

Professional Network News

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Announcements

Journey Forward – Helping Cancer Survivors Move Ahead

Thousands of people surviving a cancer diagnosis may benefit from *Journey Forward*, a new program created by WellPoint, the UCLA Cancer Survivorship Center, the National Coalition of Cancer Survivorship (NCCS), and Genentech.

Journey Forward – launching as a pilot program in California, Colorado, Maine, Nevada and New Hampshire but being made available throughout the country – promotes physician and patient understanding of the “late effects” of cancer treatment and survivorship, and improves continuity and coordination of care for cancer survivors throughout their lives. Late effects may occur months to years after treatment ends and can include a range of physical and psychological conditions.

This first-of-its-kind program was created in response to recommendations by the Institute of Medicine (IOM), which concluded in a November 2005 report (“From Cancer Patient to Cancer Survivor: Lost in Transition”) that “the consequences of cancer and its treatment are substantial” and largely unmet. The report says many cancer survivors

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Journey Forward — Helping Cancer Survivors Move Ahead

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are “lost in transition” from active treatment to survivorship, with few clues about how to manage their follow-up care.

Journey Forward has been in planning stages for more than two years. In early 2009, it began mailing kits to healthcare providers and patients that explain the importance of follow-up care plans, offer tools for providers to generate those plans and offer interactive tools for patients to participate in the process. The effort initially targets survivors of breast and colon cancers as well as oncology and primary care providers. The program will be expanded in the future to target providers and survivors throughout the country of additional types of cancers. By providing tools and information to both parties, Journey Forward opens the door for improved dialogue between physicians and patients and promotes the coordination of long-term care for people with cancer.

The kits are tailored for their audiences. The oncologists' kit includes sample care plans, an electronic Survivorship Care Plan Builder CD to help oncologists quickly create custom care plans for their patients, reimbursement information and other resources. The patients' kit includes a description of Survivorship Care Plans, patient-friendly follow-up guidelines, an electronic Medical History Builder CD designed to facilitate easy electronic provision of their medical history, talking points to facilitate patient-provider dialogue and a resource directory. Primary care physicians will also receive information about survivorship care plans and be directed to **JourneyForward.org** for additional provider and patient materials.

For more information about Journey Forward, please visit **JourneyForward.org**.

Anthem Care Comparison

Anthem Care Comparison (ACC) is an on-line tool which provides total estimated costs for nearly 40 specific medical procedures performed in area hospitals. ACC provides consumers with the tools to help them make cost efficient decisions regarding their healthcare, changing behaviors about their healthcare, and saving the consumer money.

ACC also provides measures of quality for 161 inpatient procedures and conditions obtained from state, federal and private sources. Members can access information regarding the number of patients treated, complication rates, average length of stay, and mortality rates.

WellPoint collaborative partnership for provider information

We have partnered with other Blue Cross and Blue Shield Plans from across the country to provide our members with cost ranges from additional hospitals, outpatient surgery centers, free-standing radiology facilities and other medical facilities so members can have access to even clearer, concise health cost information. Our goal is always to work to enhance the offerings and programs available to our members and to make sure they have the tools they need to make informed health decisions.

Physician level estimated episode of care costs and quality information

Members have access to estimated episode of care costs and quality information at the physician level. This program was developed to provide users with physician level cost, quality, demographic and accessibility information enabling them to make informed decisions.

Members will be able to view specific doctor cost and quality information across 12 medical specialties (e.g. dermatology, pediatrics, internal medicine, family practice, etc.) Each provider within the 12 specialties will display up to 10 common episodes of care (e.g. tonsillitis, bronchitis, diabetes, etc) based on that physician's claim history.

Cost and quality information cannot be viewed by anthem.com/ca visitors. Only registered users can view physician cost and quality data through the secure member portal and going through the provider directory.

New non-contracting Ambulatory Surgery Center fee schedules

Anthem Blue Cross anticipates that it will begin paying non-contracting Ambulatory Surgery Centers (ASC) according to an established Customary and Reasonable (C&R) fee schedule for dates of services on or after June 20, 2009.

The new fee schedule was developed to provide a straightforward methodology which is consistent with applicable California regulatory requirements for the reimbursement to non-contracted facilities in California.

Goodyear Tire & Rubber Co. — ALPHA Prefix Changes That Will Affect Claims

Due to new standards from the Blue Shield and Blue Cross Association for member identification cards, Anthem Blue Cross Goodyear members will be receiving new identification cards with new Alpha prefixes.

Please note the changes below to avoid a delay in claim processing and resubmissions. Please submit claims with correct alpha prefix and advise our members to destroy 'old' ID cards they may have received prior to January 1, 2009. The only acceptable alpha prefixes for Goodyear members are *GYR* and *GYC* as noted below:

<i>Previous 2008 Prefixes</i>	<i>New 2009 Prefixes</i>
DNL	GYR
DLN	GYR
GYD	GYR
WJO	GYR
GYA	GYR
DPT	GYC
GYB	GYC

If you have questions about this update, please contact the number on the back of the member's identification card.

Circuit City Health Plans with Anthem Blue Cross will end March 31, 2009

Circuit City with a number of retail locations across the country that are closing will be terminating their employees' health plans with (name of plan) effective March 31, 2009. As a result of this termination we are encouraging providers to file claims under these plans as quickly as possible.

Circuit City members can be identified by the prefix "CCX" and/or group number 294800.

If you have a patient that may need assistance with medical coverage during this period of transition, we would encourage you to refer to information on our website about the **CoverMe Foundation**. The CoverMe Foundation is a non-profit organization committed to assisting uninsured individuals obtain health care coverage when eligible for state and federal programs.

If you have questions about this Update or need assistance from Anthem on this process, please refer to the Customer Service number on the back of the member identification card.

Billing

Best Practices that Make Electronic Transactions Work for You

Anthem Blue Cross encourages providers to use electronic transactions as a means to significantly reduce administrative and operating costs, gain efficiency in processing time, and improve data quality. To ensure the efficient and timely processing of your electronic transactions, please follow our list of EDI Best Practices.

- Stay current by reading Provider Newsletters.
- "What's on the Anthem Blue Cross Website?" Check out our website for the latest Electronic Data Interchange (EDI) information at www.anthem.com/edi — Select State.
- Familiarize yourself with various EDI claims transactions types:
 - 837 Claims Transmission (Institutional and Professional)
 - Electronic Remittance Advice
 - Electronic Funds Transfer
 - Electronic Reports on Transactions
 - Eligibility and benefit information, and claim status

- Obtain current member eligibility and benefit information prior to submitting a claim.

- Check patient eligibility at the time of the appointment.
- Check claims status electronically by using ProviderAccess®.
- Submit your claims electronically and review your reports on a daily basis.
- Immediately correct and resubmit rejected claims electronically.
- Receive your payments via Electronic Funds Transfer (EFT).
- Receive your remittance advices electronically (ERA).
- Contact the EDI Solutions Help Desk at **800-227-3983** if claim rejections are not understood.
- Have specific claim information available when contacting your local EDI Solutions Help Desk.
- Contact your vendor or clearinghouse for updates.

Coming Soon — On-Line, Printable EOB and Remittance Advice!

On-line tools provide convenience and efficiency. Anthem Blue Cross continues to improve the features of our internet self-service tool — ProviderAccess®. Later this summer, you will be able to print your own explanation of benefit and remittance advice; they will be available on ProviderAccess. This on-line format means that you can access information sooner and in a more environmentally friendly way. You will still see the detailed line item explanation and financial summary. Stay tuned ... more information to come about this exciting enhancement!

HMO Co-Pay Tracking

In June 2009, Anthem Blue Cross will begin capturing co-payment information from PMGs and IPAs on behalf of our HMO members. This is a positive step for our members, as they will now have an automated tracking mechanism for their co-pays throughout the year, as well as an automated communication notifying them when their annual maximums are attained. This new tracking capability will also benefit PMGs and IPAs, as it will help prevent billing adjustments related to maximum co-pay thresholds. PMGs and IPAs will also receive a notification regarding member attainment of co-pay maximums.

Detailed information and instructions will be communicated very soon. In the meantime, please direct any initial questions to Network Relations at **800-933-6633**.

For technical questions and concerns, please contact your clearinghouse for further information.

Anthem to Accept ONLY NPIs Effective Feb. 21 — Impacts All Electronic Transactions

Beginning February 21, 2009, Anthem will begin accepting only National Provider Identifier (NPI) numbers on electronic claims and other transactions requiring a provider number to meet required HIPAA compliance. Currently, Anthem accepts electronic transactions with NPIs and Anthem provider numbers (legacy IDs). Through February 20, 2009, Anthem will continue accepting electronic transactions with NPI numbers only, Anthem provider numbers or both. After February 20, 2009, the 10-digit NPI numbers will become the only compliant provider numbers we will accept.

Impact to providers

After February 20, 2009, anyone who submits an electronic transaction with a provider identifier other than the NPI (even if the NPI is also on the

transaction) risks rejected claims and payment delays. (This does not apply to providers who are exempt from submitting NPIs.)* These claims will generate rejects (Failed Claims) on submitters' Level 2 Status reports. Previously assigned Anthem legacy IDs will be considered invalid; therefore, claims should not be submitted with these numbers.

Note: If you use a vendor or clearinghouse, make sure they do not submit your claims with your legacy ID number after February 20, 2009.

File transactions using valid NPI numbers

All 10-digit NPI numbers filed with us **MUST** be valid. Anthem will verify the validity of NPI numbers by requiring that they successfully pass the Luhn formula logic. The Luhn formula is an algorithm (mathematical computation) that is also used to generate and/or validate the accuracy of other identification numbers, such as credit card numbers.

***** NOTE: Always file the TIN even when billing the NPI number. *****

*Exempt providers are those individuals and organizations who are "not eligible" to receive NPIs, and therefore not required to use them. Examples of exempt providers include taxi services, home and vehicle modifications and health clubs.

Attention 835 Trading Partners: Change to Forwarding Balance Segment

Effective December 22, 2008, the data being returned in the PLB forwarding balance (FB) segment contains your patient account number for the overpayment recovery. Previously, the check number where the forwarding balance was originally created populated this segment.)

This change effects payments for both local and commercial business.

If you have any questions pertaining to this change, please contact an EDI Solutions Specialist at:

Telephone: **800-227-3983**

Fax number: **818-234-9847**

E-mail address: **edi.operations@wellpoint.com**

Hours available: **8 a.m.-4:30 p.m. PT**

Using Specific Codes Speeds Reimbursement

As you know, NOC/NOS* codes are defined as "not otherwise classified/specified. Equivalent to Unspecified. This abbreviation refers to a lack of sufficient detail in the statement of the diagnosis to be able to assign it to a more specific sub division within the classification."

That means that if there is not a more specific code with which to bill the service, a provider may use the non-classified or non-specified code. However, did you know that you get a quicker turn around of your reimbursement decision with an identified code versus an NOC code?

Why is it quicker? Our reimbursement system is designed to process identified ICD-9 and HCPCS/CPT codes without manual intervention, so you get a faster turn around time with fewer errors when you submit specific codes. NOC codes, on the other hand, are stopped by the reimbursement system for a manual review.

This process entails:

- A processor to review the code submitted,
- Review notes on the system about the code,
- Review YOUR documentation of what the code is being billed for,
- Send the claim to nurse review to make a decision
- The processor finishes the claim and reimbursement is made

Additionally, if there is no documentation for the service being billed then the process stops while we send a letter asking you for the back up documentation for the code and services billed. This delays your reimbursement decision and the possibility of errors increases. If you do submit and NOC code for a service you can speed up the process by submitting the claim with a full detailed description of the service rendered. You can add this detailed information to the miscellaneous field/lines of the HCFA or to the miscellaneous field/lines on the UB92 claim form. You can also always attach any type of supporting documentation or descriptions when you submit the claim.

Network

Zagat Health Survey tool expanded to San Francisco, San Diego and Sacramento

Zagat Health Survey, the online survey tool that allows consumers to share their physician experiences, has been expanded to the greater San Francisco, San Diego and Sacramento areas. This will allow members to review and share feedback about physicians throughout these additional areas of the state.

Since launching the tool last year in the greater Los Angeles area, we have seen a very positive response from members. Nearly 90 percent of members who completed the survey recommended their providers and offered useful comments about their experiences.

More about the Zagat Health Survey tool

Working with Zagat Survey, Anthem Blue Cross is helping to address an unmet need for peer-to-peer interaction among health care consumers. The Zagat Health Survey tool provides a vehicle for members to review physicians based on a set of distinct criteria, creating a trusted resource to support informed member decision-making. This tool not only helps members, but is also designed to assist doctors in understanding members' experiences.

The online survey tool allows consumers to review their doctor visits based on trust, communication, availability and environment. Members are asked whether they would recommend their doctor to others. The survey also features a comments section, allowing members to explain their ratings. These categories are designed to assist consumers but can also provide useful feedback for providers.

For each network physician, the online entry displays contact information, ratings on a 30-point scale for each of the four categories, and the percentage of members who recommend that physician. The most recent comments are displayed first, and members have the option to rate the usefulness of comments and report suspicious comments. Members can complete the Zagat Health Survey by logging on to the secure member portal on the Anthem Blue Cross website.

Changing hours of operation for BlueCard® Claims Customer Service Unit

Beginning Friday March 13, 2009, we changed our hours of operation for the BlueCard Claims Customer Service unit on Friday's **ONLY** to the following: 8 a.m. — 3:30 p.m. (closed from 3:30 — 4:30 p.m.) reopen at 4:30 — 6 p.m. Mountain Time. Please note that Monday through Thursday operation hours **will not change**.

Rapid Update: Provider e-mail Communication is Now Available!

Connecting with Anthem Blue Cross and staying informed will be even easier, faster and more convenient. Important “need-to-know” provider updates are a click away.

Rapid Update is our latest web-based tool for sharing vital information. It features short topic summaries and links that let you dig deeper into timely critical business information, but only when necessary:

- Important website updates
- System changes
- Fee schedules
- Medical Policy updates
- Mailed communications
-and more!

It's easy to register. Just go to anthem.com/ca, choose “Provider”, then click on enter. Select the tab “Provider Home” and scroll down and click on the link Network –eMail Rapid Updates fill in your e-mail address and contact info and click SUBMIT; then start watching your e-mail.

The screenshot shows a web form titled "Anthem Network Rapid Update Email Sign-up Form". It contains several input fields: "Last Name", "First Name", "Zip Code", "Phone Number", and "Email Address". There are also radio buttons for "Provider" and "Subscriber", and "Yes" and "No" options for "I would like to receive..." and "I would like to receive...". A "Submit" button is located at the bottom right of the form.

2009 Provider Network Seminars – May and June

Come and enjoy an open dialogue between all provider types and the Anthem Blue Cross Provider Network Education Team. Anthem-S.O.S. (Solutions On Sight) will offer a variety of critical topics of interest: Provider Disputes, Operations Manual Navigation, ProviderAccess®, Revenue Cycle, Timely Filing, Overpayment Adjustments, BlueCard/Out-of-State, e-Learning solutions and more!

We are offering 14 complimentary sessions throughout the state from May 6 through June 17. For locations and registration information, logon to: <http://www.anthem.com/ca/home-providers.html>. In the **Spotlight** section, click on the link **2009 Provider Education Seminars**, which will take you to our SOLUTIONS brochure and registration form. We look forward to seeing you at the seminar of your choice! Register early! Space is limited! You can contact us at network.education@wellpoint.com or by telephone at **818-234-1016** or fax at **818-234-8959**.

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 those other payors and affiliates are treated like Anthem members. As such, they are entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. You can obtain the “other payors” list on the ProviderAccess® portion of the Anthem website, at www.anthem.com/ca. If you do not have Internet access, please contact us at **800-933-6633** for assistance.

Workers’ Compensation Medical Provider Network

The Workers’ Compensation Reform Legislation was conceived to tackle many of the primary cost drivers and related issues regarding the state Workers’ Compensation system. The bill allows self-insured employers and insurance carriers to form Medical Provider Networks (MPNs).

An MPN is a group of health care providers selected by the insurer or self-insured employer (usually administered by their TPA) and approved by the DWC’s administrative director to provide medical care to injured workers. **The health care professionals must provide medical services to all injured workers including existing and new work-related injuries.** By establishing an MPN, employers will be able to control the medical care of an injured worker’s claim for most injuries.

We are providing access to our Prudent Buyer network and Occupational Medicine Network to use as a state-certified MPN for treating eligible injured workers. Our MPN currently provides network access, bill review, case management and utilization review services to insurance companies, TPAs and self-insured employers in California.

Please note that if you choose to terminate your participation in the workers’ compensation network by terminating your contract, opting out or if your demographic information is not current, you will not appear in our online directory thus causing you to be terminated from our client’s MPN.

If you renew your contract, opt back in or update your demographic information, this will reinstate you into the Anthem Blue Cross workers’ compensation network. However, this does not automatically reinstate you into the insurer or employer’s MPN. To confirm your MPN status after one of the above occurs, please contact the insurer or employer directly.

For additional information regarding the obligations of the treating physician within the MPN other MPN issues, or if you do not treat Workers’ Compensation patients, visit the Blue Cross’ Workers’ Compensation Services website at <http://wcs.anthem.com/WCMCSHomePage.htm> or call us at **866-700-2168**.

Program

MyHealth Advantage

Effective March 1, 2009, the Anthem 360° Health® MyHealth Advantage program will be included in some of your patients’ health benefit plans at no additional cost.

MyHealth Advantage is designed to help improve member health and coordination of care by working with doctors to identify potential medical gaps and health risks. The program scans medical, pharmacy and lab claims and compares it with current evidence based medical guidelines and best clinical practices. When potential health risks are identified, members receive a confidential, personalized message called a *MyHealth Note* via mail at their home which suggests specific actions that when endorsed by with their doctor can help the member comply with best practices for medical care. All the messages within the MyHealth Note direct members to speak with their doctor before making any changes in their medical care. The MyHealth Note also includes a list of recent medical, lab, and pharmacy claims which can be helpful if shared with the treating physicians especially if the member is following care plans from multiple providers.

In addition, if a clinical issue is identified, like the member is overdue for an annual test or there is a drug therapy issue, their physician is notified by mail as well. If you receive a notice and would like to provide additional information regarding the member or the recommendation, you have the option of faxing a form back or calling to speak with a MyHealth Advantage nurse.

MyHealth Advantage also helps members make the most of their health care dollars by alerting members when they can save money by switching to a specific generic or formulary-preferred medication.

The results can include better health through improved compliance with medical standards. In fact, a recent internal analysis showed **46% of participants who received a MyHealth Note were brought back into clinical compliance.**¹

The personal health guidance in the MyHealth Note helps members understand their current health status, make better informed health care decisions and achieve and maintain wellness.

¹ Based on an internal review of current participants; Members acted within 12 months of receiving the initial MyHealth Note.

Pre-Service Medical Review Program for Specialty Drugs – Improving claims reimbursement efficiency!

We want to remind you about the Pre-Service Medical Review program that was launched in May 2007. In response to provider concerns about the billing requirements, submission of medical records, and lengthy retrospective medical review for specialty drugs, Anthem Blue Cross introduced our voluntary prior authorization UM program over a year ago. The program improves claims reimbursement efficiency by allowing us to perform the UM review prior to claims submission. This program is supported by our **Specialty Pharmacy Medical Management (SPMM)** unit, comprised of nurses and physicians who perform the UM reviews. Specialty Pharmacy Medical Management is designed to ensure that appropriate prescribing is observed, clinical effectiveness is demonstrated, and patients are adequately monitored for positive and adverse effects or outcomes. This program also allows us to prospectively identify and refer members to case management if appropriate.

This program gives our providers the opportunity to ascertain prior authorization approval(s) before submitting a specialty drug professional claim for reimbursement. It is designed to help expedite provider reimbursement for specialty drug claims that require UM review. When the professional claim is submitted with a UM approval number that is already recorded in our system, this allows the claim to move forward to adjudication without stopping for review. In addition, this program affords us the opportunity to partner with our providers to ensure that specialty drugs are appropriately prescribed and that our members receive optimal and appropriate care. If providers choose not to request for prior authorization, submitted

claims will continue to be processed through our usual method and will be retrospectively reviewed, whereby medical records are generally required to be submitted.

To submit a prior authorization UM request for a specialty drug, follow the steps below.

1. Go to our website at **www.anthem.com/ca**, select Providers (do not log into Provider Access)
2. Scroll down to the Learn More section
3. Click on Pre-Service Medical Review for Specialty Drugs
4. Click on the link to Pre-Service Medical Review Request Forms
5. Find the drug that you are requesting UM review for; they are listed in alphabetical order by brand name. Click on the link to open the form.
6. Complete for the form in its entirety and fax it to the number printed on the form; **866-815-0839**

Note: Our SPMM team will respond within 5 business days (with a decision to approve or deny) if the completed requests had all the necessary clinical information attached. Otherwise, the request may be pended for additional clinical information required.

Additionally, providers can access our medical policies and clinical UM guidelines on our website at **www.anthem.com/ca**; select Providers, scroll down to the Learn More section, and click on the link to Medical Policies and Clinical UM Guidelines. These are the policies and guidelines by which the UM requests are reviewed against. Our policies and guidelines are well referenced, documenting the clinical literature and sources where the information was obtained.

Prescription Savings Opportunities for Your Patients

It is no surprise that the economy is on the minds of most people right now and many are looking for options to save money in these difficult times. Unfortunately when people are looking at ways to cut costs; even medications may not fit neatly into the monthly budget.

- Patients who are concerned about medication costs often restrict their use of prescription drugs. This under use has been associated with serious health consequences. Less costly generic drug alternatives may improve patient compliance, and thereby reduce adverse events. Piette JD, Heisler M, et al: *Archives of Internal Medicine*. 2004 Sep 13:749-1755.
- A Kaiser Family Foundation survey found that uninsured non-elderly adults (ages 18-64) are more than twice as likely as insured non-elderly adults to say that they or a family member did not fill a prescription (45% vs. 22%) or cut pills or skipped doses of medicine (38% vs. 18%) in the past year because of the cost.

Initiating discussions about medication costs and prescribing generic medications gives you the opportunity to help your patients save money on their healthcare expenses. Generic medications are a viable option in most therapeutic categories, but here are a couple of "generic" facts:

- *Approximately three-quarters of FDA-approved drugs have generic counterparts.* In 2007, 21% of total prescription drug sales and 65% of total prescriptions dispensed were generic medicines. Kaiser Family Foundation, Prescription Drug Trends, (September 2008), p2.
- *The average brand name prescription price in 2007 was over 3 times the average generic price (\$119.51 vs. \$34.34).* Kaiser Family Foundation, Prescription Drug Trends, (September 2008), p2.

Due to recent patent expirations, there are several therapeutic categories that have additional generic alternatives available. Here are some examples:

Use/Therapeutic Category	Generic Options
Osteoporosis/Bisphosphonates	alendronate
Sleep/Non-benzodiazepine/Hypnotics	zolpidem
Cholesterol/Statins	simvastatin, pravastatin, lovastatin
Allergies/Nasal Steroids	fluticasone propionate
Migraines/Triptans	sumatriptan

If cost and compliance are potentially an issue for your patient, there are older, proven generic medications from a similar therapeutic class that may serve as an option for their disease state. A couple of examples:

Therapeutic Category	Generic Options
Serotonin Norepinephrine Reuptake Inhibitors (SNRI) to Selective Serotonin Reuptake Inhibitors (SSRI)	sertraline, paroxetine, fluoxetine, citalopram
Angiotensin Receptor Blockers (ARB) to Angiotensin Converting Enzyme Inhibitor (ACE-I)	benazepril, enalapril, fosinopril, lisinopril, quinapril, trandolapril, ramipril

Everyday there are several opportunities to educate patients on the importance of taking their medication correctly. Cost can be a negative factor for patients taking their medications and generic alternatives are a viable option in many therapeutic categories. In general, members pay the lowest copay/coinsurance when filling generics as opposed to brand medications. Prescribing generic medications whenever possible helps to keep their healthcare costs affordable while assuring quality care. For additional resources to facilitate a dialog with your patients please refer to the FDA website at http://www.fda.gov/cder/consumerinfo/generic_text.htm.

California Immunization Registry Gives a Boost to P4P

submitted by the California Immunization Coalition Registry Committee

Most physicians keeping up a pediatric or family practice acknowledge that the rewards of keeping patients healthy rarely come in monetary form. But that has changed. You have probably heard about Pay-for-Performance (P4P) and maybe you have participated in the past. The fact is, in recent years, P4P has gained the attention of managed care organizations and physician organizations nationwide as an effective means to reach measurable performance standards. Bonus payments totaled \$65 million in 2007 across all participating groups in CA physician groups in eight participating health plans. The premise is straightforward: your provider group shows good outcomes, you get compensated.

Those familiar with P4P clinical measures know that childhood immunizations top the list. Fewer providers may know that the ways to meet P4P clinical measures have become more innovative, turning to information technologies to achieve objectives.

Since 2004, the Integrated Healthcare Association (IHA) who oversees the P4P program in California has used information technology (IT) measures in its measurement set. The goal is to drive health care settings to take advantage of available technology that, in turn, can improve clinical outcomes. By participating in the IT domains in your P4P program, your practice could receive 20% of your possible P4P allocation. While allocation amounts differ, individual payouts can

be as much as \$10,000 per provider for participating in P4P incentive programs.

To take advantage of the P4P's IT domains, providers must participate in four qualifying activities in the two IT domain categories:

- Integration of clinical electronic data sets
- Clinical decision making at the point of care

Making CAIR work for you

The California Immunization Registry (CAIR) has been qualified by NCQA¹ in both IT domains under the P4P program. CAIR is a free system supported by the California Department of Public Health and California's local health departments. Nine regional CAIR offices ensure easy access to enroll in CAIR and get the benefits of compiling scattered immunization records into a shared database, generating lists of which patients need shots, programming reminders, and forecasting shots due for future visits, including individual patient immunizations-due routing slips. The CAIR software is user-friendly enough for medical assistants, and already in use at thousands of provider offices throughout California.

Under P4P compliance rules developed by IHA, to fulfill measurement 1, physician groups would need to submit documentation that during the current year they were using CAIR for population management related to immunizations (e.g., creating actionable reports or query lists from the CAIR).

For P4P measurement 2, physician groups must measure what percent of their primary care providers (PCPs) — or the percent of commercial HMO members PCPs are serving — are using CAIR at the point-of-care to determine what immunizations are needed. At least 50% of a group's PCPs (or 50% of their commercial HMO members) must be using the registry

during the current year. Data audits of participants are handled by IHA.

To learn more about how to enroll in CAIR to help your group qualify for the two P4P IT domains, visit www.ca-siis.org to contact your regional CAIR affiliate. To learn more about participating in P4P in California, visit www.iha.org.

1 NCQA — National Committee for Quality Assurance

New Chronic Care Risk Adjustment Program Helps Medicare Members

To better manage the care of our Medicare Advantage members, Anthem Blue Cross recently launched the Chronic Care Risk Adjustment (CCRA) program. The new program helps to ensure that our Medicare Advantage HMO, PPO and private fee for service members with chronic conditions are receiving the health care that they need.

The program's chronic care nurse managers reach out to Anthem Blue Cross Medicare Advantage members who have more than one chronic medical condition. Care managers work with our members to ensure that they are visiting their physician regularly; identify members who need an additional level of assistance; and refer them appropriately. For more information about the CCRA program, please contact Tim Binkley at **614-880-6145**.

Balancing Patient Safety with Needed Radiation Exams

The dramatic increase in advanced imaging exams reflects the extraordinarily important role these procedures assume within health care. Between 1980 and 2005, the number of nuclear medicine studies performed in the United States (U.S.) is estimated to have almost tripled. The number of computed tomography (CT) scans increased to 60 million in 2005.¹

Although the increase in cancer incidence resulting from radiation exposure is still under debate, radiation dose and patient safety concerns have received significant media attention over the past year and a half.² A White Paper on radiation dose in medicine issued by the American College of Radiology (ACR) in April 2007 attracted national interest from non-health care related news outlets such as CNN, NBC and *USA Today*. Further attention was generated later that year when the *New England Journal of Medicine* also released an article on radiation exposure.³

The concern emanates from the cumulative effect of all forms of radiation (natural background, industrial, medical, etc.) to which an individual is exposed. Medical procedures associated with radiation exposure range from plain film radiography and fluoroscopy (including fluoroscopically guided interventional procedures), to routine CT and specialized CT studies such as CT angiography (CTA) and CT colonography, as well as a wide variety of nuclear medicine imaging exams including Myocardial Perfusion Imaging and PET Scans. The amount of radiation exposure from imaging procedures can be significant. For example, the estimated dosage from a single routine CT of the abdomen has an estimated exposure of approximately 10 milliSieverts (mSv), which is equivalent to about 500 PA chest x-rays or 3.3 years of natural background radiation.¹

In order to help patients and providers get more information regarding the radiation dose associated with imaging procedures, American Imaging Management® ("AIM®"), the radiology benefits manager for (health plan) has developed an interactive patient safety website (www.americanimaging.net/safety) including a unique tool called "Ask AIMEE". Ask AIMEE allows users

to select commonly ordered imaging procedures and obtain the estimated radiation dose associated with those procedures in an adult patient. The radiation dose is expressed in three different units of measurement: effective dose in mSv, chest x-ray radiation equivalent and natural background radiation equivalent. Users will also find the latest news and research regarding patient safety and advanced diagnostic imaging.

Consistent with recommendations from the ACR White Paper on Radiation Dose in Medicine, AIM in collaboration with Anthem Blue Cross has recently implemented a new educational campaign informing physicians when they request an imaging procedure for a patient that has already been exposed to high estimated doses of radiation. Radiation exposure is estimated from previous imaging that has been ordered through AIM's programs. This information is being provided to physicians for informational purposes in order to raise awareness and assist them in their decision making process.

For more information on the Patient Safety Program, please visit www.americanimaging.net/safety today.

References:

- 1 Amis ES, Bulter PF, Applegate KE, et al. American College of Radiology white paper on Radiation Dose in Medicine. *J Am Coll Radiol* 2007; 4: 272-284.
- 2 Martin DR, Semelka RC. Health Effects of Ionizing Radiation From Diagnostic CT Imaging: Consideration of Alternative Imaging Strategies. *Appl Radiol* 2007; 36(6): 20-29.
- 3 Brenner, DJ, Hall, EJ. Computed Tomography—An Increasing Source of Radiation Exposure. *N Engl J Med* 2007; 357: 2277-84.

Radiology management administered by American Imaging Management, a separate company.

Guidelines

California Regional PPO Medical Management Requirements for Hospital Admissions

All elective inpatient admissions require prospective review. This includes elective admissions to acute care facilities, skilled nursing facilities, inpatient rehabilitation facilities and long-term care facilities. For unplanned emergency admissions, the facility must notify the plan on the first business day following admission.

To request prior authorization of an elective admission, or to provide notification of an unplanned admission, please call our toll free number **1-877-811-3107**, between the hours of 8 a.m. and 5 p.m. Pacific Time, Monday through Friday.

HEDIS® Immunization Guidelines: We Need Your Help!

As a physician, you play a vital role in educating patients about the benefits of life-long, life-protecting vaccines and the importance of up-to-date immunization records. As a physician you also have a positive impact by urging parents to have their infants and young children receive the recommended immunizations by age two. Childhood immunizations are part of the medical record data collection through the Healthcare Effectiveness Data and Information Set (HEDIS®).

HEDIS® will add 3 vaccinations to the Childhood Immunization Status (CIS) measure in 2010. This change affects children from birth up to 2 years old.

These include the following:

- 2 Hepatitis A
- 3 Rotavirus
- 2 Influenza

To receive HEDIS® credit the medical record must have proper documentation of each immunization:

- name of specific antigen
- date administered
- should include those given at birth

The patient must receive the full number of doses recommended by the Advisory Committee on Immunization Practices (ACIP) and all immunizations must be given before the patient's 2nd birthday. **NOTE:** HEDIS® did revise the required number of doses for the Hib vaccine, per ACIP recommendations, to defer the third Hib booster during vaccine shortage. During the shortage, only two of the three doses are required for HEDIS compliance.

The Clinical Quality Department reviewed a sample of medical records from the 2008 Childhood Immunization HEDIS® measure. Where possible, 100-150 records were reviewed, representing a variety of provider offices in each state. The purpose of the review was to determine if physicians are currently giving 2 Hep A, 3 Rotavirus, and 2 Influenza vaccinations to children prior to their 2nd birthday.

Our Findings for California showed an opportunity for improvement. *Medical Record Review results vary among states and vaccination: Hep A was found most often, followed by Influenza. Rotavirus was seldom found documented.

For best practices on providing up-to-date immunizations, please make sure the following information is documented in the medical record and that all doses of the ACIP recommended immunization are received by the patient's 2nd birthday.

- Name of specific antigen given
- Date administered
- All immunizations given at and since

birth. In the event the member received an immunization elsewhere (health department or another physician) that documentation must be evident in the patient's current chart.

- If a parent states their child's immunizations are up to date, documentation must be evident in the patient's chart.
- When possible, ask the parent to book the next appointment prior to leaving the office to help keep them on schedule.

For more ideas to keep immunizations up-to-date, please visit the Immunization Action Coalition at <http://www.immunize.org/catg.d/p2045.pdf> to review the "Suggestions to Improve Your Immunization Service" check list.

Immunization & Preventive Health Guideline Statement

Anthem Blue Cross supports ACIP (CDC), AAP, and AAFP immunization recommendations. These recommendations are considered medically necessary (subject to the member's benefit booklet) even if they have not yet been incorporated into the Anthem Blue Cross Preventive Health Guidelines.

Practice Guidelines and Medical Policies Available on the Web

Anthem Blue Cross considers clinical practice guidelines to be an important component of our medical care delivery system, and we require contracted providers and PMG/IPAs to adopt our practice guidelines. The most current Anthem Blue Cross adopted Clinical Practice and Preventive Health guidelines are available on the Anthem Blue Cross web site at <http://www.anthem.com/ca>. Please select the "Provider" option from the available choices on the left hand side of the web page and click

"Enter," select the "Provider Services" tab, from the drop down menu click on "Practice Guidelines" and select the practice guideline of your choice. Most recently, updates have been posted to Hypertension and Cardiovascular Disease Prevention (CAD) in Women Guidelines.

In addition to their availability on our web site, we provide (upon request) copies of our adopted Clinical Practice and Preventive Health guidelines to Anthem Blue Cross contracted PMG/IPAs and providers. To obtain a hard copy, please call **877-273-4189**.

Current Medical Policies adopted by Anthem Blue Cross are also available on the Anthem Blue Cross website www.anthem.com/ca. From the "Practice Guidelines" page, click on the blue button reading, "Medical Policy and Clinical UM Guidelines."

Pre Teen/Adolescent Health Care

We are encouraging the parents of our preteen and adolescent members to visit their child's physician on a regular basis for well care visit and not just when they are sick to receive annual screenings and recommended vaccinations.

We remind parents that their preteen/adolescent should have the following screenings and vaccinations, recommended by the Department of Health and Human Services Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP):

Annual screenings:

- Vision screening
- Hearing
- Blood Pressure
- Height, Weight, Body Mass Index (BMI)* percentile for age
- Chlamydia screening for sexually active females under age 25

Vaccines:

- Diphtheria, Tetanus, Pertussis (Tdap).
- Human Papillomavirus (HPV)* females only
- Meningococcal (MCV4)
- Influenza - (Flu)

In addition, we would also like to suggest the following items to help keep the patients medical records up to date.

- Prior to a patient visit review the immunization record for each patient and flag charts of those who are due or overdue
- Use all patient encounter visits including acute care and follow up to assess and provide vaccinations
- If a parent/patient states "My child's vaccines are up to date" or "I am up to date with vaccines". We request written documentation to place in the patients chart.

For more suggestions like these please visit the Immunization Action Coalition at <http://www.immunize.org/catg.d/p2045.pdf> to review the "Suggestions to Improve Your Immunization Service" check list.

Behavioral Health

Attention Deficit Hyperactivity Disorder Program

Anthem Blue Cross has various programs designed to improve patient outcomes. The Attention Deficit Hyperactivity Disorder Therapy Management Program is an initiative that represents an opportunity to increase the percent of children 6-12 years of age who initiated a prescription for ADHD and ensure they have follow up visits with the prescribing provider, by sending an educational mailing to the parents or guardians of the member. It includes the Vanderbilt Assessment Follow-up Parent Evaluation and encourages parents/guardians to complete the screen and review it with the prescribing physician.

Preferred Practice Guidelines for the evaluation and treatment of children with Attention Deficit Hyperactivity Disorder are available to providers on the Anthem website at www.anthem.com.

Coordination of Care

The Atypical Antipsychotic Medication Monitoring Program, Concurrent Antipsychotic Medication Program, and Psychotropic Medication Monitoring Program are programs that strongly support efforts directed at the coordination of care between medical and behavioral health professionals to ensure patient medication awareness and safety and reducing health care costs. Physicians are encouraged to communicate with one another and take whatever clinical action they deem necessary. If you do receive one of these mailings; please take the time to review the patient detail report and complete the program evaluation forms. We are interested in your feedback and any other suggestions on ways we can further improve communication

Atypical Antipsychotic Medication Monitoring Program

Weight gain is a common complication of antipsychotics and lithium, increasing the risk for hypertension, hyperlipidemia and diabetes. The Atypical Antipsychotic Medication Monitoring Program aims to ensure the appropriate monitoring of physical/metabolic side effects by addressing the concern that has been raised regarding atypical antipsychotic medications and new-onset hyperglycemia and abnormalities in glucose regulation and lipid metabolism.

Educational letters are mailed to primary care physicians and psychiatrists who are prescribing atypical antipsychotic medications and these letters contain monitoring recommendations. The letter is accompanied with a joint consensus document formulated by the American Diabetic Association and the American Psychiatric Association, as well as a list of the provider's members who were prescribed antipsychotic medications. The goal of the program will result in an overall increase in the number of members receiving fasting blood sugar and lipid labs following a prescription for an atypical antipsychotic medication.

If you do receive one of these mailings, please take the time to review the educational and informational information on your members. We are interested in your feedback and any other suggestions on ways we can further improve coordination of care and member safety and health.

Concurrent Antipsychotic Medication Program

The Concurrent Antipsychotic Medication Program is a program that utilizes pharmacy data to identify members who are using more than one antipsychotic medication for more than 45 days out of a 60-day period. One of the goals of this program is to decrease concomitant usage by at least 15 percent. The prescribing physicians (psychiatrists and primary care physicians) for these members receive a mailing containing a cover letter along with educational material, a patient-specific 60-day psychotropic and opioid medication profile and patient-specific fax-back form. Peer-to-peer consultation is also offered to the prescriber.

It is estimated that aside from the obvious benefits of this program, it also will save over \$125,000 per 1 million commercial members and \$3.5 million per 1 million Medicare members annually.

Psychotropic Medication Monitoring Among Adult Members with Chronic Diseases Program

The Psychotropic Medication Monitoring among Adult Members with Chronic Diseases Program is a program that uses pharmacy data to identify patients who are simultaneously receiving medications for chronic medical illnesses and psychiatric disorders from more than one prescribing physician. The prescribing physicians (psychiatrists and primary care physicians) receive a mailing containing medical/psychiatric concerns, patient medication profiles and a brief program fax-back evaluation form.

This patient medication profile ensures patient safety by review of all drugs, doses, duration of medications taken and refill patterns.

Pharmacy

Medicare Part D: Formulary Transition Notice

New members in our plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. As a provider, you may be asked by your patients for guidance in switching to a formulary alternative, or assistance in requesting a formulary exception.

Patients are directed to contact their physician to determine the appropriateness of switching to a drug that we cover, or requesting a formulary exception to cover the current medication taken. In the interim we may provide a temporary supply of the Part D drug in certain cases during the first 90 days of membership in our plan.

For each of the Part D drugs not on our formulary or if the ability to obtain the Part D drugs is limited, we will cover either:

A temporary 30-day supply of the Part D drug (unless the prescription is written for fewer days), when obtained via a network retail pharmacy or home infusion pharmacy.

A temporary 90-day supply of the Part D drug (unless the prescription is written for fewer days), when obtained via a network mail service pharmacy, home infusion pharmacy, or network retail pharmacy that has contracted with us to fill a 90-day supply of prescriptions.

After the initial transition supply we will not pay for these drugs, even if the patient has been a member of the plan less than 90 days.

If the patient is a resident of a long-term care facility, we will cover a temporary 34-day transition supply (unless the prescription has been written for fewer days). We will cover more than one refill of these drugs for the first 90 days if the patient is a member of our plan. If the patient requires a Part D drug that is not on our formulary or the ability to obtain the Part D drug is limited, but greater than 90 days have elapsed since the coverage effective date, we will cover a 34-day emergency supply of that Part D drug (unless the prescription has been written for fewer days) while the patient pursues a formulary exception.

Medications obtained at retail, mail order, Indian tribal or home infusion pharmacies are eligible for this transition policy.

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Attn Anthem Blue Cross Communications
anthem.com/ca/home-providers.html



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