Anthem BlueCross

Working together to improve the health of our members.

September 2014

Network Update

PROFESSIONAL

In this issue

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

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CANL (09/14)

In this issue Continued

Health Care Reform Updates (including Health Insurance Exchange)

Covered California and behavioral health

Did you know that all Covered California covered individuals have open access to our participating Anthem Blue Cross Behavioral Health providers? As an Anthem Blue Cross participating Behavioral Health provider you can be assured that Covered California covered individuals are covered for services, and your Anthem Blue Cross Behavioral Health Network contract rates apply. Be sure to confirm benefits and eligibility for Covered California covered individuals as you would any other Anthem Blue Cross covered individual before rendering services.

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

Announcements and General Updates

CoramRx/CVS Caremark change for specialty drugs covered under the medical benefit

Anthem Blue Cross 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**.

Attention oncologists and hematologists! The Cancer Care Quality Programs begins November 1, 2014

If you specialize in oncology or hematology most likely you recently received notification that Anthem Blue Cross will be implementing the new WellPoint Cancer Care Quality Program ("Program") **beginning November 1, 2014**. The Program includes online tools to provide decision support to oncologists in selecting cancer treatment regimens that are consistent with current evidence and consensus guidelines. In addition, the Program includes WellPoint Cancer Treatment Pathways based on medical evidence and best practices developed with leading cancer experts to support oncologists in identifying therapies that are highly effective and affordable for our members. When you order a treatment regimen that is on a WellPoint Cancer Treatment Pathway, you will be eligible for enhanced reimbursement if you are an in-network provider for the member's health benefit plan.

Pathway regimens are widely accepted as a key component to manage oncology quality and costs. More specific than guidelines, pathway regimens identify treatments selected based on clinical effectiveness, favorable toxicity profiles, and cost. Organizations that have implemented pathway regimens have found that survival outcomes are equivalent for individuals treated on and off pathway regimens, while treatment costs decrease substantially for individuals treated on pathway regimens.

- Peer-reviewed published literature
- Expert consensus statements and guidelines from professional organizations including ASCO, the American Society of Hematology (ASH), and The National Comprehensive Cancer Network (NCCN)
- Government agencies including the Food and Drug Administration (FDA) and the National Cancer Institute (NCI)

The Program will be administered by AIM Specialty Health® (AIM), a separate company, on behalf of Anthem Blue Cross. AIM collaborates with payers to help improve healthcare quality and manage costs for some of today's complex tests and treatments, promoting patient care that's appropriate, safe and affordable.

Members included in the Program
All Anthem Blue Cross members in your area are included **except for** the following groups:

- Federal Employee Program® (FEP)®
- BlueCard (except for members with health plans issued or administered by the following Anthem Affiliates: Anthem Blue Cross and Blue Shield in Indiana, Kentucky, Missouri, Ohio, or Wisconsin; and Blue Cross and Blue Shield of Georgia. Additional Anthem Affiliates will be added in 2015.)
- Medicare Supplement
- Medicaid
- Medicare Part D
- CA Hospital only (members with hospital only health plans)
- HMO

How to submit your request with AIM
Get convenient online service via the AIM ***Provider****Portal*℠. ***Provider****Portal* is available twenty-four hours a day, seven days a week, processing requests in real-time. Go to https://providerportal.com to login, or click "**Register Now**" to register. If you have previously registered for other services managed by AIM (diagnostic imaging, radiation therapy), there is no need to register again. **Orders will be accepted beginning October 27, 2014 for treatment start dates on or after November 1, 2014.** You can also submit your request by calling AIM toll-free at **(877) 291-0360**, Monday through Friday, 7:00 a.m.–5:00 p.m. (PT).

View the FAQs to find out more about the Program. In addition, a special website offers tools and information about the Program. To view it, go to www.cancercarequalityprogram.com.

We are also conducting webinars: select the session that works best for your schedule and click ***"Register Now"***

Session 1: Friday, September 19, 2014, 7:30-8:45am PT ***Register Now***
Session registration closes at 5:00pm (PT) Friday, September 12, 2014

Session 2: Thursday, September 25, 2014, 10:30-11:45am PT ***Register Now***
Session registration closes at 5:00pm (PT) Friday, September 19, 2014

Session 3: Friday, October 3, 2014, 8:00-9:15am PT ***Register Now***
Session registration closes at 5:00pm (PT) Friday, September 26, 2014

There is no cost to attend the webinars. Access to the internet, an e-mail address and telephone is all that's needed. **Attendance is limited, so please register today.**

Update regarding self-injected drug coverage for ACA compliant health plans

Beginning in October 2014, the self-injected drugs indicated below will no longer be covered under medical benefits for Anthem Blue Cross compliant individual health plans purchased *on* or *off* the Exchange. **Anthem Blue Cross members with HMO health plans purchased *on* or *off* the Exchange are *not* impacted by this change.** Coverage for certain self-injected drugs may be available under the member's pharmacy benefit.

Please note that provider administration of these drugs will also be non-covered under medical benefits for impacted members. When prescribing self-injected drugs, providers should verify member benefits and providers may need to make arrangements for member training on self-injection.

In situations where provider administration may be medically necessary for self-injected drugs, please contact Provider Services at **(855) 854-1438**.

Self-Injected Drugs Not Covered Under Medical Benefit October 2014			
Indication	**Brand**	**Generic**	**HCPC**
BONE CONDITIONS	FORTEO	teriparatide	J3110
ENDOCRINE DISORDERS	BRAVELLE	urofollitropin	J3355, Q2018
ENDOCRINE DISORDERS	CHORIONIC GONADOTROPIN, NOVAREL, PREGNYL	chorionic gonadotropin	J0725
ENDOCRINE DISORDERS	FOLLISTIM AQ	follitropin beta	S0128
ENDOCRINE DISORDERS	GONAL-F, GONAL-F RFF	follitropin alfa	S0126
ENDOCRINE DISORDERS	REPRONEX, MENOPUR	menotropins	S0122
GROWTH DEFICIENCY	GENOTROPIN,GENOTROPIN MINIQUICK,HUMATROPE,NORDITROPIN,NORDITROPIN FLEXPRO,NORDITROPIN NORDIFLEX,NUTROPIN AQ NUSPIN,OMNITROPE,SAIZEN,SEROSTIM,ZORBTIVE	somatropin	J2941
GROWTH DEFICIENCY	INCRELEX	mecasermin	J2170
HEPATITIS	INFERGEN	interferon alfacon-1	J9212
HEPATITIS	PEGASYS	pegylated interferon alfa-2a	S0145
HEPATITIS	PEGINTRON, PEGINTRON REDIPEN	pegylated interferon alfa-2b	S0148, S0146
INFERTILITY	GANIRELIX ACETATE	ganirelix acetate	S0132
INFLAMMATORY CONDITIONS	CIMZIA	certolizumab pegol	J0717, J0718
INFLAMMATORY CONDITIONS	ENBREL	etanercept	J1438

INFLAMMATORY CONDITIONS	HUMIRA	adalimumab	J0135
MULTIPLE SCLEROSIS	AVONEX	interferon beta-1a	J1825, J1826, Q3025, Q3027
MULTIPLE SCLEROSIS	BETASERON, EXTAVIA	interferon beta-1b	J1830
MULTIPLE SCLEROSIS	COPAXONE	glatiramer acetate	J1595
MULTIPLE SCLEROSIS	REBIF	interferon beta-1a	Q3026, Q3028, J1826

Please note this list is subject to change and may affect member coverage.

Additions to the spinal surgery pre-service clinical review list

In an effort to speed payment to providers and reduce the number of retrospective reviews for spinal surgeries, we want to let you know that the following services will be added to the spinal surgery pre-service clinical review list. Anthem Blue Cross will utilize MCG™ guidelines, UM clinical guidelines or medical policy medical necessity criteria to determine the medical necessity of these procedures when performed on an inpatient or outpatient basis.

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

Please note that these recommendations do not apply to HMO, Medicare, Medicare Advantage (MA), the Federal Employee Program® (FEP), State Sponsored Business (SSB) or selected National accounts. In addition, please be advised that existing requirements for review of inpatient stays will continue.

The procedure codes listed below will be added to the CA Prior Authorization list effective December 1, 2014.

Procedure Code	Description
22224	Osteotomy of spine, including discectomy, anterior approach, single vertebral segment; lumbar
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
0309T	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace (List separately in addition to code for primary procedure)

Pre-authorization of non-emergent ground ambulance services for certain destinations

In January of this year, our member benefit certificate language was updated. We now require pre-certification for certain non-emergent ground ambulance services. The pre-certification requirement is based on the location where the member is picked up and the final destination where the member is delivered. .

The following non-emergent transports are now considered for pre-certification (these changes do not apply to the Federal Employee Program® (FEP) :

Modifier	Description
PN	Physician's Office to SNF
NP	SNF to Physician's Office
HR	Hospital to Residence
HE	Hospital to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
PR	Physician's Office to Residence
RP	Residence to Physician's Office
JR	Non-Hospital based dialysis facility to Residence
RJ	Residence to Non-Hospital based dialysis facility
EP	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility) to Physician's Office
HP	Hospital to Physician Office
GY	Item or service statutorily excluded
GZ	Item or service expected to be denied

The new non-emergent ground ambulance clinical guideline (CG-ANC-06) was approved during our Medical Policy & Technology Committee meeting, held on the May 15, 2014. The new guideline outlines the medically necessary and not medically necessary indications for non-emergency ground ambulance services. **The policy will be effective on December 2, 2014.**

To view our medical policies online go to www.anthem.com/ca, select "***Provider***", then choose the "***Provider Home***" page and click on "***Medical Policies and Clinical UM Guidelines***".

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

As a part of your provider agreement with Anthem Blue Cross, it's important that you continue to refer our members to other participating providers. Referring to in-network providers is an essential benefit to the member. When it is necessary to refer a member to a non-participating provider, remember to inform the member that services provided by a non-participating provider may result in reduced benefits.

Notification of new codes for Applied Behavior Analysis

The American Medical Association (AMA) has established new Current Procedural Terminology (CPT®) codes for Applied Behavior Analysis (ABA). A notice will be sent to all ABA contracted providers in September 2014 outlining the changes to ABA CPT Codes that will take effect on **January 1, 2015**. If you are a contracted ABA provider, please be sure to read the notice*.

The new codes will only be authorized for full ranges of service dates that begin on or after January 1, 2015. For members with services authorized in date ranges prior to January 1, 2015 you should continue to use current ABA CPT Codes. **Coding other than what is reflected in an authorization for ABA services is not allowed or covered.**

Below is a list of the new codes and definitions which will only apply with dates of service that begin on and after January 1, 2015. You may refer to the CPT manual for more information. If you have a question about new ABA CPT Codes and your Anthem Blue Cross contract, please contact our Behavioral Health Provider Relations team by email at BHNetworks@wellpoint.com.

***Formal notice will only be sent to providers contracted with the Anthem Blue Cross ABA Network**.

Below is a summary of the new codes and some helpful billing tips. Additional information and discussion can be found in the AMA publication "CPT Assistant" June 2014, Volume 24, Issue 6,

0359T	Behavior identification assessment, by the physician or other qualified health care professional,
0359T	Behavior identification assessment, by the physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report
0360T	Observational behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient
0361T	each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service) • Use 0361T in conjunction with 0360T
0362T	Exposure behavioral follow-up assessment, includes physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient
0363T	each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure) • Use 0363T in conjunction with 0362T • 0362T, 0363T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians • Do not report 0359T, 0360T, 0361T, 0362T, 0363T in conjunction with 90785-90899, 96101-96125, 96150, 96151, 96152, 96153, 96154, 96155

CODES	TREATMENT
0364T	**Adaptive behavior treatment by protocol**, administered by technician, face-to-face with one patient; first 30 minutes of technician time per authorization period
0365T	each additional 30 minutes of technician time (List separately in addition to code for primary procedure) • Use 0365T in conjunction with 0364T • Do not report 0364T, 0365T in conjunction with 90785-90899, 92507, 96101-96155, 97532
0366T	Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time per authorization period
0367T	each additional 30 minutes of technician time (List separately in addition to code for primary procedure) • Use 0367T in conjunction with 0366T • Do not report 0366T, 0367T if the group is larger than 8 patients • Do not report 0366T, 0367T in conjunction with 90785-90899, 92508, 96101-96155, 97150
0368T	Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time per authorization period
0369T	each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure) • Use 0369T in conjunction with 0368T • Do not report 0368T, 0369T in conjunction with 90791, 90792, 90846, 90847, 90887, 92507, 97532
0370T	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
0371T	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present) • Do not report 0371T when the families of more than 8 patients are participants • Do not report 0370T, 0371T in conjunction with 90791, 90792, 90846, 90847, 90887
0372T	Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients • Do not report 0372T if the group is larger than 8 • Do not report 0372T in conjunction with 90853, 92508, 97150
0373T	Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient per authorization period
0374T	each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) • Use 0374T in conjunction with 0373T

	• 0373T, 0374T are reported based on a single technician's face-to-face time with the patient and not the combined time of multiple technicians • Do not report 0373T, 0374T in conjunction with 90785-90899, 96101-96155

Important updates to our pharmacy prior authorization form

Effective January 1, 2015, all providers treating members enrolled in a **California fully insured medical plan**, regardless of the state where the member resides, the state where the provider is located, or the state where services are provided, must begin utilizing the uniform Pharmacy Prior Authorization form required by the Department of Managed Healthcare (DMHC), when utilizing a form for submission. **The DMHC requires all health plans and their delegated entities reviewing pharmacy authorization requests to use this form no later than January 1, 2015**. However, for your convenience Anthem Blue Cross will allow use of the California standardized pharmacy authorization form for DMHC fully insured members starting October 1, 2014. If you are a delegated entity performing Pharmacy Prior Authorization review, please keep in mind you must notify providers within 2 business days of your treatment authorization decision after January 1, 2015. More details will be provided to delegated entities in a separate communication shortly.

In our last provider newsletter posted in July, Anthem Blue Cross provided an initial heads-up regarding a critical mandate impacting providers submitting pharmacy authorization forms. **Effective October 1, 2014,** all providers treating members enrolled in a **California fully insured medical plan,** regardless of the state where services are provided, must begin utilizing the uniform *Pharmacy Prior Authorization* form required by the **California Department of Insurance** (CDI).

In order to prepare you for this important operational change, we have prepared a FAQ answering key questions which will assist you in submitting the pharmacy authorization form to Anthem Blue Cross.

Q: May I submit the CA standardized pharmacy authorization form for any CA members prior to October 1, 2014?

A: No, this CA standardized pharmacy authorization form must be used for CDI members on and AFTER October 1, 2014, and it must be used for DMHC members on and AFTER January 1. 2015. Please continue to use existing CA pharmacy authorization forms until that date.

Q: What does the new CA standardized pharmacy authorization form look like?

A: This document will be made available on our WellPoint/Anthem Prior Authorization website effective October 1, 2014, at http://www.anthem.com/pharmacyinformation/priorauth.html.

Q: May I submit the CA standardized pharmacy authorization form on and after October 1, 2014 for DMHC members?

A: Yes, for operational ease and to eliminate confusion, you may begin using the CA new standardized pharmacy authorization form after October 1, 2014. If you prefer to continue using existing CA pharmacy authorization forms for DMHC members, we will accept existing CA pharmacy authorization forms for DMHC members until December 31, 2014. Please keep in mind existing decision response timeframes will remain until December 31, 2014.

Q: What CA standardized pharmacy authorization form must be used after January 1, 2015 for DMHC members?

A: All providers treating members enrolled in a California fully insured medical plan must use the CA standardized pharmacy authorization form provided for DMHC members on and after January 1, 2015.

Q: May I submit the CA standardized pharmacy authorization form after October 1, 2014 for ASO members?

A: Yes, for operational ease and to eliminate confusion, you may begin using the CA new standardized pharmacy authorization form after October 1, 2014. If you prefer to continue using existing CA pharmacy authorization forms for ASO members, we will accept existing CA pharmacy authorization forms for ASO members. Please keep in mind existing decision response timeframes will remain.

Q: May I submit the CA standardized pharmacy authorization form after October 1, 2014 to the same fax number, mail address or portal in the same manner I do today?

A: Yes, you may continue to submit your CA standardized pharmacy authorization form using existing methods however a new fax number specific for the CA standardized pharmacy authorization form will be posted on the WellPoint/Anthem Prior Authorization Website along with the new form on and after October 1, 2014. Please note that effective for dates of service on or after November 1, 2014, chemotherapy requests should be submitted to AIM Specialty Health (see "The Cancer Care Quality Program begins November 1, 2014" on page 3). The CA standardized pharmacy authorization form can also be accessed through AIM's at https://providerportal.com. The ***Provider***Portal can also assist by automating completion of the authorization form.

Q: When will I be notified regarding an outstanding pharmacy authorization request for a fully insured member after October 1, 2014?

A: For CDI fully-insured members only, Anthem Blue Cross will notify the prescribing provider **within two business days of receipt** of a completed Request Form that:

1. The prescribing provider's request is approved;
2. The prescribing provider's request is disapproved as not medically necessary or not a covered benefit;
3. The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the request;
4. The patient is no longer eligible for coverage; or
5. The request was not submitted on the required form, and must be resubmitted using the approved Request Form.

Q: When will I be notified regarding an outstanding pharmacy authorization request for a fully insured member after January 1, 2015?

A: For **CDI AND DMHC** fully-insured members only, Anthem Blue Cross or its delegated medical group will notify the prescribing provider within two business days of receipt of a completed Request Form that:

1. The prescribing provider's request is approved;
2. The prescribing provider's request is disapproved as not medically necessary or not a covered benefit;
3. The prescribing provider's request is disapproved as missing material information necessary to approve or disapprove the request;

4. The patient is no longer eligible for coverage; or
5. The request was not submitted on the required form, and must be resubmitted using the approved Request Form.
6. For any additional questions, please contact your provider relations representative or your contract manager.

Billing

CalPERS Health Plan – EFT and ERA processing and check EOB and RA changes

The California State Controller's Office (SCO) processes payments issued for the CalPERS PPO Benefit Plans administered by Anthem Blue Cross. **Effective August 2014**, we will be implementing changes to claims payment and EOB processing for the CalPERS health plans. Providers do not need to make any changes.

Currently, the SCO processes all provider check reimbursements, with a single check for each claim. After August 2014, claims processed for the same payee ID at the same address will be bundled into a single payment, instead of being processed as separate payments for each claim.

In addition, providers who are currently registered for Electronic Funds Transfer (EFT) with Anthem Blue Cross will begin receiving payments via EFT, instead of receiving paper checks from the SCO. Provider's that have also elected to receive their claim payment details via an 835 ERA (Electronic Remittance Advice) will now receive those details electronically.

Paper checks with summary and separate Remittance Advice (RA)
Providers that have not elected EFT payments will continue to receive paper checks issued by the SCO. However, these checks will be processed differently than they are today. If multiple claims are being paid to the same payee ID at the same address, the claims will be combined into one payment, which will include a one-page summary remittance indicating the number of claims paid and the total dollar amount of the payment. Detailed claims payment EOBs will be provided separately from Anthem Blue Cross either as a paper RA or 835 ERA. Participating providers will also be able to view the detailed EOBs on the provider portal at**https://provider2.anthem.com/wps/portal/ebpmybcc.**

Questions?
If you have questions related to the changes to CalPERS Health Plan claims payments and EOBs please contact our **(877) 737-7776**. Providers wanting to register for EFT should use the **CAQH website** and complete the online registration.

Non-participating lab referrals

This is a reminder to refer Anthem Blue Cross members **only** to participating labs. Help us ensure that members receive their full benefits by continuing to refer our members to in-network providers. We realize that some labs that are not in our network may offer to waive, or cap co-payments, coinsurance or deductibles. However, some member benefit plans explicitly exclude coverage for any out-of-network services for which the provider waives the additional out-of-pocket costs to members. We appreciate your constant support.

Click here for a listing of Anthem Blue Cross participating laboratories.

Contracted provider claim escalation process

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

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

Network

Moved your office?

To ensure proper processing of all changes to addresses, tax ID numbers and provider profiles, please e-mail them to Provider_Database-Anthem-Wellpoint@Wellpoint.com.You can also send your changes by f**ax** to **818-234-2836** or **866-243-3183**. Keep in mind that all changes must be submitted on the physicians or medical group's letterhead and signed by the physicians or authorized personnel.

Other convenient online options for updating practice information can be easily found on anthem.com/ca:

- Physician/Physician Group Change Form
- Behavioral Health/EAP Practice Profile
- Institutional Provider Change Request Form

"New" ProviderAccess account administrator change form

GOOD NEWS ... for all ProviderAccess Account Administrators in your organization!

- *Do you need to update your ProviderAccess Account Administrator profile?*
- *Has your Account Administrator changed and you have not notified Anthem Blue Cross?*

We are pleased to introduce the new, easy to use ***ProviderAccess Account Administrator Change Form.*** This form can also be utilized to request a variety of updates including:

- Updating your account TAX ID number
- Updating your NPI number
- Adding Site Codes
- Adding an alternative TAX ID.

To request a change to the Account Administrator assignment for your organization, simply complete the change form by tabbing and following the instructions listed on the form. Each change form must be submitted with a signed ***ProviderAccess Account Agreement*** (original signature is required). Both completed forms can be emailed to Anthem Blue Cross at provideraccess.pins@wellpoint.com or faxed to **(818) 234-8926** for processing.

It is very important to keep your ProviderAccess Account Administrator information accurate and updated.

IMPORTANT: For your change request to be processed, **BOTH** forms are required. Incomplete forms will be returned for correction. You can locate both forms by going to our Anthem Blue Cross website at http://www.anthem.com/ca then selecting: *Providers* → *Provider Home* → *Answers@Anthem* → *Provider Forms* link.

New ProviderAccess account administrator training

A new on-demand training opportunity is offered by the Anthem Blue Cross Provider Network Education team. It is now available on our Provider Network Education page on anthem.com/ca and is called 'Provider Portal Access Management Training'. It is an interactive 20-minute e-course offered **specifically for the person or persons responsible for granting access rights to their users on ProviderAccess and/or the Availity Web Portal**. These individuals are identified as the 'Account Administrator' for ProviderAccess and the 'Primary Access Administrator' (PAA) for the Availity Web Portal.

This on-demand training, is available 24/7/365, for your convenience, is an overview of the registration process that grants Anthem Blue Cross ProviderAccess users the ability to log into their ProviderAccess account through the Availity Web Portal using a process referred to as ***single sign-on***. One logon can access two portals!
The following process steps are covered in detail:

- Granting or verifying the user's access on ProviderAccess
- Updating the ProviderAccess Account Administrator's information on ProviderAccess
- Granting or verifying the user's access on the Availity Web Portal
- Granting *single sign-on* access for the user on the Availity Web Portal
- The user's *single sign-on* functionality is activated.

Of special note, this course also contains resources for updating the ProviderAccess Account Administrator's information. It is critical that your provider organization designates and retains an Account Administrator who is registered with Anthem Blue Cross and remains in active status in order to manage all accesses for users within their organization.

Guidelines are provided for completing the 'ProviderAccess Account Administrator Change Form' along with the requirements for an authorized signature on the 'ProviderAccess Account Agreement'. Both completed forms are to be emailed or faxed to the numbers provided on the form.

Click here to access this new on-demand course from our Training Catalog.

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

2014 Fall seminars and e-solutions

The Provider Network Education team develops, delivers and supports quality educational programs and materials for the staff of physicians, hospitals, medical groups, ancillary, behavioral health and other health care professionals. Our education programs offer 'blended learning', combining face-to-face and web-based opportunities. Our '**complimentary**' education programs are offered to all contracted providers throughout California.

In the ***Spotlight*** section of the Anthem Blue Cross website click on the '*2014 Provider Education Seminars and Webinars'* link, which takes you to the Provider Network Education landing page and take a look at the collection of provider education tools available to attend, view and print.

Seminars
Our Fall **'Contracted Provider Information Exchange'** seminars are interactive and offer tips, process improvements and best practices. Many relevant Anthem Blue Cross business topics of interest are presented. These seminars will be offered in twelve different locations throughout California in October and November. **All contracted providers are welcomed to attend**! Click here to register and view the schedule.

e-Solutions
The following web-based learning opportunities are available 24/7/365 from your own office and personal computer, at your convenience:

- SEMs – Supplemental Education Materials are available on a variety of Anthem Blue Cross business subjects. These documents will display in pdf format and can be viewed, saved or printed.

On-Demand e-Courses offer a self-paced instruction environment. Currently there are (3) three e-Courses available for you to take at your convenience! To register for an e-Course, select the click here link on the Provider Network Education landing page.

Webinars offer 'live' interactive sessions conducted remotely through the internet and facilitated by the Network Education team and Subject Matter experts. Currently the (4) four topics offered are:

- Behavioral Heath Practitioner and Office Staff Orientation
- BlueCard® (Out-of-Area) Refresher
- Health Insurance Exchanges (HIX)
- Provider Manual (Professional)

Our ***new*** "Listening Library" of recorded webinar sessions is available for your convenience on our Provider Network Education landing page.

Webinar Recordings offer our providers the opportunity to request a copy of a previously presented webinar. Simply send an email request to: network.education@anthem.com

Questions?
E-mail: network.education@anthem.com
Phone: 818-234-1016
Fax: 818-234-8959

Anthem Blue Cross 2014 Select HMO Manual

We are pleased to announce the *Anthem Blue Cross 2014 Select HMO Manual* [CD], was mailed certified on August 19, 2014, and will become **effective on December 1, 2014.** This effective date allows a 90 day notification.

In this Manual, you will find important updates; including Misrouted Protected Health Information (PHI), Availity Web Portal (Availity)*, Data Performance, SB-866 Prior Authorization form, "Electronic Data Interchange, Continuity and Coordination of Care, Independent Review Organization Dispute Resolution Process for Medical Necessity Disputes and Medical Records, just to name a few content items.

IMPORTANT NOTE: Availity replaced ProviderAccess' eligibility and benefit and claim status inquiry functions.* ***Effective immediately**, log on to www.availity.com and get registered. This registration is required for all ProviderAccess users.*

For a complete list of changes, see the "*Summary of Changes*" section within the manual CD.

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

Workers' compensation referrals to participating providers

Anthem Workers' Compensation has recently noticed a high volume of referrals to non-participating workers' compensation providers. This note is a reminder that as a participating provider you are contractually obligated to make every effort to refer a member or injured worker to other Participating Providers, this includes referrals to reference laboratories, ambulatory surgery centers as well as hospitals. Please note that referrals to non-participating providers could result in non-payment of that workers' compensation bill. We value your participation in our network and want to work with you to make your daily operations smooth. If you have any questions regarding who is contracted for workers' compensation contact workers' compensation customer service at **(866) 700-2168**. Please be aware that workers' compensation resources are also available at www.bclhwcmcs.com for more information.

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

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

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

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

.....and much more

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

Network leasing arrangements

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

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

Guidelines and Quality Programs

HEDIS® 2014: Provider incentive winners announced!

We have completed the HEDIS data collection for 2014 and want to thank all of our provider offices and their staff who assisted us. Your collaboration in this process allows us to achieve the best HEDIS results possible.

This is the 3rd year for our incentive program to acknowledge some of our providers who either responded in a timely manner or went "Above & Beyond" to help make our HEDIS data collection successful. Any practices that responded within 5 business days of our initial request or who went out of their way by taking additional steps to help us with data collection were entered in a drawing to receive a gift. In the event an office was not able to accept a tangible gift, a special written recognition was given. We are pleased to announce our incentive winners as follows:

- Dennis Chan, MD, Monterey Park, CA
- Advanced Cardiovascular Specialists, Mountain View, CA
- Bipin C. Patadia, MD, Upland, CA
- Cuesta Medical Group, Los Osos, CA
- San Diego Primary Care Medical Group Inc., San Diego, CA
- VA Clinic and Hospital, Long Beach, CA
- Michael Rutman, MD, Vista, CA
- Providence Medical Institute, Torrance, CA
- Center for Family Health, San Diego, CA
- Suresh Sachedeva, MD, San Ramon, CA
- Greg Beach, OD, Napa, CA

Thanks again to all of our provider offices and their staff for assisting us in collecting HEDIS data. Our HEDIS results reflect the excellent care you provide to our members. An overview of our HEDIS rates will be published in the 4th quarter provider newsletter. We look forward to working with you next HEDIS season!

Clinical practice and preventive health guidelines available on the web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to www.anthem.com/ca, select > Provider > Enter > Home Page and then Health & Wellness>Practice Guidelines.

Boeing home colon cancer screening

Anthem Blue Cross would like to make you aware of a home colon cancer screening program that Boeing is implementing beginning in September 2014. Boeing is a National Account of Blue Cross Blue Shield of Illinois (BCBSIL) that has significant membership in Southern California.

The program will send an initial mail communication to eligible members asking them to opt into receiving a kit, which is a fecal immunochemical testing kit (FIT). It is a simple, at home kit which allows the member to take a sample and send back to the lab in a postage paid envelope. Members will be asked if they want to share their test results with their provider. If the member chooses, they can provide their provider name and address to ensure the test results are also sent to their provider. BCBSIL primary nurses will outreach to members with positive results to make sure they know they need to follow-up with their physician on their result. Members will also be able to call BCBSIL with general questions on the kit, or benefit coverage questions they may have.

Medicare Advantage Updates

Medicare Advantage reimbursement policy changes

Anthem Blue Cross' Medicare Advantage reimbursement policies have been updated, effective January 1, 2015. These policies apply to participating providers who serve Individual Anthem Blue Cross Medicare Advantage business. A non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates. To view the updated Anthem Blue Cross Medicare Advantage reimbursement policies, visit the provider self-service website at www.anthem.com/ca. Anthem Blue Cross Medicare Advantage Employer Group Retiree business will not be affected by this update.

What does this means to you?

Policy changes will impact the Individual Anthem Blue Cross Medicare Advantage business, which will be moving to a different claims processing platform. Please refer to the reimbursement policy website, your provider manual, and/or your provider contract as a guide for reimbursement criteria. These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross Medicare Advantage benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. Proper billing and submission guidelines are required along with the use of industry-standard, compliant codes on all claim submissions.

Reimbursement policies undergo reviews every two years for updates to federal or CMS contracts and/or requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an Anthem Blue Cross Medicare Advantage business decision. When there is an update, the most current policies are published on the provider self-service website.

Anthem Blue Cross Medicare Advantage Employer Group Retiree business will remain on the current claims processing platform. Members under an Employer Group Retiree plan will have one of the following prefixes on their member card:

Employer Group Prefixes		
FKB	JQF	JWM
VZM	VZP	WGK
WMN	WSP	XDK
XDT	XGH	XGK
XKJ	XVJ	XVL
YCG	YGJ	YGS
YLR	YLV	YRA
YRE	YRS	YRU

Why is this change necessary?

Anthem Blue Cross Medicare Advantage reimbursement policies were updated in order to streamline our Medicare Advantage business, improve our overall efficiency, and better align with CMS.

What if I need assistance?

The following table highlights some of the changes to the reimbursement policies. The complete set of policies is available at www.anthem.com/ca. If you have questions, please visit the provider self-service website or call the number on the back of the member's ID card.

These changes apply only to Individual Anthem Blue Cross Medicare Advantage Business. The Employer Group Retiree Business will maintain current policies. Please refer to the complete list of reimbursement policies on the reimbursement policy website, your provider manual, and/or your provider contract as a guide for reimbursement criteria. These policies apply to participating providers unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

Policy Name	Prior to January 1, 2015	As of January 1, 2015
Allergy Treatment: Immunotherapy	No previous reimbursement policy	Anthem Blue Cross Medicare Advantage allows reimbursement of allergy immunotherapy. Claims billed for more than 240 doses during a 12-month period will be denied.
Professional Anesthesia Services	When Modifier AD is appended to a claim, the reimbursement percentage is based on the 3 base units. This rate is determined by the Conversion Factor x 3 regardless of the procedure base units reported. Anthem Blue Cross allows additional reimbursement for services reported with physical status modifiers P3, P4, and P5.	When Modifier AD is appended to a claim, reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for up to three base units for anesthesiologists who supervise three or more concurrent or overlapping procedures. Anthem Blue Cross Medicare Advantage does not reimburse for the use of physical status modifiers or qualifying circumstances codes denoting additional complexity levels.
Assistant at Surgery (Modifiers 80/81/82/AS)	Assistant Surgeon services reported with Modifier AS will be eligible for reimbursement at 16 percent of the maximum allowance under the applicable physician extender fee schedule. If there is no applicable physician extender fee schedule, the Assistant Surgeon services will be eligible for reimbursement under the applicable physician fee schedule at 14 percent of the maximum allowance for the primary procedure.	Assistant Surgeon services reported with Modifier AS will be eligible for reimbursement according to CMS reimbursement guidelines, currently 13.6 percent.
Claims Timely Filing: Participating and Non-Participating*	No previous reimbursement policy	Anthem Medicare Advantage allows reimbursement of claims for covered services for covered members using appropriate claims timely filing requirements. Anthem Medicare Advantage

		follows the standard of 12 months for participating and non-participating providers and facilities.
Consultations*	Anthem recognizes consultation services, which are divided into two sections based on place of service: office or other outpatient consultations and inpatient consultations.	Anthem Medicare Advantage does not recognize office, outpatient or initial inpatient consultation codes.
Diagnoses Used in DRG Computation	No previous reimbursement policy	Anthem Medicare Advantage ensures that the diagnosis and procedure codes that generate the Diagnosis Related Groups (DRG), and therefore the hospital invoice, are accurate, valid and sequenced in accordance with national coding standards and specified guidelines. Anthem Medicare Advantage performs DRG audits to determine that the diagnostic and procedural information that led to the DRG assignment is substantiated by the medical record.
Documentation Standards for Episodes of Care	No previous reimbursement policy	Anthem Medicare Advantage requires that, upon request for clinical documentation to support claims payment for services, the provided information should identify the member, be legible, and reflect all aspects of care. This policy outlines the minimum elements needed in order for documentation for episodes of care to be considered complete, and instructs providers to refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC). Other documentation not directly related to the member, but relevant to support clinical practice, may be used to support documentation regarding episodes of care; examples are listed within the policy. Anthem Medicare Advantage may request providers submit additional documentation to support their claims. If documentation is not provided following the request or notification or does not support the

		services billed for the episode of care, Anthem Medicare Advantage may deny the claim and recover and/or recoup monies previously paid on the claim.
Drug and Injectable Limits	No previous reimbursement policy	Reimbursement will be considered up to the Clinical Unit Limits (CUL) allowed for the prescribed/administered drug. We use the CMS Medically Unlikely Unit (MUE) value. When there is no MUE assigned by CMS, identified codes will have a CUL assigned or calculated based on the prescribing information, The Food and Drug Administration, and established reference compendia. Claims that exceed the CUL will be reviewed for documentation to support the additional units. If the documentation does not support the additional units billed, the additional units will be denied.
Inpatient Facility Transfers*	No previous reimbursement policy	Anthem Medicare Advantage allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for same episode of care. In the absence of federal guidelines regarding facility transfers payment, transferring facilities will receive a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting, and receiving facilities will receive full DRG payment. This policy only affects those facilities reimbursed for inpatient services by a DRG methodology.
Maternity Services	Anthem outlines when various obstetric services are included in the global reimbursement for obstetric services or when these services are eligible for separate reimbursement.	Anthem Medicare Advantage allows reimbursement for global obstetrical codes once per period of a pregnancy (defined as 279 days) when billed by a single provider or provider group reporting under the same federal Tax Identification Number (TIN). Reimbursement is based on the global obstetric care package (i.e. antepartum, delivery and postpartum) being provided by the provider or provider group. If a provider or provider group does not provide all antepartum, delivery and postpartum services, global obstetrical codes may not be used and providers are to submit only

		the elements of the obstetric package that were actually provided. Anthem Medicare Advantage will not reimburse for duplicate or otherwise overlapping services during the course of the same pregnancy. The policy outlines services included and not included in the global package.
Modifier 62: Co-Surgeons	63 percent of the maximum allowance is reimbursed for each of the two operating surgeons with the appended 62 modifier.	Reimbursement to each surgeon is based on 62.5 percent of the applicable fee schedule or contracted/negotiated rate.
Modifier 66: Surgical Teams	Surgical Team services are identified by appending the Modifier 66 to the designated CPT code(s).	Each physician participating in the surgical team must bill the applicable procedure code(s) for their individual services with Modifier 66. If any or all physicians participating in the surgery fail to use the modifier appropriately, claims may be denied or pended for duplicate or suspected duplicate services, respectively.
Modifier 76: Repeat Procedure by the Same Physician	A claim may be reviewed to determine the eligibility for separate reimbursement for the repeated procedure code.	Providers must submit supporting documentation for the use of Modifier 76 with the claim. If a claim is submitted with Modifier 76 without supporting documentation, the claim will be denied.
Modifier 77: Repeat Procedure by Another Physician	A claim may be reviewed to determine the eligibility for separate reimbursement for the repeated procedure code.	Providers must submit supporting documentation for the use of Modifier 77 with the claim. If a claim is submitted with Modifier 77 without supporting documentation, the claim will be denied.
Portable/Mobile/Handheld Radiology Services	No previous reimbursement policy	Anthem Medicare Advantage allows reimbursement for portable/mobile radiology services when furnished in a residence used as the patient's home if ordered by a physician and performed by qualified portable radiology suppliers. Portable/mobile radiology studies should not be performed for reasons of convenience. Medicare Advantage allows preventive screenings performed by portable/mobile radiology studies for routine purposes. Reimbursement is based on the applicable fee schedule or contracted/ negotiated rate for the radiological service, and transportation and setup components with the use of applicable modifiers; transportation and setup component

		reimbursement guidelines are outlined within the policy. The policy also addresses reimbursement for the use of handheld radiology instruments.
Preadmission Services for Inpatient Stays*	No previous reimbursement policy	Anthem Medicare Advantage allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital. For admitting hospitals, applicable preadmission services are included in the inpatient reimbursement for the three (3) days prior to and including the day of the member's admission, and therefore are not separately reimbursable expenses. For other hospitals or units (e.g. children's hospitals, psychiatric hospitals), applicable preadmission services are included in the inpatient reimbursement within one (1) day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses.
Prosthetic and Orthotic Devices	The replacement of a DME item may be necessary through normal wear and tear.	Anthem Medicare Advantage allows reimbursement of prosthetic and orthotic devices and outlines in this policy their reimbursement methodology for these devices. For example, reimbursement is allowed for replacement of prosthetic and orthotic devices due to irreparable wear in consideration of the reasonable useful lifetime of the device of not less than 5 years based on when the equipment is delivered to the member, among other criteria listed in the policy.
Reimbursement for Reduced and Discontinued Services	No previous reimbursement policy	Anthem Medicare Advantage allows reimbursement to professional providers and facilities for reduced or discontinued services when appended by the appropriate modifier. When Modifier 73 is appended, reimbursement is reduced to 50 percent of the applicable fee schedule or contracted/negotiated rate. When Modifier 74 is appended, reimbursement is 100 percent of the

		applicable fee schedule or contracted/negotiated rate.
Scope of Practice	No previous reimbursement policy	Anthem Medicare Advantage allows reimbursement for services that are within the provider's scope of practice under state law in accordance with CMS guidelines. The provider shall be licensed in or hold a license recognized in the jurisdiction where the patient encounter occurs.
Split-Care Surgical Modifiers	For Modifier 56, reimbursement will be calculated at 10 percent of the applicable surgical reimbursement maximum allowance.	Anthem Medicare Advantage does not allow separate reimbursement for Modifier 56.
Unlisted or Miscellaneous Codes	No previous reimbursement policy	Anthem Medicare Advantage allows reimbursement for unlisted or miscellaneous codes (a.k.a. Not Otherwise Classified (NOC) codes). Unlisted or miscellaneous codes should only be used when an established code does not exist to describe the service, procedure, or item rendered. Claims submitted with unlisted or miscellaneous codes must contain the following information and/or documentation for consideration during review: a written description, office notes, or operative report describing the procedure or service performed; an invoice and written description of items and supplies; and/or the corresponding National Drug Code (NDC) number for an unlisted drug code.

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HIPPS codes required for all skilled nursing and home health providers

Starting July 1, 2014 all claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) received by Anthem Blue Cross Medicare Advantage, must contain a valid HIPPS code. **This pertains to both Contracted and Non-Contracted Providers.** Anthem Blue Cross understands that in the past we did not require these codes from all of our Contracted Providers; however CMS now requires that we must include this information on **all processed claims** data we submit to CMS. As a result, all SNF and HHA claims for services rendered on or after July 1st that are sent to Anthem Blue Cross without the valid HIPPS code may be denied and sent back to the provider.

What and How to Bill

- SNFs should bill the HIPPS code derived from the "Admission Assessment"
- HHAs should bill the HIPPS code derived from the "Start of Care Assessment"
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable PPS Revenue Code (022 or 023), the HIPPS code, 1 unit, and billed charges of 0.00.

Additional Information

- This billing instruction applies to all Medicare Advantage Plans including Dual Eligible Special Needs Plans. But does not, however, apply to Medicare Supplemental Plans.
- HHAs are not required to bill Treatment Authorization Codes.
- If you currently have a contract with Anthem, the CMS mandated addition of the HIPPS code on your claim will not affect your payment.

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Medicare Advantage specialty pharmacy team requires pre-certification of certain drugs within the WellPoint Cancer Care Quality Program

Anthem Blue Cross will introduce the WellPoint Cancer Care Quality Program beginning **November 1, 2014**. This quality initiative brings you evidence-based cancer treatment information that will allow you to compare planned cancer treatment regimens against evidence-based clinical criteria. The Cancer Care Quality Program also identifies certain evidence-based WellPoint Cancer Treatment Pathways ("Pathways"). When you determine that a treatment regimen on Pathway is appropriate for one of our Medicare Advantage members, you may be eligible for enhanced reimbursement. Treatment regimens for breast, lung and colorectal cancer, as well as lymphoma, myeloma, pancreatic and ovarian cancers, can be submitted to the Cancer Care Quality Program through AIM's ***Provider****Portal* or by contacting AIM at **(877) 291-0360**. Additional Pathways for other common malignancies will be added throughout 2014 and 2015. Enhanced reimbursement when a treatment regimen is on Pathway is only available for participating providers who are in-network for the member's health benefit plan.

Anthem Blue Cross Medicare Advantage Medical Management requires precertification for a number of specialty drugs for its non-HMO Medicare Advantage members.

A small number of oncology drugs on this precertification list overlap with the Cancer Care Quality Program. Effective **November 1, 2014,** if an oncology drug on the pre-certification list is submitted to the Cancer Care Quality Program through AIM's ***Provider***Portal and is not on Pathway, or if an oncology drug on the pre-certification list is not included under the Cancer Care Quality Program, providers should call the Medicare Advantage Specialty Pharmacy to request precertification at the appropriate phone/fax number listed below; the Specialty Pharmacy team will review the requested drug to determine if it meets medical necessity criteria.

The following drugs require a precertification by Medicare Advantage Specialty Pharmacy:

Abraxane	Avastin	Granix	Jevtana®	Neulasta	Prolia®
Adcetris™	Campath	Halaven®	Kadcyla	Neupogen	Provenge®
Alimta®	Epogen/Procrit	Herceptin	Kyprolis	Perjeta	Rituxan
Aranesp	Erbitux	Hycamtin®	Leukine/Prokine	Proleukin®	

If a precertification is not obtained, the request will be subject to a post service review for medical necessity. 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.

Anthem Blue Cross pre-certifications can be obtained at the following phone or fax numbers. Follow the prompts to reach the Medicare Advantage Specialty Pharmacy team.

State	Phone	Fax
Colorado and Nevada	(866) 797-9884, option 5	(866) 959-1537
California non-HMO MA members	(866) 797-9884, option 5	(866) 959-1537

A complete list of pre-certification requirements can be found at the Provider Forms section of the Anthem Blue Cross Medicare Advantage Public Provider Portal (www.anthem.com/ca/medicareprovider).

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.

Improving quality of care for rheumatoid arthritis (RA) members

Evidence-based guidelines support early initiation of disease modifying anti rheumatic drug (DMARD) therapy in patients diagnosed with RA. According to the American College of Rheumatology, all patients with RA are candidates for DMARD therapy, and the majority of the newly diagnosed should be started on DMARD therapy within three months of diagnosis.

During recent quality reviews of our RA members-some challenges were noted. These include:

- Members correctly diagnosed with RA but not receiving treatment, and
- Members who were being worked up for joint pain but incorrectly coded RA

You can help:

Review clinical practice guidelines and treatment recommendations at www.rheumatology.org. New treatments have come a long way and -- if started early -- can prevent joint damage and promote "remission." Early treatment has been shown to decrease the need for joint replacement and improved quality of life for those diagnosed with RA.

Ensure your documentation is clear and coded correctly. If treating a member for unknown joint pain, there are alternates to "rule-out RA" as a diagnosis code. Until a true diagnosis is made, consider using codes for joint pain (719.40), swelling (719.0) or difficulty with walking (719.7). Attention to clinical practice guidelines and coding will allow for proper identification as well as to initiate early effective treatment for our RA members.

Select cardiac services to be reviewed

Appropriate care is the key to achieving the best outcomes for our Medicare Advantage members. To help ensure that Anthem Blue Cross members receive evidence-based care, Anthem Blue Cross is collaborating with NIA Magellan to ensure that previous invasive cardiac procedures were reasonable and necessary for the diagnosis and/or treatment of coronary artery disease. Cardiac Catheterizations and Percutaneous Coronary Interventions that occurred in 2012 – 2013 for Medicare Advantage members will be the focus of a claims data analysis that may result in a medical record audit.

Providers who have submitted claims for either of these services for Anthem Blue Cross Medicare Advantage members during this time period may receive a request for records and related digital images. The process for submitting records and related images will be streamlined by providing you with a HIPAA-compliant, secure internet portal for uploading the needed information. Instructions on this process will be included with the request. Requests will be delivered beginning third quarter, 2014.

A board-certified cardiologist will review the records and images to determine if the services were reasonable and necessary for the patient's underlying health status. Should you receive a medical record request, we would appreciate your timely compliance. We look forward to working with you to help ensure that our Medicare Advantage members receive the highest quality care.

Notice of Medicare Non-coverage Requirements

The Centers for Medicare and Medicaid Services (CMS) requires providers to deliver a "Notice of Medicare Non-Coverage" (NOMNC) to every Medicare beneficiary at least two days prior to the end of their skilled nursing facility (SNF), home health or comprehensive outpatient rehabilitation facility (CORF) care.

SNFs are responsible for delivering the NOMNC on behalf of Anthem Blue Cross to the member or representative. SNFs also are responsible for obtaining signature(s) the same day the NOMNC is received by Anthem **and returning the signed NOMNC to Anthem that same day,** but no later than two days before the member's covered services end. In the event the SNF is not able to deliver the NOMNC and obtain signature(s) the same day Anthem issues the NOMNC, the SNF provider is responsible for re-issuing a NOMNC with the appropriate Last Approved Day (LAD) to give the member or the member's representative at least two calendar days advance notice.

In addition, Anthem Blue Cross does not provide verbal notification of NOMNC. CMS requires 100 percent compliance. To help ensure CMS compliance, please:

- Submit Notice of Medicare Non Coverage (NOMNC) notices no later than two days before the termination of services
- Verify notices are signed and dated by the member or member's representative and **return to Anthem Blue Cross the same day.**
- Provide complete and accurate records/documentation.

Anthem Blue Cross will continue to work with providers to reach the 100 percent compliance goal.

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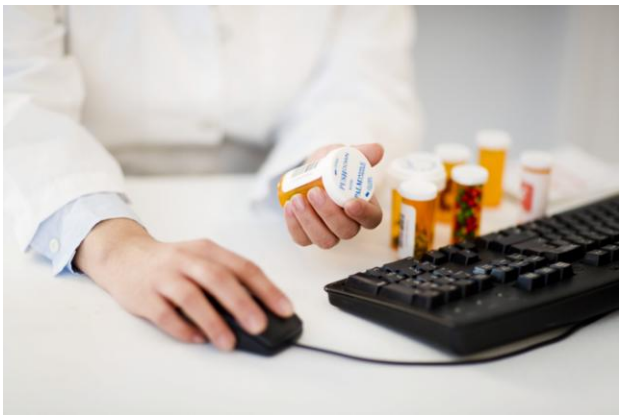
Pharmacy

Pharmacy information available on anthem.com/ca

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 drug list is reviewed and updates are posted to the web site quarterly



Generic pipeline – quarterly update

Our quarterly generic pipeline update provides you with a quick view of the brand name medications that have come off patent or are expected to lose patent protection and become available as a generic during the second quarter of 2014.

Within the next four years, more than $83 billion in annual U.S. sales of brand-name medications will be coming off patent. A one percent increase in generic utilization can result in approximately a one to two percent reduction in total drug spend. When appropriate for your patients, we encourage you to prescribe generic drugs to help reduce prescription drug costs.

For more information about our Drug List, including prior authorization, Drug List selection and drug alerts, log on to anthem.com/pharmacyinformation.

Source: Internal WellPoint data

Generic launch schedule 2Q 2014

Brand Name	Generic Name	Manufacturer	Therapeutic Class	Probability of Launch (Low, Medium, High)
Actonel (5, 30 & 35 mg tablets)	Risedronate	Warner Chilcott	Calcium Regulators - Misc.	High
Actonel (150 mg tablets)	Risedronate	Actavis, Warner Chilcott	Calcium Regulators - Misc.	Launched
Actonel w/Calcium	Risedronate/ calcium carbonate	Warner Chilcott	Calcium Regulators - Misc.	Medium
Alrex (0.2% ophthalmic suspension)	Loteprednol Etabonate	Bausch + Lomb	Ophthalmic Steroids	Medium
Astepro (0.15% nasal solution)	Azelastine Hydrochloride	Meda Pharmaceuticals	Nasal Antiallergy	Launched
Atelvia (35 mg delayed release tablets)	Risedronate sodium	Warner Chilcott	Bone Density Regulators	Medium
Differin (0.3% Gel)	Adapalene	Galderma	Acne Products	Launched
Ertaczo	Sertaconazole nitrate	Valeant	Antifungals - Topical	TBD
Exalgo (8, 12, & 16 mg extended release tablets)	Hydromorphone hydrochloride	Mallinckrodt	Opioid Agonists	Launched
Humalog Humalog Pen	Insulin Lispro Recombinant	Lilly	Insulin	Low
Humalog Mix (all strengths)	Insulin Lispro Protamine Recombinant, Insulin Lispro Recombinant	Lilly	Insulin	Low
Lipofen (50 & 150 mg capsules)	Fenofibrate	Cipher Pharmaceuticals, Kowa Pharmaceuticals	Fibric Acid Derivatives	Launched
Lotemax (0.5% ophthalmic suspension)	Loteprednol Etabonate	Bausch + Lomb	Ophthalmic Steroids	Medium
Lovaza (capsules)	Omega-3 Acid ethyl	GSK, Pronova BioPharma	Antihyperlipidemics - Misc.	Launched
Lunesta (1, 2 & 3 mg tablets)	Eszopiclone	Sunovion	Non-Barbiturate Hypnotics	Launched
Lupron Depot (3.75 mg/vial)	Leuprolide acetate	Abbott	Antineoplastic - Hormonal Agents	Low
Naprelan	Naproxen Sodium	Shionogi	Nonsteroidal Anti-	High

			inflammatory Agents (NSAIDs)	
Orapred ODT (10, 15 & 30 mg dispersible tablets)	Prednisolone sodium phosphate	Shionogi	Glucocorticosteroids	High
Ortho Evra (transdermal patches)	Norelgestromin / Ethinyl Estradiol	Janssen	Combination Contraceptives - Transdermal	Launched
Pennsaid (1.5% transdermal solution)	Diclofenac sodium	Mallinckrodt	Anti-inflammatory Agents - Topical	Launched
Renvela (800 mg tablets)	Sevelamer carbonate	Genzyme	Phosphate Binder Agents	Launched
Rhinocort Aqua (nasal suspension)	Budesonide	AstraZeneca	Nasal Steroids	Launched
Supprelin LA	Histrelin acetate	Endo	LHRH/GnRH Agonist Analog Pituitary Suppressants	TBD
Tazorac (0.05% & 0.1% gel)	Tazarotene	Allergan	Antipsoriatics	Medium
Viracept (250 & 625 mg tablets)	Nelfinavir Mesylate	Pfizer	Antiretrovirals	Low
Viramune XR (400 mg extended release tablets)	Nevirapine	Boehringher Ingelheim	Antiretrovirals	Launched
Zylet (0.5-0.3% ophthalmic suspension	Loteprednol Etabonate, Tobramycin	Bausch + Lomb	Ophthalmic Steroids	Medium