Anthem. Working together to improve the health of our members.

July 3, 2014

Network Update

COLORADO

Drug fee schedule update

CMS average sales price (ASP) third quarter fee schedule with an effective date of July 1, 2014 will go into effect with Anthem Blue Cross and Blue Shield (Anthem) on August 1, 2014. To view the ASP fee schedule, please visit the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

Spring 2014 Provider Webinars – recorded versions now available online

Even if you missed one of our "in-person" meetings or one of our "webinars", you still have the opportunity to listen to one of our recorded versions. The sessions included important updates and information to make it easier to do business with us. We split our seminar content into two portions; Part 1 (general content), and Part 2 (Provider Connectivity specific content). Decide which content portion most applies to you, and listen to Part 1, Part 2, or both! To access a recorded version, go to **anthem.com** and select the **Provider** link (top center of page). Next, select **Colorado** from the drop down list and **enter**. On the **Provider Home** page, select the **Provider Seminars** link under the Communications and Updates section. From the Provider Seminars landing page, select either the Part 1 or Part 2 recorded version; Spring 2014 Provider Webinar – Part 1 (General Content), recorded version or Spring 2014 Provider Webinar – Part 2 (Provider Connectivity content), recorded version.

Anthem and the QuitLine Partnering to Strengthen Tobacco Cessation Program

Anthem is excited to expand our tobacco cessation program we have with the CO QuitLine for your patients. We have found that patients who have gone through the QuitLine's enhanced tobacco cessation program, QuitLogix, have a **47.6% quit rate at 6 months**! The success of the program stems from the excellent quit tobacco coaching services in multiple languages, free nicotine replacement products, interactive tools such as smart phone apps and personalized support through text and email messaging. **Under the ACA coverage mandates, if you write a prescription for tobacco cessation products, your patients can fill them at no expense**. They may be subject to prior authorization edits. Coaching services paired with tobacco cessation products are a successful combination. We encourage you to refer your patients to the QuitLine (800-QUIT-NOW or https://anthembcbs.quitlogix.org/) for that extra support in their quit attempts.

Once your patient fills your prescription for an ACA covered tobacco cessation product, the **QuitLine does the rest – they will make an outreach call to enroll your patient in the program**. There is no cost to the patient for this service or for the QuitLine program. If you have any questions about the program, please contact Cissy Kraft, MD at 303-831-2824.

Behavioral Health Audits

Anthem is instituting a behavioral health coding program. The program objective is to ensure that the providers understand the CPT ® Coding Guidelines. One area we will be focusing in on will be central nervous system assessment/test (e.g., neuro-cognitive, mental status and speech testing) CPT codes 96101-96125. When billing these codes, providers are required to clearly document the time to

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administer, interpret and prepare a report to support the number of units billed. Anthem will utilize Santé Analytics located in Nashville, Tennessee to administer these audits. These audits will begin June 2014.

Any questions related to the audit process and/or results should be directed to the Santé Analytics Customer Service Line at (615) 600-0252. When calling, physicians will need to provide name, telephone number, tax ID number, and the Santé Analytic case ID (when applicable).

Upcoming Accessibility Survey for Behavioral Health Providers

Behavioral Health providers may receive a call from a representative with the North American Testing Organization (NATO). NATO conducts a survey every year for Anthem regarding appointment availability for our members. Not every behavioral health provider is contacted for this survey. The information NATO obtains is provided to Anthem to compile a report. It is a brief survey to obtain information regarding routine appointments, urgent appointments and non-life threatening emergent care. They also obtain information regarding the out-going message on the provider's voicemail or the information provided by his/her answering services. They will also ask about coverage when the provider is out of the office (vacation). **If you are contacted, it is important that you respond to the surveyors**. This information is very important to Anthem. It helps add to the quality care provided by our providers for our members. Thank you for your support in gathering this important information.

CoramRx/CVS Caremark Change for Specialty Drugs Covered Under the Medical Benefit

Anthem currently contracts with CoramRx Specialty Pharmacy Services and CVS Caremark for specialty pharmacy drugs covered under the medical benefit. CVS Caremark recently purchased Coram and is re-organizing the combined company. Effective July 1, 2014, Coram is the primary point of service for medications that are administrated by infusion; CVS Caremark Specialty Pharmacy is the primary point of service for specialty drugs that are administrated by injection.

Active contracts will be maintained for specialty medications under the medical benefit with both branded pharmacies. Coram is primary for infused specialty mediations going to the home or Ambulatory infusion Suites. CVS Caremark is primary for injected specialty medications sent to the physician office. For more information, contact CVS Caremark Specialty Pharmacy at 800-238-7828.

Update to Claims Processing Edits and Professional Reimbursement Policies

We have updated ProviderAccess, with the following revisions to our professional reimbursement policies:

Anesthesia

The Anesthesia policy was updated to clarify how time is *currently* rounded for anesthesia services. To calculate reimbursement for time, the number of minutes reported is divided by 15 (minutes) and rounded up ***or down*** to the next tenth *(according to standard accounting practices for rounding)* to provide a unit of measure. [Please refer to reimbursement policy: *Anesthesia].*

Bundled Services and Supplies

Effective for dates of service July 1, 2014 and after Disease Management Program codes S0315-S0317 have been added to section one of the Bundled Services policy.

According to the Healthcare Common Procedural Coding System (HCPCS), "S" codes are temporary codes requested and used by the Blue Cross and Blue Shield Association (BCBSA) or other private sector insurance carriers through the Health Insurance Association of America (HIAA). "S" codes are used to report drugs, services, supplies, or carrier specific health programs for which there are no other national codes; but for which codes are needed for the purpose of meeting the needs of the private sector to implement their particular policies, programs, or claims processing procedures.

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Unless there are specific, specialized contracts or criteria for a provider to report particular “S” codes, Anthem will consider “S” codes to be always bundled codes. Therefore, for claims processed on or after August 18, 2014 non-contracted drugs, services, supplies, or specific health programs identified by HCPCS “S” codes (for example S0270-S0274, S0341, S1030, S3000, S3652, S3655, S3708, S3850, S3902, S3904, S4030, S4031, S5131, S5185, S8210, S9007, S9015, S9339, S9438, S9439, S9482 and S9996) will be included in our always bundled edit as described in Section 1 of the Bundled Services policy. [Please refer to reimbursement policy: *Bundled Services and Supplies].*

Co-surgery and Team Surgery

The Co-surgery and Team Surgery policy received an annual with no substantive changes. [Please refer to reimbursement policy: *Co-surgery and Team Surgery].*

Frequency Editing

The Frequency policy was updated to add additional rationale; “the Centers for Medicare & Medicaid Services’ (CMS’s) Medically Unlikely Edits (MUEs) designation, industry standards”, to the Description section. The code list was revised to be in numerical then alphabetical order by procedure code. [Please refer to reimbursement policy: *Frequency Editing].*

ICD-10-CM Information

Anthem realizes ICD-10 implementation has been delayed; however, we are updating our related reimbursement policies to include ICD-10 codes in anticipation of the eventual implementation. The ICD-10 codes will be for informational purposes only until the official implementation date becomes effective. In addition, these policies have minor language updates with no changes to the policy positions.

- **Anesthesia**
- **Claim Editing Overview**
- **Prolonged Services**
- **Routine Obstetric Services**

Telemedicine and Telehealth Services – COLORADO

The policy name was changed from “Telemedicine Services” to “Telemedicine and Telehealth Services”. The following additions or changes were made to the policy:

- “/telehealth” added to references to telemedicine throughout the policy so it now reads “telemedicine/telehealth”
- Added “Telehealth may also include ancillary preventive, educational, and non-clinical or curative services”.
- Information on Anthem approved telemedicine program, LiveHealth Online was added for those products that cover this service as some plans/products do not cover telemedicine.
- Added additional references.

[Please refer to reimbursement policy: *Telemedicine and Telehealth Services – COLORADO*]

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

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Anthem is available to offer assistance in these difficult moments with our ***Case Management Program***. Our case 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 case management process 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.

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. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

CM Telephone Number	CM Email Address	CM Business Hours
Phone 888-613-1130 Fax 800-947-4074	Case.management@wellpoint.com	Monday - Friday 8:00 a.m. – 5:00 p.m.
Medicare 1-866-797-9884	CM-concierge@wellpoint.com	Monday - Friday 8:00 a.m. – 5:00 p.m.

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 **anthem.com**. Select the "**Provider**" link in the top center of the page. Select **Colorado** from the drop down list, and **enter**. Select the **Health & Wellness tab**, then the link title "**Practice Guidelines**". You can then choose from Clinical Practice Guidelines, Preventive Health Guidelines, or Behavioral Health Clinical Practice Guidelines.

Important Information about Utilization Management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem's medical policies are available on Anthem's website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. UM criteria are also available on our website.

The complete list of our Medical Policies and Clinical UM Guidelines may be accessed on Anthem's Web site at **anthem.com.** Select **Provider** link *(top center of page)*, then **Colorado** *(from the drop down list)*, and **enter**. On the **Provider Home** page, from the **Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements tout** (*2nd blue box on the left side of page*), select **enter**. Click on the link titled "**Medical Policies and Clinical UM Guidelines (for Local Plan Members)**". **For Clinical UM Guidelines for Local Plan members**: Follow the information for Medical Policies listed above. From the Medical Policies and Clinical UM Guidelines page for Local Plan members, at the bottom of the page, before the "continue" button, is a link titled "**Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Colorado**". Please note all of our Clinical UM Guidelines for our entire organization are displayed by

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clicking the "continue" button, but not all of them apply to Colorado. ***Please reference the Colorado specific link to determine which Clinical UM Guidelines have been adopted by Colorado*.**

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll free from 8 a.m. – 5:00 p.m. Monday through Friday (except on holidays).
- After business hours, you can leave a confidential voicemail message. Please leave your contact information so one of our associates can return your call the next business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

To discuss UM Process and Authorizations	To Discuss Peer-to-Peer UM Denials w/Physicians	To Request UM Criteria	TTY/TDD
1-800-832-7850	Local: 1-303-764-7227 Toll-free: 1-866-287-1654	1-800-797-7758	711 or 800-659-2656(T) / 800-659-3656(V)
For Medicare: 1-866-797-9884 opt 1, 1-866-959-1537 – Fax 1-888-449-4642 – Fax *(for providers who previously used 1-800-266-3504 or 1-877-236-5173)*			

For language assistance, **members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.**

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

Pharmacy information available on anthem.com

Visit http://www.anthem.com/pharmacyinformation for more information on pharmacy copayment/coinsurance requirements and their applicable drug classes, Drug Lists and 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.

Members' Rights and Responsibilities

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem has adopted a Members' Rights and Responsibilities statement.

It can be found on our Web site. Go to **anthem.com**, and select **Provider** link in upper right corner. Select **Colorado** from drop down list and **enter**. From **Health & Wellness** tab, select the link titled "**Quality Improvements and Standards**", and then the link titled "**Member Rights and Responsibilities**".

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Medicare Advantage Updates

Anthem Coordinates Office Visits for Preventive Screenings

Anthem is helping Medicare Advantage members make appointments for preventive screenings and other services to manage chronic conditions. If the member would like help scheduling an office visit or screening, we will place a call to the member's physician or screening facility to schedule an appointment while we're on the phone with the member. If we are unable to reach the provider while the member is on the phone, we will leave a message with the provider to call the member back to schedule an appointment. We appreciate your return calls and follow up to help ensure our Medicare Advantage members receive key services recommended by the Centers for Medicare & Medicaid Services.

Tips for improving HEDIS Documentation on Asthma

While delayed, ICD-10 changes ultimately will impact your documentation related to Asthma. For instance, ICD-9 has no codes to identify members with persistent asthma. This will change with ICD-10. Health Effectiveness Data Information Set (HEDIS)® will include members with persistent asthma in the eligible population. These new codes will improve identification of members through a combination of provider visits along with medication use.

Listed below is the portion of ICD-10-CM (J45) with codes specific to persistent asthma:

[J45.30] Mild persistent asthma, uncomplicated

[J45.31] Mild persistent asthma with (acute) exacerbation

[J45.32] Mild persistent asthma with status asthmaticus

[J45.40] Moderate persistent asthma, uncomplicated

[J45.41] Moderate persistent asthma with (acute) exacerbation

[J45.42] Moderate persistent asthma with status asthmaticus

[J45.50] Severe persistent asthma, uncomplicated

[J45.51] Severe persistent asthma with (acute) exacerbation

[J45.52] Severe persistent asthma with status asthmaticus

[J45.901] Unspecified asthma with (acute) exacerbation

[J45.902] Unspecified asthma with status asthmaticus

To use codes J45.3x, J45.4x and J45.5x, documentation must state whether the asthma was mild persistent, moderate persistent or severe persistent. Persistent asthma is defined as having one or more of the following both this year and last year: ED visit for asthma, four outpatient visits on different dates with asthma as part of diagnosis, along with four asthma medication dispensing events among those age 5 to 64.

To improve your HEDIS score even more, document any education to member and significant others about the use of and compliance with their asthma action plan. Provide information to members on using metered inhalers, avoiding asthma triggers, smoking cessation and schedule their next appointment for regular assessments of asthma severity and control. NCQA plans to monitor the use of these codes to assess the validity of using a simpler method to identify this population.

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

Measure members' body mass index regularly

Per Healthcare Effectiveness Data and Information Set (HEDIS)* guidelines, **adults 18 to 74 years of age should receive a Body Mass Index (BMI) assessment at the time of an office visit**. By meeting this requirement, you can help manage and ideally prevent members' obesity and related comorbidities.

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Specific recommendations:

- Measure members' height and weight at least annually and calculate BMI
- Incorporate appropriate nutritional and weight management questioning and counseling into your routine clinical practice
- Identify, plan and integrate lifestyle interventions for the treatment of obesity into members' management plans
- Document the BMI percentile for members younger than 19 years of age, which will also meet the following HEDIS criteria:
  - BMI percentile documented as a value (e.g., 85th percentile)
  - BMI percentile plotted on an age-growth chart

When completing an encounter claim, use the appropriate V code from the tables below. Please note: The V code cannot be used as a primary diagnosis code.

Under Healthy Weight	
BMI	**V Code**
<19	V85.0

Healthy Weight	
BMI	V Code
19 – 24	V85.1

Overweight	
BMI	**V Code**
25	V85.21
26	V85.22
27	V85.23
28	V85.24
29	V85.25

Obese I	
BMI	**V Code**
30	V85.30
31	V85.31
32	V85.32
33	V85.33
34	V85.34

Obese II and III			
BMI	**V Code**	**BMI**	**V Code**
35	V85.35	40 – 44.9	V85.41
36	V85.36	45.0 – 49.9	V85.42
37	V85.37	50.0 – 59.9	V85.43
38	V85.38	60.0 – 69.9	V85.44
39	V85.39	70 & > (adult)	V85.45

Pediatric	
Percentile	**V Code**
Less than 5th percentile for age	V85.51
5th percentile to < 85th percentile for age	V85.52
85th percentile to < 95th percentile for age	V85.53
Greater than or equal to 95th percentile for age	V85.54

* HEDIS is a registered trademark of The National Committee for Quality Assurance

Reminder: Please Precertify Cardiac Catheterizations

This is a reminder that providers should precertify elective or non-emergent cardiac catheterizations for our Medicare Advantage members. Cardiac catheterization and other precertification requirements were posted on the Medicare Advantage Public Provider Portal in late 2013 and again in 2014. The following cardiac catheterization procedures should be precertifed:

93458	**93454**	**93456**	**93453**
93460	**93451**	**93455**	**93457**
93459	**93461**	**93452**	

Precertification is the determination that selected medical services meet medical necessity criteria under the member's benefits contract. For the member to receive maximum benefits, the health plan must authorize or "precertify" these covered services prior to being rendered. Precertification includes a review of both the service and the setting.

Submit all required clinical information at least three business days before the requested procedure to allow a thorough clinical analysis. For Institutional Admissions, all facilities must notify us within 24 hours or the next business day (whichever is earlier) after admission. In an urgent or emergent situation, the above time frames will be waived. Please provide notice to the plan as soon as possible. Precertifications can be obtained at the following phone or fax numbers: Phone: 866-797-9884 / Fax: 800-959-1537

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A complete list of precertification requirements can be found at the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal

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

Y0071_14_19855_I 05/02/2014

Update: Routine Physical Exams Are Covered in 2014

Anthem Medicare Advantage (MA) plans have returned to offering coverage for routine physicals (subject to plan benefits) through 2014 for individual and Employer Group Retiree Medicare Advantage members. Any outstanding claims with dates of service from January 1, 2014 to current will be adjusted as necessary.

When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member's plan.

Anthem Medicare Advantage plans also will continue to provide benefits for the following Medicare covered services:

- **Initial Preventive Physical Exam** (IPPE) also known as the "Welcome to Medicare Preventive Visit"
- **Annual Wellness Visit** (AWV)

The IPPE (preventive physical exam) and AWV (wellness visit) are not a routine physical exam. Please refer to the chart below to ensure accurate coding for each type of exam.

The Welcome to Medicare Visit (IPPE) G0402	The Annual Wellness Visit (AWV initial and subsequent) G0438 & G0439	Routine Physicals/Preventive Medicine Services (99381-99397) Now covered during 2014 by Anthem's Medicare Advantage Plans
G0402 Welcome to Medicare Visit/ Initial Preventive Physical Exam: A preventive evaluation and management service; a face-to-face evaluation. This exam is a preventive physical exam and **not a comprehensive physical checkup.** This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a **once in a lifetime benefit**.	**G0438 *Initial* Annual Wellness Visit (AWV):** Services limited to beneficiary during the **Second** year the patient is eligible for Medicare Part B. **Only one first** AWV per beneficiary per lifetime. Includes a personalized prevention plan of services; face-to-face visit. **G0439 – *Subsequent* Annual Wellness Visit (AWV):** One year after the patient's Annual Wellness Visit. Once every 12 months. Includes a personalized prevention plan of services; face-to-face visit. This exam is a preventive physical exam and **not a comprehensive physical checkup.**	**99381-99397 – Preventive Medicine Services:** The examination for this visit is multi-system, and the exact content and extent of the exam is based on the patient's age, gender, and identified risk factors; face-to-face visit. "The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of

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	Note: The AWV is intended to build upon the previously established "Welcome to Medicare Visit" physical exam.	pertinent risk factors." Includes clinical laboratory tests.

Ob/Gyn providers please note: A Pap test and pelvic exam for our Medicare Advantage members is covered annually *only* if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past three years. Otherwise a Pap test and pelvic exam is covered every two years for women at normal risk. These services should be filed as separate codes from the routine physical, if they are rendered.

Medicare Advantage member benefits are subject to change from year to year – please review 2015 benefits when they are posted on the Medicare Advantage Providers page of the Anthem provider portal in late 2014. Annual summaries of Medicare Advantage plan changes also can be found under Important Medicare Advantage Updates. This will advise what coverage of what will and/or will not take place for routine physicals.

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

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Health Care Reform Updates (including Health Insurance Exchange)

We invite you to go to anthem.com 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 achieved articles, go to **anthem.com**; select the **Provider** link in the top center of the page. Select **Colorado** from the drop down list, and click **Enter**. From the **Provider Home** page, select the link titled **Health Care Reform Updates and Notifications** or **Health Insurance Exchange information**.

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The content of this update is for informational purposes only and should not be construed as treatment protocols or required practice guidelines, nor should anything herein be construed as legal advice. Readers are strongly advised to consult their own legal counsel as necessary. Diagnoses, treatment recommendations and the provision of health care services for Anthem Blue Cross and Blue Shield members are the responsibility of physicians and providers.

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