

Network Update

C E N T R A L R E G I O N

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Welcome to *Network Update* online

Welcome to your first online edition of *Network Update*. As you may recall, in the December 2008 edition we advised you that we'd begin distributing *Network Update* exclusively online beginning in 2009 and thereafter. We'll mail you a brief postcard outlining important information, updates and announcements as a reminder to check out the latest edition of *Network Update* online.

You can easily download/print current and past quarterly editions of *Network Update* by logging on to anthem.com > **Provider (select your state)** > **Publications** > **Network Update**. We also encourage you to sign up for e-mail delivery of a link to the newsletter directly in your e-mail mailbox. Sign up is quick and easy on anthem.com > **Provider (select state)** > **Answers@Anthem** > **E-mail Updates Sign Up**.

Online newsletters help get timely information to you sooner and in a more efficient, environmentally friendly way.

If you would like a printed copy of *Network Update*, please contact your local provider representative (see the back panel of this newsletter for the phone number in your state).

Account update

New groups

Logan Aluminum, Inc.

Effective January 1, 2009, Logan Aluminum began offering Blue Access[®] HRA and HSA products through Anthem Blue Cross and Blue Shield to their members who reside in Kentucky. The group alpha prefix is LGK. The precertification phone number is **866-513-6934** and the customer service number is **877-380-1507**.

Pikeville Medical Center

Effective January 1, 2009, Pikeville Medical Center began offering Blue Access[®] PPO products, along with Anthem Blue Dental Blue[®] 300, through Anthem Blue Cross and Blue Shield to their members who reside in Kentucky. The group alpha prefix is YRP. The precertification phone number is **877-814-4803** and the customer service number is **888-650-4047**.

Trover Health System

Effective January 1, 2009, Trover Health System began offering Blue Access[®] PPO products through Anthem Blue Cross and Blue Shield to their members who reside in Kentucky. The group alpha prefix is YRP. The precertification phone number is **877-814-4803** and the customer service number is **888-650-4047**.

Administrative

2009 Precertification changes effective June 30; Oncolytics added

Please note the date change for Specialty Pharmacy below.

The 2009 Pre-certification changes are for the following products:

OH/IN/KY Blue Products

Blue PrioritySM (HMO), Blue PrioritySM Plus (POS),¹ Blue Preferred[®] (HMO), Blue Preferred[®] Primary (HMO), Blue Preferred[®] Primary (EPO Ohio), Blue Preferred[®] Plus (PPO), Blue Preferred[®] Primary Plus (POS), Blue Access[®] (PPO), Blue Access[®] HSA (PPO), Blue Access[®] Hospital-Surgical (PPO), Blue Access[®] HCR² and Blue Traditional[®]

MO Blue Products

Blue Preferred[®] (HMO), Blue Preferred[®] Plus (POS), Blue Access[®] (PPO), Blue Access[®] HSA (PPO), Blue Access[®] (PPO), Blue Access[®] Choice (PPO), Blue Access[®] Choice HSA (PPO), Blue Access[®] Hospital-Surgical (PPO), Blue Access[®] Choice Hospital-Surgical (PPO)

WI Blue Products

Blue Preferred[®] (HMO), Blue Preferred[®] Plus (POS), Blue Access[®] (PPO), Blue Access[®] Choice PPO

Medicare Advantage Products

IN, KY, OH — Blue Medicare AccessSM — (RPPO)

IN, KY, OH, MO, WI — Anthem Senior Advantage — (HMO)

IN, KY, OH, MO, WI, VA — Anthem Medicare Preferred — (PPO)

¹ Ohio only
² Kentucky only

Lumenos[®] Products

OH, IN, KY, MO — Lumenos Health Savings Account, Lumenos Health Reimbursement Account, Lumenos Health Incentive Account

WI — Lumenos Health Savings Account, Lumenos Health Savings Account Plus, Lumenos Health Reimbursement Account, Lumenos Health Reimbursement Account Plus, Lumenos Health Incentive Account, Lumenos Health Incentive Account Plus.

Healthy Indiana Plan

The following change to the Precertification list will occur June 30, 2009 and includes all products listed above, except for members enrolled in Anthem National accounts or select Anthem local self funded groups. These services do not require pre-certification for coverage for National accounts or select Anthem local self funded groups, but are recommended for pre-determination of medical necessity due to the existence of post service claim review edits. Precertification guidelines for National account members and select Anthem local self funded groups are available online by clicking the Precertification guidelines on the provider home page of **anthem.com**.

The following changes to the Precertification list will occur June 30, 2009. **Please note:** this is a date change from previous communication.

Specialty pharmacy medications effective June 30, 2009. Includes all outpatient settings (i.e. office, outpatient, home infusion, dialysis centers if billed separately, ambulatory infusion centers):

<i>Generic Name:</i>	<i>Trade Name:</i>	<i>Medical Policy or Clinical Guideline:</i>
Abatacept	Orencia	Abatacept (Orencia®)-MP – DRUG.00040
Adalimumab 20mg	Humira	Tumor Necrosis Factor Antagonists – MP DRUG.00002; Biologics for Psoriasis and Psoriatic Arthritis – CG-DRUG-12
Bevacizumab 10mg	Avastin	Bevacizumab (Avastin®) for Oncologic Indications- MP DRUG.00038; Treatment for Age-Related Macular Degeneration – MP DRUG.00028
Botulinum toxin Type A	Botox	Surgical Treatment of Migraine Headaches- MP SURG.00096; Treatment of Hyperhidrosis MP MED.00032; Botulinum Toxin DRUG.00006
Botulinum toxin Type B	Myobloc	Treatment of Hyperhidrosis MP MED.00032; Botulinum Toxin DRUG.00006
Certolizumab Pegol	Cimzia	Tumor Necrosis Factor Antagonists; MP DRUG.00002
Cetuximab 10mg	Erbix	Cetuximab (Erbix®) MP DRUG.00036
Darbepoetin Alfa	Aranesp	Recombinant Erythropoietin Products – CG-DRUG-05
Epoetin Alfa	Procrit, Epogen	Recombinant Erythropoietin Products – CG-DRUG-05
Epoprostenol 0.5mg	Flolan	Prostacyclin Infusion Therapy for Treatment of Pulmonary Hypertension (epoprostenol [Flolan®], treprostinil [Remodulin®]) – MP DRUG.00004
Etanercept 25mg	Enbrel	Biologics for Psoriasis and Psoriatic Arthritis – CG-DRUG-12; Tumor Necrosis Factor Antagonists MP DRUG.00002
Hyaluronic acid	Hylgan, Supartz	Hyaluronan Injections for Musculoskeletal Conditions – MP DRUG.00017
Hyaluronic acid	Synvisc	Hyaluronan Injections for Musculoskeletal Conditions – MP DRUG.00017
Hyaluronic acid	Euflexxa	Hyaluronan Injections for Musculoskeletal Conditions – MP DRUG.00017
Hyaluronic acid	Orthovisc	Hyaluronan Injections for Musculoskeletal Conditions – MP DRUG.00017
Immune globulin	IgIV Carimune	Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013; Intravenous Immune Globulin Therapy (IVIG)- CG-DRUG-09
Immune globulin-liquid	Gammunex	Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013; Intravenous Immune Globulin Therapy (IVIG) – CG-DRUG-09
Immune globulin-liquid	Octagam	Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013; Intravenous Immune Globulin Therapy (IVIG) – CG-DRUG-09
Immune globulin-liquid	Gammagard	Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013; Intravenous Immune Globulin Therapy (IVIG) – CG-DRUG-09
Immune globulin-liquid	Flebogamma	Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013; Intravenous Immune Globulin Therapy (IVIG) – CG-DRUG-09
Immune globulin-liquid	Privigen	Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013; Intravenous Immune Globulin Therapy (IVIG) – CG-DRUG-09
Immune globulin-powder		Intravenous Immunoglobulin as a Treatment of Recurrent Spontaneous Abortion and Associated Laboratory Tests – MP DRUG.00013
Immune globulin	Vivaglobulin	
Infliximab 10mg	Remicade	Biologics for Psoriasis and Psoriatic Arthritis- MP CG-DRUG-12 and Tumor Necrosis Factor Antagonists MP DRUG.00002
Omalizumab	Xolair	Omalizumab (Xolair®) for Treatment of Asthma – MP DRUG.00024
Palivizumab 50mg	Synagis	Prevention of Respiratory Syncytial Virus Infections- MP DRUG.00015
Panitumumab 10mg	Vectibix	Panitumumab (Vectibix™)- MP DRUG.00035
Pegaptanib	Macugen	Treatment for Age-Related Macular Degeneration – MP DRUG.00028
Ranibizumab 0.1mg	Lucentis	Treatment for Age-Related Macular Degeneration – MP DRUG.00028
Sermorelin acetate 1mcg	Geref	Growth Hormone – MP DRUG.00009

Generic Name:	Trade Name:	Medical Policy or Clinical Guideline:
Somatrem 1mg	Protropin	Growth Hormone – MP DRUG.00009
Somatropin 1mg	MULTIPLE	Growth Hormone – DRUG.00009
Trastuzumab	Herceptin	Trastuzumab (Herceptin®) – MP DRUG.00039
Filgrastim (G-CSF)	Neupogen	White Blood Cell Growth Factors – CG-DRUG-16
Pegfilgrastim	Neulasta	White Blood Cell Growth Factors – CG-DRUG-16
Sargramostim	Leukine	White Blood Cell Growth Factors – CG-DRUG-16
Ziconotide	Prialt	Ziconotide Intrathecal Infusion (Prialt®) for Severe Chronic PainMP-DRUG-27
Treprostinil	Remodulin	Prostacyclin Infusion Therapy for Treatment of Pulmonary Hypertension (epoprostenol [Flolan®], treprostinil [Remodulin®]) – MP DRUG 00004
Oncolytics	Abraxane, Alimta, Aloxi Campath, Eloxatin, Faslodex, Neumega, Novantrone Rituxan- MP RAD 00031, Proleukin, Velcade, Vidaza, Zometa	

Please note: Home Infusion providers should continue to work with the local Home Infusion administrator in Kentucky

Note for Medicare Advantage: All specialty pharmacy drugs listed above, except oncolytics, are reviewed post service currently.

Always check for the phone number on the back of the member's card. For quick reference, we have included a few of the most common numbers:

Indiana, Kentucky, Ohio Local Pre-certification	877-814-4803
Wisconsin Pre-certification	800-242-1527
Missouri Pre-certification	800-992-5498
Medicare Advantage Products Pre-certification	800-304-9919
Radiology	888-730-2817
Predetermination – Central (IN, KY, OH, MO, WI)	888-769-9143 ext 08129
Predetermination- Indiana National Account	866-776-4793

If you would like to fax your request you may use the fax numbers below:

Indiana Local	317-287-8916
Kentucky	800-730-6061
Medicare Advantage Products	800-266-3504
Missouri	314-923-8542
Ohio Pre-certification	800-266-3504
Predetermination Central (IN, KY, OH, MO, WI)	888-656-5721
Specialty Pharmacy Pre-certification	513-770-4484
Wisconsin Pre-certification	262-717-3296
Radiology	888-730-2831
Predetermination Indiana National	800-773-7797

Pre-certification Guidelines for Indiana, Kentucky, Missouri, Ohio and Wisconsin are also available online by clicking the Pre-Certification Guidelines link on the provider home pages on Anthem.com.

Coverage for services is subject to the terms and conditions of the member's health benefit plan. Anthem's reimbursement, if any, is reduced by any applicable deductibles, co-payments and/or coinsurance as defined in the member's health benefit plan.

Other changes that were communicated previously for local business and Medicare Advantage include:

Effective Jan 1, 2009 – Transplant Evaluations – Please note: this does not include Kidney or Cornea Transplants

Effective Jan 1, 2009 – Lumbar spine fusion surgery outpatient (does not include National or Medicare Advantage)

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Convenient new fax process for decision letters

Anthem Blue Cross and Blue Shield now has the ability to fax utilization management decision letters (Approvals, Denials and Requests for Additional Information) to you. This new process allows you to receive your decision letters immediately.

If you're interested in receiving faxed UM decision letters, please print-out this page and fill out the form on the right and fax to the appropriate number in your region. A secure fax number is required to use this service.



Please provide me with Utilization Management decision letters via fax.

Please fax this information to:
ATTN: Outbound Fax Information
Ohio/Indiana fax — **866-959-1395**
Kentucky fax — **800-730-6061**
Wisconsin fax — **866-959-2154**
Missouri fax — **866-959-2184**

If you have questions about this update, please contact your Network Management Representative.

Provider/Facility Name:

Address:

City

State

ZIP Code

Provider/Facility ID:

Secure Fax Number:

If we are able, would you like the requests for additional information letters to go to a different fax number?

Yes

No

If yes, please provide Secure Fax Number:

Name of Person Completing Form:

Phone Number:

Email Address (if you wish to provide):

(Cut along line)

Claim filing

Use these claim filing tips to help reduce delays, save time

Eliminate processing delays and unnecessary correspondence with these claim filing tips.

You can enroll to receive claim, eligibility and benefits inquiries online at anthem.com > “My Anthem for Providers” or by contacting your clearinghouse for available options.

Electronic Data Interchange (EDI) allows providers to submit claims and inquiries and retrieve remittance advices from their computer system via modem and phone lines. Anthem accepts all institutional, professional and dental claims for all provider specialties. This includes claims from the Federal Employee Program (FEP), national accounts and the BlueCard® Program (out-of-area) and claims requiring supporting documentation.

Anthem has teamed with MD On-Line, Inc., a leading national clearinghouse, to offer professional providers submitting the CMS 1500 claim form the ability to exchange secure HIPAA-compliant transactions with Anthem Blue Cross and Blue Shield through a web-based suite of services – at no charge.

Claims submitted electronically typically experience faster reimbursement and fewer rejections due to missing or incorrect information. Visit anthem.com/edi for more information on how to begin submitting claims electronically.

Paper claim filing

Submit all paper claims using the standard RED CMS-1500 claim form for professional claims and the UB-04 (CMS-1450) for facility claims.

It is critical that claims be mailed to the address indicated below, based on the state in which services were rendered, or through which your Anthem contract is held. Mailing your claim to an incorrect address may result in it being handled improperly or otherwise being returned to you.

INDIANA

PO Box 37010
Louisville, KY
40233-7010

KENTUCKY

PO Box 37690
Louisville, KY 40233-7690

MISSOURI

PO Box 36550
Louisville, KY 40233-6550

OHIO

PO Box 37180
Louisville, KY 40233-7180

WISCONSIN

PO Box 34210
Louisville, KY 40232-4210

Claim filing – general tips (UB-04 and CMS-1500)

- If your electronic claim is rejected by EDI, please do not resubmit it on paper. Rather, correct the electronic claim and resubmit via EDI.
- Please do not handwrite your claims, as this may result in misinterpretation of data or having your claims returned as illegible.

- Do not use highlighter on your claim, as it may make the data unreadable.
- Use black ink, as it is easier to read.
- Do not use a dot matrix printer, which is difficult to read.
- Change the printer cartridge regularly to improve the quality of your claims.
- Check the printing of your claims from time to time to help ensure proper alignment and that characters are easy to read.
- Make sure all characters are inside the fields and do not “lie” on the lines or extend beyond the boxes or fields. Claims may be returned if we are unable to clearly identify or read the data within a box/field.
- Avoid sending photocopies. If you must send us a photocopy of a claim form, Explanation of Benefits or other document, please be sure it is legible and no data is cut off the copy. Copies of faxes typically are very difficult to read, so please avoid these documents whenever possible.
- When submitting a claim with another carrier (or Medicare) EOB, the header information must be included on the EOB, so we are able to properly apply other carrier payment information. Your claim will be returned if this information is not present.
- To avoid disclosing PHI when attaching another carrier’s Explanation of Benefits (Medicare or commercial insurer), please mark through other insureds’ claims data. Be careful to NOT mark through any information for the member whose claim is attached.
- It is critical that the name on the claim match exactly the name as printed on the EOB.

- Unless submission rules do not allow, please file your secondary claim exactly as it was filed to Medicare or the other carrier (same to and from dates, same lines and charges, etc.)
- It is typically not necessary for you to submit a claim for payment secondary to Medicare. You may check with Provider Services to ensure your patient's Medicare information is on file with us. Information on covered members is forwarded to the Medicare carriers so they can "cross-over" these secondary claims. To help ensure that Medicare refers your claim to us after they complete processing, be sure to include, as part of the Medicare claim, the Anthem identification number (including any prefixes) in the appropriate other insurance/payer fields on the claim form.
- Medicare claims are sometimes not "crossed over" until several days after you are notified of the Medicare payment, so please allow at least 14 days before filing a secondary claim on paper. This helps reduce the receipt of duplicate claims and allows us to process all claims in a timelier manner. If you wait until you receive your Medicare Explanation of Benefits, you can verify that the claim was forwarded by the "MA18" remark code, which reads, "The claim information is also being forwarded to the patient's supplemental insurer."
- When submitting a claim with multiple pages, all information is required on each page (patient information, insured information, provider information, etc.)
- If you receive a rejection letter on which we request correction of data, please resubmit the claim on a new claim form.

CMS-1500 tips

For more information on how to complete your CMS-1500 claim form, please visit:

http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_ad090254.pdf

<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

http://www.nucc.org/index.php?option=com_content&task=view&id=33&Itemid=42

- Include the entire Member Identification number (including any prefix) in field 1a.
- All insured information is needed in fields 4 and 7 (Insured's Name and Insured's Address). Please do not use "Same" in field 7 (even if the addresses are the same) unless the insured and the patient are the same person and "self" is noted in field 8.

Provider Information

You are strongly encouraged to submit your National Provider Identifier (NPI) on all claims. However, as of this writing, Anthem does not require that NPI be included on paper claims. You may choose to submit your paper claim with either the NPI or Anthem PIN, or both. Any change to this requirement will be communicated in advance.

Provider information is to be noted in the following fields:

- 17 – Name of Referring Provider – if applicable
- 19 – Reserved for Local Use (Rendering Provider Taxonomy Code) – if applicable. This is currently not a required field, but including this information may help us process your claim.

- 24j upper (shaded area) – Rendering Provider ID# and/or Anthem PIN – if applicable and desired
- 24j lower – Rendering Provider ID#, NPI – recommended if applicable
- 25 – Tax ID – required, and claim may be returned if not present
- 31 – Signature of Physician or Supplier – required
- 32 – Service Facility Location Information – complete name and address required if different than field 33
- 33 – Billing Provider – complete name and address is required
- 33a – Billing Provider (Billing or Group NPI) – this or Anthem PIN I (field 33b) is required
- 33b – Billing Provider (Anthem PIN) – this or NPI (field 33a) is required

UB-04 (CMS-1450) tips

For more information on how to complete your UB-04 (CMS-1450) claims, please see:

<http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf>

- Include the entire Member Identification number (including any prefix) in box 60.
- Room rate data should be noted in boxes 39, 40 and 41 a, b, c, d for inpatient claims.
- Note the room rate as dollars ("1081" or "\$1081.00"; NOT "1081").

Provider information

You are strongly encouraged to submit your National Provider Identifier (NPI) on all claims. However, as of this writing, Anthem does not require an NPI to be included on paper claims. You may choose to submit your paper claim with either the NPI or Anthem PIN, or both. Any change to this requirement will be communicated in advance.

- 1 – Provider of Service – complete name and address of facility providing service
- 2 – Pay To – complete name and address of payee, if different than box 1
- 5 – Tax ID – required, and claim may be returned if not present
- 56 – NPI – this or Anthem PIN (field 57) is required
- 57 – Prv ID (PIN) – this or NPI (field 56) is required

81 – CC (Health Care Provider Taxonomy Code) – if desired. This is currently not a required field, but including this information may help us process your claim.

eBusiness

Visit us online

Anthem.com is your online resource to access:

- Members' rights and responsibilities
- Privacy policy
- Complaints and appeals process
- Quality Improvement program
- Nationally recommended medical and behavioral health guidelines for Asthma, Cardiac, COPD, Diabetes, Musculoskeletal Conditions: Low Back Pain*, Osteoporosis*, Osteoarthritis*, and Rheumatoid Arthritis*, Maternity/Perinatal, Adult Depressive Disorder*, Attention Deficit/Hyperactivity Disorder in Children*, and Bipolar Disorder*. Guidelines are also provided for Preventive Health*, Antenatal Depression, Postpartum Depression and Postpartum Psychosis*, and Substance Abuse*
- Financial incentives for utilization management decision makers and to find out how to get UM criteria

* Guideline is new or reviewed/updated since last quarter.

On anthem.com you can also:

- Learn how to obtain UM Criteria and how to access an appropriate practitioner to discuss any UM denial decision.
- Learn about and enroll a patient in our health promotion and disease management programs.
- Learn about pharmacy program policies and procedures, and use the online drug list/formulary.
- Refer to the Network Reference Guide for standards relating to office accessibility and availability goals.
- View our online provider directory.
- Use the online Precertification Request Form.
- Complete the online form to share your gender and spoken languages with Anthem members.
- Get patient safety and transition care information on **MyHealth@Anthem**[®], powered by WebMD[®]

FEP Telephone IVR Process Flow for Providers and Facilities Quick Reference



What is the FEP IVR?

The FEP IVR is an interactive voice response program that provides information for and about members of the Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program, or FEP. These members can be identified by the "R" prefix of their member identification number. The FEP IVR can be reached by dialing:

<i>Indiana</i> 800-382-5520	<i>Kentucky</i> 800-456-3967	<i>Missouri</i> 800-392-8043
<i>Ohio</i> 800-451-7602	<i>Wisconsin</i> 800-242-9635	

The capability to receive an automatic fax document that contains all information received verbally from the IVR. Watch for future updates!

What does the FEP IVR do?

The FEP IVR offers providers and facilities the opportunity to obtain eligibility, benefits, claim status, including check information and ability to request copies of remits; also Pre-certification guidelines with option to be connected to the Pre-cert area and Anthem addresses by specific state.

FEP's IVR is 24/7, quick and easy access to specific data without the need to speak to a customer service representative.

Benefits on FEP IVR:

The FEP IVR provides the following benefits:

- Physician Services
- Hospital Services
- Dental Benefits
- Prescription Drugs
- Mental Health Substance Abuse (MHSA)
- Outpatient Rehab

Claim status on FEP IVR:

The FEP IVR indicates claim status, paid or not, based on date of service and patient's date of birth, or based on Provider ID. A claim status IVR inquiry will provide:

- Claim number
- Paid to (member or provider)
- Paid on date
- Paid amount
- Member's total liability
- Calendar year-to-date amount
- Coinsurance amount

1. Contact the Federal Employee Program in your state by calling the appropriate toll free number listed on the other side.
2. **Press 2** (if you are calling from a **facility**), **OR Press 3** (if you are calling from a provider's office)
3. **Enter** your NPI or Anthem Provider Identification Number
4. Press 1 to confirm your NPI or Anthem Provider Identification Number is correct, **OR** if you need to re-enter, **Press 2**
5. **Choose from the following options...**

6. If you want to:	7. Press	8. Then	9. Then	10. Then	11. Then	12. Then
<i>Verify Eligibility</i>	1	1	Key Member ID#; Then ↓	Key Patient DOB; Then ↓		
<i>Verify Physician Benefits</i>	1	2	Press 1 if Member ID# entered is correct, OR ↓ Press 2 to re-enter ID# if incorrect	Press 1 if DOB entered is correct OR ↓ Press 2 to re-enter DOB if incorrect.	Press 1	Select desired benefit: 1 = Routine Physical Therapy 2 = Medical Office Visit 3 = Preventive Child Care 4 = Surgical Services 5 = Maternity Benefits
<i>Verify Hospital Benefits</i>	1	2	Same as above	Same as above	Press 2	Select desired benefit: 1 = Inpatient Medical & Surgical 2 = Outpatient Medical 3 = Outpatient Surgical 4 = Maternity
<i>Verify Dental Benefits</i>	1	2	Same as above	Same as above	Press 3	
<i>Verify Prescription Benefits</i>	1	2	Same as above	Same as above	Press 4	
<i>Verify Mental Health Benefits</i>	1	2	Same as above	Same as above	Press 5	Select desired benefit: 1 = Office Visit 2 = Inpatient 3 = Outpatient 4 = Outpatient Partial Hospitalization and Intensive Outpatient
<i>Verify Rehab Benefits</i>	1	2	Same as above	Same as above	Press 6	Select desired benefit: 1 = Physical Therapy 2 = Occupational and Speech Therapy 3 = Cardiac Rehab
<i>Check Claims Status</i>	1	3	Same as above	Same as above	Key Date of Service	
<i>Verify Check # and Check Clear Date</i>	1	3	Same as above	Same as above	Key Date of Service	Press 2
<i>Request Provider Remittance</i>	1	3	Same as above	Same as above	Key Date of Service	Press 3
<i>Hear Pre-certification Info</i>	2					
<i>Obtain Mailing Address for services rendered in Indiana, Kentucky or Ohio</i>	3	1	Select State: 1 = IN 2 = KY 3 = OH			
<i>Obtain Mailing Address for services rendered in Connecticut, Maine or New Hampshire</i>	3	2	Select State: 1 = CT 2 = ME 3 = NH			
<i>Obtain Mailing Address for services rendered in Colorado, Nevada or Virginia</i>	3		Select State: 1 = CO 2 = NV 3 = VA			

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Health care management

Clinical quality interventions: childhood immunizations

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. You can also have a positive impact when you urge 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 vaccinations include the following:

- Two Hepatitis A
- Three Rotavirus
- Two 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 second birthday.

NOTE: HEDIS® revised 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 two Hep A, three Rotavirus, and two Influenza vaccinations to children before their second birthday.

Our findings for Central zone states showed an opportunity for improvement.

Central zone states (Indiana, Kentucky, Missouri, Ohio, Wisconsin):

Medical Record Review results vary among states and vaccines given. 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 second 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 parents state 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 before leaving the office to help keep the immunizations 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" checklist.

Talk with your patients about managing antidepressant medication

Prescribing effective antidepressant medications is an important part of practicing medicine, regardless of provider specialty. A recent survey found that patients taking antidepressant medication are about as likely to receive appropriate care today as they were in 1999.¹ This survey suggests that early discontinuation of selective serotonin reuptake inhibitor medications reflects poor communication between the prescriber and their patient, especially about treatment duration and possible side effects.

Based on practitioner feedback, the National Committee on Quality Assurance (NCQA) has modified the Antidepressant Medication Management HEDIS® measure for 2009.

- The Optimal Practitioner Contacts Rate has been retired.
- The Effective Acute Phase Treatment and the Effective Continuation Phase Treatment, which measure continuation on antidepressant medication for 84 days and 180 days respectively, remain unchanged.

We encourage you to keep educating your patients and their families about medications, especially about how long to take antidepressant medications and common side effects of this class of drugs.

¹Anderson, B. HEDIS Antidepressant Medication Management Measures and Performance-based Measures: An Opportunity for Improvement in Depression Care. *Am J of Manag Care*. 2007; 13: S98-S102.

Anthem 360° Health® launches in the Central Region

Anthem Blue Cross and Blue Shield is proud to announce the launch of Anthem 360° Health® in five states. 360° Health is the most robust benefits program in the industry to comprehensively address preventive care, health improvement and care coordination.

360° Health is a total health strategy, integrating members' health needs throughout the continuum of services they receive. The services provided through 360° Health are member-focused, and harnesses the knowledge of medical professionals including physicians, nurses, dietitians, exercise physiologists and more.

360° Health is the industry's first program to integrate health management programs and tools into a centralized, consumer-friendly resource that assists members in navigating the health care system, using their health benefits and providing information to help them access comprehensive and appropriate care.

Consumer response to 360° Health has been extremely positive. Where other Anthem health plans have introduced 360° Health, 95 percent of members found 360° Health programs and tools to be helpful. Eighty-five percent of our members have either reached a health goal or have seen an improvement in their health by using their 360° Health benefits.

360° Health is being introduced to Anthem Blue Cross and Blue Shield members this year over five consecutive months:

- Indiana: March
- Ohio: April
- Kentucky: May3
- Missouri: June
- Wisconsin: July

360° Health includes*:

24/7 NurseLine — Trained registered nurses are available to answer confidential, health-related questions any time of the day or night, every day of the year.

Future Moms — Members receive support from trained obstetrical nurses dedicated to helping expectant parents have a healthy pregnancy and delivery. This award-winning maternity management program has resulted in fewer low birth-weight babies, fewer preterm births and more initial prenatal visits than national averages.

ConditionCare — According to the Agency for Healthcare Research and Quality (AHRQ), more than 108 million adults in the United States already suffer from chronic diseases such as coronary artery disease, heart failure and diabetes. ConditionCare helps members manage these and other chronic health conditions and to improve health outcomes.

ComplexCare — This program identifies and assists members who will benefit most from the intervention of a nurse care manager — sometimes before

the member knows he or she could use the extra help. Members also can be referred to the program by their doctors or through other programs offered by Anthem Blue Cross and Blue Shield. A typical example of a member who could benefit from ComplexCare would be someone who was recently diagnosed with cancer and was previously diagnosed with osteoarthritis — multiple, difficult-to-manage conditions.

MyHealth Coach — The entire family can sign up for health and lifestyle coaching from a registered nurse, with help from other health care professionals including dietitians and exercise physiologists. According to an independently chartered satisfaction survey, nine out of 10 members feel the MyHealth Coach program is helping them receive maximum benefits from the health care system.

MyHealth Advantage — This program combines safety and savings. If a member has missed an important test, MyHealth Advantage will alert the member's doctor. MyHealth Advantage also will suggest less expensive, equally effective alternatives to expensive prescription medications and show how much the member may be able to save by switching. MyHealth Advantage may save individuals hundreds of dollars a year in prescription costs.

MyHealth Record — an online personal health record owned and managed by Anthem members. MyHealth Record can be automatically populated by claims data and member self-reported information. Claims can be accessed from any computer with an Internet connection, empowering members to track and share their health histories with their doctors to help achieve the highest quality of care.

Healthy Lifestyles — Helps members with weight management, stress management, physical activity, diet and nutrition and smoking cessation. The three-tiered program includes:

- Healthy Lifestyles Online — Web-based support
- Healthy Lifestyles One-on-One — telephonic support from a registered nurse
- Healthy Lifestyles Complete — Web and telephonic support, plus free access to the Prime fitness center network

Worksite Wellness — Promotes better health by providing worksite programs such as health screenings, health education seminars, flu vaccinations and stress management — even therapeutic massage.

In addition to the wealth of health care information available through 360° Health, the program helps members access a wide range of services including online wellness and lifestyle programs, discounts on health-related products and alternative medicine therapies.

*Specific programs offered may vary depending on the member's plan.

Medicare Advantage

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.

Members 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 individual has been a member of the plan less than 90 days.

If the member 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 individual is a member of our plan. If the individual 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 member pursues a formulary exception.

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

Medicare Part B covered prescription drugs: changes in copayments for 2009

This is a follow-up communication to the “2009 Medicare Advantage Update,” distributed December 11, 2008. Based on comments and questions from providers during the month of January 2009, we want to give you more information about the changes made from 2008 to 2009 to cost sharing for Part B drugs.

In 2008, member cost sharing was based on a fixed dollar office visit copayment when the drug was provided by and administered by the provider. In 2009, members are responsible for 20% coinsurance for Medicare Part B covered prescription drugs in addition to the fixed dollar office visit copayment.

We understand Part B drugs are expensive. Market research conducted on benefits in this category showed that 20% coinsurance was the most common level of cost sharing and the change we made for 2009 was necessary to keep our benefits comparable with most other Medicare Advantage Plans.

In 2009, Anthem Blue Cross and Blue Shield has also added an out-of-pocket maximum that is designed to limit costs for members taking expensive Part B drugs and/or undergoing costly treatments. Generally, costs paid by the member for Medicare-covered services will apply to the out-of-pocket maximum. When that out-of-pocket maximum is reached, Anthem Blue Cross and Blue Shield will pay 100% of the allowed amounts for covered services, including Part B drugs.

Please note that Original Medicare requires a 20% coinsurance without the protection of an out-of-pocket maximum. Many Medicare Advantage plans offer additional benefits that aren't covered by Original Medicare, such as routine vision and hearing benefits, in addition to the security of an out-of-pocket maximum. Anthem Blue Cross and Blue Shield also offers Medicare-covered preventive care benefits, such as routine physical exams, mammograms, colorectal screenings and prostate cancer screenings, without member cost sharing. Please refer to our website at anthem.com/medicare, and select Provider Services for additional information and the full 2009 Summary of Benefits.

Anthem Blue Cross and Blue Shield notified members of these and other 2009 benefit changes through the Annual Notice of Change letter. This communication is standardized, approved by the Centers for Medicare and Medicaid Services (CMS) and uses clear language to explain all changes to plan benefits for the coming year. The Annual Notice of Change helps Medicare beneficiaries consider the benefit changes made and decide whether to retain or change their existing coverage.

Members still have the opportunity to change their coverage plan during the Open Enrollment Period, which ends March 31, 2009, provided the change meets CMS enrollment guidelines.

If you have questions regarding this communication, please contact customer service at the number located on the back of the member's ID card.

Questions and answers about changes to copayments for Medicare Part B covered prescription drugs

- Q. Has CMS approved your 2009 plans?*
- A. Yes, CMS has approved the Anthem Blue Cross and Blue Shield Medicare Advantage plans.
- Q. Can you provide the specific cost sharing and out-of-pocket maximum for 2009?*
- A. Yes, for 2009, Anthem received approval to apply a 20% cost share for Part B covered drugs. For Indiana, Kentucky, Missouri, Ohio and Wisconsin plans, the 2009 out-of-pocket maximum is \$3,500 for HMOs and ranges from \$3,500 to \$4,500 for PPO plans.
- Q. In addition to chemotherapy drugs, what other drugs are covered under Medicare Part B?*
- A. Drugs that usually are not self-administered by the patient and are injected while receiving services in a physician's office.
- Drugs you take using durable medical equipment (such as nebulizers) that are authorized by the plan.
- Q. Will you do anything to assist those members who will be most impacted by these changes in 2009?*
- A. Yes, the out-of-pocket maximum is the primary member protection we are offering in 2009. Many competitors or Original Medicare do not offer this protection. We also offer members additional assistance including:
- Our care management team will work to find alternative community resources where available.

Medicare Advantage PFFS Payment Reconsideration/Adjustment Form

The Medicare Advantage PFFS payment reconsideration/adjustment form is now posted on www.anthem.com/medicare, go to **Additional Information > Provider Services > Anthem SmartValue Private Fee for Service (PFFS) > PFFS Payment Reconsideration/Adjustment Form**.

Providers should only use this form for Medicare Advantage Private Fee for Service (PFFS) claim requests.

Using the form properly will help improve the response time of claims being reviewed for payment reconsideration or adjustment. The form can also be used to initiate a claim consideration review or claim adjustment request (instead of calling the plan) and to submit:

- a corrected claim (a copy of the corrected claim should accompany the form)
- additional information to support a claim or,
- to address a special claim situation as needed

If the remittance advice for the claim(s) on the reconsideration/adjustment form is from your local Blue plan, please send the form to your local plan to be processed.

If the original remittance advice for the claim(s) on the reconsideration/adjustment form is not from your local Blue plan, please send the form to:

Anthem/PFFS Plan
P.O. Box 795180
San Antonio TX, 78279

.Log on to www.anthem.com/medicare often to familiarize yourself with Medicare Advantage products, services, payment methodology grid, provider manuals, important telephone numbers and more helpful information.

If you have questions about the form, please contact our dedicated provider service line at **866-364-2374**, Monday-Friday, 7 a.m. to 7 p.m.

Prescription

Prescription savings opportunities for your patients

It's 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 troubling times. Unfortunately, when people are looking at ways to cut costs, even medications may not fit neatly into the monthly budget.

- Individuals 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 help 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 nonelderly adults (ages 18-64) are more than twice as likely as insured nonelderly adults to say that they or a family member did not fill a prescription (45% vs. 22%) or they cut pills or skipped doses of medicine (38% vs. 18%) in the past year because of the cost. Kaiser Family Foundation, Kaiser Public Opinion Survey Brief, Economic Problems Facing Families (April 2008), p4.

Initiating discussions about medication costs and prescribing generic medications gives you the opportunity to help your patients save money on their health care 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 three 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 which have additional generic alternatives available.

Here are several examples:

<i>Therapeutic Category</i>	<i>Generic Options</i>
Osteoporosis	alendronate
Sleep/Hypnotics	zolpidem
Cholesterol	simvastatin, pravastatin, lovastatin
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.

Two examples:

<i>Therapeutic Category</i>	<i>Generic Options</i>
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

Every day, 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 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.

Reimbursement

Reimbursement change delayed for assistant surgeon services; ACS designations effective April 15, 2009

The change to the reimbursement percentage rate for assistant surgeon services, scheduled to occur on April 15, 2009 (published in Network Update Issue 4, 2008), has been delayed. Please visit the Provider home page at anthem.com for future Rapid Update postings that provide updated information on the implementation.

Although the revised date for the reimbursement rate change has not been announced at this time, it will apply to providers in Indiana, Kentucky, Missouri, Ohio and Wisconsin, will be determined by the reported modifier and will change to one of the following:

- Modifiers 80, 81 and 82 will be reimbursed at 16% of the maximum allowance
- Modifier AS will be reimbursed at 16% of the maximum allowance (if there is a physician extender fee schedule); otherwise,
- the procedure will be reimbursed at 14% of the MD fee schedule.

Codes reported with an assistant surgeon modifier are subject to the standard multiple surgery reimbursement rule, if applicable.

Assistant surgeon designations effective April 15, 2009

On April 15, 2009 we will begin using the “always” and “never” guidelines, established by the American College of Surgeons (ACS), as a guide for determining assistant surgeon designations.

In instances where the ACS indicates an assistant surgeon may “sometimes” be required, or the ACS does not assign a designation, we will refer to the designations assigned by the Center for Medicare and Medicaid Services (CMS) or to our own national Health Care Management physicians, *except when the health plan considers CPT codes 59510, 59515, 59618, and 59622 as global delivery and not eligible for assistant surgeon reimbursement.*

If you have any questions about this change, please contact your Network Management Representative.

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Network Update

ISSUE 1, 2009

We urge you to submit your
claims electronically.

Important phone numbers and addresses

Indiana

Provider Inquiry: 800-345-4344
Precert/Referral: See back of member's ID card.
Claims Filing: P.O. Box 37010
Louisville, KY 40233-7010

Kentucky

Provider Inquiry: 888-850-4133
Precert/Referral: See back of member's ID card.
Claims Filing: P.O. Box 37690
Louisville, KY 40233-7690

Missouri

Provider Inquiry: 800-490-6217
Precert: HMO 800-235-1113
PPO 800-392-8740
Lumenos 866-398-1922
Claims Filing: P.O. Box 36550
Louisville, KY 40233

Ohio

Provider Inquiry: 888-290-9160
Precert/Referral: 800-282-1016
Claims Filing: P.O. Box 37180
Louisville, KY 40233-7180

Wisconsin

Provider Inquiry: See back of member's ID card
Precert/Referral: 800-472-6909
Claims Filing: P.O. Box 34210
Louisville, KY 40232-4210

PLEASE PROVIDE UPDATES USING THE ANTHEM PROVIDER MAINTENANCE FORM

We are continually updating our provider directories to help ensure that your current practice information is available to our members. When a provider recently joins or leaves your practice, or you have a change in your address, phone number, etc., please let us know by completing the Anthem Provider Maintenance Form at anthem.com. Thank you for your help and continued efforts to keep our records up to date.