Anthem BlueCross

Working together to improve the health of our members.

April 2015

Network Update

PROFESSIONAL

In this issue

Page

Health Care Reform Updates (Including Health Insurance Exchange)

- Preventive care services covered with no member cost-share (updated 2/12/15) 3
- Integrated care model for plans purchased on the health insurance marketplace benefits patients and physicians 3
- Important information available online 4

Announcements and General Updates

- Specialty pharmacy update 4
- Availity to launch new eligibility and benefits functionality 5
- Anthem Blue Cross 2015 Professional Manual 5
- Federal Employee Program® Medical Policy Manual 6
- Update to the Cancer Care Quality Program 6
- Quality and cost program to expand 6
- More ACO providers in Northern California 7

Billing

- Missing 1099 IRS form? 8
- Importance of reference numbers 8
- Coding tip: Adaptive behavioral health follow-up assessments 0360T – 0363T 8
- CalPERS health plan: EFT/ERA processing and check EOB/RA changes 9
- Access online remits on ProviderAccess via the Availity Web Portal 10
- ICD-10 updates: Free coding practice tool, end-to-end testing results 11
- Contracted provider claim escalation process 11

Network

- Provider webinars: April, May and June sessions 12
- Did your practice or provider information change? 13
- Sign-up for our *Network eUPDATE* today - it's free! 14
- Network leasing arrangements 14

Guidelines and Quality Programs

- HEDIS® 2015: Colorectal cancer screening 15
- Clinical practice and preventive health guidelines available on the web 15
- ConditionCare program benefits patients and physicians 16

Professional Network Update is produced bi-monthly by Anthem Blue Cross and comments may be addressed to:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91365

Editor: Lana Turner

E-mail: Prov.Communications@Wellpoint.com

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

anthem.com/ca

Network Relations:
855-238-0095

CANL (04/15)

In this issue Continued   Page

Medi-Cal Managed Care Updates

- Screening, brief intervention and referral to treatment provider trainings 17
- Smoking cessation program just got easier through Medi-Cal 17
- ClaimCheck versions 55 and 56 upgrades 18

Medicare Advantage Updates

- Anthem Blue Cross encourages Medicare Advantage members to stay up-to-date on preventive care 19
- ACIP updates pneumococcal vaccine policy 19
- ClaimCheck version 55 upgraded 20
- CMS weighs monitoring statin use among diabetics 20
- Precertification required on four new Part B injectables 21
- OrthoNet to conduct post-service prepay medical necessity reviews for select cardiac procedures 21
- Precertification requests and information available through Availity 22
- Find medical record information through Patient360 22
- Medicare Advantage reimbursement policy changes posted on anthem.com/medicareprovider 22
- Clinical practice guidelines assist with chronic condition management 23
- ICD-10-CM: Breathe easy with these coding tips for COPD 23

Pharmacy Updates

- Pharmacy information available on Anthem.com/ca 24

Health Care Reform Updates (including Health Insurance Exchange)

Preventive care services covered with no member cost-share (updated 2/12/15)

The Affordable Care Act (ACA) or health care reform law requires Anthem Blue Cross to cover certain preventive care services with no member cost-sharing (copayments, deductibles, or coinsurance). [1] Cost-sharing requirements may still apply to preventive care services received from out-of-network providers.

Click here for an overview of services, drugs, and pharmacy items covered by Anthem Blue Cross under preventive care benefits.
[1] Services listed may not be appropriate for all members, as some may be covered based on member age and health conditions(s). **These benefits may not apply to grandfathered health plans. Providers should continue to verify eligibility and benefits for all members prior to providing services or receiving member copayments, deductibles, or coinsurance.**

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost-share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. Members may have additional coverage under their health plan. Providers should verify eligibility and benefits for all members.

Integrated care model for plans purchased on the health insurance marketplace benefits patients and physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the exchange) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The integrated model utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Nurse Care Managers encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals. **Use the contact numbers below to contact Case Management**.

CM Telephone Number	CM Email Address	CM Business Hours
Phone: (888) 613-1130 Fax: (800) 947-4074	case.management@anthem.com	Monday - Friday 8:00 a.m. – 9:00 p.m. Saturday 9:00 a.m. – 5:30 p.m.

Important information available online

We invite you to go to our website to learn about the many ways health care reform and health insurance exchange may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance exchange, and all archived articles, go to anthem.com/ca, select the **Provider** link in the top center of the page, and click **Enter**. From the **Provider Home** page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Exchange Information.

Announcements and General Updates

Specialty pharmacy update

In order to reduce unexpected post-service claim denials, Anthem Blue Cross will be adding specialty pharmacy drug codes to the Specialty Pharmacy Prior Authorization list. The specialty pharmacy codes from new or current medical policies are being added to our existing pre-service review process are listed below.

Please note that these recommendations do not apply to Blue Card out-of-area, HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program® (FEP®), State Sponsored Business (SSB), or selected National accounts.

The changes listed below will become effective on July 15, 2015.

Medical Policy or Clinical Guideline	Drug Name	Drug Code
DRUG.00072	Alpha-1 Proteinase Inhibitor Therapy	Existing codes J0256 and J0257 (previously reviewed using CG-DRUG-01 Off-Label Drug and Approved Orphan Drug Use)
DRUG.00073	Rilonacept (Arcalyst®)	Existing code J2793 (previously reviewed using CG-DRUG-01 Off-Label Drug and Approved Orphan Drug Use)
DRUG.00074	Alemtuzumab (Lemtrada™)	No specific code for Lemtrada; J3490 and J3590 NOC - will be reviewed for medical necessity when specified as Lemtrada
CG-DRUG-42	Asparagine Specific Enzymes (Asparaginase)	J9019, J9020, J9266

Note: If the service is not prior authorized/pre-certified, records will be requested for post service review based on the same criteria listed in the medical policy or clinical guideline.

Availity to launch new eligibility and benefits functionality

Watch for upcoming changes in 2nd quarter 2015 to the Availity Web Portal, which includes the launch of new eligibility and benefits (E&B) functionality and features. These changes will make finding eligibility and benefits easier and faster for you. Below is 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. Plus only information relevant to that member is displayed.
Menu by benefit type	Located under the 'Coverage and Benefits' tab, this interactive list includes key coverage elements and only shows information that is returned from the payer.
Organization-wide view of E&B transactions	Users can see transactions by other users within their organization (shared history). This means less duplication of work.
Organization drop down menu	Users responsible for more than one organization can switch organizations while staying on the same page, resulting in a convenient and streamlined workflow.
Payer section	Includes value-added services on one page so that users can access multiple value-added services, such as patient care summary, from the same page.

Availity will offer training to learn more about these time-saving features. Details will be shared soon.

Anthem Blue Cross 2015 Professional Manual

We are pleased to announce the release of the *Anthem Blue Cross 2015 Professional Manual* [CD] mailed on March 20, 2015, and will become effective on **July 6, 2015.** This effective date allows a 90 day notification.

In this Manual, you will find important updates; including but not limited to, Misrouted Protected Health Information (PHI), Availity Web Portal (Availity)*, Data Performance, SB-866 Prior Authorization form, "Electronic Data Exchange, Continuity and Coordination of Care. Two new sections added are *Medicare Crossover* and *Health Insurance Marketplace (Exchanges).* Four new exhibits added are, *Advance Patient Notice Form*, *Coordination of Care Form*, *Cover Letter for Behavioral Health Practitioner* and *Cover Letter for Medical.*

> * **IMPORTANT NOTE***: Availity replaced ProviderAccess®'s eligibility and benefit and claim status inquiry functions. To register for an Availity account, log on to* **www.availity.com** *and get started. This registration is required for all Participating Providers using ProviderAccess.*

For a list of changes, refer to the "*Summary of Changes*" section within the Manual CD.

- How to use the CD or request additional copies, email **prov.communications@anthem.com** or fax to **(818) 234-8959**

This Manual is also available online through Anthem Blue Cross' ProviderAccess website for physicians, hospitals and health care professionals that provide services to Anthem Blue Cross Covered Individuals. ProviderAccess links you to financial reports and brings health information, medical policies and more, right to your computer. Go to **https://provider2.anthem.com/wps/portal/ebpmybcc** to login.

- ProviderAccess support - email **provideraccess.pins@anthem.com** or call **(866) 755-2680**.

Note: For providers who see members with Medi-Cal Managed Care, Medi-Cal Access Program, and the Major Risk Medical Insurance Program (MRMIP), the latest State Sponsored Programs Provider Manual is available online. You can always find the most up-to-date

version at **www.anthem.com/ca** > OTHER ANTHEM WEBSITES: Providers > Learn More: State Sponsored Plans > Provider Manuals and Important Updates.

Federal Employee Program® Medical Policy Manual

The Federal Employee Program Medical Policy Manual may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies. You can also find the FEP Medical Policy Manual on our provider website by clicking on Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements after entering the website.

Here providers can review specific medical policies that pertain to the Blue Cross and Blue Shield Service Benefit Plan, also known as FEP. The policies contained in the FEP Medical Policy Manual are developed to assist in administering plan benefits and do not constitute medical advice. They are not intended to replace or substitute for the independent medical judgment of a practitioner or other health care professional in the treatment of an individual member. The Blue Cross and Blue Shield Association does not intend by the FEP Medical Policy Manual, or by any particular medical policy, to recommend, advocate, encourage or discourage any particular medical technologies. Medical decisions relative to medical technologies are to be made strictly by members/patients in consultation with their health care providers. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that FEP covers (or pays for) this service or supply for a particular member.

Update to the Cancer Care Quality Program

Attention Oncologists, Hematologists and Urologists - As a reminder, Anthem Blue Cross launched the Cancer Care Quality Program ("Program"), a quality initiative, on **November 1, 2014**. The Program provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways ("Pathways"). Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.

To help ensure the Cancer Treatment Pathways remain consistent with current evidence and consensus guidelines, they will be reviewed quarterly or more frequently as needed. When it is necessary to make a change to existing Pathways where a specific Pathway treatment regimen moves from "on Pathway" to "off Pathway," Anthem Blue Cross will provide 30 days' notice of the change to physicians in Network Update, our online provider newsletter. After the effective date of the change, physicians will no longer be eligible to receive enhanced reimbursement for the S codes once the number of months specified in any previous notification and instructions issued to the physician by AIM via the AIM ***Provider***Portal or AIM Call Center has expired. Any new requests will need to be on Pathway to be eligible for enhanced reimbursement.

Quality and cost program to expand

Anthem Blue Cross previously has implemented an integrated management program to help members compare facility costs on imaging and sleep services. The program is administered in partnership with AIM.

On May 1 2015, this program will expand for some of your patients to include surgical procedures. Surgical procedures included in the expansion are:

- Colonoscopy- screening, biopsy, and lesion removal
- Endoscopy – Upper GI with Biopsy
- Arthroscopic ACL Repair
- Knee Arthroscopy with Cartilage Repair
- Shoulder Arthroscopy
- Shoulder Arthroscopy with Rotator Cuff Repair

Program components:

1. *Provider notification*
   You may contact AIM when your patient requires one of the surgical procedures listed above. Both ordering and servicing providers may contact AIM.
2. *Provider/patient transparency*
   Once AIM is notified, surgical facility cost information will be shared with you and your patient to help select a lower-cost option. This enhancement is available for fully-insured members. Cost information is based on Anthem's historical paid claims data for the various services in scope. This data is updated twice per year.

You may contact AIM in one of two ways:

- Online through ***Provider****Portal*SM at *www.aimspecialtyhealth.com/goweb*
- Via telephone at **(800) 554-0580** or by using the number displayed on the back of the member ID card

Claims will not be denied for failure to inform AIM. Members will not be denied access to services if they do not choose a lower-cost option. Our goal is simply to provide members with information to make informed choices about their health care.

Note: FEP® members are not included in this program. If you have any questions about this information, please contact your local Network Relations consultant.

More ACO providers in Northern California

We are pleased to announce that **Community Hospital of Monterey Peninsula** (CHOMP) has joined our Accountable Care Organization (ACO) network, effective April 1, 2015, to provide coordinated, evidenced-based care to members with multiple chronic conditions. Community Hospital of Monterey Peninsula with multiple locations serves members in the Monterey area.

They are joining the 18 other provider groups in our growing ACO network in California. These provider groups are part of a collaborative approach toward delivering personalized care called Enhanced Personal Health Care. This approach aims to improve the health of members primarily with chronic conditions. Members participating in Enhanced Personal Health Care will have access to a personalized health team, which includes a physician, a care coordinator and other health care practitioners as needed. It is available to a select number of PPO members at no extra cost.

Look forward to hearing more exciting news about Enhanced Personal Health Care in 2015.

Billing

Missing 1099 IRS Form?

Use the following link for information www.1099dept@anthem.com. Or call (888)-246-4893.

Importance of reference numbers

As part of our continued efforts to improve efficiencies in the Utilization Management process, we have identified an opportunity to expedite information received by fax.

Asking providers to include the *reference number* on fax cover sheets is one such opportunity. This will make it easier to match new information with previously received material. It will benefit the provider and member by providing timelier, cost-efficient communications.

What you need to do:

- Include the reference number on the fax coversheet on all future correspondence.
  - The reference number is provided on our fax communications or when a case is set up via phone.
- As a reminder, please do not include PHI on fax coversheets.

Coding tip: Adaptive behavioral follow-up assessments 0360T – 0363T

Based on 2015 CPT's description for CPT codes:

- 0360T-0361T (Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first and each additional 30 minutes of <u>technician time, face-to-face with the patient</u>) and
- 0362T-0363T (Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of <u>one or more technicians;</u> first and each additional 30 minutes of technician(s) time, face-to-face with the patient).

These services are to be reported based on the time that the patient is face-to-face with one or more technician(s) however <u>*only the time of one technician is counted and reported.*</u>

If the physician or other qualified health care professional personally performs the technician activities, his or her time engaged in these activities may be included as part of the required technician time to meet the elements of the code.

In addition, the Health Plan follows CPT's "Time-Rule for Face-to-Face Technician Time" guidelines that a unit of time is attained when the mid-point is passed and that the time reported is for a single day and is not cumulative over a longer period of time.

CalPERS health plan: EFT/ERA processing and check EOB/RA changes

The California State Controller's Office (SCO) processes payments issued for the CalPERS PPO Benefit Plans administered by Anthem Blue Cross. The SCO implemented changes in January, 2015 to claims payment and EOB processing for the CalPERS health plans. We wanted to take this opportunity to address some frequently asked questions:

Why did Anthem Blue Cross, CalPERS and the SCO make this change?

We wanted to provide the opportunity for EFT payments to providers currently signed up with Anthem Blue Cross. Previously, through our relationship with the SCO, they could only issue paper checks. In addition, one check was produced for each paid claim. This change will benefit the providers by combining multiple claims payments onto one single check. This was never available in the previous relationship. Finally, it allows the compliance with obligations in the Administrative Simplification rules. Providers wanting to register for EFT should use the **CAQH website** and complete the online registration.

I only get a summary from the SCO; how can I see the details?

The SCO issues a summary statement with each physical check. Anthem Blue Cross provides a detailed paper statement or electronic detailed statement, depending upon the provider's setup. The detailed paper statement will typically arrive a couple days after the physical check and summary statement.

Why is the process separate between summary statement and detailed advice?

In order to take advantage of simplification offered by Anthem Blue Cross, we had to separate the process. The SCO is still obligated to make provider payments on behalf of CalPERS members, but by separating the process, Anthem is able to deliver the detailed explanation through a Remittance Advice, Electronic Remittance Advice, provider portal, or Availity.

Can I now see my CalPERS payments on-line?

Yes, California participating providers can now view CalPERS Remittance Advice online. You can utilize your standard Anthem Blue Cross on-line protocols to view the detailed Remittance Advice on the provider portal at **https://provider2.anthem.com/wps/portal/ebpmybcc.**

We understand there have been challenges with locating Remittance Advices on our provider portal. You will now be able to search by check number or check amount.

What if I have further questions?

If you have questions related to the changes to CalPERS Health Plan claims payments and Remittance Advice, please contact our customer service at: **(877) 737-7776**. Providers wanting to register for EFT should use the **CAQH website** and complete the online registration.

Access online remits on ProviderAccess via the Availity Web Portal

Online remits are available to providers on our secure provider portal, ProviderAccess, via the Availity Web Portal. Your organization's Primary Access Administrator (PAA) is responsible for registering new Users and granting access to functionalities in Availity.

Following are step-by-step instructions that are required to gain access to online remits.

Adding a New User to ProviderAccess

The Account Administrator for ProviderAccess should follow the steps below to grant access to new Users.

1. Log in to ProviderAccess (or go directly to url: https://provider2.anthem.com/wps/portal/ebpmybcc)
2. Select the **Account Admin** tab
3. Select **Create User** and complete the required fields to obtain a new ProviderAccess User ID (aka "Health Plan User ID")

Anthem Services Registration - Linking the ProviderAccess User ID and the Availity User ID

Once a new User is granted access to ProviderAccess, the PAA must then register the new User's ProviderAccess User ID (aka "Health Plan User ID") by completing the following steps on Availity:

1. Log in to the Availity Web Portal at www.availity.com
2. Select **My Account**, from the left side navigation menu
3. Select **Anthem Services Registration**
4. Select **Non Registered Users**
5. Enter the ProviderAccess User ID into the **Health Plan User ID** field
6. Click **Register**

Please note, Users must log out of Availity and back in for new functions to take effect.

Accessing Online Remits

After a User is registered on Availity, the User can access online remits by following the steps below:

1. Log in to the Availity Web Portal
2. Select **My Payer Portals**, from the left side navigation menu
3. Select **Anthem Provider Portal**
4. Click **I agree** on the redirection page to be routed to the secure home page of **ProviderAccess**
5. Once routed to ProviderAccess, select the **Claims** tab
6. Select **Remittance Advice Inquiry**. You may select one of the following search criteria options:
   - Date range (Date Range must be no more than 7 days)
   - Check Number/EFT#
   - Paid Amount

Online Remit Inquiries are Available for the following Member Types:

- Local Plan members (including Health Insurance Marketplace/Affordable Care Act members)
- BlueCard (Out-of-Area) members
- Federal Employee Program® (FEP®) members - **Now Available**
- CalPers - **Now available** to search **by Check Number** and **Paid Amount**
- Online inquiry includes historical remittances (18 months after the issue date)

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

ICD-10 updates: Free coding practice tool, end-to-end testing results

Visit our ICD-10 Updates on **Anthem's ICD-10 webpage** for these resources, as well as our latest information on ICD-10.

- **Free Coding Practice Tool Available to Code Medical Scenarios in ICD-10:** Starting in April, we are offering a free scenario-based coding practice tool designed to give physicians and their coders the opportunity to test their knowledge of the ICD-10 codes set by applying it to medical scenarios. These customized scenarios are based on provider type and specialty, so you can practice using codes relevant to you. ***Registration is required.*** This tool will be available until September 2015.

- **End-to-End Testing Results:** In 2014, we conducted extensive end-to-end claims testing with facility providers, professional providers and clearinghouses. Visit our ICD-10 webpage to learn about the insights we gained during the testing. We've also included a list of clearinghouses we've successfully tested with.

Contracted provider claim escalation process

In an effort to better service our contracted providers right the first time, Anthem Blue Cross has improved our provider claim escalation process. Just click, Provider Claim Escalation Process to read, print, download and share the improved process with your office staff.

Our Network Relations Team is available by e-mail at CAContractSupport@anthem.com to answer questions you have about the process, if you need clarification.

Network

Provider webinars: April, May and June sessions

Join us at our 2015 second quarter webinars! Our Provider Network Education team offers quality educational programs and materials specially designed for the office staff of physicians, hospitals, medical groups, ancillary and other health care professionals. Our 'complimentary' education programs offer 'blended learning' via face-to-face and web-based learning opportunities exclusively for our contracted provider network.

For a complete schedule of our seminar, webinars, job aids, and on-demand e-courses, log on to the Anthem Blue Cross website: http://www.anthem.com/ca/home-providers.html. Scroll down to the **SPOTLIGHT** section and click on the 2015 Provider Education Seminars and Webinars link.

Webinars - offer a "live" interactive, 60 minute session conducted remotely via the internet and facilitated by the Provider Network Education team and Subject Matter Experts. **Registration opens March 23rd**.
Here is a schedule of the topics and dates:

Time: 2:00pm – 3:00pm [PST]
"Complimentary"

DATES	TOPIC	AGENDA	WHO SHOULD ATTEND
April 8 May 6 June 3	BlueCard [Out-of-Area] Refresher	• How to verify out-of-area eligibility and benefits • Ancillary Claim Filing • Electronic Provider Access (EPA) • The BlueCard Program Provider Manual	All Contracted Providers and billing staff.
April 15 May 13 June 10	Facility Manual Overview	• What the Provider Manual is • Which Provider Manual to use • Where the Facility Manual is located • Facility Manual navigation • Facility Manual "critical content" sections • How to use the Facility Manual "search" tool.	All Contracted Facility and Institutional Providers and in-take/billing staff that bill on a UB-04 claim form.
April 22 May 20 June 24	Behavioral Health Provider Resources – Online Access	• Learn the Behavioral Health Provider Resources Web page on anthem.com/ca • Navigate the Web page to find what you need for Behavioral Health services – Availity Web Portal, forms, guidelines, EOB, and more. • Use all Behavioral Health Provider business and service tools on anthem.com/ca	All Contracted Behavioral Health Providers and Staff.

QUESTIONS: phone: **(818) 234-1016** or email at: network.education@anthem.com

Did your practice or provider information change?

As you know it is critical that your patients/our members receive accurate and current data related to provider availability. As outlined in your contract with Anthem Blue Cross, please be sure to notify us on a regular basis (within 10 business days of the change is requested) of all changes listed below. **Please note tax ID changes must be accompanied by a W-9 to be valid.**

- Telephone number for members to schedule appointments at your practice location
- Provider location address
- Provider Office Hours
- Provider name
- Practice affiliation changes (i.e. provider joined another group)
- Providers leaving, retiring or joining your practice
- Billing address
- Tax ID number
- Specialties
- Hospital privileges
- Accepting new patients
- Handicapped Accessibility
- Languages offered

Please send us this information timely, preferably **within 10 business days**, in one of the following ways:

- **Online form**: Go to www.anthem.com/ca and select "Provider", then click on "Enter" and choose Answers@Anthem. Under "Tools and Resources" click on Provider Forms.
- **E-Mail Address**: ProviderDatabaseAnth@anthem.com
- **Fax Number**: **(818) 234-2836** or **(866) 243-3183**
- **Address**: Anthem Blue Cross, P.O. Box 70000, Van Nuys, CA 91470

Sign-up now for our *Network eUPDATE* today – it's free!

In with Anthem Blue Cross and staying informed will be even easier, faster and more convenient than ever before with our *Network eUPDATEs*.

Network eUPDATE is our web tool for sharing vital information with you. It features short topic summaries and links that let you dig deeper into timely critical business information:

- Important website updates
- System changes
- Fee Schedules
- Medical policy updates
- Claims and billing updates

……and much more

Registration is fast and easy. There is no limit to the number of subscribers who can register for *Network eUPDATEs*, so you can submit as many e-mail addresses as you like.

Network leasing arrangements

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call *Other Payors*. Other payors and affiliates use the Anthem Blue Cross network.

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem Blue Cross members. As such, they're entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payors* list on ProviderAccess®, which can be accessed through the Anthem Blue Cross website at www.anthem.com/ca. If you don't have internet access, please contact us at **(855) 238-0095** for assistance.

Guidelines and Quality Programs

HEDIS® 2015: Colorectal cancer screening

One of the HEDIS measures we are collecting this year is **Colorectal Cancer Screening**. This measure is collected to ensure that our members between the ages of 50 and 75 have been screened appropriately for colorectal cancer. The following items are needed from the member's medical record:

1. Documentation must indicate the date that the member had one of the following screenings:
   - **Colonoscopy** – Completed within the last 10 years (1/1/05- 12/31/14)
   - **Flexible Sigmoidoscopy** - Completed within the last 5 years (1/1/10 – 12/31/2014)
   - **Fecal Occult Blood Test (FOBT)** – Completed in 2014
   - There are two types of FOBT tests: guaiac (gFOBT) and immunochemical (iFOBT). Depending on the type of FOBT test, a certain number of samples are required.

   A result is **NOT** required if the documentation is clearly part of the "Medical History" section of the record. If this is not clear, the result or finding must also be present to ensure that the screening was performed and not merely ordered.

2. To exclude a member from the measure, please provide documentation of one of the following at any time through December 31, 2014:
   - History of colorectal cancer
   - History of total colectomy

Documentation of a digital rectal examination does not count as evidence of a colorectal cancer screening because it is not specific or comprehensive enough to screen for colorectal cancer.

Often colorectal screenings are not documented in health histories, but are typically included on Health History Forms. Please be sure to include these forms when completing HEDIS requests.

Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures.

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

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

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 www.anthem.com/ca, select > Provider > Enter > Home Page and then Health & Wellness>Practice Guidelines.

ConditionCare program benefits patients and physicians

Anthem Blue Cross members have additional resources available to help them better manage chronic conditions. The ConditionCare program is designed to help participants' improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

Engagement methods vary by risk level but can include:

- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Coaches and other health professionals.

Physician benefits:

- **Save time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient's progress in the program.

The goal of our nurse coaches is to encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Please visit the Anthem Blue Cross website to find more information about the program such as program guidelines, educational materials and other resources. Go to www.anthem.com/ca > Providers > Enter > Health and Wellness > ConditionCare**.** Also on our website is the **Patient Referral Form**, which you can use to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call **(877) 681-6694**. Our nurses are available Monday-Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 5:30 p.m.

Please note that we also have a care management program specifically for members with health plans purchased on the Health Insurance Marketplace (also called the exchange). More information is available in the article entitled "**Integrated Care Model for plans purchased on the Health Insurance Marketplace Benefits Patients and Physicians".**

Medi-Cal Managed Care Updates

Screening, brief intervention and referral to treatment provider trainings

Effective **January 1, 2015**, Anthem Blue Cross began offering the Screening, Brief Intervention and Referral to Treatment (SBIRT) benefit to Medi-Cal beneficiaries. This benefit aligns with the U.S. Preventive Services Task Force recommendation and is offered annually to all Medi-Cal beneficiaries 18 years and older in primary care settings. In accordance with the Bright Futures/American Academy of Pediatrics recommendation, adolescent Medi-Cal beneficiaries, ages 11 to 17, are to be given an alcohol and drug use assessment annually in primary care settings using the CRAFFT screening tool.

The four-hour SBIRT training sessions are approved by the California Department of Health Care Services (DHCS) and fulfill the four-hour SBIRT training requirement noted in the Provider Manual and All Plan Letter dated **February 10, 2014** (APL 14-004). Continuing education credits/contact hours (CMEs and CE) equaling 4.0 units will be awarded upon completion of the course. No partial credit will be awarded.

Training sessions should be attended by:

- Physicians
- Nurse Practitioners
- Physician Assistants
- Registered Nurses
- Psychologists
- MFTs and LCSWs
- Medical Assistants
- Certified Substance Disorder Treatment Counselors
- Other Behavioral Health Specialists/Clinicians

The training sessions are co-sponsored by the: California Department of Health Care Services (DHCS), California HealthCare Foundation (CHCF), Pacific Southwest Addiction Technology Transfer Center, UCLA Integrated Substance Abuse Programs, and Harbage Consulting. To view the most current training list, visit **www.uclaisap.org/sbirt**. This calendar is updated regularly as new training opportunities are scheduled. Preregistration is required and online registration. For more information, please visit the DHCS SBIRT webpage.

Smoking cessation program just got easier through Medi-Cal!

For a limited time, through December 2015 or while supplies last, the Medi-Cal Incentives to Quit Smoking (MIQS) project is offering additional incentives to eligible Medi-Cal members, age 18 and older, who want to quit smoking or other tobacco, such as snuff and chewing tobacco. These incentives include **free nicotine patches and a $20 gift card bonus** for Medi-Cal members who call the California Smokers' Helpline at **(800)-NO-BUTTS** and enroll in telephonic counseling. The nicotine patches and the gift card are mailed directly to the member's home.

For more information and to get tobacco cessation materials for your office at no cost, visit **www.nobutts.org**.

ClaimCheck versions 55 and 56 upgrades

Anthem Blue Cross will complete two upgrades to ClaimCheck® 10.1, a nationally recognized code auditing system. The changes included in the Version 55 upgrade will become effective **July 2015.** The changes included in the Version 56 upgrade will be effective in **August 2015.**

Background information

Anthem Blue Cross uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes, and processes those services according to industry standards.

Why is this change necessary?

ClaimCheck is updated periodically to conform to changes in coding standards and includes new procedure and diagnosis codes.

Anthem Blue Cross uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Procedures billed with inappropriate modifiers

What if I need help?

If you have questions about the ClaimCheck upgrades, contact Provider Services at **(855) 817-5786**.

Medicare Advantage Updates

Anthem Blue Cross encourages Medicare Advantage members to stay up-to-date on preventive care

Anthem Blue Cross is committed to helping your Medicare Advantage patients maintain good health habits and stay up-to-date on preventive screenings. We encourage you to check in with your senior patients about the following issues to help ensure they are monitoring their own health and receiving needed care.

Physical Health/Monitor Physical Activity

- Discuss and encourage the importance and benefits of exercise
- Discuss applicable exercise options
- Discuss any problems/pain members are having with accomplishing daily activities

Mental Health

- Discuss overall mental health and if physical and emotional health is affected
- Discuss feelings of anxiety, blues, depression
- Discuss members' overall energy level

Bladder Control

- Assess whether the member has had any leaking of urine
- Advise the member of bladder treatment options such as bladder training, exercises, medication and surgery

Breast Cancer Screening

- Women 50-74 need to have a mammogram at least every 24 months

ACIP updates pneumococcal vaccine policy

Anthem Blue Cross would like to make you aware that the Advisory Committee on Immunization Practices (ACIP) has changed its policy regarding pneumococcal vaccines for persons over the age of 65.

Effective September 19, 2014, Anthem Blue Cross covers:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and

- A different, second pneumococcal vaccine one year after the first vaccine was administered (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

ClaimCheck version 55 upgraded

Effective April 1, 2015, ClaimCheck upgraded to version 55 of ClaimCheck® 10.1 a nationally recognized code auditing system.

Anthem Blue Cross uses the auditing software product from McKesson to reinforce compliance with standard code edits and rules. Additionally, ClaimCheck increases consistency of payment to providers by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, ClaimCheck determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to industry standards. ClaimCheck is updated periodically to conform to changes in coding standards and include new procedure and diagnosis codes.

Anthem Blue Cross uses ClaimCheck to analyze outpatient services, including those that are considered:

- Rebundled or unbundled services
- Multichannel services
- Mutually exclusive services
- Incidental procedures
- Inappropriately billed medical visits
- Diagnosis to procedure mismatch
- Upcoded services
- Fragmented billing of pre- and postoperative care

Other procedures and categories reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/sex mismatch procedures
- Investigational or experimental procedures
- Procedures billed with inappropriate modifiers

The information above is applicable to claims for individual Medicare Advantage members only. It is not applicable to group-sponsored Medicare Advantage claims.

CMS weighs monitoring statin use among diabetics

Endocrinologists and primary care providers (PCPs) please note: In November of 2013 the ACC/AHA released new guidelines for the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults. One major focus in this recommendation is reducing the risk of atherosclerotic cardiovascular disease (ASCVD) in persons with diabetes who are 40-75 years of age. According to the ACC/AHA guideline, "Moderate-intensity statin therapy should be initiated or continued for adults 40-75 years of age with diabetes mellitus," and "High-intensity statin therapy is reasonable for adults 40-75 years of age with diabetes mellitus with a ≥7.5% estimated 10-year ASCVD risk unless contraindicated." *

To align practice standards, the Pharmacy Quality Alliance (PQA) has developed a measure to support the ACC/AHA guidelines. The measure is labeled "Statin Use in Persons with Diabetes," and calculates the percentage of patients ages 40-75 years who received a medication for diabetes that also receive a statin medication during the measurement period. The Center for Medicare and Medicaid Services (CMS) is closely following this measure and is evaluating the addition of this measure as **a future Medicare Part D health plan rating**.

Please consider initiating statin therapy in patients who fit these criteria in conjunction with the recommendations from 2013 ACC/AHA Guidelines for the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. The 2013 ACC/AHA Guidelines for the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults can be found at: http://circ.ahajournals.org/content/129/25_suppl_2/S1 .

*Formulary moderate-intensity statin therapies include **atorvastatin** 10-20 mg, **Crestor** 5-10 mg, **simvastatin** 20-40 mg, **pravastatin** 40-80 mg, **lovastatin** 40 mg; while formulary high-intensity statins include **atorvastatin** 40-80 mg and **Crestor** 20-40 mg. **Simvastatin** currently costs our members $0 to $5 (varies by plan) for a 30-day fill at a preferred pharmacy. This would be the least expensive option for them.

Precertification required on four new Part B injectables

Anthem Blue Cross is adding the following four new injectable drugs to the 2015 Medicare Advantage list of Part B Injectables/Infusibles requiring precertification. **As of March 1, 2015, providers must call for prior authorization of these drugs.**

1. Benlysta (belimumab) for treatment of lupus (SLE) (J0490)
   Drugs billed with NOC HCPCS J code (J3490)

2. Iluvien (fluocinolone acetonide injection): for treatment of diabetic macular edema (DME) (unlisted, no J code established at this time)

3. Lemtrada (alemtuzumab injection): for treatment of relapsing forms of multiple sclerosis (MS) (unlisted, no J code established at this time)

4. Opdivo (nivolumab) for treatment of unresectable or metastatic melanoma (unlisted, no J code established at this time)

Please note for drugs currently billed under the Not Otherwise Classified J code (J3490), the plan's denial will be for the drug, and not the HCPCS. This applies to all Medicare Advantage Group Sponsored and Individual Medicare Advantage plans.

To contact the plan for prior authorization of these services, please use one of the three options:

- Phone - (866) 797-9884 (option 5)
- Fax - (866) 959-1537
- Email - maspecialtypharm@anthem.com.

51763WPSENABC 02/09/15

OrthoNet to conduct post-service prepay medical necessity reviews for select cardiac procedures

Appropriate care is the key to achieving the best outcomes for our Medicare Advantage members. To help reach that goal Anthem Blue Cross is collaborating with OrthoNet to help ensure that invasive cardiac procedures are reasonable and necessary for the diagnosis and/or treatment of coronary artery disease.

Effective April 1, 2015, Anthem Blue Cross is contracted with OrthoNet to conduct post-service prepay medical necessity reviews of selected cardiac procedures, including reviews of facility and professional Cardiac Catheterizations and Percutaneous Coronary Interventions (PCIs). These reviews will apply to individual Anthem Medicare Advantage members.

Providers who submit claims for these services for individual Anthem Blue Cross Medicare Advantage members after the effective date may receive a request for records and related digital images. The process for submitting records and related images will be streamlined by providing you with a HIPAA-compliant, secure internet portal for uploading the needed information. Instructions for completing this process will be included with the request.

A board-certified cardiologist will review the records and images to determine if the services were reasonable and necessary to diagnose and/or treat the patient. Should you receive a medical record request, Anthem Blue Cross would appreciate your timely compliance.

OrthoNet will use Medicare national coverage determinations, local coverage determinations, Anthem Blue Cross' medical policies, and clinical utilization management guidelines to determine medical necessity of the requested therapies. You may access these coverage

determinations, medical policies and clinical guidelines here.

If you have questions about this communication or need assistance with any other item, contact OrthoNet:

Phone: 844-278-5477
Fax: 844-876-4924

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

Y0071_15_23430_I 02/04/2015

Precertification requests and information available through Availity

Precertifications for Anthem Blue Cross individual Medicare Advantage members can be initiated via the Availity web portal at www.Availty.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.

Find medical record information through Patient360

Patient360 is a read-only dashboard available through our secure provider portal that gives you instant access to detailed individual Medicare Advantage member information. By clicking on each tab in the dashboard, you can drill down to specific items in a patient's medical record:

- Demographic information – member eligibility, other health insurance, assigned PCP and assigned case managers
- Care summaries – emergency department visit history, lab results, immunization history, and due or overdue preventive care screenings
- Claims details – status, assigned diagnoses and services rendered
- Authorization details – status, assigned diagnoses and assigned services
- Pharmacy information – prescription history, prescriber, pharmacy and quantity
- Care management-related activities – assessment, care plans and care goals

Medicare Advantage reimbursement policy changes posted on anthem.com/medicareprovider

Anthem Blue Cross Medicare Advantage published Medicare Advantage Reimbursement Policy Changes in your October 2014 provider newsletter and posted the information under Important Medicare Advantage Updates in August 2014. Anthem Blue Cross has updated and expanded this initial communication to help address any questions you may have. To view this communication, please click here.

Medicare Advantage information is located at www.anthem.com/medicareprovider. For Anthem Blue Cross Medicare Advantage reimbursement policy updates, please visit our website and select 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 Blue Cross Medicare Advantage business unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

Clinical practice guidelines assist with chronic condition management

Clinical Practice Guidelines (CPGs) are resources to assist providers and members in the management of chronic medical conditions. They are reviewed by board-certified practitioners and distributed to network providers to reduce unnecessary variation in care. Anthem Blue Cross CPGs are located on the provider website under the Health &Wellness tab.

ICD-10-CM: Breathe easy with these coding tips for COPD

In ICD-9, COPD code 496 is not to be used with any code from categories 491 (chronic bronchitis), 492 (emphysema), or 493 (asthma). In ICD-10, code category J44 encompasses asthma and bronchitis associated with COPD. Code category J44 includes other COPD, asthma with COPD, chronic asthmatic (obstructive) bronchitis, chronic bronchitis with airways obstruction, chronic bronchitis with emphysema, chronic emphysematous bronchitis, chronic obstructive asthma, chronic obstructive bronchitis and chronic obstructive tracheobronchitis. Furthermore, in ICD-10 there is a note to use an additional code to identify exposure to environmental tobacco smoke (Z77.22), history of tobacco use (Z87.891), occupational exposure to environmental tobacco smoke (Z57.31), tobacco dependence (F17.-), or tobacco use (Z72.0).

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

ICD-9 (COPD documented with a more specific respiratory Condition fell under multiple code categories)	**ICD-10** (COPD documented with a more specific respiratory condition falls under one code category)
• 491.2-, Obstructive chronic bronchitis • 493.2-, Chronic obstructive asthma • 496, COPD	• J44.-, Other chronic obstructive pulmonary disease - Code also type of asthma, if applicable (J45.-)

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

As a reminder, claims/encounters with dates of service October 1, 2015 and later must be submitted with ICD-10 codes. CMS will reject those submitted with ICD-9 codes resulting in delay or denial of payment. We must all be prepared to meet CMS guidelines.

Y0071_15_23499_I 02/12/2015

Pharmacy

Pharmacy information available on anthem.com/ca

Visit http://www.anthem.com/pharmacyinformation 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 certain drugs. The commercial drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate the "Marketplace Select Formulary" and pharmacy information for Health Plans offered on the Exchange Marketplace, go to Customer Support, select your state, Download Forms and choose "Select Drug List".