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Announcements

Anthem's 2016 webinars get under way in April

We are excited to announce our 2016 provider education webinars that begin in April. These webinars address Anthem business updates that impact your business interactions with us. For your convenience, we offer these informative, hourly sessions online to eliminate travel time and help minimize disruptions to your office or practice. Our first webinar for the year is scheduled on April 13. Please see the registration form in the “Bulletin Board” section of this edition of the Network Update to sign up today for the April webinar.

Precertification list expansion

Effective May 1, 2016, outpatient hip resurfacing and replacement, and knee replacement will be added to the precertification list for our members enrolled in our PPO and Anthem HealthKeepers plans. This includes health plans our members purchase on or off the Health Insurance Marketplace (also called the exchange).

Please note that this precertification list does NOT apply to claims for members enrolled in Anthem HealthKeepers Plus (Medicaid), Medicare Advantage, the Medicare-Medicaid Plan (MMP or also called the Dual Integration product), or the Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program or FEP).

NOTE: Some of these codes are used for both the inpatient setting and outpatient setting. When used for an inpatient admission, the codes are already on the precertification list.
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Coverage and clinical guideline update

Coverage guidelines effective May 1, 2016

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective May 1, 2016. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage and the Medicare-Medicaid Plan (MMP or also called the Dual Integration product). Furthermore, the guidelines were among those recently approved at the quarterly Medical Policy and Technology Assessment Committee meeting held on November 5, 2015.

Guidelines addressed in this edition of the Network Update are:

- Pemetrexed (Alimta®) (CG-DRUG-38)
- Cardioverter-Defibrillators (SURG.00033)
- Cervical Fusion (CG-SURG-42)
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities (CG-SURG-49)
- Knee Arthroscopy (CG-SURG-43)
- Neutron Beam Radiotherapy (THER-RAD.00008)
- Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT) (THER-RAD.00011)
- Proton Beam Radiation Therapy (THER-RAD.00002)

Pemetrexed (Alimta®) (CG-DRUG-38)

This clinical UM guideline addresses the use of pemetrexed disodium (Alimta, Eli Lilly & Company, Indianapolis, IN) in the treatment of oncologic conditions. Pemetrexed disodium is an antineoplastic agent that works as a folic acid antagonist by inhibiting folate-dependent metabolic processes which disrupts cell replication.

Effective May 1, 2016, HCPCs code J9305 will be subject to review of medical necessity criteria outlined in this clinical UM guideline.
Cardioverter-Defibrillators (SURG.00033)

This guideline addresses the use of implantable transvenous and subcutaneous cardioverter-defibrillator devices to monitor heart rhythm and deliver an electrical shock when a life threatening ventricular arrhythmia is detected.

Effective May 1, 2016, subcutaneous cardioverter-defibrillator (S-ICD) devices are considered medically necessary for the following at-risk individuals when the medically necessary criteria for implantable transvenous cardioverter-defibrillator (ICD) therapy have been met:

- Individuals with a lack of venous access; or
- Individuals who are immunocompromised; or
- Individuals with prosthetic valves; or
- Individuals with recurrent transvenous lead-related, device-pocket or systemic infections; or
- Individuals with endocarditis; or
- Pediatric individuals.

The CPT and HCPCS codes associated with this coverage guideline are 00534, 33202, 33203, 33216, 33217, 33230, 33231, 33240, 33249, 33270, 33271, C1721, C1722, C1777, C1882, C1895, C1896, and G0448.

Cervical Fusion (CG-SURG-42)

This clinical UM guideline addresses the clinical indications for anterior and posterior cervical fusion.

Effective May 1, 2016, CPT codes 22548, 22551, 22552, 22554, 22585, 22590, 22595, 22600, 22614 will be subject to review of medical necessity criteria.

Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities (CG-SURG-49)

This clinical UM guideline addresses the use of peripheral vascular angioplasty, with and without stenting, and with or without atherectomy, for the treatment of occlusive peripheral arterial disease (PAD) of the lower extremities.

Peripheral vascular angioplasty is considered medically necessary for the treatment of claudication and critical limb ischemia (CLI) when the medical necessity criteria are met.

The CPT codes associated with this clinical UM guideline are 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37233, 37234, 37235.
Knee Arthroscopy (CG-SURG-43)

This clinical UM guideline addresses knee arthroscopy surgery when done primarily for therapeutic intervention of confirmed pathology.

Effective May 1, 2016, CPT and HCPCs codes 29870, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29999, and G0289 will be subject to review of medical necessity criteria outlined in the clinical UM guideline.

Neutron Beam Radiotherapy (THER-RAD.00008)

Services addressed in this coverage guideline were previously reviewed under RAD.00047. It has been revised to consider neutron beam radiotherapy investigational for all indications.

The CPT codes associated with this coverage guideline are 77422 and 77423.

Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT) (THER-RAD.00011)

This new coverage guideline addresses image-guided radiation therapy (IGRT) when used in combination with conformal external beam radiation therapy (EBRT).

Image guidance for radiation therapy (IGRT) is considered medically necessary in conjunction with external beam radiation therapy (EBRT) when any of the following indications are met:

1. There is significant setup variation affecting the treatment target, for example:
   a. There is significant organ movement (for example, tumor moves due to respiration) and a 4D planning CT scan was performed with documentation demonstrating that the treatment plan addresses tumor motion that is both accounted for and managed; or
   b. Individual is morbidly-obese (body mass index [BMI] greater than 35) and receiving treatment of tumors in the mediastinum, abdomen or pelvis; or
2. Implanted fiducial markers have been placed; or
3. Bony anatomy fails to accurately delineate a tumor location and fiducial markers or intensity modulated radiation therapy (IMRT) are not indicated (for example, head and neck cancer); or
4. Use of IGRT will allow significant reduction of radiation dose to sensitive normal structures, for example:
   a. Individual is receiving left-sided breast cancer treatment with deep inspiration breath hold technique (DIBH); or
   b. Narrow planning margins are required to reduce treatment-related toxicity; or
5. The individual's treatment field abuts a previously irradiated area.
Image guidance for radiation therapy (IGRT), in conjunction with external beam radiation therapy (EBRT) is considered investigational when the medical necessity criteria is not met and for all other indications.

Effective May 1, 2016, CPT codes 77387, 77014, G6001, G6002, and G6017 will be subject to review of medical necessity criteria when billed in conjunction with external beam radiation therapy (EBRT).

Proton Beam Radiation Therapy (THER-RAD.00002)

This coverage guideline addresses different applications of proton beam radiation therapy (PBRT) in the treatment of benign and malignant tumors and arteriovenous malformation.

This coverage guideline has been revised to consider proton beam radiation therapy that does not meet the medical necessity criteria and for all other indications, including but not limited to, the treatment of localized prostate cancer to be investigational.

The CPT and HCPCS codes associated with this coverage guideline are 61796, 61797, 61798, 61799, 61800, 63620, 63621, 77432, 77435, 77520, 77522, 77523, 77525, S8030.

These coverage and clinical UM guidelines are available for review on our website at www.anthem.com beginning January 5, 2016.

REMINDER: Specialty pharmacy site-of-service reviews – Effective November 1, 2015

In November 2015, Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. implemented a new requirement:

- The setting for specialty pharmacy infusions will be reviewed for appropriate clinical setting beginning November 1, 2015.

While we provided advance notification about this change in our August and October editions of our Network Update, we included a reminder in the December edition of the Network Update. For your convenience and easy reference, we are also including a reminder here in this edition.

Anthem and 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 convenient for the member, results in lower member financial responsibility and, in many cases, is a clinically appropriate setting. For our members who require infusion therapy services, out-of-pocket expenses, the place of infusion service, safety, time and convenience are contributing factors that can impact health care quality, value and member satisfaction.

However, there may be other circumstances where a patient’s medical situation requires that he or she receive infusions in a hospital facility. Therefore, the setting for specialty pharmacy infusions will be reviewed for appropriate clinical setting. Since November 2015, Anthem and HealthKeepers, Inc. has reviewed the drug appropriateness for clinical indications and the site
of service using the clinical guideline CG-DRUG-47. During the review process, the nurse reviewer will provide other options if a setting is considered not medically necessary. More information follows below about CG-DRUG-47.

Our members count on their physicians to provide comprehensive information so the members can make informed decisions about their health care choices. Members may have questions about alternate settings in which they can receive their intravenous infusions and costs associated with other aspects of their intravenous infusion therapy. We encourage you to discuss with our members the options available to get their intravenous infusions safely and conveniently, at a lower, out-of-pocket cost.

**Level of Care: Specialty Pharmaceuticals (CG-DRUG-47)**

This new clinical UM guideline provides clinical criteria for use of outpatient infusion therapy service in the hospital outpatient department or hospital outpatient clinical level of care for intravenous (IV) infusion therapy.

An outpatient infusion therapy service in the hospital outpatient department or hospital outpatient clinic level of care for the use of an infused pharmacologic or biologic agent is considered **medically necessary** when all of the following are present:

1. The inherent complexity or risk of the infusion required by an individual is such that it can be performed safely and effectively only by or under the general supervision of skilled nursing personnel; **AND**

2. The individual’s medical status or therapy is such that it requires enhanced monitoring beyond that which would routinely be needed for infusion therapy; **AND**

3. The potential changes in the individual’s clinical condition are such that immediate access to specific services of a medical center/hospital setting, having emergency resuscitation equipment and personnel, and inpatient admission or intensive care is necessary, for example, the individual is at significant risk of sudden life-threatening changes in medical status based on clinical conditions including but not limited to:
   a. Concerns regarding fluid overload status, **or**
   b. History of anaphylaxis to prior infusion therapy with a related pharmacologic or biologic agent, **or**
   c. Acute mental status changes.

All other uses of outpatient infusion therapy services in the hospital outpatient department or hospital outpatient clinic level of care for the infusion of pharmacologic and biologic agents are considered **not medically necessary**.

*The services addressed in this coverage guideline 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, the Medicare-Medicaid Plan (Dual Integration product) and the Blue Cross Blue Shield Service Benefit Plan (also known as the Federal Employee Program or FEP) which will not be reviewed at this time with this guideline. A pre-determination can be requested for our Anthem PPO products.*
REMINDER: New precertification requirements for certain radiation therapy services begin March; Webinars available in February

In the December 2015 edition of the Network Update, we announced our plans to expand our Radiation Therapy Program. Effective March 1, 2016, Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. are expanding the Radiation Therapy Program to require precertification of:

- Image Guided Radiation Therapy (IGRT).

- Fractions (also referred to as units) for breast and bone metastases for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT). Clinical guideline CG-THER-RAD-01 will be implemented as criteria for medical necessity review.

Special treatment procedure and special physics consult (CPT® codes 77470 and 77370) (e.g., total body irradiation, hemibody radiation, or endocavitary irradiation and special medical radiation physics consultation). Clinical guideline CG-THER-RAD-02 will be implemented as criteria for medical necessity review.

AIM Specialty Health® (AIM®), a separate company, administers the Radiation Therapy Program on behalf of Anthem and HealthKeepers, Inc. A complete list of CPT codes requiring precertification is available on the Point of Care pre-authorization inquiry via the Availity Web Portal or the actual guidelines for the listing. Effective March 1, 2016, the newly added CPT codes under the expanded Radiation Therapy Program include:

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<tr>
<td>G6001</td>
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<td>G6003-6</td>
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<tr>
<td>77427</td>
<td>EBRT</td>
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<tr>
<td>77470</td>
<td>Special Treatment (e.g., total body irradiation,</td>
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<tr>
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<td>endocavitary irradiation)</td>
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hemibody radiation, per oral, or endocavitary (irradiation)

Special medical radiation physics consultation 77370

All Anthem local members who currently require precertification for non-emergency outpatient radiation therapy are included in this program. For Anthem in Virginia and HealthKeepers, Inc., these precertification requirements do not apply to the following:

- Blue Cross and Blue Shield Service Benefit Plan also known as the Federal Employee Program® (FEP).
- Medicare Advantage and Medicare Supplement plans.
- Department of Corrections.
- National Accounts.
- Anthem HealthKeepers Plus/FAMIS plans (Medicaid).
- Anthem HealthKeepers Medicare-Medicaid Plan or MMP. [Members are enrolled in both Medicare and Medicaid under the Commonwealth Coordinated Care Plan, also known as the Duals Demonstration (“Demonstration”) Program.]
- Members with Anthem as secondary coverage.
- Unicare and HealthLink.

Determine if precertification is needed for an Anthem or HealthKeepers, Inc. member by clicking the “Coverage & Clinical UM Guidelines, and Pre-Cert Requirements” link on anthem.com or by calling the precertification phone number printed on the member’s ID card.

Starting February 22, 2016, ordering physicians may submit a precertification request for these additional requirements to AIM through the AIM ProviderPortalSM (available 24/7 to process orders in real-time), through the Availity Web Portal or by calling the AIM call center toll free at 1-866-789-0158 (weekdays, 8 a.m. to 5 p.m. ET).

Note: Retrospective requests received more than two business days after the date of service will not be accepted by AIM for precertification review. Any post-service clinical review will be handled by Anthem or HealthKeepers, Inc. according to the terms of the applicable health benefit plan and/or provider agreement.

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through Anthem’s inpatient precertification process. Members currently undergoing treatment on March 1, 2016, will not be impacted by the new enhancements to this program. However, members starting treatment on or after March 1, 2016 must follow the enhanced Radiation Therapy Program precertification requirements noted above.
Webinars addressing radiation therapy program enhancements available in February

AIM will be hosting two webinars in February to provide additional information and clarification about the radiation therapy program enhancements. Attend one of the following webinars by phone or by clicking on the WebEx meeting link.

<table>
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<tr>
<th>Date and Time</th>
<th>How to Join the Webinars</th>
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| Friday, February 19, 2016; 12 p.m. ET | Join WebEx meeting  
Meeting number: 621 880 300  
Meeting password: Anthem  
Join by phone: 877-668-4490 or 408-792-6300  
Access code: 621 880 300 |
| Friday, February 26, 2016; 2 p.m. ET | Join WebEx meeting  
Meeting number: 629 387 251  
Meeting password: Anthem  
Join by phone: 877-668-4490 or 408-792-6300  
Access code: 629 387 251 |

Thank you for your collaboration and ongoing support of the Radiation Therapy Program. If you have further questions, please contact your local network manager or call the provider customer service area at the phone number on the member’s ID card.

Precision Medicine: Cancer Care Quality Program expansion supports NCI-MATCH

The Cancer Care Quality Program is expanding to include enhanced reimbursement for treatment planning and care coordination services provided by network providers for those eligible members who enroll in NCI-Molecular Analysis for Therapy Choice (NCI-MATCH), a National Cancer Institute clinical trial. NCI-MATCH seeks to determine whether treating cancers according to their molecular abnormalities will show evidence of effectiveness.

The Cancer Care Quality Program Precision Medicine expansion provides a unique opportunity to support the White House’s Precision Medicine Initiative through the National Cancer Institute to accelerate knowledge and learn as rapidly as possible which genes and therapies are clinically effective. It also supports your practice with enhanced reimbursement for treatment planning and care coordination services provided to those eligible members who enroll in NCI-MATCH.

Learn more

Visit our special website to learn more about the program:

- How to participate
- Member eligibility
Enhanced reimbursement

Frequently asked questions

Go to: www.CancerCareQualityProgram.com/PrecisionMedicine

AIM online precertification requests (for ordering and servicing providers) can be accessed via the Availity Web Portal

In 2015, AIM Specialty Health® (AIM) enhanced its Web portal experience to enable servicing providers (those free-standing or hospital facilities that perform imaging procedures) to initiate and complete diagnostic imaging requests through AIM. Previously, servicing providers could only initiate requests for review of diagnostic imaging exams by phone. As a reminder, servicing providers should continue to coordinate care with the member’s ordering provider.

AIM precertification requests (for ordering and servicing providers) can be accessed online 24 hours a day, seven days a week

Your office can save time, save money, and help eliminate hassles by requesting and obtaining precertifications online for radiology, cardiology, sleep, oncology, and specialty drugs. Information is available for both ordering and servicing providers.

Ordering and servicing providers may submit online precertification requests to AIM by either of the following options:

- Access AIM Provider Portal directly at www.providerportal.com, or
- Access AIM via the Availity Web Portal at www.availity.com

To submit a precertification request through Availity

If you have an Availity user ID and password, use the following steps:

- Log in to the Availity Web Portal at www.availity.com
- Enter your Availity user ID and password
- Click the Auths & Referrals link, from the left side navigation menu
- Then select AIM Specialty Health
- Click Continue to accept the AIM Specialty Health Internet Hyperlink Disclaimer, that you are leaving the Availity site and being routed to AIM
- Once routed to AIM, from the My Homepage screen, click Start Your Order Request Here
Complete requested information. If submitted information meets criteria, an authorization number will be issued.

Note: The user must have an active user ID on Point of Care (our Web-based provider tool) to access the AIM system through Availity. The Availity primary access administrator (PAA) must complete the Anthem Services Registration for each user to access AIM.

Business update

HEDIS® 2016 starts early February – Impacts PPO and Anthem HealthKeepers members

In February 2016, we will begin requesting medical records via a phone call to your office followed by a fax. These requests will impact members who are enrolled in our PPO and Anthem HealthKeepers health plans including plans purchased on or off the Health Insurance Marketplace (also known as the exchange).

This particular effort does NOT include medical record requests for members enrolled in Medicaid/FAMIS, Medicare Advantage or the Medicare-Medicaid Plan. As appropriate, you will receive separate notifications regarding medical record requests for our other lines of business such as Medicare Advantage or Medicaid.

The fax will contain:

1. A cover letter with contact information if you have any questions;
2. A member list, which includes the member and HEDIS measure(s) for which the member was selected;
3. An instruction sheet listing the details for each HEDIS measure.

As a reminder, under the Health Insurance Portability and Accountability Act (HIPAA), releasing protected health information (PHI) for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information are permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within five business days. Meeting this time frame will make your office eligible for a drawing to win a small prize, and the winners will be announced in the Network Update in the third quarter.
To return the medical record documentation back to us in the recommended five-day turnaround time, simply choose one of these options:

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

   **OR**

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

   **OR**

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

   Anthem, Inc., 10897 S. River Front Parkway, Suite 110H, South Jordan, UT  84095-9984

Thank you in advance for your support of HEDIS.

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

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**Incentive opportunity for physicians treating patients with ACA-compliant plans; ePASS® webinars available**

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. continue to work with Inovalon – an independent company that provides secure, clinical documentation services – to conduct outreach efforts regarding our Affordable Care Act (ACA) health plans (plans purchased on or off the Health Insurance Marketplace or the exchange). We have engaged Inovalon to help ensure that our members, who have purchased ACA-compliant plans, get their diagnoses confirmed, corrected, and updated every year, as well as have potential preventive care gaps addressed. To accomplish this goal, Anthem network providers – usually primary care physicians – may receive letters from Inovalon, asking you to perform patient outreach and assessments, followed by submission of a SOAP Note (also called Encounter Facilitation Form). SOAP Note stands for Subjective, Objective, Assessment, and Plan which is the standardized document format of a medical record.

If you receive a request from Inovalon, we understand that completing these SOAP Note requests may take time. We would like to offer contracted providers the opportunity to increase your reimbursement when seeing a member with an ACA plan. **As a reminder, you are eligible to receive $100 in addition to your office visit fee for each properly submitted electronic SOAP Note submitted through Inovalon’s ePASS tool.**

You may also elect to submit your patient assessment data for the members we request using the **paper SOAP Note option** via Inovalon’s secure fax line at 1-866-682-6680. For **each** paper SOAP Note properly submitted for patient assessments performed, you are eligible to receive **$50** in addition to your office visit fee.
Submitting a SOAP Note

**Paper:** You have the option to fax in a completed paper SOAP Note to Inovalon at 1-866-682-6680. To ensure that the paper SOAP Note is fully processed, all required fields must be completed and signed by the member’s physician.

**Electronically:** You may use ePASS (Electronic Patient Assessment Solution Suite), an electronic tool that retrieves information about your Anthem patients with ACA plans, including potential preventive care gaps, and drops this data into the SOAP Note to document your patients’ conditions. The ePASS tool may be used for members Inovalon identifies, and the members have purchased individual and small group ACA plans on and off the exchange. To utilize ePASS, please sign up online at the following Web address: [https://ePASS.inovalon.com](https://ePASS.inovalon.com)

Overview of the ePASS tool

If you receive a request from Inovalon to complete a SOAP note and you’re interested in an overview of the ePASS tool, please see below for various webinar dates. We encourage you to register in advance by sending an email to ePASSProviderRelations@Inovalon.com with your name, organization, contact information and date of the webinar you’d like.

This webinar provides a practical overview of how ePASS can be used to access a supplemental clinical profile and complete a compliant electronic encounter SOAP Note for patients Inovalon identifies on Anthem’s behalf. The webinar typically lasts 30 minutes with time for questions.

Tips for joining an ePASS tool overview webinar:

- First: Join by calling the toll-free number and enter the access code.
- Second: click on WebEx Link and enter meeting code.

**Upcoming ePASS webinar dates**

<table>
<thead>
<tr>
<th>Webinar date</th>
<th>Time</th>
<th>How to Join the ePASS Webinars</th>
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<tbody>
<tr>
<td>February 3, 2016</td>
<td>All sessions are scheduled for:</td>
<td>The following dial-in information and WebEx link/entry code are the same for all webinar dates scheduled in February and March 2016.</td>
</tr>
<tr>
<td>February 10, 2016</td>
<td>3 to 3:30 p.m. ET</td>
<td>Phone Number/Access Code: 1-888-850-4523</td>
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<tr>
<td>February 17, 2016</td>
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<td>Enter Access Code: 108607</td>
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<tr>
<td>February 24, 2016</td>
<td></td>
<td>WebEx Link/Meeting Code: <a href="https://inovalon.webex.com">https://inovalon.webex.com</a></td>
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<td>March 2, 2016</td>
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<td>Enter: 746707227</td>
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<td>March 9, 2016</td>
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<td>Note: Once you join the call, live support is available at any time by dialing *0.</td>
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<td>March 16, 2016</td>
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<td>March 30, 2016</td>
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For more information on the outreach process or the ePASS tool, please click HERE. Or, go to anthem.com>Providers (select Virginia)>Health Insurance Exchange> “Anthem engages Inovalon to conduct outreach efforts for our ACA individual and small group on and off exchange business – FAQs.” You may also contact Inovalon toll free at 1-877-448-8125.

Improving documentation of high blood pressure

Hypertension (HTN) is the most common condition seen in primary care practices and if managed well can reduce the burden of cardiovascular disease for a patient. The Eighth Joint National Committee (JNC 8) guideline on the management of adult hypertension was released in 2014. The new changes recommend physicians treat to 150/90 mmHg in patients over age 60 and 140/90 for everybody else, including those patients who have diabetes.

Each year, health plans collect data from provider records to look at patients with hypertension to see if their blood pressure (BP) is under control. The National Committee for Quality Assurance (NCQA) made changes to the 2015 Healthcare Effectiveness Data and Information Set (HEDIS®) Controlling High Blood Pressure (CBP) measure to align with the new JNC8 guidelines.

Improvements in documentation of the diagnosis and blood pressure can make a difference in whether CBP is considered compliant or not. The 2015 medical record review findings from provider offices that contributed to decreased scores included:

- No Diagnosis confirmed.
  Diagnosis must be noted in the chart on or before June 30 of the measurement year being reviewed.

- Diagnosis confirmed, but either no blood pressure was taken since diagnosis or no blood pressure was taken at all during the measurement year.

- Diagnosis listed as pre-hypertension.
  Pre-hypertension is not acceptable for confirming a diagnosis of HTN. Also, “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm diagnosis.

- Blood pressure documented as exactly 140/90.
  Blood pressure must be less than 140/90 mmHg unless your patient is 60 to 85 years of age and not a diabetic, in which case the blood pressure needs to be less than 150/90 mmHg.

- Blood pressure out of control.
  Many times, there are no follow-up visits in the chart or additional blood pressures are not taken the same day as an elevated blood pressure reading.
You can take the Journal of American Medical Association CME course to earn a maximum of 1 AMA PRA Category 1 Credit™ for the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JAMA. 2014;311(5):507-520).

You access the course and JNC8 guidelines at the following link:


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1 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, JAMA. 2014;311(5):507-520 Retrieved on 12/10/2015 from:


**Important information about providing services to out-of-state Medicaid members with plans administered by a Blue Cross and Blue Shield health plan**

Beginning **April 18, 2016**, Anthem Blue Cross and Blue Shield in Virginia will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims that are administered by a Blue Cross and Blue Shield health plan. Additional information may require the provider to enroll in the out-of-state member’s state Medicaid program, or provide missing Medicaid encounter data.

**Enrolling in an out-of-state Medicaid program**

At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Some state Medicaid programs require providers to enroll in the out-of-state member’s home state Medicaid program when services are performed for their members (Section 1902(kk)(7) of the Social Security Act, 42 CFR 455.410, and 42 CFR 455.440). If a provider submits a claim for an out-of-state Medicaid member with a plan that is administered by a Blue Cross and Blue Shield health plan, and provider enrollment is required, the provider will receive a remittance with a denial. Anthem will also send the provider a letter with information about how to enroll in the member’s state Medicaid program online. If the provider does not enroll in the member’s state Medicaid plan, the member may be held harmless.

Providers are encouraged to always verify member eligibility and benefits prior to performing services. This step will help determine if a member is enrolled in an out-of-state Medicaid program, and if provider enrollment is required. Whenever possible, the enrollment process should take place prior to submitting the claim to prevent delays in processing the claim. If the claim has been denied prior to enrollment, providers are advised to resubmit the claim for processing once enrollment is complete.
Medicaid encounter data

Encounter data includes records of health care services for which managed care organizations pay. In order to process a claim and apply appropriate benefits, providers are asked to submit all encounter data when billing for Medicaid services. The list below reflects fields that are needed and if not included can result in claim denial. The provider should submit the claim following the directions on the back of the member’s identification card.

If an out-of-state Medicaid claim is denied, Anthem will send a letter to indicate the encounter data needed. Upon return of this information, the claim will be reprocessed.

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<thead>
<tr>
<th>Professional Encounter Data</th>
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<tr>
<td>Actual ambulance mileage</td>
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<td>Billing provider address</td>
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<td>Billing provider middle initial</td>
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<td>Provider NPI</td>
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<th>Institutional Encounter Data</th>
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<tr>
<td>Actual ambulance mileage</td>
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<td>Attending physician number and attending physician number qualifier</td>
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<td>Condition code</td>
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<td>National drug code</td>
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<th>837 Field Name</th>
<th>Claim Type</th>
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<tr>
<td>Claim or line note text</td>
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<tr>
<td>Certification condition applies indicator and Condition indicator - early and periodic screening diagnosis and treatment (EPSDT)</td>
<td>Institutional and professional</td>
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<tr>
<td>Service facility name and location information</td>
<td>Institutional</td>
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<tr>
<td>Ambulance transport information</td>
<td>Professional</td>
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<tr>
<td>Ordering provider identifier and identification code qualifier</td>
<td>Professional</td>
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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 that are available to providers on our website. The guidelines, which are used for our quality programs, are based on reasonable medical evidence and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually and updated as needed. The current guidelines are available on our website. To access the guidelines, go to the "Provider" home page at anthem.com. From there, select “Provider” and Virginia> then Health & Wellness> Practice Guidelines.

Facility footnotes

Facility audit vendor partner name change

Connolly Healthcare, an Anthem facility audit vendor partner, has recently changed its name to Cotiviti Healthcare and is in the process of rebranding all of the company’s communications. Should you receive correspondence from Cotiviti Healthcare on behalf of Anthem, please accept this as a valid request. The rebranding is expected to be completed during the first quarter of 2016. You may still receive documentation from Connolly Healthcare until the process is complete.

FEP update

FEP benefit information for 2016 available online

To view the 2016 benefits and changes for the Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org >select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2016. For questions, please contact FEP Customer Service toll free at 800-552-6989.
Anthem to change frequency of remittance information on Point of Care for Federal Employee Program® business

The frequency of remittance vouchers/payments is changing for claims processed for members enrolled in the Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program or FEP. In the late second quarter of 2016, all FEP claims (for member ID numbers with the “R” prefix) will be removed from our regular Anthem weekly remittance and delivered on a new, separate FEP-only remittance with a daily distribution/ disbursement cycle.

Impact to providers receiving electronic 835 transactions

- Today, most Anthem medical providers receive multiple remittances delivered to their electronic mailboxes. For example, these are:
  - Our standard Anthem weekly remittance.
  - Our daily remittance for Affordable Care Act (ACA) compliant health plans that our members purchase on or off the Health Insurance Marketplace or the exchange.
  - Our daily remittance for Anthem HealthKeepers Plus (Medicaid) and the Medicare-Medicaid Plan or MMP (also known as the Duals Demonstration) business.

- The new FEP remittance will be added as another daily remittance. Dental providers will receive an additional remittance for FEP members as well.

- The daily FEP 835 remittance will be delivered to the same electronic mailbox as your weekly Anthem 835 remittance. The new FEP 835 remittance will have the GS02 value of ANTHEMFCS, as does our ACA/exchange daily remittances, instead of 058916206CMSCOS which is the value for our weekly remittance. Trading partners and providers should review that difference to determine possible impacts.

Impact to providers receiving paper remittances

- The paper remittance for FEP claims will have a different look from our standard Anthem remittance, as it will be formatted in a way to be consistent with our FEP business across our other Anthem plans nationally. The content will be similar to that of our other remittances; however, there will be some differences in the format of how information is displayed.

As a benefit of Anthem participation, contracting providers will be able to view the new FEP remittance through the “My Payer Portal” option on our online provider tool – Availity at availity.com. This will take providers with secure access to Point of Care on anthem.com. There, providers should select the “Daily Search” option under Reports, then Payment Vouchers – just as they do today when viewing all of their Anthem remittances.
Health care reform (including health insurance exchange)

Refer to anthem.com for information about health care reform and the exchange in 2016

With the new year under way, we want to share 2016 updated information regarding preventive care services covered with no member cost-share. Visit anthem.com for an update about this topic, as 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

Secure Web portal user profiles and HIPAA compliance reminder

As part of compliance with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and Anthem’s Information Security Policy, Point of Care users must NOT share User ID information on our secure site. Rather, please ensure that ALL individuals who access our secure portal have their own individual User ID for each system (Point of Care and Availity), registered under their names and with their own individual contact information.

In order to remain compliant with your contractual online, usage agreements, review your user lists at least quarterly to ensure all current employees have the access they need to use our secure Web portal and to disable the profiles of any individuals who are no longer employed. Please take a few moments to do this now.

Anthem to discontinue delivery of multiple “F” checks in the HIPAA 835 payment cycle – Impacts professional and institutional 835 transactions

Anthem will eliminate the use of the financial control (“F”) check number in the Health Insurance Portability and Accountability Act’s (HIPAA) electronic 835 (payment advice/remittance voucher) transaction. Rather, we will combine ALL claims – paid and zero* pay – into a single 835 file for each payment cycle. This single 835 file will contain one check number. The 835 will report all finalized claim activity for that weekly payment cycle. This notice impacts both professional and institutional 835 transactions.
**Change:** The HIPAA 835 transaction file can contain both paid and rejected claims under the assigned check number. This is consistent with what is reported on the provider voucher/explanation of payment or EOP.

In the event there is no monetary payment, the 835 associated with the non-paid claims reported under that 835 will be grouped in a single file.

*Effective December 19, 2015, when the HIPAA 835 transaction file has all zero pay claims, there will be no check/EFT number. The number mapped in TRN02 (check number field of the HIPAA 835 transaction) will be the voucher’s Financial Document Serial Number (FDSN).*

The FDSN begins with the letter ‘V’ followed by up to nine numeric characters – (Example: V123456789).

This number – minus the “V” – is located at the bottom right of the provider voucher/EOP under the page number.

There is no change to the provider voucher/EOP, or where the FDSN is located.

**Note:** Blue Exchange 835s will not be impacted by this change and will continue to produce single 835s for non-paid claims.

To view provider voucher examples, go to anthem.com/edi, select Virginia, click on the Communications tab then the EDI Latest News link.

*Zero or non-payment claims include rejected claims; claims where all money is being applied to the member’s cost share such as a deductible and/or copayment; statistical adjustments and those adjustments that result in a “$0” payment (prior payment being recouped); and any other instance where the claim payment is zero dollars.

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**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

(Anthem HealthKeepers Plus offered by HealthKeepers, Inc.)

IMRT codes require precertification

Effective March 1, 2016, two intensity modulated radiation therapy (IMRT) codes will require precertification. HealthKeepers, Inc. will require precertification for these IMRT codes for Anthem HealthKeepers Plus members:

- 77385: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386: Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex

Please use one of the following methods to request precertification:

- Phone: 1-800-901-0020
- Fax: 1-800-964-3627

For more information about prior authorization, visit http://www.anthem.com/vamedicaid and click on Precertification.

Custom molded orthotics require prior authorization

Effective March 1, 2016, HealthKeepers, Inc. will require prior authorization for custom molded orthotics for Anthem HealthKeepers Plus members. Custom molded orthotic requests must be reviewed by HealthKeepers, Inc. for dates of service on and after March 1, 2016. Please refer to the Precertification Lookup Tool at www.anthem.com/vamedicaid for detailed authorization requirements.
**Medicaid provider enrollment and encounter data**

Beginning **April 18, 2016**, HealthKeepers, Inc. will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims. Additional information may require the provider to “enroll” in the member’s out-of-state Medicaid program, or provide missing Medicaid encounter data.

If an Anthem HealthKeepers Plus provider sees a Medicaid patient from another state, and that state Medicaid program requires the provider to be enrolled, the Anthem HealthKeepers Plus provider must enroll in that state’s Medicaid program in order to be paid.

Read more about providing services to out-of-state Medicaid members in this edition of the Network Update on page 18 or click [HERE](#).

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**Medicare-Medicaid Plan update**

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

**Boniva requires prior authorization**

HealthKeepers, Inc. is adding Boniva to the list of injectables/infusibles requiring prior authorization when prescribed to members enrolled in the Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan. As of **March 1, 2016**, providers must receive prior authorization when prescribing these drugs to MMP members. Boniva (ibandronate) is used to treat osteoporosis (J1740). [Find out more about prior authorization and get necessary forms here](#).
Avoid diagnostic claims denials by completing item 20 (CMS-1500) correctly

The Centers for Medicare & Medicaid Services requires that providers billing for diagnostic tests subject to anti-markup payment limitation complete item 20 on the CMS-1500 claim form. A “yes” check indicates that an entity other than the billing entity performed the diagnostic test. A “no” check indicates “no anti-markup tests are included on the claim.” When checking “yes,” providers are required to complete item 32.

Claims for members enrolled in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, will be denied with denial Z01 “claim must be billed with provider’s NPI” if claims are received with item 20 checked “yes,” and there is incomplete or missing information in item 32. To prevent unnecessary claims denials, only complete item 20 when you are billing diagnostic tests subject to the anti-markup payment limitation.

HIPPS codes required for skilled nursing facilities and home health agency claims

All claims from Skilled Nursing Facilities (SNFs), not including custodial facility claims billed by a SNF, and Home Health Agencies (HHAs) received July 1, 2014, and after must contain a valid Health Insurance Prospective Payment System (HIPPS) code. Read the full article in the Medicare information section of this Network Update on page 29 or click HERE.

Medicare information

(Anthem’s Medicare Advantage and Medicare Supplement plans)

Anthem encourages care coordination for Medicare Advantage members with depression

Anthem encourages care coordination and continuity of care for members with a diagnosis of depression who have been admitted to a hospital. To enhance care coordination efforts, Anthem behavioral health case coordinators will ensure that care plans are sent to the hospital, the member, the members’ primary care physician and/or the members’ behavioral health provider upon notice of an inpatient admission.
Medicare Advantage webinars for all imaging providers: Learn how to complete the AIM OptiNet imaging services registration

Anthem is collecting information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of a number of outpatient diagnostic imaging services for our individual Medicare Advantage members.

AIM's online registration tool, OptiNet®, will collect modality-specific data from providers who render X-ray, ultrasound, Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

This data will be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. All participating providers who provide imaging services, including X-rays and ultrasounds as noted above, should complete the registration. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements. Previous communications incorrectly indicated that the OptiNet imaging services registration was not applicable to providers with delegated risk agreements.

Providers who score less than 76 or who do not complete the survey by second quarter 2016 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

Anthem strongly encourages any providers who score below 76 to improve their site score for the applicable modality before the line-item denial of claims for dates of service on or after second quarter 2016. Providers who have not registered and therefore have no score also will be subject to line-item denials for claims submitted for dates of service on or after second quarter 2016.

Attend one of the webinars below to learn how to:

- Access the OptiNet Assessment
- Copy previously completed OptiNet Assessments to your Anthem Medicare Advantage account
- Complete a new AIM OptiNet registration
- Interpret and improve your site score

Choose one of the sessions below to register for the webinar.

Thursday, February 4 from 2 p.m.-3 p.m. Eastern

Thursday, February 18 from 12 p.m.-1 p.m. Eastern

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.
Additional support available for individual Medicare Advantage members with rare conditions

Please note: The article below does not apply to providers with certain delegated risk agreements

Anthem will be working with Accordant Health Services – a company that provides care management solutions to help individuals with rare, chronic diseases get the care and support they need to improve their health via its “AccordantCare” service. On behalf of Anthem, AccordantCare will provide targeted disease management services for our individual Medicare Advantage members with rare medical conditions, including:

- Amyotrophic Lateral Sclerosis (ALS)
- Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- Crohn’s Disease
- Cystic Fibrosis
- Dermatomyositis
- Epilepsy
- Gaucher Disease
- Hemophilia
- Multiple Sclerosis (MS)
- Myasthenia Gravis
- Parkinson’s Disease
- Polymyositis
- Rheumatoid Arthritis
- Scleroderma
- Sickle Cell Disease
- Systemic Lupus Erythematosus
- Ulcerative Colitis
Members in your care who may benefit from additional outreach and information may receive letters, emails or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention.

If you feel that an individual Medicare Advantage member would benefit from this program, please have the member contact AccordantCare via phone or fax at 1-866-247-1150.

**HIPPS codes required for SNF and HHA claims**

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. CMS requires Anthem to include this information on all processed claims data that we submit, regardless of the payment methodology. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including Medicare-Medicaid Plans. This does not apply to Dual Special Needs Plans (D-SNPs) or Medicare Supplement plans.

**SNFs**

- SNFs should bill the HIPPS code derived from the “Admission 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 revenue code (0022), the HIPPS code, 1 or more units, billed charges of 0.00 or one cent.

**HHAs**

- HHAs should bill the HIPPS code derived from the date of assessment.
- Bill the first line with the applicable revenue code (0023), the HIPPS code, date of the first covered visit, one or more units, billed charges of 0.00 or one cent.
- 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 contracted rate but is required to process your claim for payment.
Help ensure Anthem members have accurate information about your practice

Please keep Anthem informed of any changes to street address, phone number, office hours or any other change that affects your availability to see existing Anthem Medicare Advantage members. In addition, Anthem also needs to know if you are accepting new patients or if you stop accepting new patients. This helps ensure that our Medicare Advantage members have accurate information about your practice when accessing our online provider finder tool.

Provider requirements and Medicare notices

The Centers for Medicare & Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two (2) days prior to the end of his or her skilled nursing, home health or comprehensive outpatient rehabilitation facility services, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires that providers deliver the Important Message from Medicare About Your Rights (IM) notice to every Medicare beneficiary within two calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than two calendar days before discharge.

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

For more information about compliance with the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Federal Clinical Compliance Department – phone: 317-287-0196, fax: 877-261-2134, email: carol.bossingham@anthem.com.

Check Important Medicare Advantage Updates at anthem.com/medicareprovider for additional information.

Attention SNFs, home health and long-term care providers: Contact OrthoNet for outpatient OT and PT precertifications

Anthem is collaborating with OrthoNet, LLC to conduct medical necessity reviews for outpatient physical therapy and occupational therapy for our individual Medicare Advantage members.

Effective April 1, 2016, OrthoNet will accept precertification requests for outpatient and home-based Occupational Therapy and Physical Therapy from Skilled Nursing Facilities (SNFs), home health providers and long-term care facilities (LTC). SNF
and LTC providers please note: Inpatient PT/OT services rendered as part of a Skilled Nursing level of care are excluded from this authorization process.

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.

Please review formulary changes to help members find best medication values

Each year, we evaluate our benefits and formulary and may make changes to update them. Formulary changes for 2016 include: tier changes, drug removals and new Prior Authorization and Quantity Limit requirements. Our members will need your help to ensure they get their medications at the most affordable cost.

Please, encourage your patients to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications that will meet their needs at a lower cost.

Current and previous year Medicare Advantage formularies for plans sold directly to individuals are published at www.anthem.com/medicareprovider. An overview of plan changes for 2016, including notable formulary changes, can be found at www.anthem.com/medicareprovider under Important Medicare Advantage Updates. See the 2016 Medicare Advantage Plan Changes for your state dated October 1, 2015.

Drug coverage provided to members of group-sponsored Medicare Advantage Plans and Part D Pharmacy Plans varies by employer or union. Patients who have group-sponsored Medicare Advantage or Part D Pharmacy coverage receive a new formulary booklet prior to the start of each calendar year that they can bring to their appointment with you.

Keep up with Medicare Advantage news

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

Medicare Advantage reimbursement policies

Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning June 1, 2016
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 anthem.com/pharmacy information. The drug list for our PAR, PPO and Anthem HealthKeepers lines of business is reviewed, and updates are posted to the website quarterly (the first of the month for January, April, July and October). To locate “Marketplace Select Formulary” (for Affordable Care Act health plans our members purchase on or off the Health Insurance Marketplace or the exchange) and pharmacy information, go to Customer Support, select Virginia, Download Forms and choose “Select Drug List.”

For State-sponsored Business [Anthem HealthKeepers Plus (Medicaid/FAMIS)], visit SSB Pharmacy Information. Website links for the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP) formulary Basic and Standard Options are Basic Option: https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and Standard Option: https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated quarterly.

FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies.
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 for 2016 WEBINAR if you wish to attend:

☐ Wednesday, April 13 (10:30 a.m.-11:30 a.m. ET) – Anthem Updates

PLEASE COMPLETE FORM AND FAX IT TO (804) 354-2979