

# Network Update

CENTRAL REGION

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*Network Update* is produced bi-monthly by Anthem Blue Cross and Blue Shield's Marketing Communications Department.

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IN, KY, MO, OH, WI

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## Health Care Reform (including Health Insurance Exchange)

### Anthem to discontinue mailing paper remittances to all ERA registered providers beginning October 1, 2015

Anthem began notifications to providers about HIPAA Administrative Simplification requirements to discontinue the mailing of paper remittances for providers registered for electronic remittance advices (ERA) in May 2014. **In support of these requirements, Anthem will discontinue the mailing of paper remits to all providers currently registered for ERA beginning October 1, 2015.** As previously communicated, in-network providers can continue to conveniently access copies of paper remits online via the [Availity Web Portal](#). **If you are an ERA registered provider, please ensure you have completed the steps to access copies of your paper remits online via Availity immediately.** Read instructions to access your remits online via Availity [here](#).

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

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

## New Ohio HMO exchange networks

### Notice of Other or Separate Provider Networks, or Programs and Provider Panels for Ohio HMO Exchange Networks

This is to inform you that effective January 1, 2016, Anthem will be offering new HMO products in the Health Insurance Exchange marketplace. As a result, Anthem will be developing additional HMO networks to support these products. Initially, these products will have very limited distribution in Ohio, and will not be marketed in all Ohio counties so participation will not be offered to all providers.

Pursuant to your Agreement with Anthem for Provisions related to Other or Separate Provider Networks, or Programs and Provider Panels - you will be considered Out of Network for these HMO networks if Anthem does not amend your Agreement and contract with you for the new HMO Exchange participation. This communication does *not* affect your current participation in any other Anthem network for which you currently participate.

In most cases, members do **not** have Out of Network benefits for HMO products. In the case where Out of Network benefits do exist, Ohio providers participating in Anthem's managed care networks will generally be reimbursed at an Out of Network rate that is equivalent to the Blue Preferred Primary rate; and those Ohio providers participating only in Anthem's Traditional program will be reimbursed at the Traditional rate for Out of Network services rendered.

To ensure the highest level of benefits and coordination of care for Anthem members and to streamline the approval process for your office, it's important that you identify the appropriate member plan and refer members to In-Network providers whenever possible. When you do, you will not need to contact the Plan/Anthem for preapproval of those referrals unless the referral is for a service identified on the Blue Products Precertification List.

Thank you for your continued support of our Anthem customers.

## Updates and Notifications

### Health Care Reform Updates and Notifications

Please check our website regularly for new updates on health care reform at [www.anthem.com](http://www.anthem.com)>Providers (select state)>Health Care Reform/Health Insurance Exchange.

### Health Insurance Exchange

Please check this section of our website for updates on the networks that support Health Exchange products, how the Health Exchange works, who is affected, Plan names, how to identify members covered by a Health Exchange plan and much more.

- Missouri providers: Click [here](#) to see new articles recently posted on your state's page.

# Administrative Update

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

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

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

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

- To assist with our ongoing medical chart review program for members enrolled in our exchange plans, Anthem is again collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon's Web-based workflows help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. Anthem is working with Inovalon in retrieving and reviewing our members' medical records.
- Inovalon is using the following methods of collecting medical record information:
- Scanned or faxed medical records that providers' offices send to Inovalon
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider's EHR system

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

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

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

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

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. **When members visit your practice or office, we encourage you to**

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document ALL of the members' health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.

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

#### Reminder about ICD-9 CM coding

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

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

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.
- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider's overall management or treatment of that patient in the remaining positions.
- Always assign the ICD-9 code to the highest level of specificity, using four- or five-position codes as appropriate.

#### Reminder about completing SOAP Notes

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

Here are some tips for completing SOAP Notes that we hope you find helpful:

- The exam date for the patient must match the exam date on the completed SOAP Note.
- A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note.
- The provider signature date should be the actual date the SOAP Note is signed.
- All "mandatory" fields on the paper SOAP Note must be completed.
- The exam date must occur between January 1, 2015, and December 31, 2015, for this benefit year.
- All "mandatory" fields on the paper SOAP Note must be completed properly and accurately.

If you're interested in an overview of the ePASS tool, please see below. Click on the date/time link to join!

\*\*Upcoming webinars take place on Wednesdays – 6/10, 6/17, and 6/24 -- at 11 am ET and 3 pm ET.\*\*

\*\* 11 am: Click this link --

<https://webexmeeting.apps.inovalon.com/online/joinmeeting.do?MK=998708876>

Dial in -- 855-571-6759 (Toll-Free), Access Code: 998 708 876

\*\* 3 pm: Click this link --

<https://webexmeeting.apps.inovalon.com/online/joinmeeting.do?MK=991705416>

Dial in -- 855-571-6759 (Toll-Free), Access Code: 991 705 416

Note: Register by email at: [ePASSProviderRelations@Inovalon.com](mailto:ePASSProviderRelations@Inovalon.com)

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For additional information about SOAP notes, the medical record review process or the outreach effort, please refer to the frequently asked questions document [here](#), also available online at [www.anthem.com](http://www.anthem.com)>[Providers](#) (select state)>Health Exchange Information.

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

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

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

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

If you have questions about the Inovalon effort and this ongoing outreach effort, we've compiled a list of questions and responses for your reference [here](#).

## Provider manuals posted online

Anthem reviews and updates our online Provider Manuals annually. New versions of the Indiana, Missouri, Ohio and Wisconsin Provider Manuals are available online now; Kentucky's Provider Manual will be available online soon. To view your state's manual online, click the link below, or go to [www.anthem.com](http://www.anthem.com)>[Providers](#) (select state)>Communications>Publications.

- [Indiana Provider Manual July 2015](#)
- [Missouri Provider Manual July 2015](#)
- [Ohio Provider Manual September 2015](#)
- [Wisconsin Provider Manual July 2015](#)

## Update provider demographic information via Availity

If you are the Primary Access Administrator (PAA) or PAA assistant for your organization, you can now submit changes for your practice profile, i.e. address changes, tax ID changes, provider leaving a group, etc. using the electronic **Provider Maintenance Form**. The form is the same as the one you are able to access via the Provider Home page of [anthem.com](http://anthem.com), but it is now also conveniently available on Availity. To access via Availity, go to [www.availity.com](http://www.availity.com) and enter your Availity User ID and password. The form can be found under the **Payer Resources Page | Anthem | Physician Change Requests | Provider Maintenance Form**.

## IN Reminder: Anthem has launched a new RLN

Anthem has launched a new Reference Lab Network (RLN) that provides a lower cost option for outpatient lab services. In an effort to curb unnecessary costs, the UAW Retiree Medical Benefits Trust (the "Trust") has partnered with Anthem, making the RLN available to its more than 15,000 non-Medicare Indiana members. **Beginning July 1, 2015, the Trust has requested that Indiana providers refer retired UAW retirees of General Motors, Ford and Chrysler covered through the Trust who are enrolled in the Traditional Care Network (TCN) plans to an Anthem Reference Lab Network (RLN) provider for lab services. Member alpha prefixes for these plans include: UGD, UCK, and UFK.** For more details, please see the Network eUPDATE [here](#).

## Claims

### ICD-10 updates

#### ICD-10 preauthorizations to begin in June for service dates October 1, 2015 or after

Starting June 1, 2015, we will begin accepting and processing **preauthorization requests containing ICD-10 codes for services scheduled on or after October 1, 2015**, the mandated ICD-10 compliance date. Note that you must continue to use ICD-9 codes to pre-authorize services scheduled through September 30, 2015. Some preauthorizations may span the October 1, 2015 compliance date. The code set of the preauthorization will vary, depending on the scenario. This chart will help you determine what code set to use for your preauthorizations.

A printable version of this chart is available on Anthem's **ICD-10 Updates** webpages.\*

Type of Service	Begins	Ends	Pre-Authorization	Claim
<b>Inpatient</b>	Admission begins <i>on or after</i> 10/1/2015	Discharge <i>on or after</i> 10/1/2015	Preauthorization must be requested with ICD-10 codes.	Claim for services rendered on or after 10/1/2015 must be billed with ICD-10 codes.
<b>Inpatient with <u>unknown</u> discharge date</b>	Admission begins <i>before</i> 10/1/2015	Unknown at the time of admission, then discharge occurs <i>on or after</i> 10/1/2015	Preauthorization must be requested with ICD-9 codes. This preauthorization will be valid for the entire admission.	The code set used on the claim will be based on the discharge date, so the entire claim must be billed with ICD-10 codes.
<b>Inpatient with <u>known</u> discharge date</b>	Admission begins <i>before</i> 10/1/2015	Known discharge <i>on or after</i> 10/1/2015	Preauthorization should be requested with ICD-10 codes.	The code set used on the claim will be based on the discharge date, so the entire claim must be billed with ICD-10 codes.

Type of Service	Begins	Ends	Pre-Authorization	Claim
<b>Outpatient Services</b>	Service <i>on or after</i> 10/1/2015	NA	Preauthorization should be requested with ICD-10 codes.	Claim must be filed with ICD-10 codes.
<b>Long-term Outpatient Services (such as Physical Therapy, Radiation Therapy, Chemotherapy, etc.)</b>	Services begin <i>before</i> 10/1/2015	Services end <i>on or after</i> 10/1/2015	Preauthorization obtained in ICD-9 will be valid for services rendered on or after 10/1/2015.	The claims for these services need to be separated and filed with the correct code set for the date(s) of service. Claims with both codes sets, or mixed claims, will not be accepted.

Visit our ICD-10 Updates webpages\*

\* ICD-10 webpage by state: IN - [Anthem's ICD-10 webpage](#), KY - [Anthem's ICD-10 webpage](#), MO - [Anthem's ICD-10 webpage](#), OH - [Anthem's ICD-10 webpage](#), WI - [Anthem's ICD-10 webpage](#)

### Reminder: Filing air ambulance claims for Blue plan members

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

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

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

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

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



Service Rendered	How to file (required fields)	Where to file	Example
<b>Air Ambulance Services</b>	<p><b>Point of Pickup ZIP Code:</b>  <i>Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup:</i></p> <p><i>For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.</i></p> <p><i>Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.</i></p> <ul style="list-style-type: none"> <li>– <i>Form Locators (FL) 39-41</i></li> <li>– <i>Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.</i></li> <li>– <i>Value: Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.</i></li> <li>– <i>For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.</i></li> </ul>	<p><i>File the claim to the Plan in whose service area the point of pickup ZIP code is located.</i></p> <p><i>BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.</i></p>	<p><i>The point of pick up ZIP code is in Plan A service area. The claim must be filed to Plan A, based on the point of pickup ZIP code.</i></p>

1. The air ambulance claims filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
2. Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1-800-676-BLUE.
3. Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Anthem network manager.
4. Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
5. Providers who wish to establish Trading Partner Agreements with other Plans should contact the Plans directly if they are not currently billing through a clearinghouse. Clearinghouses can assist providers with setting up access for electronically billing other Plans. In order to avoid claims rejections, these providers should set up Trading Partner agreements with Plans with whom they don't currently contract.
  - Our contracted ancillary providers can call the EDI HelpDesk at 800-470-9630, or go to <http://www.anthem.com/edi> to request assistance with submitting to other Anthem Plans (CA, CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI), Empire Blue Cross and Blue Shield and Blue Cross and Blue Shield of Georgia.
6. If you have any questions about where to file your claim, please contact provider customer service at the phone number on the back of the member ID card.

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

## Federal Employee Program® (FEP)

### FEP Integrated Imaging Solution program

As we notified you in our February newsletter, we are dedicated to meeting the evolving needs of our members and are pleased that the Federal Employee Program® (FEP) has begun the Anthem FEP Integrated Imaging Solution program effective May 1, 2015. Below are some clarifications and reminders about the program because it is different for the FEP members.

There are two components:

- AIM Specialty Health® (AIM) will perform clinical appropriateness review for non-emergent diagnostic high tech imaging services performed in the office and/or outpatient setting. *Services performed in conjunction with the emergency department services or inpatient hospitalization are excluded.* Exams included for clinical review are:
  - Computed Tomography (CT, CTA)
  - Magnetic Resonance (MRI, MRA, MRS)
  - Nuclear Cardiology
  - Positron Emission Tomography (PET)
  - Stress Echocardiography (SE)
  - Resting Transthoracic Echocardiography (TTE)
  - Transesophageal Echocardiography (TEE)

For a complete list of CPT codes, please log in to the AIM **ProviderPortal**<sup>SM</sup> and click on “Reference Desk” for the Diagnostic Imaging CPT Codes.

*The FEP program is a quality initiative. Physicians are encouraged to contact AIM to help ensure high-tech radiology procedures meet the clinical criteria for appropriateness.*

- The FEP program includes a voluntary member transparency component, referred to as the **Imaging Cost & Quality** component. Members may receive an outbound call sharing information about high value alternative MR/CT locations that are available to them. After clinical appropriateness of the imaging service is confirmed and the choices are identified, a proactive call is made to the member to aid in scheduling the service at a “best value” site. This service guides our members to facilities offering high quality, affordable imaging services. Exams included in this component are:
  - Computed Tomography (CT, CTA)
  - Magnetic Resonance (MRI, MRA, MRS)

To submit your exam request for an FEP member, contact AIM via their **ProviderPortal** at [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb). You may also contact AIM at the *dedicated* FEP number at 866-789-0397, Monday - Friday 7 am – 7 pm.

An AIM order number is not a guarantee of benefits. Payment is subject to the member's active enrollment, benefit limitations and other terms of the member's contract at the time the services are provided.

In our February newsletter we also indicated that Advanced Benefit Determinations (ABDs) are available upon request for the imaging services listed below:

- Computed Tomography Angiography (CTA)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) Scans
- Nuclear Cardiology

For an ABD, call the FEP UM department at 800-860-2156, or send a fax to 877-606-3807. For more information about the ABD process, please see the article titled "FEP advanced benefit determination process" on page 5 of the February 2015 [issue](#) of *Network Update*.

## Health Care Management

### Medical policy update

The following Anthem medical policies were reviewed on May 7, 2015 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on September 15, 2015:

**DRUG.00075    Nivolumab (Opdivo®)**

This new medical policy addresses the use of nivolumab, which is a human programmed death receptor-1 (PD-1) blocking antibody used for the treatment of unresectable or metastatic melanoma and metastatic squamous non-small lung cancer (NSCLC).

**DRUG.00076    Blinatumomab (Blinicyto™)**

This new medical policy addresses uses of blinatumomab, which is a bispecific T-cell engager designed to promote the lysis of cancer cells by binding simultaneously with both the CD3 protein on cytotoxic T-cells and the CD19 protein, a B-cell specific lymphocyte antigen expressed in specific types of acute lymphocytic leukemia (ALL).

**LAB.00031    Advanced Lipoprotein Testing in Cardiac Disease Risk Assessment and Management**

This new medical policy addresses the use of advanced testing of lipoproteins for cardiovascular disease (CVD) risk assessment and management. (Editor note: See the following article, *Advanced lipoprotein testing*, for more details.)

**MED.00118    Continuous Monitoring of Intraocular Pressure**

This new medical policy addresses the continuous monitoring of intraocular pressure (IOP).

**SURG.00140    Peripheral Nerve Blocks for Treatment of Neuropathic Pain**

This new medical policy addresses the use of peripheral nerve blocks for the treatment of peripheral neuropathy.

**GENE.00023    Gene Expression Profiling of Melanomas**

This medical policy was revised to expand the scope of the medical policy to include gene expression profiling of cutaneous melanomas.

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

The medical policy was revised to address PET scanning of the prostate using C-11 choline radiotracer or any other radiopharmaceutical (such as FDG-PET).

**RAD.00014      Brachytherapy for Oncologic Indications**

This medical policy was revised to include other indications for oncologic brachytherapy, including but not limited to, intracavitary treatment of central nervous system tumors.

To view online, go to [www.anthem.com](http://www.anthem.com)>[Providers](#) (select state)>Medical Policies and Clinical UM Guidelines.

## Advanced lipoprotein testing

**Advanced lipoprotein testing is considered investigational and not medically necessary for cardiovascular disease (CVD) risk assessment and management. Therefore, for dates of service effective October 9, 2015 claims submitted with these codes will be denied.**

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

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

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

- Apolipoprotein A-I (apoAI);
- Apolipoprotein B (apoB);
- Apolipoprotein E (apoE);
- Intermediate density lipoproteins (IDL);
- Lipoprotein(a) (Lp(a)) enzyme immunoassay;
- Lipoprotein-associated phospholipase A2 (Lp-PLA2);
- Small density lipoproteins.

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

Codes that will not be reimbursed include:

82172:	Apolipoprotein, each
83695:	Lipoprotein (a)
83698:	Lipoprotein-associated phospholipase A2 (Lp-PLA2)
83700:	Lipoprotein, blood; electrophoretic separation and quantitation
83701:	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (eg, electrophoresis, ultracentrifugation)
83704:	Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (eg, by nuclear magnetic resonance spectroscopy)

## Specialty drug audit notice

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

Examples of specialty drugs:

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

Inaccurate information may result in overpayment recovery or other action by the Plan to address the issue.

## Specialty pharmacy drugs will require precert

Effective September 15, 2015, the following specialty drugs will require precertification for members covered by Anthem local plans:

Medical Policy or Clinical Guideline Number	Medical Policy or Clinical Guideline Name	Drug Name(s)	Drug Code(s)
DRUG.00075	Nivolumab (Opdivo®)	Opdivo	J9999
DRUG.00076	Blinatumomab (Blincyto™)	Blincyto	C9449, J9999
CG-DRUG-09	Immune Globulin (Ig) Therapy	HyQvia	J3490, J7799
CG-DRUG-16	White Blood Cell Growth Factors	Zarxio	J3490, Q5101

For a complete listing of plans, please go online to [www.anthem.com](http://www.anthem.com)>Providers (select state)> [Precertification Guidelines](#). For a complete listing of drugs and codes, including specialty pharmacy medications, please go online to [www.Anthem.com](http://www.Anthem.com) > Providers (select state) >Precertification> [Specialty Pharmacy Precertification Drugs and Codes](#).

To submit your precertification request for specialty pharmacy drugs, the preferred method is to go online to AIM Specialty Health® via the Availity Web Portal. (For more information on how to access, see the article, "Important: Pre-service clinical review of specialty pharmacy drugs will transition to AIM," in the August 2014 [issue](#) of *Network Update*.) You also may use the Specialty Pharmacy Clinical Data Submission tools, which help you make sure that all necessary information has been submitted so that Anthem can complete the review. You can find the tools at [www.anthem.com](http://www.anthem.com)>Providers (select state)> Precertification>[Commercial Specialty Pharmacy Clinical Data Submission Tools](#). (Note: Tools are not available for all specialty pharmacy data submissions.)

*Note: In most cases, the changes do not apply to Blue Traditional®, National Accounts, Medicare Advantage (MA), or Federal Employee Program® (FEP). These accounts can generally be identified by the prefixes National: AN, GMP, NWM, GHP, GME, BXZ; Medicare: YRA, YRE, YRS, JWM, VZM, YRF. FEP: R.*

# Medicare

## New CLIA & ADI requirements for Individual MA

Effective July 1, 2015, Anthem Individual Medicare Advantage (MA) will deny claims billed without CMS-required criteria and will send them back to the provider who submitted the claim. The denials will include:

- Advanced Diagnostic Imaging (ADI) supplier is not accredited for the service it is billing.
- Clinical Laboratory Improvement Amendment (CLIA) certification is missing or invalid, based on the laboratory code billed. CLIA certification should be billed in Box 23 on the claim form. February's *Network Update* erroneously stated that an informational message will be included starting on your March remittance when you bill a laboratory code that requires certification. This message was not included on your March remittance, however the message will appear on your remittance in the coming months.

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

## Medicare crossover EOBs and URMBT members

Anthem has noticed an increase in providers filing the Medicare EOMB and BCBSM Medicare Secondary vouchers to Anthem. *We wanted to let you know that since Anthem is not a tertiary coverage, no additional benefits would be allowed beyond what was already processed by BCBSM.*

You can confirm a Medicare Crossover claim was received and processed to the eligible benefit level by contacting our Provider Service Center at the number noted on the voucher.

For reference, below is a list of the UAW Retiree Medical Benefits Trust groups:

Group Name	Plan Name	Alpha Prefix	Group Number
URMBT General Motors	TCN	UGD	71436
URMBT Chrysler	TCN	UCK	71400
URMBT Ford	TCN	U FK	71435

If you have questions, please contact Provider Inquiry or your local Network Relations consultant at 866-324-9666.

## Osteoporosis screening, medication encouraged for women

Osteoporosis is a condition that commonly affects women 67 and older. Once a woman has had a fracture, she has a four times greater risk of another fracture, reports the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

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

Screening and treatment can significantly improve health outcomes by preventing fractures. Osteoporosis therapy may reduce the risk of fracture by nearly 50 percent, according to the Journal of Rheumatology.

## DMARDs help prevent long-term disability

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

## Encourage MA members to control high blood pressure

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

## Dual eligible special needs plans new for 2015

In 2015, Anthem is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs) in IN, MO, OH, KY and WI. D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are \$0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors' appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items.

More information about D-SNPs and a list of Frequently Asked Questions can be found [here](#).

## CMS requirements for special needs plan members

Medicare requires that Primary Care Physicians review all prescription and non-prescription drugs, vitamins, herbals, and other supplements at least once per year for members in a Special Needs Plan (SNP).

SNP members age 66 or older also should have one functional status assessment each year. According to HEDIS® guidelines, notations for a complete functional status assessment should include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed (includes bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking).
- Notation that Instrumental Activities of Daily Living (IADL) were assessed (includes shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances).
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®
  - Assessment of Living Skills and Resources (ALSAR)
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
  - Bayer Activities of Daily Living (B-ADL) Scale
  - Barthel Index
  - Extended Activities of Daily Living (EADL) Scale
  - Independent Living Scale (ILS)
  - Katz Index of Independence in Activities of Daily Living
  - Kenny Self-Care Evaluation

- Klein-Bell Activities of Daily Living Scale
- Kohlman Evaluation of Living Skills (KELS)
- Lawton & Brody's IADL scales
- Notation that at least three of the following four components were assessed:
  - Cognitive status
  - Ambulation status
  - Sensory ability (including hearing, vision and speech)
  - Other functional independence (e.g., exercise, ability to perform job)

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year.

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

### House call program: Available at no out-of-pocket cost to MA members

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

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

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

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

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

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

### IN, KY, OH, WI: Anthem, Optum deliver regular reports

Anthem collaborates with Optum to educate our individual and group-sponsored members on the importance of annual wellness exams and improvement of chronic conditions.

The Patient Assessment Form (PAF)/Healthcare Quality Patient Assessment Form (HQPAF) are used to ensure individual and group-sponsored MA members receive a complete and comprehensive assessment at least once a year. The PAF is



always sent when an appointment is scheduled with an Anthem member. Some providers, depending on volume, will receive a PAF for all members regardless of an appointment being scheduled.

The Members without Office Visit (MWOV) report identifies the patients that have not visited a provider in 12 months. Optum will work with a practice to ensure a patient schedules an updated office visit. These reports are available for individual and group-sponsored MA members in the following states and MA plans: IN LPPO, KY HMO & LPPO, OH HMO, RPPO & LPPO, WI LPPO, WI HMO and IN/KY RPPO and IN HMO. Should you have any questions about Optum's relationship with Anthem, please call 1-317-287-0719. For questions about the Healthcare Quality Patient Assessment Form program, please call the Optum Provider Support Center at 1-877-751-9207.

## Please follow CMS guidelines for MA Part B immunizations claims filing

Anthem follows Centers for Medicare & Medicaid Services' [Medicare Part B Immunization Billing](#) guidelines.

Please use the following forms when filing flu, pneumonia or Hepatitis B claims for Anthem individual and group-sponsored MA members.

- Professional claims should be filed on the CMS 1500 form with the appropriate Current Procedural Terminology code and/or Health Care Procedural Code for the vaccine and administration.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes
  - Revenue Codes (except Rural Health Clinics and Federally Qualified Health Centers)
    - 0636 – vaccine (and CPT or HCPC)
    - 0771 – administration (and HCPC)
  - Rural Health Clinics and Federally Qualified Health Clinics – 052X revenue code series)

Please refer to page three of the [Medicare Part B Immunization Billing Guide](#) for specifics on institutional billing.

## MA precert requirements available online

Network physicians are required to obtain precertification for specified services for MA members. For the member to receive maximum benefits, the health plan must authorize or precertify the covered services prior to being rendered. Additional information on 2015 MA precertification requirements can be found [here](#) or go online to [www.anthem.com](http://www.anthem.com)>Providers>Medicare Solutions.

## Reminder: MA precertification requirements for admissions

**Failure to precertify an admission or provide notice of emergent inpatient admission will result in administrative denial effective May 1, 2015**

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

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

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

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

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

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

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

Please visit [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider) to learn more about this online provider self-service tool.

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## MA reimbursement policies

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

## Reminder: Individual MA membership moved to new claims system

Effective Jan. 1, 2015, Anthem moved Individual (non-group) MA members to a new claims processing system. Please continue to check [Important Medicare Advantage Updates](#) on your [provider portal](#) for additional information, including these [FAQs](#).

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# Pharmacy

## Pharmacy information available at [anthem.com](http://www.anthem.com)

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit <http://www.anthem.com/pharmacyinformation>. The commercial drug list is reviewed and updates are posted to the

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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.”

## Quality

### Update to the Cancer Care Quality Program

#### Attention Oncologists, Hematologists and Urologists

As a reminder, Anthem’s Cancer Care Quality Program (“Program”), a quality initiative, 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.

#### Effective July 1, 2015 Anthem is removing some cancer treatment Pathways from the Cancer Care Quality Program.

This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members’ benefit plans.

#### The following regimens will be moving from “on” pathway to “off” pathway status:

- R-DHAP (rituximab, dexamethasone, cisplatin, and cytarabine) for diffuse large B-cell lymphoma, second and subsequent lines of therapy
- R-DHAP (rituximab, dexamethasone, cisplatin, and cytarabine) for follicular lymphoma, second and subsequent lines of therapy
- Dacarbazine for melanoma, first and subsequent lines of therapy
- Temozolomide for melanoma, first and subsequent lines of therapy

The Pathways developed for this Program are intended to support quality cancer care. To access the full Pathways document, go online to [CancerCareQualityProgram.com](http://CancerCareQualityProgram.com), our dedicated provider website.

*Note: 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.*

### Clinical practice & preventive health guidelines

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](http://www.anthem.com)>Providers (enter state)> Health & Wellness> [Practice Guidelines](#).

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# Reimbursement

## Claim editing notifications

Anthem currently utilizes a proprietary, comprehensive, nationally recognized code auditing system to ensure consistent physician reimbursement by automatically evaluating provider claims in accordance with our professional reimbursement policies, industry standard guidelines, and current coding guidelines as documented in *Current Procedural Terminology* (CPT®), Healthcare Common Procedure Coding System (HCPCS Level II), National Correct Coding Initiative (NCCI), plus International Classification of Diseases (ICD) 9 and 10.

**This is a notice to advise providers that during the timeframe of September 11, 2015 through October 12, 2015, Anthem will phase in claim editing systems, such as McKesson Inc.'s ClaimsXten® along with other proprietary auditing systems.\***

These editing systems are based on industry standards, including but not limited to, NCCI and American Medical Association (AMA) guidelines, to assist in determining how procedure code combinations will be adjudicated. These editing systems will assist in our continued efforts to ensure that claims are properly coded. The edits will be effective for claims with dates of service on or after September 11, 2015 unless otherwise indicated. Reimbursement policies will be updated to include new editing.

**More details concerning these edits will be included in a Special Edition of *Network Update*, scheduled to post online on June 11, 2015. Please refer to it for further information.**

*\*Notice of Material Changes to Contract may apply.*

## View Anthem reimbursement policies

Anthem's reimbursement policies are available online at MyAnthem; access via the Availity Web Portal.\* (Note: To view online reimbursement policies, you must be registered for access to Availity and MyAnthem functionality.)

*Non-Registered for Availity:* To register for access to Availity, go to [www.availity.com/providers/registration-details/](http://www.availity.com/providers/registration-details/).

*Non-Registered for MyAnthem:* If your organization is not registered for MyAnthem, sign onto [www.anthem.com](http://www.anthem.com), select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. If you do not have a MyAnthem user id and password, your organization's site administrator must register you as a new user and assign required Anthem-specific functionality. Note: Effective June 21, passwords are no longer generated.

*Registered for MyAnthem:* If you are a registered MyAnthem user, sign onto [www.availity.com](http://www.availity.com), select "My Payer Portals," then choose "Anthem Provider Portal" to be navigated into MyAnthem without entering an additional log-in or password. Select the Administrative Support tab, then select the link labeled **Procedures for Professional Reimbursement or Procedures for Facility Reimbursement**.

\*For more information, see "MyAnthem and the Availity Web Portal: Access both with one log-in" on page 7 of the June 2014 issue of [Network Update](#) and "[Logging into MyAnthem](#)" at [www.anthem.com>Providers](http://www.anthem.com>Providers) (enter state)>Answers@Anthem.

# Medicaid Notifications

## For IN, KY, WI

### Distinct procedural service coding update

On **January 1, 2015**, **CMS** established four new HCPCS modifiers to define subsets of the -59 modifier used to define a Distinct Procedural Service. Currently, the -59 modifier is used when a code for a service which would usually be bundled is being considered separate and distinct from another service.

CMS has defined four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier). These modifiers, collectively referred to as -X{EPSU} modifiers, are as follows:

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

Anthem will begin following the CMS Modifiers for Distinct Procedural Services. We will continue to recognize the -59 modifier; however, CPT instructions state that the -59 modifier should not be used when a more descriptive modifier is available. The -X{EPSU} modifiers are more selective versions of the -59 modifier; it would be incorrect to include both modifiers on the same line.

Anthem will be accepting the -X{EPSU} modifiers prior to the National Corrective Coding Initiative (NCCI) edits update. Anthem requires the use of selective modifiers instead of the general -59 modifier when the -X{EPSU} modifiers provide more clarity for the service/procedure performed.

### Body mass index and obesity – tips and tools

For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called body mass index (BMI). BMI is used for most adults since it correlates with an individual's amount of body fat. However, BMI does not directly measure body fat; instead, it gives ranges of weight that show what is generally considered healthy for a given height. The following list displays the ranges for adult BMI in relation to the corresponding clinical diagnosis per the Centers for Disease Control and Prevention (CDC):

<b>BMI</b>	<b>Less than 18.5</b>	<b>Underweight</b>
<b>BMI</b>	<b>18.5-24.9</b>	<b>Healthy weight</b>
<b>BMI</b>	<b>25.0 -29.9</b>	<b>Overweight</b>
<b>BMI</b>	<b>30.0-39.9</b>	<b>Obese</b>
<b>BMI</b>	<b>40.0 or more</b>	<b>Morbidly obese</b>

A child's weight status is determined by using an age and gender specific percentile for BMI rather than the height and weight measures used for adults. This is because a child's body composition varies based on gender and as he or she ages. BMI for pediatrics, ages 2-20, is based on growth charts published by the CDC. The list below shows pediatric BMI in relation to the corresponding clinical diagnosis:

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<b>BMI</b>	<b>Less than 5<sup>th</sup></b>	<b>Underweight</b>
<b>BMI</b>	<b>5<sup>th</sup>-less than 85<sup>th</sup></b>	<b>Healthy weight</b>
<b>BMI</b>	<b>85<sup>th</sup>-less than 95<sup>th</sup></b>	<b>Overweight</b>
<b>BMI</b>	<b>At or above 95<sup>th</sup></b>	<b>Obesity</b>

Obesity can have very harmful effects on the body. A 2007 study from the *Journal of Pediatrics* concluded that 70 percent of obese children had at least one cardiovascular risk factor, such as high blood pressure or high cholesterol. Many health risks can be caused by obesity, including diabetes, breathing issues, joint problems, fatty liver disease, gallstones and gastroesophageal reflux (GERD, chronic heartburn). Providers should report the BMI on claims for patients with weight related health issues. While many providers have electronic medical records software that automatically calculates BMI for patients, for those who do not, the CDC offers [BMI calculators](#) for children, teens and adults.

#### *Obesity related services*

Services that help address unhealthy weight are known as obesity related services. Anthem Blue Cross and Blue Shield covers a range of services to prevent and reduce obesity, including BMI screening, education and counseling about nutrition and physical activity, prescription drugs, and surgery. Health care providers should conduct height, weight and nutrition assessments as part of all well-child visits and adult annual checkups. If primary care providers counsel patients regarding obesity, there are procedure codes that can be billed to report the services for reimbursement. Providers should ensure the correct diagnosis and BMI codes are billed that correlate to obesity to support the counseling.

#### *Documentation and coding*

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

The ICD-9 codes for reporting weight related clinical diagnoses include:

<b>278.00</b>	<b>Obesity unspecified</b>
<b>278.01</b>	<b>Morbid obesity</b>
<b>278.02</b>	<b>Overweight</b>

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

AHA Coding Clinic advice

Per American Hospital Association Coding Clinic 2010, Q2, BMI itself may be retrieved from nonphysician documentation such as a dietician; however, the clinical diagnosis must come from physician documentation.

Per AHA Coding Clinic 2011, Q3, individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the BMI code meets the requirement for clinical significance when obesity is documented.

#### *Obesity and BMI coding in ICD-10*

Document the type (i.e., morbid, obese, overweight) and cause of obesity for ICD-10 (e.g., excess calories, drugs, etc).

ICD-10	Description
E66.3	Overweight

<b>E66.8</b>	Obesity, other causes
<b>E66.9</b>	Obesity, unspecified
<b>E66.01</b>	Morbid obesity, due to excess calories
<b>E66.09</b>	Other obesity due to excess calories
<b>Z68</b>	Body mass index

## For Indiana only

### Coordinated medical and behavioral health care

Coordinated and integrated care starts with good primary and behavioral health care. It refers to the delivery of comprehensive health care services with communication among providers so that patients are informed and encouraged to be actively involved in their treatment. Essential to integrated health care delivery is a high-performing primary medical provider (PMP) and behavioral health provider who can manage the delivery of seamless, well-coordinated care.

The impact of untreated behavioral health conditions on individual lives, and the cost of health care delivery in the United States, is staggering. Data from the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2013 National Survey on Drug Use and Health (NSDUH) indicates that people with mental illness are more likely to have chronic health conditions such as high blood pressure, asthma, diabetes, heart disease and stroke than those without mental illness. Those individuals are also more likely to use costly hospitalization and emergency room treatment.

Similarly, people with physical health conditions such as asthma and diabetes report higher rates of substance use and serious psychological distress. According to the Centers for Medicare & Medicaid Services:

- 50% of Medicaid enrollees have a mental health diagnosis.
- People diagnosed with mental illness and chronic health conditions have health care costs that are 75% higher than those without a mental health diagnosis. For individuals with a co-occurring mental or substance use disorder, and a chronic health condition, the cost is two to three times higher than what an average Medicaid enrollee pays for health care.
- For those with diabetes, the cost of treatment is as much as four times higher when a co-occurring condition such as depression or alcohol addiction is untreated.

The coordination and integration of care between medical and behavioral health has consistently been shown to improve quality, cost and health care outcomes.

#### *How to integrate care?*

Coordinating and integrating care is something that is simple to describe yet hard to do in the context of a busy practice. It is essential that both medical and behavioral health providers screen patients.

The resources for initial screening, coordinating and integrating care are widely available. Several tools can be found at **[www.anthem.com](http://www.anthem.com)**. In addition, you can visit the SAMHSA website for adult, child and adolescent screening tools. PMPs and behavioral health practitioners should screen all patients about their overall health conditions and treatment upon intake and annually.

When a patient is receiving primary care and behavioral health services, all practitioners should obtain a signed release of information form that gives permission to share information with other providers. Explicit consent is needed for certain types of information (i.e., HIV/AIDS, substance abuse).

If a member is seen by a behavioral health provider, and reports that it has been more than a year since his or her last visit with a PMP, or the member does not plan to see the PMP, work with the member to arrange an annual PMP visit.

## For Kentucky only

### Physician Pharmacy Alliance

Anthem Blue Cross and Blue Shield Medicaid is committed to supporting you in the care of your patients. We have contracted with Physicians Pharmacy Alliance (PPA), a medication care management services company, specializing in providing collaborative support to patients who have challenges in staying adherent to therapies you prescribe.

#### *Adding a layer of support*

We have identified patients for PPA services through both claims data and utilization history. Specifically, we review patients who are at risk, using the following indicators as a guide for selection:

- Frequent hospital admissions or emergency department visits
- Complex medication regimen
- Poor adherence rates to specific medications
- Poor adherence rates to specific clinical tests

#### *PPA's commitment to you and your patients*

The program is provided at no additional cost to your patients and provides your practice with an additional resource for reaching optimal clinical performance measurements. Once enrolled, your patients will receive support from PPA's multidisciplinary team, including pharmacists, nurses and other clinical staff. We want you to be aware of this service in the event that a patient asks you about it.

As your patients begin to enroll in the services, your office will be contacted by a PPA representative and more information will be shared with you at that time. If you have questions about the programs, a PPA representative can be reached at **1-866-933-8064** (provider designated line).

### New genetic testing rates effective June 1

Beginning **June 1, 2015**, Anthem will use updated National Reference Lab Fee Schedule rates for certain genetic testing codes for all markets and products.

Per your existing contract, Anthem is required to furnish written notice on any Anthem-initiated changes to the National Reference Laboratory Fee Schedule.

For dates of services on or after **June 1, 2015**, the rates for the below referenced CPT codes will be updated as outlined. Each provider will be paid the contracted percentage of these rates for medically necessary and covered laboratory tests (for example, if you are contracted at 39 percent, you would be paid \$180.00 for 81220).

CPT code	New rate	CPT code	New rate
81201	\$638.41	81222	\$123.08
81203	\$248.03	81223	\$625.64

# Network Update



81220	\$461.54	81224	\$46.15
81221	\$64.10	81229	\$2,546.00

**Reimbursement limitations for CPT codes 99214 and 99215**

In accordance with Kentucky Administrative Regulations (KAR) 907 KAR 3:010, Reimbursement for physicians' services, Anthem Blue Cross and Blue Shield Medicaid (Anthem) has placed a reimbursement limitation on Current Procedural Terminology (CPT) codes 99214 and 99215. With the exception of chemotherapy administration to a recipient under the age of 19 years, reimbursement for Evaluation and Management (E/M) services with a corresponding CPT code 99214 or 99215 will be limited per provider to two per member per 12 months.

This policy will still apply when billing with modifier 25 for significant, separately identifiable E/M services by the same physician on the same date of the service.

Any claims billed with CPT codes 99214 or 99215 in excess of the established limit will be denied. In accordance with Kentucky Revised Statutes (KRS) 304.17A-714, Collection of claim overpayments -- Dispute resolution, Anthem will be reviewing claims retroactively, which may result in recoupments.

Providers who receive a claim denial due to billing over the established limit for CPT Codes 99214 or 99215 will need to resubmit a corrected claim with the appropriate and applicable E/M code.

**Itemized bill required for DRG outlier claims**

Anthem is collaborating with The Assist Group, an Equian company, to ensure consistency in claims review and reimbursement practices for hospitals by reviewing all facility claims that exceed outlier threshold. You may receive correspondence from The Assist Group regarding these reviews.

Effective **May 9, 2015**, Anthem began to require hospitals to submit itemized bills for all facility claims anticipating DRG outlier reimbursement. You must submit an itemized detail listing for each supply and service provided to the patient, matching the billed charge amount to the underlying claim, when submitting all facility outlier claims.

**Itemized Bill Requirements:**

- The itemized bill must list each supply and service provided to the member, matching the dollar amount and date of service to the request.
- The request is for claims submitted with other insurance, changes in coverage, lapse in coverage, or if coverage terminated during the length of stay.
- Interim billing will not require an itemized bill; however, it will be requested when the final bill is submitted.
- The itemized bill must be submitted via paper and cannot be sent electronically.

If the itemized bill is not included with the claim, the claim will result in a denial, requesting the itemized bill. A new claim must be submitted with the itemized bill. To avoid a duplicate denial, resubmit as a corrected claim.

If The Assist Group identifies billing issues during its review, you will receive a detailed findings report explaining the issues. At that time you will also receive information about discussing and resolving these concerns. Please send all formal appeals correspondence by mail or email to:

Appeals Department  
The Assist Group

300 Union Blvd., Suite 515  
Lakewood, CO 80228  
[appeals@assistgroup.com](mailto:appeals@assistgroup.com)

### **Lock-in program**

The Lock-in program requires an Anthem Medicaid member to receive health care services from a designated provider, including a primary care physician, controlled drug prescriber, pharmacy, and hospital emergency room. A member may be assigned to the program due to overutilization of services in amount, duration, or scope from one or more providers, which exceed the amount that would be reasonably expected in medical or health benefits.

1. Members subject to the program are:
  - a. A new member restricted under a prior managed care plan Lock-in program, when the restriction period for covered services has not expired. Anthem will apply the imposed restriction on the member's effective date or as soon as the restriction is communicated to Anthem. The restriction will remain in place for at least 24 months from initiation of the original lock-in. Anthem will inform the member, in writing, of the continued restriction. When the initial lock-in period expires, Anthem will re-evaluate the member's claims data to determine if the lock-in can be released. If lock-in criteria are still met, Anthem will recommend that the member continue enrollment in the Lock-in program.
  - b. A current member who may potentially meet criteria for enrollment in the Lock-in program.
2. Members exempt from the lock-in restrictions include:
  - a. Members residing in a nursing facility, group home, or personal care home.
  - b. Members under the age of 18 years.
  - c. Members receiving services through a home- and community-based waiver program.
  - d. Members receiving hospice services.
  - e. Members who have utilized health care services at a frequency or amount which was medically necessary to treat a complex, life threatening medical condition, as determined by Anthem.
  - f. A member who the Department of Medicaid Services has determined exempt due to their belief that it is not in the best interest of the member.

A member's lock-in status can be determined by accessing Patient360 from our web portal. Patient 360 is a read-only dashboard available through our secure provider [website](#).

If you have questions or need additional information, please contact your Provider Relations representative or Provider Services at **1-855-661-2028**.

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Anthem Kentucky Managed Care Plan, Inc., independent licensee of the Blue Cross and Blue Shield Association.

## For Wisconsin only

### **Anthem adding SSI to Medicaid portfolio**

The Anthem implementation of the Social Security Income (SSI) plan has been delayed. We previously communicated an implementation date of **June 1, 2015**. We now anticipate that the Anthem SSI plan will be offered to eligible participants mid to late summer. Future communications will share the exact implementation date.

The plan will be available to participants living in our 23-county service area including Brown, Calumet, Dodge, Door, Fond du Lac, Jefferson, Kenosha, Kewaunee, Manitowoc, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Rock, Shawano, Sheboygan, Walworth, Washington, Waukesha, Waupaca, Waushara, and Winnebago.

The Anthem SSI HMO plan will limit eligibility to individuals, ages 19 or older, who meet SSI and SSI-related disability criteria, and who live in the Anthem SSI service area. Additional information regarding SSI is available from this Department of Health Services publication: [dhs.wisconsin.gov/publications/p1/p12770.pdf](http://dhs.wisconsin.gov/publications/p1/p12770.pdf).

Reimbursement for Anthem SSI claims, claims submission processes, prior authorization requirements, and contacts will be identical to those of BadgerCare Plus. Anthem SSI members will receive an Anthem ID card with the Medicaid indicator in the upper right corner.

### **New claim denial reason code**

Anthem contracted providers must be certified with the Wisconsin Medicaid program through the ForwardHealth web portal prior to submitting claims for BadgerCare Plus members.

Currently, Anthem providers who are not certified with ForwardHealth, or who have allowed state certification to lapse, have claims denied for no prior authorization. Effective immediately, Anthem has revised the denial reason code. Providers who are not state certified through ForwardHealth will receive claim denials using a new code, GA6-State Medicaid ID required for payment.

Anthem is reminding providers to obtain or update their state certification to avoid Anthem claims denials. Providers can verify state certification status on the ForwardHealth portal, [forwardhealth.wi.gov](http://forwardhealth.wi.gov).

### **CommunityConnect website will be retired**

The CommunityConnect website will be deactivated on **June 30, 2015**. Providers are reminded that all claims and appeals with dates of service (DOS) prior to **July 1, 2014**, must be submitted to CommunityConnect HealthPlan as soon as possible. Claims must be resolved and finalized no later than **June 30, 2015**.

If you have questions or need additional information, contact Provider Services at 1-855-558-1443.

In Eastern Wisconsin, Anthem Blue Cross and Blue Shield is the trade name of CompCare Health Services Insurance Corporation (for its insurance policies offered through the BadgerCare Plus and Medicaid SSI programs), an independent licensee of the Blue Cross and Blue Shield Association.