Anthem Blue Cross

Working together to improve the health of our members.

July 2011

Network Update

INSTITUTIONAL

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Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91365

Editor: Lana Turner

E-mail: Prov.Communications@Wellpoint.com

anthem.com/ca

Network Relations:
855-238-0095

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Announcements and General Updates

Accountable care organizations pilot launch

An integrated approach to staying healthy

We're very pleased to announce an exciting new health care pilot program that will affect some of our members. A new model for health care delivery, Accountable Care Organizations (ACO), provides care in a way that is more personal, more supportive, and more efficient—at no extra cost to employers or members. In an ACO, a provider-led organization is accountable for the full continuum of care for its patients.

In 2011, selected Anthem Blue Cross PPO members will begin participation in an ACO pilot program developed by Anthem Blue Cross and a few participating provider organizations in Southern California (Monarch HealthCare, HealthCare Partners, Sharp Rees-Stealy Medical Group and Sharp Community Medical Group). Monarch HealthCare and HealthCare Partners will collaborate with Anthem Blue Cross in an initiative led by the Engelberg Center for Health Care Reform at Brookings and The Dartmouth Institute for Health Policy and Clinical Practice ("Brookings-Dartmouth"). The selection of the two California provider organizations furthers Brooking-Dartmouth's nationwide demonstration project already underway in three other communities.

The Anthem Blue Cross ACO pilot program:

- Encourages physicians, hospitals, and insurance companies to work together to coordinate care, further improve quality and reduce costs.
- Provides appropriate incentives for physicians to meet or exceed quality benchmarks.
- Is expected to produce a successful model that can be replicated throughout the country.

Members will benefit from:

- Improved care coordination.
- Increased provider accountability.
- Improved information for patient decision-making.
- Improved health care quality and lower costs.

Employers benefit from:

- Better employee health.
- Fewer employee sick days.
- Greater employee satisfaction.
- Additional cost savings associated with a healthier and more productive workforce.

We are excited about the launch of our ACO and look ahead to a successful pilot that we can replicate in other areas.

Anthem Blue Cross now available on Availity

Providers can now access Anthem Blue Cross members through Availity, our multi-payer portal partner website. With a single sign-on, you are able to access multiple payers to check eligibility, claims, clinical messaging and many other services offered by Availity (varies by carrier). California providers can access the following information for Anthem Blue Cross members nationwide on the Availity site:

- Eligibility and Benefits: Including additional benefits detail for local Anthem Blue Cross members.
- Claims Inquiry: Including claim detail for National members that are processed by Anthem Blue Cross.
- Radiology Precertification: If the user is registered with Anthem Blue Cross for access to AIM*.
- Specialty Rx Precertification: If the user is registered with Anthem Blue Cross for access to AIM*.
- Clinical Messaging: Clinical alerts on patients' care gaps and medication compliance indicators.
- CareProfile: Real-time, consolidated view of a member's medical history across multiple providers.

Features of Availity

- Single sign-on access to multiple payers (carriers vary by state).
- Standard screen format for all carriers.
- Claim detail for National and local members process by Anthem Blue Cross.
- Utilization reporting (aggregate and user specific) for administrators in real-time.
- Reporting by user allows the PAA (Primary Access Authority) to track associates work.
- Personalized training, 24/7.

Benefits for Providers

- Easy to use.
- Increase productivity for users who must check many payers' information during the course of the day.
- Gives access to additional claims information for Anthem National members.
- Fits easily into existing workflows.
- Assists administrators in monitoring and managing utilization.

For more information on Availity and to view a demo, go to www.Availity.com . If you are an Availity user, you can now ADD Anthem Blue Cross [Anthem-CA] to your payer profile.

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

Billing

FEP claims inquiry

FEP claim status inquiries submitted via EDI and MyAnthem℠ will be changed shortly. Effective June 25, claim inquiries will not offer detailed financial information, including check and EFT numbers, and effective July 1, you will not be able to see claim line level detail. These changes result from system modifications to be implemented in support of HIPAA 5010 requirements.

Please rely on your provider remittance advice or the IVR for details concerning your FEP claim submissions.

To access the IVR, please call your state's FEP customer service center number:
800-284-9093.

Then follow the IVR prompts for claims transaction inquiries and requests for duplicate remittance.

IVR Prompts for Claims Status:

- Are you a Member or Provider? Select one of the following options (Option 2 or 3).
  - Option 1 - Member
  - Option 2 – Hospital or Facility Provider
  - Option 3 – Physician or Other Healthcare Provider
- Enter NPI number, Member ID, Patient DOB.
- From the Provider Main Menu, Providers should select Option1.
- Option 1 – Eligibility, Benefits, Claim Status, and Duplicate Remittance, Providers should select Option 3 for Claim Status and Duplicate Remittances.
  - Option 1 - Eligibility

- Option 2 - Benefits
- Option 3 – Claim Status and Duplicate Remittance

- Provider will be asked to enter the 8 digit beginning DOS.
- Claim numbers and claim details will be provided for the DOS entered.
- Providers should select one of the following options (Option 1 or 2).
  - Option 1 – Fax the claim status information to the Provider
  - Option 2 – Verify check number, check status, request a duplicate remittance

IVR Prompts for Duplicate Remittances:

- Are you a Member or Provider? Select one of the following options (Option 2 or 3).
  - Option 1 - Member
  - Option 2 – Hospital or Facility Provider
  - Option 3 – Physician or Other Healthcare Provider
- Enter NPI number, Member ID, Patient DOB.
- From the Provider Main Menu, Providers should select Option 1.
- Option 1 – Eligibility, Benefits, Claim Status, and Duplicate Remittance, Providers should select Option 3 for Claim Status and Duplicate Remittances.
  - Option 1 - Eligibility
  - Option 2 - Benefits
  - Option 3 – Claim Status and Duplicate Remittance
- Providers will be asked to enter the 8 digit beginning DOS.
- Claim numbers and claim details will be provided for the DOS entered.
- Providers should select one of the following options (Option 1 or 2).
  - Option 1 – Fax the claim status information to the Provider
  - Option 2 – Request a duplicate remittance, press Option 3
  - Option 3 – Duplicate remittance will be mailed to the address on file for the selected claim

We regret the inconvenience that these changes may cause and are searching for options that will again offer financial information and line level detail for FEP claims.

If you have additional questions, please contact your local Provider Relations consultant.

EDI best practices

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 – all via electronic data interchange or EDI. To ensure the efficient and timely processing of your electronic transactions, please follow our list of EDI Best Practices.

- Stay current by reading the Anthem Blue Cross *Network Update* provider newsletter.
- Check our web site for the latest Electronic Data Interchange (EDI) information.
- Familiarize yourself with various EDI claims transaction types.
  - 837 Claims Transmission (Institutional and Professional)
  - Electronic Remittance Advices
  - Electronic Funds Transfer
  - Electronic transaction reports.
  - Eligibility, benefit and claim status information.
- Obtain current member eligibility and benefit information prior to submitting a claim.
- Check eligibility of patient at time of appointment.

- Check claims status electronically by using provider access.
- Submit your claims electronically and review your reports daily.
- Correct rejected claims immediately and resubmit them electronically.
- Receive your payments via Electronic Funds Transfer (EFT).
- Receive your remittance advices electronically (ERA).
- Have specific claim information available when contracting your local EDI Solutions Helpdesk.
- Contact your vendor or clearinghouse for updates.

For more information regarding EDI Best Practices or submissions, you may contact an EDI Solutions Specialist:
Monday through Friday from 8 am – 4:30 pm Pacific Time
Telephone: 800-227-3983
E-mail: edi-ca@anthem.com
Web/Live Chat: www.anthem.com/edi

5010 EDI – free webinars!

This webinar is specifically designed for all physicians, as well as institutional, ancillary, dental, and billing agency professionals and their staffs.

Learn how version X12 5010 will change submission formats and impact business processes and efficiencies gained with the implementation of the new mandate. This program will address all electronic transactions claims, eligibility and claim inquiries, and electronic remittance. There will also be an opportunity for a question and answer session with our experts.

Seamless Transactions with 5010
Thursday, August 18, 2011
10:30 a.m. – 12:00 p.m. pacific standard time

Registration is available for the Seamless Transactions with 5010 webinar at anthem.com/edi. Make sure you register early as space is limited. For more information, please contact the EDI Solutions Helpdesk at 800-227-3983.

Network

On June 25 FEP launched a new automated telephone system

The Federal Employee Program is proud to announce the launch of VSS—Voice Self Service—our new automated telephone system. This new system will be available for coverage and benefit information for California FEP members in July. Please listen to messages advising that our menu options have changed.

This new and improved telephone system incorporates voice recognition features as well as touch tone options. You will be able to speak responses or enter responses using corresponding options on your telephone keypad. The system is more intuitive and will prompt for missing or incompatible information. Benefits are more concise which will allow you to obtain information more quickly. New features include the ability to check the status of a preauthorization request, and claim status information can be obtained by entering a specific date of service.

The FEP Customer Service telephone numbers will not change.
A Quick Reference Guide has been created to help you navigate the system and familiarize yourself with the capabilities. When the system is available, you can obtain a copy of the Quick Reference Guide by saying More Choices or Pressing 6 in the Main Menu then Saying IVR Quick Reference or Pressing 2 in the More Choices Menu.

Provider network education – 2011 seminars and e-solutions

Time Well Spent

The Anthem Blue Cross Provider Network Education team develops, delivers and supports quality educational programs and materials specially designed for the office staff of physicians, hospitals, medical groups, ancillary and other health care professionals. Our education programs offer 'blended learning' via face-to-face and web-based learning opportunities exclusively for our contracted provider population. For locations and registration information, log on to the Anthem Blue Cross website. Scroll down to the **Spotlight** section and click on the 2011 Provider Education Seminars link.

Seminars are opportunities, Spring and Fall, for Anthem Blue Cross staff to meet with you face-to-face in an interactive learning environment. During these sessions, 'Tools for Success' are provided that explain best practices, process improvement methodologies, and 'tips' to simplify your interaction with Anthem Blue Cross. You will also receive current information on changes and enhancements taking place at Anthem Blue Cross as well as materials relevant to the seminar topics. Neither billing guidelines nor clinical guidelines are covered during these sessions. However, some topics might include:

- Availity secured multi-payor access.
- McKesson claim edits.
- Timely access regulations.
- HIPAA 5010.
- ProviderAccess® online resources and navigation.
- Anthem.com online resources and navigation.

e-Solutions are online educational opportunities available via the internet:

- **On-Demand e-Courses** offer short, informative, self-paced instruction on a variety of individual topics. They are available 24/7 at your convenience. A listing of the topics is available on the Provider Network Education web page.
- **Webinars** offer **live** interactive sessions conducted remotely via the internet and facilitated by the Provider Network Education team and subject matter experts every month. A listing of the upcoming topics and dates are available on the Provider Network Education web page.

Online registration is accomplished by logging in to http://wellpoint.intevista.com/Home.aspx.

- The Home tab provides additional information you need to participate in these learning opportunities. You can view all available by clicking on the desirable tab.
- To view details about how the registration process works, place your cursor over the **Home** tab. The **registration details** drop-down menu will display. Click this drop-down link to view more guidelines about how to register.

- You must first register on this Education web site, establish your own **Personal Education Account**, and create your personal user name and password. When you have registered, you will receive and e-mail confirmation with your newly established username and password. Important: Keep this e-mail in a safe location for future reference.
  - **Note:** Your username and password for this web site is separate from your ProviderAccess username and password:
- Once you have a **Personal Education Account** established, you only have to log in with your personal username and password and choose any of the above learning opportunities.
- **Note:** Each individual must have their own Personal Education Account in order to attend the above learning opportunities.

QUESTIONS: e-mail us at: network.education@wellpoint.com.

Sign up now for our network rapid update 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 Rapid Updates.

Network Rapid Update 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 web site 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 Rapid Updates, so you can submit as many e-mail addresses as you like.

Network leasing

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call "other" payers." Other payers and affiliates use the Anthem Blue Cross network. Under the terms of your provider agreement, members of other payers 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 payers" list on the ProviderAccess® portion of the Anthem Blue Cross website at anthem.com/ca. If you don't have Internet access, please contact 855-238-0095 for assistance.

Health Care Reform

Updates and notifications

To view the latest articles on health care reform, and all archived articles, you can access them online. Go to anthem.com/ca, select the Provider link in the lower right corner of the page and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications.

Medicare Advantage

Precertification requests

At Anthem Blue Cross (Anthem), our goal is to provide excellent service for members and providers. For Medicare Advantage (MA) precertification requests, this includes helping to ensure that Anthem and CMS coverage requirements are met for acute care or skilled nursing facility (SNF) admissions or stays. Since this type of precertification request often involves issues that must be individually researched to ensure the admission complies with Anthem and CMS guidelines, it can be processed most expeditiously when all applicable information is submitted with the initial request.

When submitting a MA precertification request for members in Medicare Advantage plans that require precertification, i.e., Anthem Medicare Preferred and Freedom Blue, please include the following information:

- Member demographic information (including the member's ID number).
- Name and contact information of the requesting (ordering) physician.
- Place and date of service

- Service(s) procedure(s) requested (include HCPC/CPT® codes).
- Applicable diagnostic codes.
- Clinical documentation to support the request for service(s) procedure(s).

It is best to submit the above required information at least three days prior to the requested service/procedure to allow a thorough clinical analysis. You will be given a precertification number as soon as all of the clinical information has been received and reviewed. (Note: In an urgent or emergent situation, the above time frames will be waived. Please provide notice as soon as possible.)

You may submit precertification requests by fax or phone.

- To send a fax request: 866-959-1537.
- To request by phone: 866-797-9884, option 1.

To help us process as quickly as possible your MA precertification request for inpatient admissions, outpatient services, or observation, please use the new Medicare Advantage Precertification Request Form. It has been developed to help ensure that all necessary information has been provided and will facilitate the processing of your request. For your convenience, this form is available online. To download or print it, please go to anthem.com>Provider (enter state)>Answers at Anthem>Medicare Advantage General Precert form.
In addition to the information listed above, please include the following documentation for specialty pharmacy requests billed under Part B (Medical Plan) and precertification requests for SNF (long-term acute care and acute rehab).

Specialty pharmacy requests:

- Pertinent clinical information, including previous treatments provided.
- Pharmaceutical prescription(s), including dose, frequency, and duration.
- Date and place of previous service(s).

SNF:

- Current history and physical.
- Current physical therapy and occupational therapy notes.
- Any additional clinical information to support the need for admission.
- Discharge plan.

For further questions, please contact your local Provider Relations consultant.

Programs

Oncology nursing society joins Journey Forward: A collaboration to benefit cancer survivors

The Oncology Nursing Society (ONS) has joined the Journey Forward collaborative to promote cancer survivorship through the use of Survivorship Care Plans.

Journey Forward, a collaboration consisting of WellPoint, Inc., the National Coalition for Cancer Survivorship (NCCS), UCLA Cancer Survivorship Center, and Genentech, welcomes the support and participation of ONS in this initiative. "Nurses are key providers of education for patients through their diagnosis and treatment, so this partnership is a natural fit as we work together to communicate about the importance of survivorship care plans," said ONS Director of Education Michele Galioto, RN, MSN. She added that incorporating ONS's evidence-based guidelines, symptom management resources, and the growing collection of quality indicators into survivorship plans will ultimately lead to improved patient outcomes. “This partnership allows us to bring valuable tools to nurses and to reach beyond our membership as we work to improve care for all patients.”

“ONS is a welcome addition to the team,” said Patricia Ganz, MD, Director of the Survivorship Center at UCLA’s Jonsson Comprehensive Cancer Center. “Oncology nurses are at the forefront of preparation of Survivorship Care Plans.”

Journey Forward provides a free, award-winning software tool designed to help survivors and their cancer team develop a customized Survivorship Care Plan based on ASCO’s treatment summary templates and surveillance guidelines. These plans improve coordination of care for cancer survivors throughout their lives, and they help survivors and their loved ones understand their cancer treatment and follow-up needs. Survivorship Care Plans also put survivors in a better position to advocate for themselves, monitor their health, and participate in decisions about their future care.

“The ONS team brings a membership of more than 35,000 oncology nurses in 61 countries with 230 chapters in the United States. We expect that the membership of ONS will help disseminate Journey Forward in their oncology settings,” said Thomas Sellers, MPA, Chief Executive Officer (and 12-year cancer survivor) of the National Coalition for Cancer Survivorship.

There is evidence that oncology nurses are important to adoption of survivorship care planning at the clinical level, since they are the ones administering care to the patients. “Nurses play a vital role in our health care system, whether in an office setting, hospital, health plan or in the classroom. The addition of ONS and its dedicated oncology nurses further strengthens the Journey Forward collaboration of organizations and supports health care professionals throughout the industry–all who are so vital to the care of patients, especially to those who are undergoing treatment for cancer,” said Dr. Lisa Latts, WellPoint’s vice president of Public Health Policy. Added Kent E. Lieginger, PharmD, Senior Vice President, Managed Care and Customer Operations at Genentech, “We know that oncology nurses are interested in resources that can help impact outcomes for their patients. We anticipate that Journey Forward will have an accelerated adoption due to their involvement.”

For more information, please contact JourneyForward.org.

Guidelines

Standardized clinical review for inpatient precertification

We announced last year that beginning January 1, 2011, we would be changing some aspects of clinical review for inpatient pre-certification. These changes apply to our local plans in California (Note: In most cases, these changes do not apply to, Medicare, Medicare Advantage (MA), or Federal Employee Plan (FEP)). These changes were implemented to standardize and improve our clinical review processes.

Utilization Management (UM) determinations

UM will continue to review length of stay (LOS) and appropriateness of setting for all inpatient admissions based upon Milliman Guidelines and will continue to follow criteria developed by Anthem Blue Cross’ medical policies, clinical guidelines and the Milliman Guideline for spinal surgery to review the medical necessity of certain applicable requested services and determine coverage.

Before coverage for inpatient admissions is reviewed and determined, clinical information may be requested for more surgeries or diagnoses for which information was not previously requested. As described in our September 2010 Institutional Newsletter, these changes occurred for a variety of services which include but are not limited to:

- All bowel obstruction procedures
- Chest pain
- All cystocele, rectocele, or enterocele and other prolapse repair (colporrhaphy)
- All exploratory laparotomy procedures
- Febrile illness
- All hysterectomy, vaginal procedures
- All lung, total pneumonectomy; extrapleural
- Pancreatitis
- All percutaneous coronary transluminal angioplasty (PTCA) procdures
- All prostatectomy (TURP) procedures
- Sepsis, unspecified, pediatric member
- All splenectomy procedures
- All throidectomy procedures
- All urethral suspension procedures (SLING procedure)
- Poisoning

Pharmacy

The drug list: Making a difference for our members

How are drugs selected for our Drug List (also known as a formulary)? We consider the health of our members first and foremost. Our unique process combines rigorous critical literature appraisal with real-world outcomes data to determine the overall value of each medication reviewed. The result is an outcomes-based Drug List containing the best medications for improving the health and well-being of our members. We call it the Drug List Difference.

This is the first in a series of articles describing the rationale behind select Drug List decisions, and provides a general overview of our Drug List selection process.

Three steps define our Drug List selection process:

1. Rigorous clinical review,
2. Thorough value assessment, and
3. Final tier placement.

A comprehensive clinical review is completed by drug information pharmacists extensively trained in critical appraisal. The data are presented to a committee of external practicing physicians and pharmacists. Using only high quality clinical trial data, they determine how a drug compares to other related drugs in terms of efficacy, safety and clinical attributes. The committee also provides practical clinical insight regarding each drug being reviewed.

Our unique value assessment process encompasses evaluation of real-world health outcomes, comparative effectiveness data, total cost of care information (medical and pharmacy), and the overall member experience – including out-of-pocket costs. All of these factors are used in combination with the clinical review to determine coverage levels (tiers) for each medication.

We are confident that our evaluation process produces an outcomes-based Drug List of the highest clinical value. Significant weight is placed on the clinical utility of each medication. Use of real-world health outcomes information further strengthens our Drug List decisions. By offering a Drug List of medications with proven benefits, we can improve the overall health of our members.

Anthem drug list updates

Visit http://www.anthem.com/pharmacyinformation for more information on copayment/coinsurance requirements and their applicable drug classes, ***Drug Lists*** and prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, limitations or incentives that apply to using certain drugs.