

Network Update

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Network Update

A bi-monthly update for the health care professional community from Anthem Blue Cross and Blue Shield and its affiliated HMOs: HealthKeepers, Inc., Peninsula Health Care, Inc. and Priority Health Care, Inc. Unless otherwise noted, the information in this newsletter pertains to all the aforementioned entities.

Provider Communications
 2221 Edward Holland Drive
 Richmond, VA 23230

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association.

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www.anthem.com

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Health care reform update for providers

Across the country, health care reform is at the forefront of many discussions in the health care industry. Whether we're consumers, providers, health insurance companies, suppliers to the industry or government agencies, our roles in health and health care will continue to evolve over the coming months and years.

As our industry moves forward with discussions around health care reform, you may have questions about the impact on your business relationship with us. We've assembled several commonly asked questions below and their responses. In addition, we'll post health care reform updates and notifications on the Virginia provider section of our website at anthem.com – so please visit the site periodically.

What is Anthem Blue Cross and Blue Shield's position on the new health care legislation?

Our priority remains the same: to meet the health care coverage needs of our members and help ensure they have access to affordable, high-quality care. Affordability is more important than ever before, and we remain concerned that the bill signed into law by the President does not do enough to reduce cost in the system or improve quality – two important keys to building a system that will help get our country on a sustainable path to providing affordable coverage for all Americans.

Does the new law impact my participation with Anthem?

The health care reform legislation does not alter our current physician or hospital networks or your status as a participating physician or other provider with Anthem Blue Cross and Blue Shield and our affiliated HMOs.

How will the new health care law change my day-to-day business with Anthem?

For the immediate future, your day-to-day business processes with Anthem will not change. Anthem has multiple teams reviewing and analyzing the impact of the new legislation to ensure we are prepared to implement all required changes in

accordance with the law. Federal departments are required to issue more detailed regulations for implementation, and it will take time to fully analyze these changes.

The far-reaching implications of the new legislation will be phased in over a multi-year implementation period, beginning in the coming months. As Anthem prepares for the post-reform environment, we will update you on any impact these changes may have to current business processes by way of our Network Update (provider newsletter) and your local Provider Network Management.

Will I see a change in patient policies or payment?

The new legislation will impact several elements of new and renewed policies beginning September 23, 2010. Examples include allowing members to add dependents up to age 26 (regardless of student status), eliminating lifetime limits on policies, and removing member cost sharing for preventive benefits (as defined by the legislation). As a proactive measure, Anthem began on June 1, 2010, to automatically retain dependents up to age 26 on their parents' policies in both fully insured group and individual health plans. Self-insured groups, where Anthem provides administration services only, will have the option of not offering this extended coverage. Many of the more significant changes of the law are set to be effective January 1, 2014.

As a physician or other provider, what action do I need to take?

As previously mentioned, Anthem will continue to provide you with updates about our implementation of health care reform as our teams prepare for changes to member policies and/or business processes. You may want to contact your professional advisors to determine the impacts, if any, of health care reform to your business. We continue to be focused on providing excellent service to our physician and provider communities.

What should I do when my patients have questions about health care reform? How can I help them?

We know that our members, customers and providers will all be impacted by health care reform. To help answer questions around the new legislation, we have launched a website dedicated to helping the public understand the many parts of health care reform. The site, www.healthychat.com, encourages open forum discussion and is designed to answer specific questions about all health care related topics. If you have questions about how health care reform will impact you or your patients, please visit www.healthychat.com to submit your questions. Additionally, if you have patients who have unanswered questions about health care reform, please encourage them to visit www.healthychat.com and join the discussion. Healthychat.com is monitored daily during business hours, and responses to questions are posted within 24 hours.

Coverage and clinical UM guideline update

Update on clinical reviews

Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield (Anthem) is revising and standardizing what is reviewed, either pre- or post-service, to be consistent across our family of companies nationwide. Using a phase-in approach, the first phase will include more services moving to pre-certification (formerly referred to as pre-authorization). This change applies to members covered by products under the following Anthem plans in Virginia: PAR, PPO, Virginia Lumenos, plus our affiliated HMO plan, including Medicaid and FAMIS. A Health Services Review will be required for those guidelines identified for pre-certification review.

Beginning November 1, 2010, the changes listed below will take effect.

- o **New clinical UM guidelines will be adopted for pre-certification review for the following services:**
 - CG-SURG-24 Functional Endoscopic Sinus Surgery (FESS). Codes include 31237, 31240, 31254, 31255, 31256, 31267, 31276, 31287, 31288, S2342

- o **The following clinical UM guidelines and coverage guidelines will move from post-service review to pre-certification review for the following services:**
 - CG-ANC-04 Ambulance Services: Air and Water. Air Ambulance will require pre-certification Codes moving to pre-certification include: A0430, A0431, A0435, A0436. Please note there is no penalty for failure to obtain pre-certification for emergent ambulance services. If pre-certification is not obtained, the claim will be reviewed for medical necessity retrospectively with no late penalty.
 - CG-DME-01 External (Portable) Continuous Insulin Infusion Pump. Codes E0784 and A9274 for the infusion pump are moving to pre-certification.
 - CG-DME-31 Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs). Codes include E1002, E1003, E1004, E1005,,E1006, E1007, E1008, E1230, E1239, K0010, K0011, K0012, K0014, K0800, K0801, K0802, K0806, K0807, K0808, K0812, K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0826, K0827, K0828, K0829, K0830, K0831, K0835, K0836, K0837, K0838, K0839, K0840, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0854, K0855, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, K0891, K0898, K0899
 - DME.00012 Oscillatory Devices for Airway Clearance including High Frequency Chest Compression (Vest™ Airway Clearance System) and Intrapulmonary Percussive Ventilation (IPV). Codes moving to pre-certification include: A7025, E0483.
 - GENE.00001 Genetic Testing for Cancer Susceptibility. Codes moving to pre-certification include: S3818, S3819, S3820, S3822, S3823, S3828, S3829, S3830, S3831, S3833, S3834, S3840.
 - MED.00073 Treatment of Tinnitus. Code 99183 will move from post service to pre-service.
 - SURG.00014 Cochlear Implants and Auditory Brainstem Implants. Codes moving to pre-certification include: 92603, 92640, L8614, L8615, L8616, L8617, L8618, L8619, S2235.
 - SURG.00023 Breast Procedures: including Reconstructive Surgery, Implants and Other Breast Procedures. Codes moving to pre-certification include: 11920, 11921, 11922, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19380, 19396, C1789, L8600, S2066, S2067, S2068
 - SURG.00024, Surgery for Clinically Severe Obesity. Codes for pre-certification include: 43632, 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888, S2083. Code 00797 remains in Post review.
 - SURG.00060 Implanted Spinal Cord Stimulators (SCS). Codes moving to pre-certification include: 63650, 63655, 63685, L8680, L8682, L8683, L8685, L8686, L8687, L8688.
 - SURG.00074, Nasal Surgery for Treatment of Obstructive Sleep Apnea, SURG.00096, Surgical Treatment of Migraine Headaches. Codes moving to pre-certification include: 15824, 15826, 30110, 30115, 30130, 30140, 30465, 30520, 30801, 30802, 31200, 31201, 31205, 31237, 31254, 31255, 67900.

As a reminder, inpatient stays must be pre-certified. Please be prepared to provide clinical information when you contact us for pre-certification.

The Office of Medical Policy and Technology Assessment (OMPTA) develops coverage guidelines and clinical utilization management (UM) guidelines. Coverage guidelines are developed to assess services requiring scientific, evidence-based direction. Clinical UM guidelines address generally accepted technologies or services that are proven standards of care in the medical community, but appropriateness and medical necessity of the technology or service may vary for different

clinical indications. All guidelines are subject to an annual review and approval process. The codes listed in this article reflect the codes that are currently on the guidelines at the time this notification was written.

To learn more about our guidelines or to obtain a copy of a Clinical UM Guideline or Coverage Guideline, visit <http://anthem.com> > Provider > Virginia > Medical Coverage Guidelines and Clinical UM Guidelines. Pre-certification (Health Services Review) requirements are available through Point of Care or by calling the phone number on the back of the member's ID card.

Coverage guideline updates

Effective November 1, 2010, Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield (hereinafter "Anthem") will implement the following revised coverage guidelines:

- Transcatheter Closure of Cardiac Defects (SURG.00032)
- Manipulation under Anesthesia of the Spine and Joints other than the Knee (MED.00079)
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT) (SURG.00017)
- Intraepidermal Nerve Fiber Density Testing (LAB.00020)

Transcatheter Closure of Cardiac Defects (SURG.00032)

With implementation of this revised version, diagnosis codes 429.71, 434.91, 435.9, 745.2, 745.5 and 745.69 will pend for medical necessity criteria review when billed with procedure codes 93580, 93581, 37204 or 75894. Refer to the complete guideline currently available on our website at www.anthem.com for a complete listing of the procedure and diagnosis codes applicable to this guideline. Anthem will continue to apply *Transcatheter Closure of Cardiovascular Defects (SURG.00032)* that became effective April 22, 2009, until November 1, 2010.

Manipulation under Anesthesia of the Spine and Joints other than the Knee (MED.00079)

The coverage guideline *Spinal Manipulation under Anesthesia (MED.00079)* has been revised to address the use of manipulation under anesthesia for joints other than the knee in addition to spinal manipulation. Manipulation under anesthesia of the shoulder is considered medically necessary for adhesive capsulitis (frozen shoulder). Manipulation under anesthesia of the shoulder for all other diagnoses is considered investigational.

Manipulation under anesthesia of the spine is considered medically necessary for the treatment of vertebral fracture, complete dislocation of the spine or acute traumatic incomplete dislocation (subluxation) of the spine. Manipulation under anesthesia of the spine for any other indication is considered investigational. Manipulation under anesthesia for any other joint or body part not addressed as medically necessary in MED.00079, except the knee, is considered investigational. CPT code 23700 has been added to this coverage guideline. Diagnosis 726.0 is considered medically necessary when billed with CPT code 23700, and all other diagnoses are considered investigational. CPT codes 24300, 25259, 26340, 27275 and 27860 have also been added to MED.00079 and are considered investigational for all diagnoses. The complete revised guideline is available for review on our website at www.anthem.com. Anthem will continue to apply *Spinal Manipulation under Anesthesia (MED.00079)* that became effective October 21, 2009, until November 1, 2010.

Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT) (SURG.00017)

Effective November 1, 2010, certain CPT and HCPCS codes will pend for medical necessity criteria review per SURG.00017 when billed with specific diagnosis codes. CPT or HCPCS codes 61796, 61797, 61798, 61799, 61800, 77371, 77372, 77432, G0173, G0251, G0339 and G0340 will start pending for review when billed with diagnosis codes 171.0, 190.0, 191.0-191.9, 192.1, 198.3, 198.4, 225.1, 225.2, 237.5, 237.6 or 350.1. In addition, CPT and HCPCS codes 63620, 63621, 77373, 77435, G0173, G0251, G0339 and G0340 will begin pending for criteria review per SURG.00017

when billed with diagnosis codes 192.2, 192.3, 198.3, 198.4, 225.3, 225.4, 237.5 or 237.6. All procedure and diagnosis code combinations that currently pend for review will continue to pend for criteria review per SURG.00017. The revised guideline is available on our website at www.anthem.com. Anthem will continue to apply *Stereotactic Radiosurgery (SRS)* and *Stereotactic Body Radiotherapy (SBRT)* that became effective July 15, 2009, until November 1, 2010.

Intraepidermal Nerve Fiber Density Testing (LAB.00020)

CPT code 88356 has been added to the coverage guideline addressing intraepidermal nerve fiber density testing. Effective November 1, 2010, CPT code 88356 will pend for review for a description of the test performed. If intraepidermal nerve fiber density testing was done, the request for coverage will be reviewed per the medically necessary criteria in LAB.00020.

Pathological analysis of intraepidermal nerve fiber density for the diagnosis of small-fiber neuropathy is considered **medically necessary** when all of the following conditions are met:

1. Individual presents with painful sensory neuropathy; **AND**
2. Physical examination shows no evidence of findings consistent with large-fiber neuropathy, such as reduced or absent muscle-stretch reflexes or reduced proprioception and vibration sensation; **AND**
3. Electromyography and nerve-conduction studies are normal and show no evidence of large-fiber neuropathy.

Pathological analysis of intraepidermal nerve fiber density for the diagnosis of small-fiber neuropathy is considered **investigational** in all other cases.

Business update

Radiology utilization management program

Since the implementation of Anthem Blue Cross and Blue Shield's Radiology Utilization Management Program in August 2005, our program has evolved over time to include the following high technology outpatient diagnostic imaging services:

- o CT (Computed tomography) scans
- o CTA (Computed Tomographic Angiography)
- o Nuclear Cardiology
- o PET (Positron Emission Tomography)
- o MRI (Magnetic Resonance Imaging)
- o MRA (Magnetic Resonance Angiography)
- o MRS (Magnetic Resonance Spectroscopy)
- o SPECT Scans
- o Cardiac Echography
- o Abdominal Ultrasounds (implementing July 2010)
- o CT Colonography (implementing October 2010)

Under this program, Anthem requires a health services review (pre-authorization) for all of the above services when performed in a freestanding imaging center, in a hospital outpatient setting or in a physician's office.

This notice is to inform you that we have recently made some additional adjustments to our processing system for our PAR/PPO and PPO POS business, to ensure that claims for these services will process for payment only if they meet

criteria for *medical necessity*. If a health services review authorization number is on file, this will accelerate processing and payment of your claim. If a health services review authorization number is NOT on file, we must manually review your claim to determine medical necessity – prompting delays in processing and payments. Under the terms of your contractual agreement with us, if the claim is determined to be “not medically necessary,” you cannot bill the member for the services as the member is “held harmless.”

These services continue to require a health services review for our HMO members; however, your claims will not pend to determine medical necessity if one is not on file. Instead, these services will be denied for “no authorization,” and you cannot bill the member for the services as the member is “held harmless.”

Health Services Reviews can be requested electronically by using our secure online portal, Point of Care, or by calling Anthem toll free at 1-800-533-1120. Select option 2, and follow the prompts to the Radiology Department.

If you have additional questions, please contact your local Anthem provider network manager.

Radiology utilization review update –

Health services reviews required for CT Colonography requests beginning October 1

Effective October 1, 2010, Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield (Anthem) is adding CT Colonography to our radiology review program. This change applies to members covered by products under the following Anthem plans in Virginia: PAR, PPO, Virginia Lumenos, plus our affiliated HMO plans, including Medicaid and FAMIS.

A Health Services Review (pre-authorization) **will be required** for CPT codes 74261, 74262 and 74263.

Coverage guideline, RAD.00029, can be viewed on our website at www.anthem.com. Health services reviews can be performed electronically via our secure online portal, Point of Care. Or if you prefer, call Anthem toll free at 1-800-533-1120. Select option 2 and follow the prompts.

Your Anthem network manager is available to assist you if you need further clarification or additional information regarding our Advanced Imaging Management Program.

Company consolidates HMO coverage exclusively under HealthKeepers Inc.

For many years, it has been necessary to retain three separate HMO affiliate companies – HealthKeepers Inc., Peninsula Health Care Inc. and Priority Health Care Inc. – due to our licensed service areas in conjunction with the locations of our customer groups. In 2010, as we celebrate our 75th year of proudly serving Virginians, we are excited to announce that that we have been able to extend our service areas over the years to the point that separate HMO affiliate designations are no longer necessary nor legally required by Virginia’s Bureau of Insurance.

Therefore, **effective January 1, 2010**, for new and renewing groups, we began offering **HMO coverage only through HealthKeepers, Inc.** Groups who were previously enrolled in Peninsula Health Care, Inc. or Priority Health Care, Inc. will see their groups transferred to HealthKeepers, Inc. upon their renewal. For the vast majority of our groups, this will be a seamless transition with no impact to covered benefits or access to providers.

The only exception to the change in coverage is with regard to members with Essential and Standard plans who were covered under Priority Health Care, Inc. These members currently have no lifetime maximum on their benefits. With the move to HealthKeepers, Inc., the following benefit changes will be made:

- o Addition of a \$1,000,000 per Individual Lifetime Maximum
- o Addition of a \$400 Inpatient Admission copayment
- o Addition of a \$20 Inpatient Physician copayment

These benefit changes are in keeping with the benefit designs already in place for our members with Essential and Standard plans covered under HealthKeepers, Inc. and Peninsula Health Care, Inc.

Updates to well child codes and related copayments for Anthem HealthKeepers Plus FAMIS members

Family Access to Medical Insurance Security Plan (FAMIS) members enrolled with Anthem HealthKeepers Plus issued through HealthKeepers, Inc., Peninsula Health Care, Inc. or Priority Health Care, Inc. are subject to cost sharing provisions that include nominal copayments for health care services. These copayments are waived for well baby and well child care including routine office visits for health assessments and physical exams, as well as age appropriate immunizations.

Effective March 5, 2010, there were updates to diagnosis codes identifying well child visits for which related copayments are waived for FAMIS members. Provider payments for those codes reflect the copayment waiver. Diagnosis codes now added to copayment waivers for well care include V70.0, V70.3, V70.5, V70.6, V70.8, V70.9 as well as CPT code 99461. Any providers who collected a copayment from an Anthem HealthKeepers Plus FAMIS member for any of the indicated well baby or well child care services on or after March 5, 2010, should refund such copayments to the Anthem HealthKeepers Plus FAMIS member or credit the member's account for the copayment amount.

Other well care codes exempt from copayment provisions include CPT codes 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394 and 99395.

Please contact your Anthem network manager if you have questions regarding this update.



FEP Refund Recovery Information Sheet

The Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program or FEP, is providing an information sheet to help facilitate refund and overpayment questions pertaining to FEP claims. A form for provider overpayments is available on the Virginia provider section of our website at www.anthem.com. Select the Answers@Anthem tab and then "Download Commonly Requested Forms."

FEP Refund Recovery Information Sheet

FREQUENTLY ASKED QUESTIONS	States – Virginia
How can providers identify FEP payment listings?	All FEP ID numbers begin with an R and have 8 digits after the R.
How will providers be notified of an overpayment?	Provider remittance advices.
When will overpayments be retracted?	Retractions occur immediately after discovery of overpayments.
What should providers do if retractions are not done in specified time?	Contact the customer service number on the payment listing.
What Information is required for refunds?	Patient ID number, Patient Name, Claim number, Service Date, Specific reason for refund, Amount of refund.
What if providers don't want the accounts receivable (AR) to recoup but would rather send a check?	Send in the check immediately upon identification of the overpayment.
What if providers send in a check and the AR still recouped?	Contact customer service.
What do providers need to include with checks for payment of an AR?	Patient ID number, Patient Name, Claim number, Service Date, Specific reason for refund, Amount of refund.
Where should providers send refund checks?	MAIL TO: Anthem BCBS Virginia Recovery P. O. Box 931766 Cleveland, OH 44193
Where should providers return checks issued by Anthem Blue Cross and Blue Shield?	MAIL TO: Anthem BCBS Virginia Recovery P. O. Box 27401 Richmond, VA 23279-7401
Additional questions?	Contact Persons: Karen Bowyer, karen.bowyer@anthem.com, 540-853-3496 Jill Pendleton, jill.pendleton@anthem.com, 540-853-3926 Alice Craft, alice.humphreys@anthem.com, 540-853-3953

Thank you for a successful 2010 HEDIS® season

Here at Anthem, we'd like to thank those of you who participated in the Healthcare Effectiveness Data and Information Set (HEDIS®) project this year. The time frame for collecting HEDIS® information is very limited, and we appreciate your cooperation and timeliness when submitting the requested medical record information and/or scheduling the on-site appointment with the review nurses. We understand the challenge of the HEDIS® season on your busy practices – often working with limited resources – and greatly appreciate your efforts with processing our requests.

We continually strive to improve our HEDIS® rates, and we can't do it without our entire physician network. Many of the HEDIS® results are a reflection of the documentation of the care our members receive from their physicians. Please also keep in mind that medical record reviews, which include reviews in support of HEDIS® activities, are a requirement of your provider contract with Anthem.

Results of our 2010 HEDIS® review (**measurement year 2009**) have been submitted to the National Committee for Quality Assurance, where they will be compiled and compared to the rates of other health plans nationally, as well as regionally. Please be sure to look for Anthem's 2010 HEDIS® rates, as well as our national ranking for certain measures, published in our provider newsletter – Network Update – in the Fall.

Again, we thank you and your staff for demonstrating teamwork and collaboration as we work together to improve the health of our members – your patients. For further information regarding HEDIS®, please refer to the Virginia “provider” section of our website at www.anthem.com. Select “Health & Wellness” tab and then “Quality.”

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Improving your patients' health care experience

Anthem is committed to working with our network physicians to make our members' health care experience a positive one. Towards this end, we want to share with you a document that outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Simply log onto our website at www.anthem.com and follow this path: Provider > Select Virginia > Enter > Health & Wellness tab > Guide to Improving the Patient Experience.

"This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California."

Annual quality program

We believe in quality improvement. Annually, Anthem prepares a quality program description that outlines the plan's clinical quality and service initiatives. The goal is to maintain a well-integrated system that consistently identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of Anthem's quality program and outcomes, visit us at anthem.com.

360° Health® – supporting your plan of care

ConditionCare program helps patients improve their health

As a physician, you know how important it is to develop care plans specific to every patient. You also know that some patients have difficulty following their recommended treatment plans, especially those with a chronic condition. This is where Anthem 360° Health's ConditionCare program comes in.

360° Health from Anthem is a comprehensive suite of programs and services designed to help your patients better manage their health so they, along with their enrolled family members, can see positive results.

Our evidence-based, ConditionCare disease management program reinforces the care plans that you establish with your patients. 360° Health is available to your Anthem patients at no additional cost and can help them:

1. Manage and improve their health
2. Make more informed health care decisions
3. Maximize the value of their health care benefits

ConditionCare proactively supports participants diagnosed with the following conditions:

- Asthma (pediatric and adult)
- Chronic Obstructive Pulmonary Disease
- Diabetes (Types I and II, pediatric and adult)
- Coronary Artery Disease
- Heart Failure

Diagnosed participants in the ConditionCare program have a dedicated nurse coach who serves to support your plan of care while providing guidance and education about their condition.

When your Anthem patients participate in our ConditionCare program they receive:

- 24-hour, toll-free access to registered nurses who can answer questions, provide support and educate program participants on how to best manage their condition.
- A health evaluation and consultation with a nurse coach over the phone, when needed, to help them manage their condition.
- Educational materials like care diaries, self-monitoring charts, self-care tips and more.

ConditionCare helps providers by:

- Reinforcing your plan of care. It's our goal to see that our program participants follow their doctors' recommendations for improved health.
- Helping participants realize that the lifestyle choices they make have a dramatic impact on their health.
- Providing routine updates and reporting to keep you informed of progress with any participant who is your patient, identifying any areas where compliance may be an issue.
- Offering Spanish translation of educational materials and Spanish-speaking nurse coaches.

Whether your patients need support to stay healthy or manage an ongoing condition or require access to specialized care for complex health needs, 360° Health provides them with the right resources and guidance to help them improve their health and support your plan of care.

If you have an Anthem patient you would like to enroll in the ConditionCare program, call us toll-free at 800-445-7922.

If you would like to speak to a medical director or provide feedback regarding the ConditionCare program, please call us toll-free at 877-681-6694.

Clinical guidelines available on the web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized clinical guidelines, which are made available to providers on our website. The guidelines, which are used for our quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and most recent medical research.

The Guidelines are available at anthem.com > Providers > Select Virginia > Enter > Health & Wellness > Practice Guidelines.

Random medical record review process

Medical record audits/reviews are performed annually on a percentage of randomly chosen primary care physicians (PCPs) identified through claims and the Healthcare Effectiveness Data and Information Set (HEDIS) process and contracted for Anthem's managed care products. These products include PAR, PPO and HMO business and Medicare Advantage. In order to pass the audits/reviews, an office must score 80 percent or greater on the medical record audit. If a practitioner fails to meet the company's standard of 80 percent, a re-review is conducted within six months. Should the practitioner continually score less than 80 percent on the medical record review, the regional Clinical Quality reviewer discusses the outcome with the local medical director, Network Management department and/or the Credentialing Committee to determine outcome.

Medical record audits/reviews are not required if the primary care provider (PCP) office has electronic medical records (EMR) or their office has been recognized by the National Committee for Quality Assurance (NCQA) Physician Practice Connection Program.

Anthem has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. Anthem performs medical record reviews to assess network PCPs relating to current medical record standards recognized by NCQA.

After determining that a specific practitioner will be audited, a Clinical Quality nurse contacts the office manager to request the office staff to fax or mail the medical records of the requested members' charts to Anthem, along with requested written policies addressing, at a minimum, confidentiality of patient information, medical record retention and signed consent forms. The audit tool used in the review is sent to the office via fax or mail prior to the audit, noting the standards that the practitioner will be assessed against.

After the review is completed by the Clinical Quality nurse, a follow-up letter is sent to the practitioner within 30 days, identifying the results of the review and any areas of opportunities for improvement, and, if applicable, sample handouts and other educational materials, to enhance the quality of care at the practice site.

There are two (2) sections on the audit tool: **Office Specific Questions** (written policies) and **Chart Elements/Content and Clinical Documentation** (organization of medical records and preventive health service documentation).

Here is an example of some of the questions on the medical record review tool:

Office Specific Questions:

- A documentation system is in place to follow-up on missed appointments.
- A system is in place to schedule appropriate preventive health services.
- Medical records are kept in a secure area away from public access, and only accessible to authorized personnel only.
- Written policy addresses confidentiality of patient information.
- Written policy addresses release of patient information.
- Written policy addresses signed consent forms are present and dated.
- Written policy or statement relating to primary language and linguistic service needs of non-or-limited English proficient (LEP) or hearing-impaired members are prominently noted.
- Written policy addresses that the office does not discriminate in the delivery of health care services.
- Written policy addresses prompt transfer of patient care records to other in or out-of-plan providers for the medical management of the member.
- Written policy addresses medical record retention.

Chart Elements/Content and Clinical Documentation:

- Every page in the record contains the patient name or ID number.
- There is one chart per patient.
- The chart is organized and the pages are secured.
- Biographical data such as name, ID number, address, employer and address, home and work telephone numbers, emergency contact information, is noted in the medical record.
- Missed or canceled appointments, along with follow-up contact and outreach efforts, is noted in the medical record.
- Allergies/NKDA and adverse reactions are prominently displayed in a consistent location.
- All presenting symptom entries are signed, dated and legible.
- A problem list is maintained and updated for significant illnesses and medical conditions.
- A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
- Past medical history is current and easily identified.
- For patients 11 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances.
- For patients 11 years to 21 or if relevant, there is appropriate notation concerning sex education, including such topics as abstinence, S.T.D., pregnancy prevention, use of condoms, etc.
- Documentation of advance directives/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are MA members.
- Continuity and coordination of care between the PCP, specialty physician, and/or facilities is shown. A summary of findings or discharge summary/progress notes is requested and is in the medical record. Examples include progress notes/report from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.
- Physician reviews and follow-up is documented when needed on all consultants, lab and test results, evidenced by MD initials and date on results or consultant letter.

- Indication that the patient has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal labs or test results.
- Is there documentation of anticipatory guidance discussion regarding depression/anxiety, beginning at 7 years of age and/or sooner or at any time the physician feels the need for referral?
- Age appropriate routine preventive services/risk screening is consistently noted, i.e., childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.
- Evidence in the medical record relating to discussions on depression and alcohol abuse for patients with chronic illnesses.
- Health education is available to the patient and documented in the medical record.
- Errors are corrected according to legal medical documentation standards.

Anthem would like to work collaboratively with our primary care providers to communicate the medical record standards in which you are monitored and measured. To obtain a copy of the complete audit tool with all the standards listed, please contact Kathy Goemaat, R.N., Clinical Quality at (404) 842-8292. Thank you in advance for your assistance in this very important quality initiative.

Member Rights and Responsibilities

In line with our commitment to a managed care system that involves the health plan, participating physicians, health care providers and members, Anthem Blue Cross and Blue Shield has adopted a Rights and Responsibilities statement for members of our HMO plans and programs, titled "Your Rights and Responsibilities." We periodically provide this information to members, participating physicians and providers.

Copies of the "Your Rights and Responsibilities" statement are available to participating providers and our members at any time upon request. The statement can be found on our website, www.anthem.com > Providers > Select Virginia > Enter > Communications > General Information > Member Rights and Responsibilities.

Anthem continues series to promote behavior change and compliance

Motivational interviewing, building blocks for successful provider-patient communication – part 3

With this edition of our Network Update, we continue our multi-part series on promoting behavioral change and patient compliance. Our first installment introduced motivational interviewing or MI (a special communications method) and the OARS technique (**O**pen-ended questions, **A**ffirmation of patient strengths, **R**eflective listening and **S**ummarization). Our second installment encouraged the use of motivational interviewing and the OARS technique to help engage your patients – our members – in taking a more active role in their health care to achieve improved outcomes and healthier lifestyles.

In this third part of our series, we again emphasize the importance of motivational interviewing and the OARS technique in gauging patients' reactions and resistance to recommended treatment plans – particularly those chronically ill patients. A patient-centered environment in a clinical setting helps build rapport for patients with chronic disease states and/or conditions. This rapport is particularly important when the provider is assessing lifestyle behaviors in an effort to promote compliance with recommended treatment plans. The use of motivational interviewing techniques can lead to a gratifying and successful provider-patient partnership. The goal in using MI is to move patients forward, as you facilitate talk of change.

MI can result in dynamic interactions between patients and providers. The technique helps:

- Elicit what the patient identifies as the problem (Elicits)
- Provide appropriate factual information, not the provider's opinion (Provides)
- Elicit the patient's reaction to the information (Elicits)
- Keep advice at a minimum, offered only when the patient is ready or requests it

The adept use of MI in the clinical setting creates positive patient/provider encounters that improve caregiver relationships and patients' health outcomes.¹ We'll continue our series in another edition of our provider newsletter, so please watch for further information.

1. Smith, Ossman, S. "Motivation Interviewing: A Process to Encourage Behavioral Change." *Nephrology Nursing Journal*: 31. (3), May-June 2004, pp 346-347.

Attention PCPs – Does your office use an electronic medical record system?

Many health care institutions in the United States are adopting information systems that provide more accurate and timely information regarding patient care. An electronic medical record (EMR) system was introduced as a way to facilitate a centralized patient information repository. To support this nationwide effort, an EMR system is continuing as an indicator for Anthem's 2010 Performance Extra program – a PCP-based program designed to reward excellent performance.

Let us know if you are using EMR software and which software and features. For your convenience, we have included a short evaluation form in this edition of the *Network Update* for you to complete if you are using EMR software. Physicians who earn recognition through the National Committee for Quality Assurance's (NCQA) Physician Practice Connections Program will automatically receive maximum credit for the EMR indicator. Please complete and fax the form to (804) 354-2979, attention Terry Tabb.

Advantages of an EMR System

Information technology is proving to be a vital element in the administration of health care. Benefits realized by an EMR system include increased patient safety and quality of care being rendered, immediate and remote access to patient records, automated clinical guidelines, direct access to international databases, automated referral and prescription generation, statistical reporting, multiple data views and reduction in office-related administrative costs and tasks.

As a reminder, PCPs must have fully implemented an electronic medical record system or achieved certification from the Certification Commission for Healthcare Information Technology (CCHIT), by Dec. 31, 2010, in order to qualify for this indicator under the Performance Extra Program. If you previously submitted information within the past five years and nothing has changed, you need not re-submit for 2010.

Electronic Medical Records System Evaluation

Physician Name: _____

Physician License Number: _____

Group Name: _____

Group Tax Identification Number: _____

- Achieved certification from the Certification Commission for Healthcare Information Technology (CCHIT) or

Electronic Medical Records (EMR) System Attributes: (Check all that apply.)

- Decision support tool using evidence-based medicine for pharmacy management (to include by not limited to the following):
- Drug recommendations using calculated or inferred knowledge (drug choice guided by lab results, drug dosing and body weight)
 - Medication alerts for the prevention of adverse drug events including complex interaction checks (drug-drug, drug-allergy, drug-disease)
 - Ability to update the system in a timely fashion for medications withdrawn from the market or changes in indications
 - Medication recommendations based on diagnoses in the EMR
- Formulary management tool
- Ability to accept Anthem formularies
 - Ability to direct drug utilization toward generic options and formulary drugs
 - Ability to capture copayments
 - E-faxing prescription (e-prescribing) capability
- Chronic disease management tool
- Preventive medicine tool
- Links to diagnostic providers – labs and X-rays
- Database capability with ability to query
- Ambulatory computerized physician order entry system

System Software Description: (Please provide any additional information you may deem helpful.)

Fax to (804) 354-2979, Attention: Terry Tabb

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO HealthKeepers, Inc. are independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Easier access to pre-certification/pre-authorization information for out-of-area Blue members

We are pleased to announce enhancements to the BlueCard Eligibility® Line. These changes are designed to improve your experience in verifying eligibility and obtaining pre-certification/pre-authorization information for your out-of-area Blue patients. The changes became effective April 1, 2010, and are as follows.

If calling 1-800-676-BLUE (2583) to obtain pre-certification/pre-authorization only:

When pre-certifications/pre-authorizations for a specific member are handled separately from eligibility verifications, your call will be routed directly to the area that handles pre-certifications/pre-authorizations. You can choose from four options regarding the type of service for which you are calling:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Medical equipment

Upon making your selection, you will be transferred to the appropriate area of the member's Plan to service your specific request.

If calling 1-800-676-BLUE (2583) to obtain eligibility only or if you need both eligibility and pre-certification/pre-authorization:

No change – your call will be handled as it has in the past. You will select the option to obtain eligibility and pre-certification/pre-authorization information. First, your eligibility inquiry will be addressed. Then you will be transferred, as appropriate, to the pre-certification/pre-authorization area.

If you have any questions about the BlueCard Eligibility line (1-800-676-BLUE), please call Anthem Blue Cross and Blue Shield in Virginia toll free at 800-533-1120, option 2 and then option 2.

Product changes and updates

Changes for Commonwealth of Virginia health plans – effective July 1, 2010

This overview addresses benefit changes for the Commonwealth of Virginia COVA Care plan and The Local Choice (TLC) Key Advantage plans for services administered by Anthem only. Overall, the benefit design will remain the same for the state's health plans. This means most deductibles, copayments and coinsurance amounts will be unchanged. However, there are changes for COVA's high deductible health plan (COVA HDHP) as well as the TLC Program that take effect July 1, 2010.

COVA HDHP

For the COVA HDHP, the plan year deductible increases from \$1,200 to \$1,750 for a single person and \$2,400 to \$3,500 for employee plus one and family to adhere to the Internal Revenue Service's (IRS) guidelines. There are no changes to the out-of-pocket maximum for members.

The 2010 General Assembly voted to exclude prescription non-sedating antihistamines (NSAs) and erectile dysfunction (ED) drugs from coverage. NSA drugs to treat allergies will no longer be covered due to the abundance of over-the-counter medications now available. ED drugs will no longer be covered due to the cost to the state's health plan.

COVA Care

There are no benefit changes to COVA Care; however, a bariatric surgery pilot was added in February 2010 in response to the 2009 General Assembly request for a progressive weight management education program as an alternative to proposed elimination of coverage for bariatric surgery. Morbidly obese members seeking bariatric surgery are required to complete a 12-month pre-surgery program before they will be considered for the surgery. The goal of the program is to help surgery candidates break through personal barriers to achieve safe and effective long-term weight loss.

The program provides 12 months of support from a Weight Management Coach through ValueOptions, the plan's behavioral health carrier. In addition, the member is responsible for completing 12 months of weight management through Weight Watchers or a comparable program.

The member's bariatric surgeon must contact Anthem to request a prior authorization for a member's entry into the program. More information can be found online at www.anthem.com/cova and click on the link New! COVA Care Know Your BMI.

The Local Choice Health Benefits Program

The Local Choice Program offers to its groups (employers) four Key Advantage plans and one high deductible health plan. For the overall Local Choice Program, the Key Advantage 200 and 300 plans have been eliminated and replaced with the new Key Advantage 250 and 1000 plans. In addition, the three-tier deductible and out-of-pocket maximum plan design becomes a two-tier structure: individual and family. Below are additional benefit changes that are specific to each TLC Key Advantage health plan that is offered within The Local Choice Program.

Key Advantage 250

In-network deductible of \$250 individual/\$500 family with an in-network, out-of-pocket maximum of \$2,000 individual/\$4,000 family.

Key Advantage 1000

In-network deductible of \$1,000 individual/\$2,000 family with an in-network, out-of-pocket maximum of \$4,000 individual/\$8,000 family.

Key Advantage Expanded and new Key Advantage 250

Will waive inpatient copayment for maternity delivery if female enrolls in Anthem's Future Mom's program within the first trimester and has a teeth cleaning during the pregnancy.

TLC HDHP Plan

For the TLC HDHP, the plan year deductible increases from \$1,200 to \$1,500 for a single person and \$2,400 to \$3,000 for employee plus one and family to adhere to IRS guidelines. There are no changes to the out-of-pocket maximum for members.

Group product offerings and changes effective July 1, 2010

At Anthem, we continue to seek ways to actively engage members in health care decisions while offering affordable health care products to meet members' needs and pocketbooks. The changes outlined below are effective for new groups and renewals beginning July 1, 2010.

New Product Highlights

The company is introducing several new HMO products that offer lower cost options similar to our KeyCare products. The first two are Value Advantage plans followed by new Open Access product offerings with lower deductibles.

Value Advantage 30/2000

- In-Plan:
 - \$30 office visit copayment (office visits, check-ups and exams)
 - \$2,000 individual/\$4,000 family calendar year deductible then 20 percent coinsurance on other services
 - Deductible does not apply to office visits, routine eye exam, office based non-stat lab (LabCorp), outpatient spinal manipulation and manual medical therapy services (ASHN) and preventive care
- Out-of-Plan:
 - \$3,000 individual/\$6,000 family calendar year deductible then 30 percent coinsurance on all services
- The standard drug is \$10 for Tier 1 drugs/\$30 – Tier 2/\$50 or 20 percent Tier 3

Value Advantage 30/2000/30

- In-Plan:
 - \$30 office visit copayment (office visits, check-ups and exams)
 - \$2,000 individual/\$4,000 family calendar year deductible then 30 percent coinsurance on other services
 - Deductible does not apply to office visits, routine eye exam, office based non-stat lab (LabCorp), outpatient spinal manipulation and manual medical therapy services (ASHN) and preventive care
- Out-of-Plan:
 - \$3,500 individual/\$7,000 family calendar year deductible then 30 percent coinsurance on all services
 - The standard drug is \$10/\$30/\$50 or 20 percent

HealthKeepers 20/500 Open Access

- \$500 individual/\$1,000 family calendar year deductible
- \$20 PCP/\$40 specialist office visit copayment
- The standard drug is \$10/\$30/\$50 or 20 percent

HealthKeepers 20/500 POS Open Access

- In-Plan:
 - \$500 individual/\$1,000 family calendar year deductible
 - \$20 PCP/\$40 specialist office visit copayment
 - The standard drug is \$10/\$30/\$50 or 20 percent
- Out-of-Plan:
 - \$750 individual/\$1,500 family calendar year deductible then 30 percent coinsurance on all services

HealthKeepers 25/500 Open Access

- \$500 Ind/\$1,000 family calendar year deductible
- \$25 PCP/\$50 specialist office visit copayment
- The standard drug is \$10/\$30/\$50 or 20 percent with \$150 deductible

HealthKeepers 25/500 POS Open Access

- In Plan:
 - \$500 Ind/\$1,000 family calendar year deductible
 - \$25 PCP/\$50 specialist office visit copayment
 - The standard drug is \$10/\$30/\$50 or 20 percent with \$150 deductible
- Out-of-Plan:
 - \$1,000 individual/\$2,000 family calendar year deductible then 30 percent coinsurance on all services

Lumenos

As part of our Lumenos plans, we are introducing a “Deductible First HRA” – a health reimbursement account that’s a tax-advantaged benefit. These employer-funded medical reimbursement plans help members and their employers to save on the cost of health care.

Employers set aside a specific amount of pre-tax dollars for employees to pay for health care expenses on an annual basis plus members can earn additional reward dollars for healthy behaviors. Based on the plan design, HRAs can generate significant savings in overall health benefits.

With the Lumenos Deductible First HRA plan, preventive care is covered at 100 percent from in-network providers. Members are responsible for a predetermined upfront deductible for medical or prescription expenses. Once the upfront deductible is met, members may use HRA funds to pay for medical care and prescription drugs.

Plan Year Administration for Deductible Products

In response to customer feedback, we’ve introduced a plan year option on our deductible based products – including our HealthKeepers HDHP – beginning July 1. (Exceptions are our BlueCare, Essential and Standard plans.) This is a change from our calendar year approach and means that benefits are accumulated on a 12-month cycle. The effective date is always on the first calendar day of the month and coincides with the renewal date of the group. There is no fourth quarter/prior quarter carryover deductible provision as in the past.

HealthKeepers HDHP and new plan year provision

On January 1, 2010, we introduced five new Health Savings Account (HSA) Compatible High Deductible Health Plans (HDHPs). Similar to the KeyCare HSA HDHPs we launched some time ago, these new plans are offered through

HealthKeepers Inc. (Please see the January/February 2010 edition of our provider newsletter for further details about these plans.)

The HealthKeepers plans give members the option to set up a tax-advantaged health savings account, allowing them an alternative method to pay for health care expenses. HSAs will have checks and/or debit card technology, allowing members to access their HSA funds directly. These plan designs work much like our existing HMO deductible plans.

Plan year provision

Beginning July 1, 2010, we've introduced a plan year option on our HealthKeepers HDHPs. This means that benefits are accumulated on a 12-month cycle. The effective date is always on the first calendar day of the month and coincides with the renewal date of the group. We've eliminated the fourth quarter/prior quarter carryover deductible provision that existed in the past.

Revised EOB

To support the change to a plan year approach, we've redesigned members' explanation of benefits (EOB) statements to include an easier to read format and to provide information regarding benefit accumulations toward the high deductible and out-of-pocket. This information will display on EOBs for claims processed beginning July 1, 2010. All accumulations prior to July 1 will be reflected on the new EOB.

Anthem introduces new individual plans with lower-cost options for members

Anthem and our affiliated HMO are committed to helping reduce the number of uninsured Virginians. One way we're doing that is through the introduction of three new plans targeted to individual consumers. These three plans – CoreShare, SmartSense and Premier – provide Virginians with lower-cost options for health care coverage and are available now.

Here are some highlights about the plans. As always, please request that members present their most current ID cards each time they visit your practice or office. Refer to the members' ID cards for billing and members' responsibility information.

CoreShare Plan

CoreShare is designed for those individuals who want a traditional plan at a lower cost, a wide range of deductibles and higher cost-sharing. In addition, CoreShare also helps lower monthly premiums, provides full major medical coverage, while giving out-of-pocket protection as well as protection against unexpected health care costs.

The CoreShare plan offers health care protection at reduced premium levels. The lower deductible levels have 50 percent coinsurance, while the higher deductible plans pay 100 percent of Anthem's allowable charge once the deductible has been met. CoreShare includes:

- A choice of nine deductibles and simple plan structure;
- A range of deductibles from \$750 to \$25,000;
- A Preferred Provider Organization (PPO);
- Access to health care across the country through the Blue Cross and Blue Shield Association's BlueCard® program.

SmartSense Plan

SmartSense is a new price-conscious, choice-driven health insurance plan ideal for individuals, “early” retirees, students and the uninsured. This plan can be tailored to fit their needs. Anthem’s SmartSense plans provide coverage for up to three physician office visits a year before a member has to meet a deductible, a number of preventive benefits and a choice of prescription drug coverage options.

SmartSense is also designed to provide protection against expensive and unexpected medical bills and offers a variety of deductibles, starting at \$750, that allow consumers to find a premium they can afford. Our plan offers:

- Coverage for first three doctor visits with a \$35 copayment before the deductible (per person per calendar year), then 30 percent coinsurance after deductible for in-network services. (Higher deductible plans do not require a coinsurance.)
- Choice of prescription drug benefits
- Inpatient, outpatient and professional services coverage

Premier Plan

The **Premier** plan is designed for customers who want a comprehensive benefit design with lower out-of-pocket costs. Comprehensive prescription drug coverage is included with no deductible (including generic and brand name drugs.) The Premier plan provides:

- Unlimited coverage for office visits with first dollar copayments, without having to meet a deductible. However, members are responsible for a \$30 copayment for visits to a primary care physician and \$40 copayment for specialists.
- Coinsurance percentages range from 20 percent for lower deductible plans to 0 percent for higher deductible plans for in-network services
- Enhanced preventive benefits and routine screenings that are not subject to the deductible.
- Annual vision exam

Mental Health Parity requirements effective July 1, 2010

On February 2, 2010, the federal government issued regulations that interpret the changes to the federal Mental Health Parity Act, which requires "parity" between the financial requirements and treatment limitations applied to medical or surgical benefits and mental health and substance use disorder benefits. Effective July 1, 2010, this law impacts group health plans, both fully insured and self-funded (groups where health plans provide administrative services only), with more than 50 total employees.

General background

Who does the Mental Health Parity law apply to?

The federal Mental Health Parity Law applies to all employer groups with more than 50 total employees. This includes all fully insured and self-funded employer plans, governmental plans, union plans and church plans. Self-funded governmental plans do have the ability to opt out of the Health Insurance Portability and Accountability Act (HIPAA) and many of the federal benefit mandates, including Mental Health Parity.

When do the new regulations apply?

The new regulations apply to group health plans starting on the group plan years beginning on or after July 1, 2010.

What do the new regulations require?

Among other things, the Mental Health Parity Act specifically requires the following to be in parity between medical and mental health and substance abuse services: deductibles, copayments, coinsurance, out-of-pocket expenses, and limits on frequency of treatment, number of visits and number of days of coverage.

Can a health plan apply utilization review requirements to mental health and substance abuse benefits?

Yes, provided the process used to determine whether to apply a utilization review requirement – preauthorization/precertification, concurrent review or retrospective review – on medical benefits is the same process used to decide to apply that utilization review requirement to mental health/substance abuse benefits. Anthem Blue Cross and Blue Shield is currently reviewing our processes to ensure that all levels of utilization review can be applied to mental health and substance abuse benefits, as appropriate, in order to ensure the care provided to members is medically necessary and not experimental/investigational.

Does a plan have to include coverage for mental health and substance abuse services?

No, the law does not require that a health plan cover any mental health or substance abuse conditions. Accordingly, a health plan could **exclude** coverage for all conditions or only exclude certain conditions, such as autism, smoking cessation, etc.

However, if the plan is fully insured, state law may require coverage for mental health and substance abuse, in which case, a group could not elect to exclude coverage.

Also, if health plans cover a mental health or substance abuse condition, they must provide coverage for that condition in the inpatient (including emergency room) and outpatient settings and for prescription drugs.

eBusiness

Anthem's affiliates participate in innovative mobile-health initiative

For a healthy baby, visit a doctor early and keep all of your appointments; hear your baby's heartbeat. Messages such as this one and many more will be chiming, beeping and ringing their way to mobile phones of expectant mothers across Virginia who participate in the text4baby campaign – a free mobile-health initiative and public-private collaboration started by the National Healthy Mothers, Healthy Babies Coalition.

Anthem's affiliated HMO – HealthKeepers, Inc. – provides Medicaid managed-care benefits for Medicaid, FAMIS and FAMIS MOM enrollees. Recently, we joined the Virginia Department of Health in the text4baby campaign. This initiative provides free pregnancy- and infant-related health tips via text messaging to expectant mothers who enroll in the program.

Expectant mothers enrolled in Anthem HealthKeepers Plus are encouraged to sign up and participate in the text4baby pilot program, which aims to educate women about the importance of maternal and newborn health, and aligns with the variety of other Anthem HealthKeepers Plus programs that focus on making healthy choices during pregnancy.

Please share with your expectant patients who are HealthKeepers Plus members about the text4baby campaign. Anthem HealthKeepers Plus members can simply text the word BABY to 511411 (or BEBE in Spanish) to enroll in this free program. Anthem HealthKeepers Plus members participating in the text4baby pilot program are also encouraged to text the word PLUS to 511411 which will inform their health plan of their participation in the pilot program. Text4baby participants

will receive free pregnancy-related text messages each week, timed to their due dates or babies' date of birth. We appreciate your help in this important initiative.

Make regulatory compliance work for you

Increase efficiency through electronic transactions

Regulatory compliance changes on the horizon

New opportunities and challenges are on the horizon as health care providers and insurers undertake further Health Insurance Portability and Accountability Act (HIPAA) and other federal requirements. At Anthem Blue Cross and Blue Shield, we're working hard to ensure you have the information you need to make informed decisions about changes coming in 2010 and beyond that will impact how you handle claims transactions with us. It's important to note that electronic data interchange (EDI) can help you meet the challenges head on with confidence – using EDI to its fullest capacity.

Here are two federal mandates that will have considerable impact on your business – **HIPAA Version 5010** (the new version of the standard transactions and code sets for electronic HIPAA transactions) and **ICD-10** (the more comprehensive numbering system that is associated with diagnosis coding). Are you making plans early to ensure your office systems will comply?

HIPAA Version 5010 standard transactions and code sets

HIPAA Version 5010 provides clarification and advantages that enhance, streamline and promote greater use of electronic data transactions. The following electronic transactions are impacted with this new version:

- Claims Institutional, Professional and Dental (837)
- Payment Remittance Advice (835)
- Authorization/Referral request and Response(278)
- Eligibility/Benefit Inquiry and Response (270/271)
- Claim Status Inquiry and Response (276/277)

Benefits of HIPAA Version 5010

HIPAA Version 5010 introduces clarity and standards that promote automation, payer consistency and many other benefits including:

- Enhanced automation of reimbursement and remittance transactions, expediting payments and improving claims turnaround.
- Clarification on the use of 10-digit National Provider Identifier (NPI) numbers.
- Better instructions for handling reversals, corrections, interest payments and prompt pay discounts.
- Clearer eligibility transactions that include comprehensive benefit and coverage information.
- More timely and appropriate decisions for authorizations and referrals to specialty care professionals.

The updated HIPAA Version 5010 also provides the framework needed to support the ICD-10 code sets.

HIPAA Version 5010 – compliance changes

The compliance date for covered entities is January 1, 2012. The 5010 structural changes that impact utilization and submission of the EDI format include:

- File formatting
- Situational and required data elements
- Loops, segments and qualifiers

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and ICD-10 Procedure Coding System (ICD-10-PCS)

Bringing further clarification of diagnosis and procedure codes, ICD-10 codes offer more detail and depth for use for diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases in virtually every aspect of a provider's operations – both clinical and administrative.

ICD-10 benefits:

- Increases the specificity of the diagnosis codes and standardized definitions.
- Increases coding consistency and accuracy.
- Reduces miscoded, rejected and improperly reimbursed claims.
- Reduces the need for supporting documentation.

The ICD-10 final rule from the U.S. Department of Health and Human Services (HHS) – Centers for Medicare & Medicaid Services (CMS) overhauls the diagnosis code scheme for health care claims and will require:

- Field size expansion
- Increases number of diagnosis codes supported on a claim
- Changes in alphanumeric code composition, values, definition and interpretation.

Plan for compliance to increase your EDI utilization

- Educate office staff on the HIPAA Version 5010 and ICD-10 compliance requirements. The HHS website offers information at http://www.cms.hhs.gov/Versions5010andD0/01_overview.asp#TopOfPage
- Review your current systems and work processes – electronic or manual.
- Investigate the potential changes to existing practice work flow and business processes.
- Contact your current practice management system vendor, clearinghouse or billing service to identify submission upgrade expectations.
- Compare options and benefits of full system upgrades vs. minimal compliance to take advantage of new automated features.
- Determine installation, testing and implementation timeframes.
- Evaluate and plan for staff training needs.

The compliance date for covered entities for ICD-10 is October 1, 2013

Stay up-to-date on compliance:

Providers preparing to become compliant with HIPAA Version 5010 and ICD-10 requirements can:

Access up-to-date information on Anthem Blue Cross and Blue Shield compliance status implementation plans and testing schedules at www.anthem.com/edi.

EDI Solutions Specialists

The EDI Solutions Helpdesk is available Monday – Friday, 8 a.m. – 5 p.m. EST

Telephone:(800) 991-7259, option 2, option2

Fax Number: (804) 354-2529

Website: www.anthem.com/edi

Anthem works with DentalXChange to offer free online service

Providers submit and receive electronic transactions free of charge

Anthem Blue Cross and Blue Shield in Virginia continues to seek ways to make it easier for providers to do business with us and is working with DentalXChange – to offer provider practices – particularly smaller offices – an innovative way to submit ADA claim forms and receive secure transactions electronically while complying with Health Insurance Portability and Accountability Act (HIPAA) requirements. The only requirement for providers is a personal computer (Mac or PC) with Internet access.

DentalXChange submission options:

- o Claim Connect Direct Data Entry (DDE) – **without charge to providers**
 - Web-based DDE claim submission for ADA claims
 - Inquiry access to pertinent patient eligibility, benefits and claim status information in a secure, real-time electronic environment.
 - Automated electronic remittance advices (ERA).
 - DDE data storage package option for one year

- o Claim Connect “All Payer” Batch Submission – **30 days free of charge**
 - A special “All-Payer” claim promotion allows providers who submit claims through a nightly batch update process using their practice management systems to send insurance claims electronically to multiple payers. It’s important to note that once the 30-day trial promotion expires, DentalXChange will charge a fee for the “all payer” batch submission option going forward.

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

Enroll with DentalXChange today

The enrollment process is simple – often providers can begin submitting electronically the same day. To enroll, visit the dental provider home section and select the link labeled Web claim submission – “DentalXChange” to be routed automatically to the DentalXChange website. Once registration is completed, DentalXChange offers unlimited training and support for providers.

The DentalXChange link is also available from the EDI section on the provider page of our company’s website at www.anthem.com/edi.

DentalXChange

www.dentalxchange.com

Support: 800-576-6412, ext. 452

Sales: 800-576-6412, ext. 455

Providers can submit and receive electronic transactions – with reliable, fast payments as the result.

File medical claims electronically – make it fast; make it easy

- Skip the paperwork, everything you usually do by hand – and more – is automated.
- Electronic submissions speed the process on our end and help ensure a clean claim is submitted every time.
- Receive electronic remittance advices (ERAs), automate posting, claim status inquiries and secondary billing to ensure account receivables are accurate and completed quickly, so patient billing can begin.

Filing an electronic claim is convenient, accurate and efficient. You can eliminate so many manual processes – resulting in fewer mistakes and less paperwork.

- Errors are automatically detected and claims can be corrected and re-submitted – often without missing a payment cycle.
- Reports track claims and provide a step-by-step audit trail.

With electronic filing, you can receive your processed claims faster with fewer errors.

- Detailed reports include receipt confirmation and status of your claims.
- Clean claims are delivered directly to the payer where the claim processing begins immediately.

Electronic filing also saves you time and money so you make fewer phone calls to payers with fewer follow-ups – no starting over.

- ERAs are delivered electronically, often the same day as issued; no lost mail or delivery delays.
- Electronic funds transfer (EFT) is available.

Filing paper claims

If you file paper submissions, you can often expect claim delays, additional follow-up and re-work. You often must spend time calling to verify benefits, eligibility and patient information – along with completing insurance claim forms. Here are some examples of other paper-intensive tasks you can expect with paper submissions:

- Order supply of forms
- Submit key member and claim detail
- Verify coding
- Double check for missing or incomplete information
- Print and sort claims by payer
- Attach supporting documentation
- Address envelopes, apply postage and mail

The waiting begins, as you must allow time for the payer to receive the mailed claim, sort and scan incoming claims and process the claims which could result in delays if you've included inaccurate or omitted key information. If there are errors, you may need to begin the process over again. Once processing is complete, we will mail an explanation of benefits (EOB) which can take several days and can be subject to mail delivery delays.

With the paper process, you receive and post the EOB after adjusting and posting contractual terms. If applicable, you can initiate secondary billing, and the process begins again for the secondary payment. The process is time consuming and paper intensive.

Consider electronic filing

If you're filing paper submissions, we encourage you to consider electronic filing and skip the paperwork. Anthem accepts all types of electronic claims:

- Professional
- Institutional
- Dental
- Ancillary
- Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP)
- National accounts
- BlueCard® Program (out-of-area program)
- Medicare Advantage

Additional information

If you'd like to learn more, contact our EDI Helpdesk:

Hours: Monday through Friday, 8 a.m. to 5 p.m., EST
Telephone: 804-354-4470, 800-991-7259 (option 2, 2)
Fax: 804-354-2529
e-mail: edihelp.va@anthem.com
Web: anthem.com/edi (select state)

“Network Rapid Update” coming soon

We're making preparations to launch our “Network Rapid Update.” Get important “need-to-know” provider updates with our **new**, streamlined e-mail communications tool – coming soon to your electronic inbox. Our Network Rapid Update will make connecting with Anthem and staying informed easier, quick and convenient.

This new tool will be delivered electronically via e-mail to providers who wish to receive this communication. We will only use Network Rapid Update as the need arises to communicate urgent and critical information that impacts you and how you do business with us.

If you'd like to receive the Rapid Updates, you'll need to provide us with an e-mail address where we can send these critical alerts. We recognize that your practice is extremely busy, and we value your time. With that in mind, we will only use the e-mail function to share critical and timely information that your office may need right away. Watch for additional information and a registration form coming soon online at anthem.com.

Pharmacy update

Prevacid® excluded from Rx coverage for most members effective June 1, 2010

Recently, Anthem's Pharmacy and Therapeutics (P&T) Committee reviewed clinical findings on Prevacid® and found Prevacid to be equivalent in effectiveness to other drugs in the same class. (The P&T Committee is a national group of physicians and pharmacists who evaluate prescription drugs for their efficacy, safety and associated costs.) As part of Anthem's strategy to manage coverage of "clinically equivalent" medications, certain higher-cost prescription drugs are excluded from coverage when equally effective, better value medications are available in the same therapeutic class. Prevacid does not offer the best value. For this reason, **Prevacid is now excluded from coverage effective June 1, 2010.**

Prescribing physicians are encouraged to talk with their patients filling prescriptions for Prevacid about covered Proton Pump Inhibitor (PPI) class drugs: lansoprazole, omeprazole, pantoprazole and Nexium®. Dexilant® (formerly known as Kapidex) is also covered at a higher copayment when a generic is tried first. These are all equally effective PPI prescription alternatives. If members choose to continue filling prescriptions for Prevacid after June 1, 2010, they must pay the full retail cost of the drug.

Anthem drug list updates

The latest drug list updates to the Anthem Drug List/Formulary are available on our website. To access the drug list/formulary updates, visit anthem.com. Select "Search the Anthem Prescription Formulary."

Bulletin board

Lowe's new prior certification for specialty drugs to be administered by Care Continuum

Effective March 1, 2010, the Lowe's Companies, Inc. medical plan option is using Care Continuum, an independent utilization management company, on all primary Lowe's medical plan options, to perform the following services:

- Prior Certification of Specialty Drugs
- Specialty and Drug Claim Management

In addition to all existing procedures, please follow the steps below when caring for Lowe's medical plan members who require specialty drugs:

- Contact Care Continuum at **866-240-4734** for prior certification of specialty drugs administered in the office or in the member's home. This phone number is also listed on the member's insurance ID card. A list of drugs requiring prior certification can be found at: www.carecontinuum.com/network/lowesspecialtydrug.htm
- Include the National Drug Code (NDC) of the drug you are billing when submitting a claim to Anthem Blue Cross and Blue Shield.
- Call Care Continuum to obtain prior certification, if you have a current patient and have not submitted a prior certification for the administration of a specialty drug in your office, clinic or in the patient's home. Please note the Lowe's medical plan requirement should follow mandatory prior certification guidelines. Failure to comply could result in financial penalties for the medical plan member.

Providers must submit appeals of adverse determinations either orally or in writing by contacting Care Continuum directly via the following:

Appeal Coordinator
1700 Eastpoint Parkway, Suite 50
Louisville, Kentucky 40223
Phone: 866-240-4734
Fax: 877-540-6223

If you have any questions concerning this change, contact Care Continuum at **866-240-4734**.

Arnold & Porter LLP enrolls with the company

As of July 1, 2010, Arnold & Porter LLP will be moving to a national accounts arrangement through Anthem. The group's headquarters is in Washington, D.C., and the group number is 174096. The company has three PPO plans, and the alpha prefix is "ALQ." For members enrolled with this national account, please refer to the members' ID cards for claims filing instructions and other pertinent information.

Anthem network managers contact information available online

Your Anthem network managers are available by phone and e-mail to address network and other questions. For the most current listing by specialty and/or geographic location, visit the Virginia provider section of our website at anthem.com. Select the Communications tab and then General Information. The following listings are available:

- Provider Representatives – Ancillary
- Provider Representatives – Facility
- Provider Representatives – Physicians and Behavioral Healthcare
- Provider Representatives – Chiropractors, Certified Nurse Midwives, Dental/Oral Surgeons (medical only), and Optometrists/Opticians (medical only)

Medical Office Seminars – register today

We continue to offer our informative medical office seminars throughout the state to **network-participating** physicians and their staffs. Those health care professionals invited to attend include medical doctors (MDs), doctors of osteopathy (DOs), doctors of podiatric medicine (DPMs) and behavioral health professionals.

New in 2010, we will also accept registrations from these additional *network-participating* providers and their staffs: doctors of chiropractic (DCs), certified nurse midwives (CNMs), dental/oral surgery providers of medical (*non-routine*) services, and optometrists (ODs) and opticians for medical (*non-routine*) services rendered to Anthem members. We will not target information specifically to these or other provider types; however, we've elected to use a more global approach to the seminar material covered so that all provider types can benefit from the information provided.

We know it's often difficult to leave your office because of your busy schedule. That's why we're working hard to include information in our sessions that will help you stay up-to-date on business changes and initiatives and make it easier for you to do business with us. These educational seminars are offered at no charge to network-participating providers and are a benefit of network participation. Please make plans now to attend a session that will be offered near you – central, eastern, northern or western regions of Virginia.

“Webinar” option coming in 2010

To make it easier for you to receive the information you need, we’re also working to develop an online “webinar” before the end of the year. Watch for details about this creative web conferencing option that brings our Anthem seminars to your office – all via the Internet.

Seminar topics

Due to the multi-specialty composition of our audiences, we are unable to focus on specific areas of medicine. We will, however, include a variety of topics useful to all practitioners, such as:

- o Claims filing for *professional* providers (those filing on the CMS-1500 claim format), with emphasis on the 837 professional electronic claim transactions, and other e-transactions.
- o Use of e-tools such as anthem.com and our secure portal, “Point of Care.”
- o Product and/or benefit changes for our PAR, PPO, HMO, Medicaid HMO and Medicare Advantage plans.
- o The BlueCard® Program (out-of-area program) from the Blue Cross and Blue Shield Association.
- o Updates for state (Commonwealth of Virginia), local (The Local Choice), and federal (Blue Cross and Blue Shield Service Benefit Plan or FEP) government programs.
- o Medical Management; Utilization Management; Pharmacy Management

Certificate of Completion

Those who complete a seminar will receive a “*Certificate of Completion*” for submission to various professional organizations for possible continuing education credit. Additionally, our seminar program has received prior approval of the American Academy of Professional Coders (AAPC) for continuing education hours. A CEU certificate from the AAPC will be available to certified coders who attend a seminar program in its entirety.

Registration/cancellation

Reservations are **required**, and seating will be available as registrations are received. We will contact you if your session has already reached capacity or is being cancelled, so it is imperative that you include your e-mail address, business telephone and fax numbers. Submit your *completed* form as follows:

- o **For Central, Northern and Eastern region seminars ONLY**
FAX: (804) 354-2979 **or**
MAIL: Anthem Blue Cross and Blue Shield
Attn: **CENTRAL, EASTERN and NORTHERN** Medical Office Seminars
Mail Drop VA4004-RR10
P.O. Box 27401
Richmond, VA 23279
- o **For Western region seminars ONLY**
FAX: (703) 227-5355 **or**
MAIL: Anthem Blue Cross and Blue Shield
Attn: **WESTERN** Medical Office Seminars
Mail Drop VACH01-A000
3800 Concorde Parkway, Suite 2000
Chantilly, VA 20151

NOTE: If you must cancel after registering, please provide us with at least 24-hours notice or as soon as possible. For CENTRAL, EASTERN, and NORTHERN seminars, call (804) 354-2723 to cancel and for WESTERN seminars, call (703) 227-5315.

2010 MEDICAL OFFICE SEMINARS
Central, Eastern, Northern and **Western** Regions of Virginia

REGION	DATE/TIME	LOCATION / ADDRESS	SEATS
NORTHERN	Thursday July 8 1 p.m. – 4 p.m.	Winchester Medical Center WMC Conference Center 1840 Amherst Street WINCHESTER, VA 22601	50
EASTERN	Tuesday July 13 1 p.m. – 4 p.m.	Bon Secours Mary Immaculate Hospital Conference Center Building - Rooms A&B 2 Bernardine Drive NEWPORT NEWS, VA 23602	50
CENTRAL/ NORTHERN	Wednesday July 21 1 p.m. – 4 p.m.	Stafford Hospital Center Level Below Main Lobby – Rooms 5&6 101 Hospital Center Boulevard STAFFORD, VA 22554	50
CENTRAL	Thursday July 29 1 p.m. – 4 p.m. (Lunch provided)	Centra Southside Community Hospital 1st Floor Conference Room 800 Oak Street FARMVILLE, VA 23901	30
WESTERN	Thursday August 5 10 a.m. – 1 p.m.	Clinch Valley Medical Center Basement Level, Classroom 2 6801 Governor GC Peery Highway RICHLANDS, VA 24641	30
CENTRAL	Thursday August 12 1 p.m. – 4 p.m.	Southside Regional Medical Center Main Floor - Classroom A/B 200 Medical Park Boulevard PETERSBURG, VA 23805	50
EASTERN	Thursday August 19 1 p.m. – 4 p.m.	Anthem Blue Cross and Blue Shield Convergence Center II - Hampton Roads Room 277 Bendix Road, Suite 200 VA BEACH, VA 23452	50
NORTHERN	Thursday August 26 1 p.m. – 4 p.m.	Sentara Potomac Hospital Hylton Education Center – Rooms ABFE 2300 Opitz Boulevard WOODBIDGE, VA 22191	50
EASTERN	Thursday September 9 1 p.m. – 4 p.m.	Shore Memorial Hospital 6th Floor Boardroom 9507 Hospital Avenue NASSAWADOX, VA 23413	25
NORTHERN	Tuesday September 14 1 p.m. – 4 p.m.	Prince William Hospital 4th Floor - Conference Room C 8700 Sudley Road MANASSAS, VA 20010	35
WESTERN	Thursday September 16 10 a.m. – 1 p.m.	Wytheville Meeting Center 333 Community Boulevard - Meeting Room 2 (across from Wytheville Community College) WYTHEVILLE, VA 24382	30
WESTERN	Thursday September 23 10 a.m. – 1 p.m.	Martinsville Memorial Hospital First Floor Classroom 320 Hospital Drive MARTINSVILLE, VA 24115	60
NORTHERN	Tuesday October 12 1 p.m. – 4 p.m.	Reston Hospital Center West Wing – Conference Room C 1850 Town Center Parkway RESTON, VA 20190	50
CENTRAL	Thursday October 14 1 p.m. – 4 p.m. (Lunch provided)	Bon Secours St. Francis Medical Center Main Level – Florence/Orvieto Rooms 13710 St. Francis Boulevard MIDLOTHIAN, VA 23114	50
EASTERN	Thursday October 28 1 p.m. – 4 p.m.	Sentara Louise Obici Hospital Garden Level – Classroom AB 2800 Godwin Boulevard SUFFOLK, VA 23434	40

ADDITIONAL IMPORTANT INFORMATION:

- o These free seminars are for *network-participating* physicians (MDs, DOs and DPMs), and their office personnel; as well as Behavioral Health providers (MDs, PhDs, LPCs, LCPs, LCSWs, MFTs, and CNSs). New in 2010, we will also accept registrations from these additional *network-participating* providers and their staffs: doctors of chiropractic (DCs), certified nurse midwives (CNMs), dental/oral surgery providers of medical (*non-routine*) services, and optometrists (ODs) and opticians for medical (*non-routine*) services rendered to Anthem members.
- o We highly recommend attendees bring a sweater or jacket for personal comfort.
- o Beverages/snacks will be provided at all seminars or you may "brown bag". *Lunch provided courtesy of hospital if specified.*
- o Please note that seminars for the **WESTERN** region are indicated by shading; please ensure you submit your completed registration to the correct fax number that corresponds with your seminar's region.

2010 Anthem Medical Office Seminar REGISTRATION FORM

<p>CENTRAL, EASTERN AND NORTHERN REGIONS OF VIRGINIA ONLY</p> <p>Complete entire form; then FAX to (804) 354-2979</p> <p>-----</p> <p>WESTERN REGION OF VIRGINIA ONLY</p> <p>Complete entire form; then FAX to (703) 227-5355</p>

IMPORTANT! Please read and complete the information below.
Remember that faxes often lose quality in transit so please print **legibly!**

- These **free** seminars are for *network-participating* physicians (MDs, DOs and DPMs), and their office personnel; as well as Behavioral Health providers (MDs, PhDs, LPCs, LCPs, LCSWs, MFTs, and CNSs). New in 2010, we will also accept registrations from these additional *network-participating* providers and their staffs: doctors of chiropractic (DCs), certified nurse midwives (CNMs), dental/oral surgery providers of medical (*non-routine*) services, and optometrists (ODs) and opticians for medical (*non-routine*) services rendered to Anthem members.
- Each 2010 Medical Office Seminar will contain current updates on a variety of topics as described on-line at www.anthem.com under Provider Seminars or in each issue of the provider newsletter, *Network Update*.
- An Anthem “*Certificate of Completion*” will be given to attendees at the conclusion of each seminar for submission to various professional organizations for possible CEU credit.
- For seating purposes, reservations are **required**; seating is on a first-come, first-served basis. *If you register and then need to cancel, please give us as much notice as possible by calling (804) 354-2723 (for Central, Eastern, and Northern region providers) or (703) 227-5315 (for Western region providers).*
- For personal comfort, we highly recommend attendees bring a sweater or jacket. Beverages/snacks will be provided at all seminars; you may also “brown bag”. If a hospital is providing lunch, this will be specified on the schedule.

Seminar Date/Time _____ and Location _____

Attendee #1 _____ Attendee #2 _____

Provider Name _____ Provider Specialty _____

NPI # (individual) _____ NPI # (group) _____

Provider Address with City /State /Zip _____

Phone Number _____ Fax Number _____

E-mail Address _____

Provider Website (if applicable) _____

CONFIRMATION of your registration or notification that your selection is full or has been cancelled will be sent to you via E-MAIL or FAX so it is critical that you include your e-mail, phone, and fax numbers when completing this form. THANK YOU.

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