

Network Update

M A I N E

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Anthem news

CoverMe Foundation helps connect uninsured with free or reduced-cost health care

The CoverMe Foundation (CMF), a national nonprofit organization, is offering free, step-by-step assistance to uninsured consumers in identifying and applying for health care coverage as part of its mission to improve the overall health of Americans throughout the United States.

“We recognize that the application process can be confusing to many of the uninsured, and that is why we first educate and then assist the applicant via our facilitation expertise to gain access to our programs,” said The CoverMe Foundation President Alec Shea. “Our goal is long-term health, and we are delighted to serve our communities on a variety of levels in order to achieve it.”

The new outreach campaign is central to CMF’s mission to improve overall quality of life in the nation by closing the gap between America’s 47 million uninsured and the health care resources that are available to many of them.

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CoverMe Foundation helps connect uninsured with free or reduced-cost health care

(continued)

In addition to the health care coverage assistance, CMF offers comprehensive health care information for often underserved groups of individuals, including the uninsured and underinsured, elderly and disabled, and children and pregnant women. It also provides information on prescription assistance programs and medical treatment programs.

CMF is funded by a \$2.5 million grant from the foundation of Anthem Blue Cross and Blue Shield's parent company, which supports innovative programs that help cover the uninsured.

For more information on The CoverMe Foundation and its services, or if you are an organization or individual interested in partnering with CMF in its efforts to help America's uninsured population, please call **877-NSURME-1** or visit the website at www.covermefoundation.org.

Administrative and policy update

Advanced imaging program to transition to AIM November 1, 2008

In September, we sent information about the upcoming transition of our diagnostic imaging management program from National Imaging Associates (NIA) to American Imaging Management (AIM), an affiliate of Anthem. Beginning November 1, we will combine both our advanced imaging utilization management program as well as our consultation management program with AIM's valuable expertise and experience.

For procedures scheduled on or after November 1, 2008, all *ordering* physicians must contact AIM to obtain a prior authorization for non-emergency outpatient advanced diagnostic imaging modalities including CT/CTA, MRI/MRA, Nuclear Cardiology and PET. Imaging studies performed in conjunction with emergency room services, inpatient hospitalization or rehabilitation, or 23-hour observations are excluded from this requirement.

Starting October 20, 2008, providers will be able to contact AIM for prior authorization or consultation via the internet or by telephone.

Internet requests

We are very pleased to announce that ordering providers will be able to request prior authorization via the Internet using AIM's web-based application, **ProviderPortalSM**. AIM's **ProviderPortal** is available 24 hours a day, seven days a week. It is fully interactive, processing prior authorization and consultation requests in real-time using proprietary clinical criteria. The **ProviderPortal** may be accessed directly at <https://providerportal.com>, or through a link available on Anthem Online Provider Services (AOPS) at anthem.com.

Telephone requests

Requests can also be submitted to AIM via telephone. Providers can call AIM toll-free at **866-714-1107**, Monday through Friday, 8 a.m. – 5 p.m. to request a prior authorization number or to verify that a number has been issued.

Required information for diagnostic imaging requests

Please utilize the checklist below as a guideline to help ensure you have all the information necessary prior to contacting AIM:

- Member identification number, name, date of birth
- Ordering physician information (name, location)
- Imaging provider information (name, location)
- Imaging exam(s) being requested (body part, right, left or bilateral)
- Patient diagnosis (suspected or confirmed)
- Clinical symptoms/indications (intensity/duration)

For most situations the above information will suffice. For complex cases, more information may be necessary, including:

- Results of past treatment history (previous tests, duration of previous therapy, relevant clinical medical history)

Based on clinical criteria, AIM will either issue a prior authorization or order number or forward the case to a nurse or physician for review. The physician reviewer may contact the ordering physician to discuss the case in greater detail. Ordering physicians may also contact AIM's physician reviewer at any time during the review process. Upon approval of a prior authorization request, AIM will provide the ordering physician with a prior authorization which will be valid for thirty (30) days from the date issued. Issuance of a prior authorization is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of the member's health benefit plan. AIM will issue an order number for consultation requests.

All prior authorizations are valid for thirty (30) days from the date issued. Note: Retrospective requests will not be considered after two business days from the date of service.

Imaging providers can obtain information on prior authorizations obtained for their imaging site via AIM's **ProviderPortal** or by contacting AIM's call center at **866-714-1107**, Monday through Friday, 8 a.m. – 5 p.m. *Note: Imaging providers are strongly encouraged to verify that a prior authorization has been obtained before scheduling and performing diagnostic imaging exams.*

Radiology Management Program – CPT® code list

A list of the CPT codes included under this program can be found in the AOPS section of **anthem.com** > Providers > Select state > Enter > Anthem Online Provider Services > Forms and Reference Materials, Reference Materials, AIM Documentation. The list may be updated from time to time to reflect changes published by the American Medical Association in the Current Procedural Terminology (CPT)* Manual.

*CPT® is a registered trademark of the American Medical Association

Anthem to transition to standardized ID cards in November 2008

In November 2008, we will begin the transition to a new standardized format for our members' ID cards. As a result, you may begin seeing the new formatted ID cards as early as October. We are making this change at the request of the Blue Cross and Blue Shield Association (BCBSA) – the organization that governs all Blue Cross and Blue Shield plans nationwide.

The BCBSA has mandated the adoption of standardized ID cards across all Blue plans effective January 1, 2009. We will begin phasing in the new ID card format in November 2008 for all new and renewing employer groups and replacement ID cards. All member ID cards will be in the new format by January 1, 2011. This means that all Blue Cross and Blue Shield member ID cards throughout the country will have a consistent and uniform look and format. Additionally, the familiar information that you've come to expect on our ID cards will be placed in a more organized and straightforward way.

As a reminder, please request that your patients present their most current ID cards each time they receive services. This will help ensure appropriate claims routing and processing. Provider offices should carefully review ID numbers on members' ID cards when filing claims. File professional, facility and dental claims according to the claims filing instructions on the ID cards. As always, please submit claims with identification numbers exactly as they appear on members' ID cards including alpha prefixes – using letters and numbers appropriately.

A sample ID card is pictured below. Watch for additional information regarding our transition to the new standardized ID cards in the next edition of *Network Update*.



Sign up to receive *Network Update* via email

Online registration for our e-mail service, *Network Rapid Updates*, is available via our website, anthem.com. Subscribers to this service will receive, via e-mail, each issue of *Network Update* and important information about other news and events from Anthem.

We are considering discontinuing the production and distribution of paper issues of *Network Update* sometime in 2009. The methods of distribution would be via e-mail and website postings on anthem.com, which are currently available. We encourage you to register for our e-mail service so that you can continue to receive each issue directly — in your e-mail mailbox. We think you'll find it easier to store past issues of *Network Update* electronically for future reference.

Take a moment and sign up now. It's fast and easy! Visit anthem.com > Providers > Select your state > Enter > Anthem Network Rapid Updates Email Service.

NPI reminder

We continue to receive many claims with NPI numbers appearing in incorrect fields. We have posted reference tools on anthem.com to assist you in understanding how to bill your NPI number.

To assist you with the placement of the NPI on electronic claims, please refer to the Professional 837 Enumeration and Contractual Chart. To view the chart, visit anthem.com > Providers > Select state > Enter > NPI Updates > 837 Enumeration and Contractual Chart. In addition, please refer to the August 2007 issue of *Network Update* which outlines the paper claim filing instructions for NPI. Our provider newsletters can be found at anthem.com > Select state > Enter > Providers > Provider Reference Materials, Provider Newsletters > August 2007.

Please keep in mind that the national initiative to adopt a standard unique provider identifier is now in effect and we accept only the NPI to be billed according to the claim filing instructions mentioned above, as well as your tax identification number.

Update to claims processing edits and reimbursement policies

We will be updating anthem.com with the following new or revised reimbursement policies on October 1, 2008. These and other reimbursement policies can be found at anthem.com > Providers > Select state > Enter > Anthem Online Provider Services > Forms and Reference Materials, Reference Materials, Reimbursement Policies.

Telemedicine and telehealth services

The policy section was revised to identify certain non face-to-face services that may be related to or be adjunctive services to the practice of telehealth medicine. These services are indicated as either not covered or not separately reimbursed.

Modifier rules

The policy has been updated to include all payment modifiers with percentage rates and effective dates where applicable.

Format changes for reimbursement policies

The following policies were updated on August 1, 2008 to identify edits and/or effective dates that were impacted as a result of the phased implementation of ClaimsXten. Please refer to the letter we sent dated July 16, 2008 for more information. These and other policies can be found on anthem.com > Providers > Select state > Enter > Anthem Online Provider Services > Forms and Reference Materials, Claim Processing Edits.

- Assistant Surgery
- Claims Editing Overview
- Co/team Surgery Services
- Customized Edits
- Frequency Editing
- Global Surgery
- Laboratory Combination Processing
- Mod 25/59
- Multiple Surgery
- Obstetrical Services

In addition to the policies mentioned above, the policies titled 'Always Bundled Services & Supplies' and 'Significant Edits' had a formatting date correction without change in content.

New URL for CAQH database

Effective September 2, 2008, the CAQH Universal Credentialing Datasource transitioned to a new URL. The Online Application System (OAS) moved from <https://caqh.geoaccess.com/oas/> to <https://upd.caqh.org/oas/>. The Practice Administrator Module (PMM) moved from <https://caqh.geoaccess.com/pmm/> to <https://upd.caqh.org/pmm/>.

If you have these links saved as favorites on your Internet Explorer, please be sure to update the links. You will be redirected to the new URLs for a short period of time, after which you will need the new URLs in order to access these databases. Additional information is available at www.caqh.org/ucdstatus/. Providers should contact CAQH directly at info@caqh.org with any questions.

Billing for state-supplied vaccines

Vaccines that are available at no cost from the Maine Immunization Program (MIP) should be reported with the appropriate vaccine code (90476 - 90749) and appended with modifier SL. The billed amount should be \$0.00. For example:

Procedure Code	Service and Modifier	Charge
Vaccine product	90701-SL	\$0.00
Administration of vaccine	90465	\$15.00

If you receive vaccines from the State of Maine that meet the criteria under the MIP guidelines (and supply is available), those vaccines are not eligible for reimbursement. We will be reviewing paid claims to assure compliance with the application of the SL modifier on the MIP eligible* vaccines. Any paid claim that contains an MIP eligible vaccine that is not billed with a modifier SL will be adjusted to reflect the appropriate reimbursement of \$0.00.

It is important to report the state-supplied vaccine codes to document the specific immunizations that were provided. The data will be used to:

- Support HEDIS® reporting
- Populate the immunization section on Anthem Online Provider Services (AOPS) in support of the Anthem Quality Insights Primary Care Quality Incentive Program. The vaccine data gathered from claims submissions will not need to be entered on AOPS by PCP offices.

**Please note that vaccines administered through the Vaccines for Children (VFC) Program will be excluded from this review process.*

Prolotherapy

Many claims for prolotherapy are billed with incorrect codes. The correct procedure code to report prolotherapy, also known as joint sclerotherapy or reconstructive ligament therapy, is M0076. Prolotherapy should *not* be reported using procedure and HCPCS codes J4390, 20550, 20551, 20552 20553 and 20555.

Prolotherapy is considered an investigational procedure by Anthem Medical Policy. Prolotherapy is proposed to stimulate the production of new ligament tissue by causing a controlled injury to a specific target area with the ultimate goal of strengthening the structure. This is usually done by injecting the ligament with any one of several different chemicals, usually referred to as proliferatives or sclerosing agents. Some of the proliferative agents used include zinc sulfate, psyllium seed oil, hypertonic glucose, and phenol or carbolic acid, which may be mixed with glycerol. Proliferatives are purported to act as inflammatory agents that cause minor injury to the ligament and, in theory, initiate the first step in the strengthening process.

Screening for chlamydia infection

Chlamydia infection is most prevalent among sexually active women and men aged twenty-six years or younger.

The most sensitive and specific testing for the diagnosis of chlamydia infection is the nucleic acid amplification tests or NAATs, which can be performed using cervical, urethral, urine and vaginal specimens. NAATs are also expensive and are only recommended for the screening of asymptomatic members who do not require a pelvic exam or urethral swab.¹

Other screening technologies include:

- Cell culture
- Direct fluorescent antibody
- Enzyme immunoassay
- Nucleic acid probes

The American College of Obstetricians and Gynecologists (ACOG) recommends “that chlamydia screening be offered to all sexually active adolescents and women younger than twenty-six (26) years, regardless of other sexual behavior risk factors.”²

1. City Health Information - Chlamydia Testing and Treatment, October 2006.

2. International Medical News Group: new guidelines may alter practice: many gynecologists fail to offer Chlamydia screening; July 2004.

Additional benefit information via AOPS soon

We are pleased to announce that soon you'll find more information about Blue Cross and Blue Shield members' benefits — both Anthem Blue Cross and Blue Shield local members and out-of-state members (BlueCard®). We expect that by year's end you'll have access to even more eligibility, benefits and claims status information for local and most out-of-state members from other Blue Plans.

You can access the same up-to-date information available to our Provider Service representatives. Just submit an EDI Eligibility Inquiry (270/271) or Claims Status Inquiry (276/277) transaction or log in to Anthem Online Provider Services (AOPS) at anthem.com.

Enhancements include:

Eligibility and benefits

- Accumulated deductible information
- Accumulated benefit limitations
- Out-of-pocket benefit information (out-of-pocket amounts include copays, deductibles and coinsurance unless otherwise noted or excluded).
- Accumulated amounts are not returned for service types that are specific to sensitive benefits, but amounts are returned for deductibles/maximum benefit limits for these service types (e.g., maternity, infertility, psychotherapy, psychiatric, etc.).

Note: AOPS will return accumulator values as of the date of the request. When date of service is outside member's current plan period, only the benefit information is returned.

Claim status

- Standard claim status reporting codes for better consistency across Blue Plans.

Search process

- Standard process that searches member verification first, then searches claim information.
 - Member verification includes:
 - Subscriber ID
 - Patient date of birth (DOB)
 - Patient first name
 - Patient last name

Note: new enhancements will correct names for claim status transactions, but DOB and subscriber ID must be an exact match.

- Continued claims search is based on provider ID, subscriber ID, patient DOB, and service date range.

What does this mean to you?

- *Lower administrative costs.* You'll need fewer calls to customer service because you'll have the information you need — right at your fingertips — through **anthem.com** or an EDI transaction.
- *Fewer “not found” responses for claim status transactions.* If the system doesn't find an exact match for a claim number, it will return all claims that match your other search criteria.
- *Patient name and relationship information is automatically corrected.* For example, if a patient is mistakenly submitted as a subscriber instead of a dependent, or vice versa, the system will display the correct information.

Register for Anthem Online Provider Services (AOPS) today. It's free!

If you're not already registered for AOPS, just visit **anthem.com** > Providers > Select state > Enter > Anthem Online Provider Services > Sign Up Now! Simply download, complete and return the form to us to apply for free AOPS access.

Reference materials available on anthem.com

Remember to visit **anthem.com** regularly for access to a variety of useful information to help you do business with us. Examples of information accessible on **anthem.com** include:

- Reimbursement and payment policies
- Anthem Online Provider Services (AOPS) — online access to membership, eligibility, and claims information
- *Network Update* newsletter archive
- Anthem Quality Insights (AQI)
- Medical Policy
- Clinical Guidelines
- Diagnostic Imaging Management Program information
- And much, much more

We encourage you to visit **anthem.com** regularly.

Notice to participating durable medical equipment providers

The Northeast Regional Durable Medical Equipment Fee Schedule has been revised to include the following codes effective for dates of service on and after August 1, 2008.

- *A9276 — Sensor*; invasive (e.g. subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, one unit = 1 day supply
- *A9277 — Transmitter*; external, for use with interstitial continuous glucose monitoring system
- *A9278 — Receiver* (monitor); external, for use with interstitial continuous glucose monitoring system

If you have any questions, please contact the following phone number in your applicable state:

Connecticut	Provider Call Center	800-922-3242
Maine	Provider Service	800-832-6011
New Hampshire	Provider Call Center	800-332-6558

Notice to participating chiropractors and chiropractor/acupuncturists

The Fee Schedule for Chiropractors and Fee Schedule for Chiropractor/Acupuncture have been revised to include the following codes effective for dates of service on and after August 1, 2008.

- *L3000 — Foot*, insert, removable, molded to patient model; “UCB” type, Berkeley Shell, each
- *L3020 — Foot*, insert, removable, molded to patient model; longitudinal/metatarsal support, each

The listing of a service on the fee schedule is not a certification of coverage or payment. Payment is made only for covered services subject to the terms, limitations and exclusions of the member's health benefit plan.

If you have any questions, please contact Provider Service at **800-832-6011**.

Credentialing for new providers

Please keep in mind that when providers are hired into your practice they must be credentialed before we will reimburse for services provided by that new provider to any Anthem managed care patient. In order to obtain an application, please go to anthem.com > Providers > Select state > Online Provider Tools > Credentialing materials > Medical Provider Application for Participation Request form. Remember to click 'Submit' when you are done to send the application to us.

BlueCard update

BlueCard IVR coming soon

During the 4th quarter of 2008, we will be implementing a new interactive voice response (IVR) system for our provider service center for Host members (Blue Cross and Blue Shield members from another state).

Providers will be able to inquire about the status of BlueCard claims using the IVR technology. Callers will experience similar IVR functionality options regardless of where membership is derived (Home Plan). By using this technology for claim status inquiries, you will help ensure that our provider service representatives will be available for calls that require personal assistance. We are excited about bringing this additional servicing option to providers. Our call center agents will continue to be available to you for any questions the IVR does not address.

EDI update

Anthem teams with MD On-Line

Submit CMS-1500 claims to Anthem — no charge

We are pleased to announce that we have teamed with MD On-Line, a leading national clearinghouse, to offer professional provider practices — particularly smaller offices — an innovative way to submit CMS-1500 claim forms and receive secure transactions electronically. *These services are available at no charge to providers who submit claims and other electronic transactions to Anthem.* The only requirement is a personal computer with Internet access.

MD On-Line's services comply with Health Insurance Portability and Accountability Act (HIPAA) requirements. In addition, providers can submit electronic transactions via these services for all of our lines of business including the Federal Employee Program (FEP) and the BlueCard Program. For providers who currently use our secure web-based provider tool, Anthem Online Provider Services (AOPS), you can continue to use this tool as in the past.

Get connected — enroll, submit and get paid with quick results

To enroll, simply contact MD On-Line to complete the registration process and begin submitting electronic transactions the same day. Providers can submit electronic transactions with or without the need for practice management software — with reliable, fast payments as the result.

MD On-Line electronic submission options

MD On-Line offers two claim submission options:

- *Link1500™* is MD On-Line's Web claim data entry submission solution for providers without practice management software.
- *WebLink™* is MD On-Line's Claims Management Solution for providers with practice management systems.

MD On-Line free electronic services

MD On-Line's services include eligibility and benefit verification, claims status, detailed reporting and delivery of electronic remittances. Here's how MD On-Line's free electronic services can help your office get the information you need to handle administrative tasks more efficiently — leaving more time to focus on patient care.

- *Real Time Patient Eligibility and Benefit Verification* — MD On-Line offers secure access to view current patient eligibility and benefit information including deductible and copayment information based on the patient's type of coverage.
- *Claim Status Verification* — Claim status verification provides an extra level of information about claims submitted. MD On-Line can make available additional information received from us.

- *Detailed Tracking and Reporting* — MD On-Line provides reports to track claims every step of the process until claims are paid. Detailed reporting helps pinpoint errors quickly, so corrections can be made to prevent future occurrences.
- *Electronic Remittance Advice (ERA)* — MD On-Line provides ERAs that you can print or automatically post payments utilizing your practice management software. This process serves as your reimbursement notice and is equivalent to a Provider Remittance Advice. There's no need to enter payment information manually for a paper remittance.

MD On-Line registration and contact information

Visit anthem.com/edi > Select state > Enter > Services > Web Claims Submission > MD On-Line. MD On-Line representatives will contact providers to complete registration, answer questions and provide system training.

MD On-Line sales, support, administration and billing:

Dial toll free at **888-499-5465** for phone registration (mention "Anthem promotion"). Customer and Technical Support Representatives are available from 8:30 a.m. to 6 p.m. at **973-734-9900**, or fax to **973-734-9910**. MD On-Line's mailing address is: MD On-Line, Inc., 4 Campus Drive, Parsippany, NJ 07054.

All payer option — MD On-Line offers free 30-day trial

For participants who register to submit CMS-1500 claims electronically to Anthem, MD On-Line is offering its "all payer" option at no charge for a 30-day trial — allowing providers to view and transmit information electronically to all health insurance payers. Providers should contact MD On-Line for details about the trial offer and applicable fees once the 30-day promotion ends.

As a reminder, MD On-Line's services are available at no charge to providers who submit claims and other electronic transactions to Anthem — even after the 30-day, all payer option expires. Once the 30-day trial period ends, providers can elect to continue the "all payer option," and MD On-Line will charge a fee. Please note that it is the provider's responsibility to work with MD On-Line regarding applicable fees for the "all payer option." We have no control over the fees MD On-Line assesses for the all payer option.

Behavioral health update

Behavioral health providers — please review the entire newsletter

While the articles in this section are of specific interest to participating behavioral health providers, there are other articles in this publication that apply to or could be of interest to behavioral health providers as well. Please review the entire issue. In addition, please note that the information and articles in this newsletter related to behavioral health services are for plans and products managed by Anthem Behavioral Health.

Behavioral health provider website

The Behavioral Health Provider website can be found at anthem.com > Providers > Select state > Enter > Anthem Behavioral Health. The Anthem Behavioral Health portal contains various information including downloadable forms, the Anthem Behavioral Health Provider Manual, Medical Necessity Criteria, Anthem-adopted clinical practice guidelines and many other provider/member resources. Visit us today!

Medical necessity criteria

Please note: Anthem's Behavioral Health Medical Necessity Criteria (MNC) has been updated for an effective date of January 1, 2009. The updated MNC can be found on our website at anthem.com > Providers > Select state > Enter > Anthem Behavioral Health > Policies and Guidelines. Please be sure to review it in advance of the effective date.

Behavioral health provider satisfaction

If you have not already done so, please complete and return the satisfaction survey that was sent to your practice location. This survey is sent to a sample of participating behavioral health providers within the Anthem network. Through your responses, we look for best practices and areas of improvement to help better serve you.

Quality programs update

2007 medical record review results

Anthem conducts annual medical record review (MRR) on a random selection of provider groups. The purpose of the review is to assess the provider's compliance with the MRR Standards. MRRs were established to facilitate communication, coordination and continuity of care and to promote efficient and effective treatment. Records are required to be maintained in a manner that is current, detailed and organized, and which permits effective, confidential patient care.

Findings

All PCP practices met or exceeded the performance goal of 85 percent. Overall, providers scored high on the following:

- Author identification
- Legibility
- Use of problem lists
- Documentation of follow up plans
- Lab and diagnostic tests initialed by the PCP
- Documentation of childhood Immunizations
- Documentation of allergies

The following standards were identified as areas for improvement:

- Documentation of Body Mass Index (BMI)
- Documentation of immunization history for adults
- The importance of specialty providers communicating with the PCP, including copies of consultation reports and diagnostic tests
- The importance of sending summary reports back to PCPs after an inpatient admission, outpatient surgery or home health care
- Documentation of colorectal cancer screening

Coordination and continuity of care findings

As part of the medical records review in 2007, records were selected for review based on specific services that members had received (an inpatient admission, outpatient surgery or home health services) in order to identify any deficiencies in providing coordination and continuity of member care across the health care spectrum.

Based on the sample of medical records reviewed, discharge summaries are often not present in the PCP's medical record. We would like to work with these facilities or providers to encourage them to send discharge summaries or appropriate documentation to the PCP.

Anthem has adopted Advanced Directive discussion and documentation as part of the member's medical record with a copy to be placed on the member's record. See: Medical Record Standards 2007 and 2008.

The medical record standards are available on our website at anthem.com > Providers > Select state > Enter > Anthem Online Provider Services > Forms and Reference Materials, Medical Record Standards. Tools are available for providers to help with medical record maintenance.

Clinical guidelines available on anthem.com

As part of our commitment to provide you with the latest clinical information and educational materials, clinical guidelines are reviewed annually and are offered to providers at least every two years. 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 most recent medical research.

The guidelines are available at anthem.com > Providers > Select state > Clinical Guidelines. If you would like a copy, please contact Clinical Quality at **203-985-6171** or **800-545-0948 ext. 6171**.

Pharmacy update

Specialty pharmacy network expanded to Lumenos® and NEHP members effective October 1, 2008

In the October 2007 issue of *Network Update* we announced a new specialty pharmacy network that would apply to most Anthem group members. Beginning October 1, 2008, the specialty pharmacy network will also apply to members enrolled in Lumenos plans and New England Health Plans (NEHP). Lumenos and NEHP members will be required to use a participating specialty pharmacy provider in order to maximize their benefits.

Participating specialty pharmacy providers strive to provide members with integrated, cost-effective solutions for purchasing and managing specialty drugs.

For members to receive the highest level of coverage for their specialty medications, they will need to transfer their specialty medication prescriptions to a participating specialty pharmacy provider before October 1, 2008. Members choosing to obtain specialty medications from a non-participating specialty pharmacy provider after October 1, 2008 may be responsible for a greater share of the cost and member out-of-pocket expenses may be higher.

Anthem's affiliated specialty pharmacy, PrecisionRx Specialty Solutions (PRxSS), participates in the specialty pharmacy network. This full service specialty pharmacy offers all the services listed above, plus nurses and pharmacists available 24-hours a day, seven days a week for urgent medication questions. In addition, medication therapy management is offered to help members get the best results possible from their treatment.

If these members choose to transition their prescriptions to PRxSS, you — as the prescribing physician — may fax a member's prescription(s) to **800-824-2642** or you may call **800-870-6419**. A pharmacy customer advocate will verify member and provider information and arrange for the member's prescription(s) to be transferred. Pharmacy customer advocates are available to take calls Monday through Friday, from 8 a.m. to midnight, and on Saturday from 10 a.m. to 6:30 p.m.

We are confident that better coordination of specialty pharmacy activities can result in increased satisfaction and the opportunity for improved clinical outcomes for members taking specialty medications. Should you or your office staff have questions about this specialty pharmacy and care management program, please call us at **800-870-6419** Monday through Friday, from 8 a.m. to midnight, and on Saturday from 10 a.m. to 6:30 p.m., or visit PRxSS website at precisionrxspecialtysolutions.com. For speech and hearing impaired assistance (TDD/TTY), please call **800-221-6915**, Monday through Friday, 8:30 a.m. to 5 p.m.

A complete list of participating specialty pharmacy providers may be found on anthem.com > Members > Select state > Enter > Plans & Benefits (located in top blue bar) > Prescription > Specialty Pharmacy > Specialty Pharmacy Network.

Anthem national drug list updates

The latest drug list updates to the Anthem Drug List/Formulary are available on our website. To access the updates, visit wellpointnextrx.com/wps/portal/wpo/provider/home.

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

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Pass it along! We only send one issue of Network Update to each provider group practice, and a limited number to facilities. Please pass along your copy to other offices/departments, or download this and previous issues from our website, anthem.com.

The information in this newsletter is for informational purposes only and should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for our members and enrollees is the responsibility of physicians and providers.

Unless otherwise noted, the information contained in this *Network Update* applies to all Anthem Blue Cross and Blue Shield's plans and programs in Maine.

Unless otherwise noted, the information contained in the Behavioral Health Update section in this *Network Update* applies to services managed by Anthem Behavioral Health.

Please note: All policies are subject to the terms, conditions and limitations of the member's plan or program.

In Maine: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Anthem Blue Cross and Blue Shield
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Network Update

SEPTEMBER 2008

Working together to improve the health of our members.

Important phone numbers

Provider Service: 800-832-6011
Monday-Friday
8 a.m.-5 p.m.

EDI Help Desk: 800-334-8262