helpdesk: 1-866-755-2680

For questions regarding Availity’s Anthem Services Registration:
Call Availity Client Services toll free at 1-800-282-4548

Availity launched new E&B functionality in June

The Availity Web Portal launched new eligibility and benefits (E&B) functionality and features on June 27, 2015. These changes make finding eligibility and benefits easier and faster for you. For easy reference, here's a list of the new features:

Feature	Description
New request page	A new design makes it easier for users to find and focus on tasks at hand. Now, users can submit multiple member inquiries without having to wait for individual results before starting another request.
Patient history list	The results list automatically summarizes user's most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).
Menu by benefit type	Located under the "Coverage and Benefits" tab, this interactive list displays all service types and benefits returned from the health plan.
Patient snap shot	The summary of patient information is easily found at the top of the page.
Clearer display of details	Users have a clearer and more complete view of specific benefit and financial information.
Advanced printing	By selecting which sections to print, users save paper and can customize prints to target necessary information.
Real-time feedback	Feedback buttons on every returned eligibility request allows users to provide instant feedback of missing or inaccurate information.

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

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

FEP update

Federal Employee Program® claims address

As a reminder, providers should use the address below for filing claims for federal employees who are enrolled in the Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program or FEP. If you have any questions about claims or need assistance please contact the FEP Customer Service area at 1-800- 552-6989.

Federal Employee Program
P.O. Box 105557
Atlanta, GA 30348-5557

Medicaid information

(Anthem HealthKeepers Plus offered by HealthKeepers, Inc.)

ICD-10 Updates: No delay yet – on track for October 1

In the "ICD-10 update" section of this edition of the *Network Update*, we are sharing the latest details we have around the upcoming implementation on October 1, 2015. The implementation of ICD-10 impacts all our lines of business including Anthem HealthKeepers Plus (Medicaid/FAMIS). Please refer to the article on page 17 in this edition or select this LINK for further details regarding ICD-10.

New CMS-1500 claim form implementation

In the "Business update" section of this edition, you'll find a notice regarding the CMS-1500 Claim Form version 08/05 for paper claims. Effective October 1, 2015, Anthem and our affiliate HealthKeepers, Inc. will only accept paper claims filed on the CMS-1500 Claim Form version 02/12.

This claims filing requirement also applies to claims filed for Anthem HealthKeepers Plus members. Providers are encouraged to switch to the new CMS-1500 claim form prior to the implementation date to ensure that claims are properly submitted.

For more information about CMS-1500 for Anthem HealthKeepers Plus member claims, contact Provider Services at 1-800-901-0020. To refer to the article about the CMS-1500 claim form in this edition of the *Network Update*, please see page 13 or select this LINK.

Practice management system and ICD-10 compliance

Are your practice management and billing systems ICD-10 ready? Talk with your vendor about the support and services you might need for ICD-10 compliance. For dates of service beginning on October 1, 2015, you must use ICD-10 codes for claims to be properly adjudicated. Please refer to the article on page 17 in this edition of the *Network Update* or select this LINK for further details regarding ICD-10 for online resources you may find helpful.

Coming soon: ICD-10 provider coding education

HealthKeepers, Inc. developed a series of six online training modules for our Anthem HealthKeepers Plus providers to offer a general overview of ICD-10 coding. The training also covers specific information about coding for respiratory conditions, cancer, behavioral health, cardiovascular conditions, diabetes, hypertensive disease and other common conditions.

The training modules will be added to the provider Web portal in stages – so be sure to check the portal on a regular basis.

Remember, there is no transition period between the use of ICD-9 and ICD-10 codes. ICD-9 and ICD-10 codes are dependent upon the date of service (DOS) or date of discharge (DOD). If the DOS or DOD is prior to October 1, 2015, ICD-9 codes must be used on Health Insurance Portability and Accountability Act (HIPAA) transactions such as claims and authorizations. If the DOS or DOD is October 1, 2015, or later, ICD-10 codes must be used or the transactions will be rejected and returned.

For additional questions about the new CMS-1500 form or the ICD-10 implementation for Anthem HealthKeepers Plus members, contact Provider Services at 1-800-901-0020.

Providers for Anthem HealthKeepers Plus members should register for ICD-10 claims testing by September 1, 2015

Our company is conducting end-to-end claims testing with Anthem HealthKeepers Plus member providers. Providers who have not already enrolled in claims testing should be registered by September 1, 2015, in order to be ready for the implementation on October 1, 2015. Claims testing is designed to help ensure providers' systems can successfully process claims. Providers should register for testing by contacting Anthem HealthKeepers Plus Provider Services at 1-800-901-0020. Read more.

Hypertensive diseases: Documentation and coding

The medical record documentation for Anthem HealthKeepers Plus members with hypertension should include each of the following:

- Type of hypertension – benign (mildly elevated arterial pressure) or malignant (severe elevation that results in complications)
- Complications – body system such as heart or kidney that are affected by hypertension
- Specific conditions – details about the conditions that result from hypertension (i.e., heart failure, nephritis, cardiomegaly)
- Assessment/treatment – all measures aimed at controlling the hypertension or treating symptoms from complications

Diagnosis code assignment is based on provider documentation, and the medical record must support the codes submitted on the claim.

Essential (primary) hypertension 401

Code assignment is based on the type of hypertension documented (benign, malignant or unspecified). Statements such as high blood pressure, hypertension and hypertensive vascular disease are all coded with category 401 essential hypertension. When only an elevated blood pressure is noted without a diagnosis of hypertension, assign code 796.2 elevated blood pressure reading without diagnosis of hypertension. Terms such as controlled and uncontrolled indicate the status of the condition and do not have a bearing on the code assignment for hypertension.

Hypertensive heart disease 402

Assign category 402 hypertensive heart disease, when a cardiac condition is stated (due to hypertension) or implied (hypertensive). The physician must document cause and effect between the two conditions. Category 402 is further specified based on the presence of heart failure. Use additional codes 428.0 - 428.43 to specify the type of heart failure, if known.

Hypertensive chronic kidney disease 403

Assign codes from category 403, hypertensive chronic kidney disease, along with additional codes for the stage of the disease, from category 585 chronic kidney disease.

Hypertensive heart and chronic kidney disease 404

When documentation supports heart and kidney complications with hypertension, the rules of cause and effect are assumed and require documentation for hypertension and heart disease.

Instructional notes state to use additional codes 428.0 - 428.43 to specifiy the type of heart failure, if known, and the stage of chronic kidney disease from category 585 chronic kidney disease. The ICD-10 equivalent code category is I1 hypertensive heart and chronic kidney disease.

Secondary hypertension 405

Secondary hypertension is caused by underlying conditions, such as adrenal gland disorders, kidney disease and drug use. Assign codes for the underlying conditions in addition to codes from category 405 for secondary hypertension when documentation supports a cause and effect relationship.

Important change to code assignment for hypertensive diseases in ICD-10

ICD-10 coding does not require type of hypertension documentation for correct code assignment. Providers are required to document the effects of hypertension along with any underlying conditions and treatment given. The table below shows code categories for hypertensive diseases in ICD-10.

ICD-10	Description
I10	Essential (primary) hypertension
I11	Hypertensive heart disease (with or without heart failure) Use an additional code from I50 to specify type of heart failure (if present).
I12	Hypertensive chronic kidney disease Use an additional code from N18 to identify stage of chronic kidney disease.
I13	Hypertensive heart and chronic kidney disease Use an additional code from I50 to specify type of heart failure (if present) and an additional code from N18 to identify stage of chronic kidney disease.
I15	Secondary hypertension Requires two codes; one for the underlying cause and one from category I15 to identify secondary hypertension. Sequencing is based on circumstances of the visit and documentation.

For more information about hypertension disease documentation and coding for Anthem HealthKeepers Plus members, call Provider Services at 1-800-901-0020.

Medicaid open enrollment continues through August 31, 2015

HealthKeepers, Inc. would like to thank you for teaming up with us to serve the needs of our Anthem HealthKeepers Plus (Anthem) members in Virginia. Open enrollment is under way in the Northern Virginia and Winchester region through **August 31, 2015.** This means your Medicaid patients have the choice to make a health plan change.

Anthem, one of five available health plans in this region, is accepting new members. As the largest Medicaid health plan contracted with the Department of Medical Assistance Services (DMAS) to administer Medicaid benefits in the commonwealth of Virginia, and the only statewide plan, we know we couldn't do it without you. We appreciate the quality care you provide our members.

If members request additional information or would like to request Anthem HealthKeepers Plus offered by HealthKeepers, Inc. as their health plan of choice, we hope you will share the Virginia Managed Care HelpLine contact information with them: 1-800-643-2273. If you have questions about open enrollment, please call Provider Services at 1-800-901-0020.

Pain management codes and modifiers

When performing anesthesia pain management (codes listed below), prior authorization is needed if the procedure is to be performed in conjunction with a surgery and is considered to be a separate surgical procedure. National Council on Compensation Insurance (NCCI) guidelines consider these codes incidental to anesthesia services; however, they can be paid separately if they are not the primary mode of anesthesia and are performed for post-op pain management. In these instances, providers can receive payment for these Anthem HealthKeepers Plus member services if prior authorization is obtained and the procedure is billed with the appropriate modifier:

All codes listed including all codes within the highlighted code ranges.

Code Ranges
G0259 - G0260
62273 - 62282
62310 - 62319
64400 - 64530
S0020 - S0020
0282T - 0282T
0283T - 0283T
0284T - 0284T
S8130 - S8131
0213T - 0213T
0214T - 0214T
0215T - 0215T
0216T - 0216T
0217T - 0217T
0218T - 0218T

For questions about pain management coding for Anthem HealthKeepers Plus members, contact Provider Services at 1-800-901-0020.

New specialty pharmacy network for Anthem HealthKeepers Plus members

On July 1, 2015, HealthKeepers, Inc. launched the new specialty pharmacy network for our Anthem HealthKeepers Plus members. The new network provides the special care needed when a specialty drug is dispensed.

As we work with the state to provide quality health care for Anthem HealthKeepers Plus members, we continually look for ways to increase efficiency — ultimately saving money for Virginia taxpayers. In addition, the new pharmacy network will enable members who have complex medical conditions to stay compliant with their specialty drug regimens.

Which pharmacies are in the network?

A complete list of in-network pharmacies is published in the Provider Directory and online under Find a Doctor. This change allows Anthem HealthKeepers Plus members to engage in optimal pharmacy care services such as counseling, member education, drug monitoring and clinical interventions.

How will members be notified of their in-network pharmacies?

If claims data indicates members have been filling prescriptions at a pharmacy that is not in the new specialty pharmacy network, Anthem HealthKeepers Plus members will receive a letter explaining how to find an in-network pharmacy.

Express Scripts has notified pharmacies not included in the new specialty pharmacy network. Also, nonparticipating pharmacies will receive a message instructing them to call HealthKeepers, Inc. to help redirect members to an in-network pharmacy.

For more information

For questions or more information about the new specialty pharmacy network for Anthem HealthKeepers Plus members, please call Provider Services at 1-800-901-0200.

Prior authorization required for drugs Entyvio and Cyramza

HealthKeepers, Inc. is adding the following new drugs to the 2015 Medicaid list of injectable or infusible drugs requiring prior authorization for Anthem HealthKeepers Plus members. As of August 1, 2015, providers must call for prior authorization of these drugs:

1. Entyvio (vedolizumab): a monoclonal antibody that is a specific integrin receptor antagonist used for the treatment of moderately to severely active Crohn's disease and ulcerative colitis in adult patients.

   HealthKeepers, Inc. medical policy: DRUG.00068 (C9026 = Injection, vedolizumab, 1 mg)

2. Cyramza (ramucirumab): a monoclonal antibody and human vascular endothelial growth factor receptor 2 antagonist used for treatment of the following:

   - Metastatic gastric or gastroesophageal junction adenocarcinoma with disease progression during or after treatment with fluoropyrimidine- or platinum-containing chemotherapy, as monotherapy or in combination with paclitaxel

   - Metastatic non-small cell lung cancer with disease progression on or after platinum-based chemotherapy, in combination with docetaxel

- Metastatic colorectal cancer with disease progression on or after therapy with bevacizumab, oxaliplatin and a fluoropyrimidine, in combination with FOLFIRI

HealthKeepers, Inc. medical policy: DRUG.00067 (C9025 = Injection, ramucirumab, 5 mg)

For more information

If you have questions about this change to prior authorization for drugs Entyvio and Cyramza for Anthem HealthKeepers Plus members, please call Provider Services at 1-800-901-0020.

Medicaid-Medicare Plan update

This section of the newsletter addresses information on the Anthem HealthKeepers 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.

Reimbursement policy

Issue #1, August 2015

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered. Services must meet authorization and medical necessity guidelines appropriate for the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions unless otherwise required by the state. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations.

Policy Update: Allergy Treatment: Immunotherapy
(Policy 06-110, effective September 20, 2015)

Reimbursement is allowed for allergy immunotherapy. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the injection, antigen dosage/preparation when meeting the below criteria.

The injection service component code and the antigen dosage/preparation component code (per dose) should be billed separately. Additionally:

- Claims submitted with a procedure code representing the complete service (collectively including the injection service, antigen dose and the antigen preparation) will be denied.

- If the antigen is prepared in other than the physician's office, the physician may bill only for the injection services.
- Physicians using treatment boards must bill with the component codes even though they prepare no vials.
- If multiple antigen doses are prepared in the same setting:
    - The injection service and the antigen dosage/preparation service code indicating the number of dosages for the injection administered during the first visit must be billed.
    - Only the injection service for remaining injections administered during subsequent visits must be billed.

Note: Reimbursement of up to 20 doses billed for preparation of single or multiple antigen doses for a 30-day period is allowed. **Claims billed for more than 60 doses during a 90-day period will be denied.**

Providers may not bill for Evaluation and Management (E&M) visits for established patients on the same day as allergy injection services unless the E&M visit represents a significant, separately identifiable service and is appended with modifier 25. Claims submitted for an E&M visit in conjunction with allergy injection services without the modifier 25 will be denied. Claims submitted for E&M visits for new patients on the same day as allergy injection services may be reviewed for medical necessity.

For additional information, refer to the reimbursement policies at mediproviders.anthem.com.
Your continued feedback is critical to our success. If you have questions, MMP providers can call 1-855-817-5788.

Medicare information

(Anthem's Medicare Advantage and Medicare Supplement plans)

Participating home health providers: Physician orders are required; precertification and face-to-face evaluations are not required

Anthem requires a physician's order for home health services for our individual and group-sponsored Medicare Advantage members. Precertification for home health services is not required. At this time, contracted Home health providers are not required to present evidence of a face-to-face evaluation for home health services claims.

Additional fax numbers available for facilities to precertify skilled nursing, long-term acute care and inpatient rehab

To help ensure timely responses to precertification requests, we've added additional fax lines for facilities to precertify admission requests or submit additional clinical information for individual and group-sponsored Medicare Advantage members for the following services:

- Acute initial hospital admissions and Continued Stay Reviews: 877-744-2319
- Patient Review Instrument/Skilled Nursing Facility/Rehab Requests: 844-211-7140 – New
- Skilled Nursing Facility Continued Stay Reviews: 844-211-7141 – New

Requests for services not listed above may cause a delay in processing requests.

All clinical information relevant to the request for acute inpatient hospital admissions should continue to be sent to the 877-744-2319 fax line.

HIPPS codes required for all skilled nursing and home health providers

All claims from skilled nursing facilities (SNFs) and home health agencies (HHAs) received on or after July 1, 2014, must contain a valid HIPPS code. This pertains to contracted and non-contracted providers. The Centers for Medicare & Medicaid Services (CMS) requires that Anthem include this information on all processed claims data we submit to CMS.

- SNFs should bill the HIPPS code derived from the "Admission Assessment"
- HHAs should bill the HIPPS code derived from the "Start of Care Assessment"
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable PPS Revenue Code (022 or 023), the HIPPS code, 1 unit, and billed charges of 0.00.
- This billing instruction applies to all Medicare Advantage Plans including Dual Eligible Special Needs Plans.
- This does not apply to Medicare Supplement Plans.
- HHAs are not required to bill treatment authorization codes.
- If you currently have a contract with Anthem, the CMS mandated addition of the HIPPS code on your claim will not affect your payment.

Medicare Advantage precertification requirements available on provider portal, Availity

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. Detailed prior authorization requirements for individual Medicare Advantage members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. 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.
Non-contracted providers should contact the health plan. General information on 2015 Medicare Advantage precertification requirements can be found here.

Participating providers: Bill Medicare Part D for shingles or tetanus vaccination claims

Providers who have administered a shingles (90736; regardless of any diagnosis) or tetanus vaccine (90714, 90715, 90718 and 90723; regardless of any diagnosis) to our individual and group-sponsored Medicare Advantage plan members with pharmacy benefits should bill the Medicare Part D Benefit. Providers will encounter a denial if these claims are billed to the medical benefit because the claim is covered under Medicare Part D only. This applies to the vaccine and the administration charges. Please note you can refer your patients to their local pharmacy for administration as well.

For Medicare Part B benefit of tetanus vaccine (90703; diagnosis range 800.00 to 897.99), this may be submitted as a medical claim for processing. More information can be found here.

Labs: Anthem Medicare Advantage plans accept G Codes for definitive drug testing

To help ensure alignment with the Centers for Medicare & Medicaid Services' billing guidelines, Anthem's Medicare Advantage plans accept G Codes for definitive drug testing. Therefore, labs should use codes G6030-G6058 for definitive drug testing for Anthem individual and group-sponsored Medicare Advantage members.

Medicare Advantage reimbursement policies available on our provider portals

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.

Adult BMI and medical records – please record exact number, not range

Please document Body Mass Index (BMI) as an exact number and not a range. BMI can be documented by billing CPT 3008F and the appropriate V code. Adding the BMI to the claim helps to decrease the number of chart reviews needed throughout the year and during the HEDIS collection season. Greater precision in charting the member's BMI will help members achieve or remain at a healthy weight.

Important screenings for Medicare Advantage members

Anthem appreciates your help in ensuring that our Medicare Advantage members receive key services recommended by the Centers for Medicare & Medicaid Services, including:

- Diabetes
  - Diabetic members ages 18-75 require a yearly dilated retinal exam (DRE), kidney function test
  - Diabetic members ages 18-75 require a HbA1C every three to six months
- Colorectal screening -- members ages 50 to 75 require a colorectal cancer screening
  - Screenings include Fecal Occult Blood Test (FOBT) during the measurement year, flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year and/or colonoscopy during the measurement year or the nine years prior to the measurement year.

Proton pump inhibitors – consider less costly alternatives to the purple pill

To help manage rising health care costs, Anthem removed Nexium and the generic from the majority of individual 2015 Medicare Advantage formularies and group-sponsored closed formularies. Lower-cost alternatives (omeprazole and pantoprazole) and over-the-counter proton pump inhibitor (Prilosec, Nexium) are available in this class and on the non-preferred generic tier in majority of Anthem Medicare Advantage formularies. (The group-sponsored Medicare Advantage Prescription Drug open formulary does cover Nexium at this time.) Nexium brand and generic pricing is significantly higher than the generic proton pump inhibitors, pantoprazole and omeprazole, which are less than $20 per prescription.

Please consider prescribing omeprazole and pantoprazole, the lower-cost alternatives for members with excess stomach acid.

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.

52734WPPENMUB 03/27/2015

Facilities: Failure to precertify an admission or provide notice of emergent inpatient admission results in administrative denial for Medicare Advantage

Facilities and network physicians 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 precertify 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 a facility does not obtain the required precertification within the specified timeframe, the claim will be administratively denied due to failure to notify Anthem of the admission. The facility will not receive payment for the service. Facilities cannot bill the member for these denied admissions.

If you do not notify us within the required timeframe, you may file an appeal. As part of the appeal, providers must demonstrate that they did notify Anthem or attempted to notify Anthem AND that the service is medically necessary. Anthem also reminds all providers – network physicians and facilities -- that they cannot bill the member if the services are denied for the failure to obtain a required precertification.

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 which 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.

54092WPPENMUB 06/15/2015

Medicare Supplement Plan "N" ID cards have a new look

Medicare Supplement Plan "N" includes an office visit benefit. The member is responsible for 20% coinsurance of the Medicare approved amount up to a maximum $20 copay for each office visit.

The identification card previously indicated "Office Visit $20 copay" or "Office Visit $20."

Going forward the wording on the new identification cards is "Office Visit up to $20." The office visit benefit is not changing. The new wording on the ID cards is a clarification of the benefit. The new wording will be on ID cards issued to new members and members requesting a duplicate card.

3569WPPENMUB 06/04/2015

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:

http://www.anthem.com/pharmacyinformation.

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."

Bulletin board

Anthem webinar scheduled for August 19 – register now

Please take time now to register today for the webinar coming later this month, the one in November, or both.
Don't miss an opportunity to attend these online sessions. For your convenience, we offer these informative, hourly sessions online to eliminate travel time and help minimize disruptions to your office or practice. Please take time now to register today for the webinar coming later this month.

Anthem. BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

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

Onsite medical office seminar scheduled for September 16 – register today

On September 16, we will offer a medical office seminar in Bristol, Tennessee, for Anthem-contracting "professional providers" and their office staffs. This informative session is offered free of charge as a benefit of network participation. "Professional providers," defined as those who submit claims using the 837P (electronic) or CMS-1500 (paper) claims format, include the following practitioners and their office staffs:

> MDs, DOs, DPMs, DCs, LCPs, LPCs, LCSWs, LMFTs, CNSs, CNMs, plus DDSs and DMDs (who render non-routine medical or dental services to Anthem members), and optometrists (ODs) and opticians (who render non-routine medical vision services to Anthem members).

Due to the wide range of medical specialties represented, we cannot target information specific to each, so we will take a more global approach in the covered material to afford useful information for all. Additionally, practitioners with other than the credentials shown above should contact their local Anthem network manager to learn of training opportunities that may be available for their respective specialties.

Please make plans now to attend the seminar and/or one of our remaining webinars that can be conveniently accessed from anywhere in the Anthem (Virginia) service area via your office computer and telephone (see seminar and webinar listings and registration form in this edition of the *Network Update*).

Date	Time	Location
September 16, 2015	10 a.m. to 1 p.m.	Bristol Regional Medical Center Walnut/Willow/Spruce Rooms 1 Medical Park Blvd. Bristol, TN 37620

Seminar Topics

The following topics may be included in this three-hour seminar. Additional topics of local interest not listed here may also be included.

- Claims filing for professional providers with emphasis on the 837P professional electronic claim transactions, and other e-transactions
- Use of e-tools found on our open Web portal at anthem.com, as well as our secure portal, Availity
- New product and/or benefit changes for our PPO, HealthKeepers, Medicaid and Medicare Advantage plans, as well as the Medicaid-Medicare Plan (Duals) and plans purchased on the Health Insurance Marketplace
- Any known updates for state (Commonwealth of Virginia plans), local (The Local Choice), and federal (Blue Cross and Blue Shield Service Benefit Plan or FEP®) government programs
- The BlueCard® Program (out-of-area program) from the national Blue Cross and Blue Shield Association

- Medical Management; Utilization Management; Pharmacy Management
- *And/or other topics of timely importance*

Registration/cancellation

Reservations are required as seminar seating is limited. We will contact you if this session has already reached capacity or is being cancelled due to low registration. Please include your e-mail address, business telephone and fax numbers. Submit your completed registration form by FAX or mail (not both) as follows:
For WESTERN Region Seminars ONLY

FAX: 540-853-3065 (Western)
or
MAIL: Anthem Blue Cross and Blue Shield
Attn: WESTERN Medical Office Seminars
Mail Drop VAG104-A200
602 S Jefferson Street
Roanoke, VA 24011

For your comfort and convenience

- We highly recommend attendees bring a sweater or jacket for personal comfort.
- Beverages/snacks will be provided at seminars with the exception noted in our schedule, or you may "brown bag" your meal if the meeting location permits.

Anthem BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

Please join us for an Educational Seminar
When: Wednesday, September 16, 2015
10 a.m. – 1 p.m.

Where: Bristol Regional Medical Center
1 Medical Park Blvd, Bristol, TN 37620
Rooms: Walnut/Willow/Spruce

Fax completed form to Michelle Brown 540-853-3065

IMPORTANT! Please read and complete the information below.
Remember that faxes often lose quality in transit so **please print legibly**.

- These FREE seminars are for network-participating physicians (MDs, DOs and DPMs), as well as Behavioral Health providers (MDs, PhDs, LPCs, LCPs, LCSWs, MFTs, and CNSs), doctors of chiropractic (DCs), certified nurse midwives (CNMs), dental/oral surgery providers of medical (non-routine) services, and optometrists (ODs) and opticians for medical (non-routine) services rendered to Anthem members, and their office personnel.

- For seating purposes, reservations are required; seating is on a first-come, first-served basis. If you register and then need to cancel, please give us 24 hours or as much notice as possible by calling as follows: for Central, call 804-354-2334; for Eastern, call 757-326-5152; for Northern, call 703-227-5315; for Western, call 540-853-3922.

- For personal comfort, we highly recommend attendees bring a sweater or jacket. Limited beverages/snacks will be provided at all seminars; you may also "brown bag". If a hospital is providing lunch, this will be specified on the schedule.

Seminar Date/Time _____ and Location _____

Attendee #1 _____ Attendee #2 _____

Provider Name _____ Provider Specialty_____

NPI # (individual) _____ or NPI # (group) _____

Provider Address with City /State /Zip _____

Phone Number _____ Fax Number _____
E-mail Address _____
Provider Website (if applicable) _____

CONFIRMATION of your registration or notification that your selection is full or has been cancelled will be sent to you via E-MAIL or FAX, so it is critical that you include your e-mail, phone and fax numbers when completing this form. THANK YOU.