

Network Update

VIRGINIA

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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

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www.anthem.com

[Important phone numbers](#)

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eBusiness

Company makes improvements to anthem.com

Anthem Blue Cross and Blue Shield is pleased to announce the implementation of enhancements to our website – anthem.com. You may have already noticed the new look and feel of our website. Once you access anthem.com, the main (landing) web page has changed. For additional details about our new consumer website changes, see the article on the following page.

To view information targeted specifically to the provider community, simply select the link labeled “Providers” – located at the lower right-hand side of the main screen on anthem.com.

anthem.com – Virginia Provider Section

Based on feedback from the provider community and other customers, we've also made several improvements that make navigating the provider section of our website easier. Click [HERE](#) to visit the Virginia provider section of anthem.com to view the new look and feel. Here are some highlights:

- The Virginia provider home page is now categorized into four main sections – 1) Self-service and Support; 2) Our Plans and Benefits; 3) Health and Wellness; and 4) Communications and Updates. (You can access links from the major categories or continue to use the tabs across the top of web page as in the past.)
- Easier navigation with fewer clicks to quickly access information you need.
- Content is segmented by categories on more streamlined web pages, helping you to more easily locate desired topics.

We hope you find these changes helpful. It's one more way we're working to make it easier for you to do business with us.

Anthem launches new consumer website

Anthem is also pleased to announce the redesign of our member website to a simplified and more engaging online experience. The main (landing) page of anthem.com has a new look of the redesigned member site and will require CONSUMER log-in on the anthem.com landing page. **This is NOT a PROVIDER log-in request.** As a reminder, providers will need to click on the PROVIDER link in the bottom right-hand corner of the new landing page for [anthem.com](#) that will then route users to the anthem.com provider home page. From there, navigation continues as usual for providers. However, we've also made improvements to the provider section of the website as outlined above.

Member website features

The new member website will include several innovative features and better navigation to help members become more aware of their health care options and encourage healthy lifestyles. Some of the new features include Personalized Account Summary, customized to what is most important to members, and Centralized Medical History – both available 24/7. In addition, the new site will provide easy-to-use tools that promote member health awareness such as Symptom Checker and MyHealth Assessment that allows members to discover risks and learn how to lower them.

With the redesigned site, members can quickly find simple answers to those everyday questions that are most important to them. Members will have easy access to their claims history or can check status of a claim. They can also find a doctor or hospital and compare the cost and quality of care.

Launch of Network Rapid Update – register your e-mail address with us

Over the last several months, we've shared with you our plans to launch a new, streamlined e-mail communications tool – Network Rapid Update. The tool is now available, and we invite you to register your e-mail addresses with us to receive the Network Rapid Update. Get important “need-to-know” provider updates – conveniently to your electronic inbox. We will only use the Network Rapid Update as the need arises to communicate urgent, critical or time-sensitive information that impacts you and how you do business with us.

Registration

If you'd like to receive the Network Rapid Update, you'll need to provide us with an e-mail address where we can send these critical alerts. Only those providers who sign up will receive the Network Rapid Update via e-mail. **To register your e-mail address with us, select the Network Rapid Update link on the Virginia provider home page of anthem.com and complete the short registration form or click [HERE](#).** Please know that you can unsubscribe at any time, and we will not share, rent or sell the information to any third party.

Include alpha prefix when entering policy IDs on Point of Care

Beginning mid-October 2010, you will be required to enter the three-position, alpha prefix along with the policy ID number in any field on Anthem Point of Care that requests the member's ID number. For example, Point of Care's eligibility and claim inquiry screens will require the alpha prefix in the policy number field. By entering the alpha prefix, this helps ensure Point of Care displays the most current and accurate information for the ID number entered.

Policy IDs vary in length and can be a combination of letters and numbers. As always, please request that members present their most current ID card at the time of service. Include the ID numbers exactly as they appear on the current ID cards when filing claims to Anthem.

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.

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.

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 *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.

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 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

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Company launches webpage dedicated to HIPAA 5010

HIPAA 5010 standards are federally mandated by the Health Insurance Portability and Accountability Act (HIPAA) that will bring sweeping changes to your practice and the health care industry. These new industry standards will enhance the consistency and usage of transactions handled through electronic data interchange (EDI). The implementation of the X12 version 5010 standard transactions brings better automation to your electronic submissions.

Launch of dedicated 5010 webpage on EDI website

Recently, Anthem Blue Cross and Blue Shield launched a webpage to help keep you and our electronic trading partners informed about our 5010 activities, timelines and current updates. Here's what you'll find on the webpage:

- News and updates about our ongoing progress, as we work to comply with the new HIPAA 5010 requirements.
- Frequently asked questions from the provider community along with detailed responses.
- Online registration – capability to sign up to receive e-mail alert messages and important updates regarding HIPAA 5010.
- Online functionality to contact us via e-mail with prompt responses to your e-mails.

To access our HIPAA 5010 webpage, simply visit www.anthem.com/edi. Once you've selected a state, click on the communications tab and then 5010.

We encourage you to visit the webpage often and to sign up to receive e-mail alert messages. If you plan to have your electronic vendor or clearinghouse to implement HIPAA 5010 changes on your behalf, we suggest that you urge them to register for e-mail alerts messages as well. It's important to note that we will not share, rent or sell e-mail addresses to any third party.

Questions about HIPAA 5010? We're here to help.

If you have questions about the upcoming mandated requirements, we'd like to help. For questions regarding HIPAA 5010, send e-mail inquiries to: 5010EHTS@anthem.com.

Looking ahead

Going forward, Anthem will be participating in industry forums with other health insurance companies and industry leaders. This will help ensure we have access to the latest information and can react quickly and appropriately to emerging challenges. In addition, we'll continue to work with our trading partners to gauge their implementation readiness through extensive testing and communication efforts. Watch for more details in upcoming editions of this newsletter.

Submit behavioral health claims electronically

If you file behavioral health claims using paper submissions, you'll be pleased to learn that Anthem Blue Cross and Blue Shield in Virginia accepts all types of claims – including behavioral health claims – filed **electronically** directly to us or through vendors via secure connections. Switching from a paper format to electronic submission is simple and easy – you don't need a practice management system or special software. The information below provides additional details about electronic data interchange or EDI. There's no better time than today to begin submitting your behavioral health claims and other transactions electronically.

Behavioral health claims have specific inpatient/outpatient criteria which can be easily transmitted electronically including:

- Pre-authorization Requests
- Specialty Care Reviews (Referrals)
- Medical Management
- Supporting Documentation

Benefits of electronic submission

Added convenience, increased efficiency and fewer administrative hassles are just a few of the benefits you can experience when you go electronic. You'll also:

- Have enhanced security — you can submit and receive electronic transactions from your computer system safely and securely.
- Have peace of mind — we acknowledge electronic claims immediately upon receipt, providing an audit trail of transactions submitted and processed.
- Correct mistakes and get paid faster — Receive prompt notice of errors so that you can correct claims quickly – helping to ensure fast payments and a more consistent revenue cycle than that of paper submissions.
- Save time and money – Claims submitted electronically help increase efficiency in your office – all while helping to reduce your administrative burden with postage, printing, mailing and other paper-related expenses.

If you are currently working with a clearinghouse or vendor and are interested in submitting claims electronically, contact our EDI Solutions Helpdesk at (800) 991-7259, Monday through Friday, 8 a.m. to 5 p.m., ET for other connectivity options.

Coverage and clinical UM guideline update

Clinical UM guideline update effective January 1, 2011 – Vestibular Rehabilitation and Canalith Repositioning

Effective January 1, 2011, Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield (hereinafter "Anthem") will implement the following changes for clinical UM guideline *Vestibular Rehabilitation and Canalith Repositioning (CG-REHAB-01.)* CPT code 95992 Canalith repositioning procedure(s) (e.g., Epley maneuver, Semont maneuver,) per day will pend all diagnoses, including diagnosis 780.4 (dizziness and giddiness) and diagnoses 386.0 - 386.9 (vertiginous syndromes and other disorders of vestibular system) for review per the medically necessary criteria in CG-REHAB-01. HCPCS code S9476 will continue to pend all diagnoses for review per the medically necessary criteria in the guideline. These changes apply to members covered by our PAR, PPO and Virginia Lumenos plans. Our affiliated HMO products, including Medicaid and FAMIS, will continue to require a Health Service Review prior to delivery of these services. The complete clinical UM guideline and medically necessary criteria are available for review on our website at anthem.com.

Health care reform updates and notifications

Health care reform – communicating updates and notifications

Anthem Blue Cross and Blue Shield in Virginia is committed to providing you with health care reform updates and critical information, as we continue to implement new business processes to support recent legislative requirements. As part of this commitment, we will post updates about health care reform to Anthem's Virginia provider portal and utilize the Network Update newsletter to communicate changes that may impact your day-to-day business with Anthem. Network Updates will also include a link called **Health Care Reform Updates and Notifications**, which will direct you to a historical library of our provider communications on health care reform.

In addition to the Anthem provider portal and Network Update newsletter, 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 discussions and is designed to answer specific questions about 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 questions. Additionally, if you have patients who have unanswered questions about health care reform, encourage them to also 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.

Surprising facts about health care spending and health insurer profits

In 2007, national spending for health care was \$2.2 trillion. Projections for 2010 anticipate spending to grow to \$2.6 trillion, and by 2018, spending will likely be \$4.4 trillion.¹ Some of the facts about national health care spending are unexpected.

On average, **87 cents of every dollar Anthem Blue Cross and Blue Shield receives from members is spent covering medical care and services like doctor visits, hospital cost, prescription drugs and more.**² Another 10 cents of the premium dollar funds services we provide like claims processing, enrollment and billing, provider credentialing and complying with government regulations. We also use this portion of the premium dollar towards efforts to control the rising cost of care, such as supporting new advances in health information technology – like electronic medical records. This leaves only three cents of each premium dollar remaining for profit.

Did you know that health insurer profit margins are among the lowest in the health care industry at 2.2 percent? Health insurer profit margins trail behind pharmaceutical profit margins at 19.3 percent, and medical products and equipment profit margins at 16.3 percent.³ In fact, the **combined annual profits** of the top 10 health insurers are equal to just **two days worth of national health care expenditures** – or 0.5 percent of the estimated \$2.5 trillion the U.S. spent on health care in 2009.⁴

Controlling the cost of care is everyone's responsibility, and Anthem is working diligently to help this effort. Educating our members about health and wellness, enrolling members with chronic conditions in care management programs, and supporting information technology advances are just a few ways Anthem is helping to control America's cost of health care.

Citations:

¹ Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistic Group, at http://www.cms.gov/NationalHealthExpendData/downloads/NHE_Extended_Projections.pdf

² PricewaterhouseCoopers' Health Research Institute "Share of Benefit Premiums" Medical Cost Trend for 2009.

³ Compiled from data from Fortune magazine's "Fortune 500 Annual Ranking of America's Largest Corporations," 2008

⁴ Kaiser Health News. June 19, 2009

Business update

Inpatient review updates

Anthem Blue Cross and Blue Shield is implementing an initiative to standardize inpatient clinical review requirements across our family of companies – thus eliminating state-by-state variances. Effective December 1, 2010, Anthem in Virginia may adjust what admissions require additional nurse clinical review as well as the goal lengths of stay based on the Milliman Care Guidelines, 14th edition.

As a result of the standardization, the following medical admissions may require clinical review and no longer approve automatically:

Bacterial infections including bacterial meningitis, endocarditis, subarachnoid hemorrhage, CVA, acute cerebral embolisms with infarctions, acute pancreatitis, complicated antepartum maternity, preterm infants, post-delivery infant complications, open and closed skull fractures, open and closed vertebral/spinal cord fractures, brain hemorrhage following injury, and burns.

Clarification regarding UM terms; UM review requirements available at anthem.com

The Utilization Management department of Anthem Blue Cross and Blue Shield in Virginia performs two types of pre-service reviews as defined and determined by a member's contract. As the name implies, the reviews are performed **in advance** of the service being rendered.

Change in terms: pre-authorization vs. pre-certification

Over the years, several terms have evolved in an attempt to better define the type of review being performed. Changes in terminology have occurred to be consistent across our family of companies and to comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.

For consistency going forward, the term *pre-authorization* will be replaced with *pre-certification*. Pre-certifications will include both inpatient and outpatient reviews and will refer to those reviews that are required of a member's contract. Pre-certifications will remain separate from Specialty Care Reviews (referrals) which are performed only by PCPs. Pre-certifications can be performed by PCPs or specialists. This terminology change will hopefully aid providers in navigating our website at anthem.com and using features that define review requirements across states – for BlueCard® members as well as other membership groups.

View UM requirements online

Anthem's Virginia membership is diverse and unique. Each membership group has individual needs, and pre-certification review requirements are tailored accordingly. For a list of the most frequently requested services, visit the Virginia provider section of anthem.com or click [HERE](#).

Reviews may be initiated by calling the telephone number found on the back of the member's health insurance identification card. Or if you prefer, access Point of Care – our secure web-based tool for network-participating providers in Virginia – to make inquiries for most services. For more information concerning Point of Care, please contact your Anthem network manager.

Attention Behavioral Health Providers: Members' cost share may change or no longer apply for some mental health and substance use disorder services – effective July 1, 2010

Recently, 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.

On July 1, 2010, members' cost share changed or no longer applies for some mental health outpatient and substance use disorder services. Therefore, if you provide services for mental health care and/or substance use disorder to our Anthem members, please verify if a cost share is required for any new patients **and** patients currently in treatment. With the change in law, you may have Anthem patients who were required to pay a copayment at the outset of mental health treatment. However, beginning July 1, the cost share changed or no longer applies. Anthem HealthKeepers Plus members (Medicaid/FAMIS Plus or FAMIS) no longer have benefit limitations on inpatient days or outpatient visits. The number of Inpatient days or outpatient visits will be based on medical necessity.

You can use Anthem Point of Care – our Web-based provider tool – to verify copayment amounts for your Anthem patients. Or if you prefer, call our service operations area at 804-342-0010 in the Richmond area or toll free 800-533-1120 outside Richmond. Select option 2 and then 3. As a reminder, please request that your Anthem patients present their most current ID cards at the time they receive services.

Diabetes and Retinopathy on a rising trend – help decrease chance of blindness by ordering eye exams annually

As you probably already noticed, obesity and diabetes are on the rise. Even with the increased media attention and all the advertisements encouraging people to take action to lose weight, the obesity epidemic continues to worsen – along with the prevalence of diabetes. Reportedly, during the past decade, there has been a 33 percent increase in the incidence of diabetes in the United States. It is estimated that about one in three Americans born in 2000 will develop diabetes within their lifetime.¹

The prevalence rate for retinopathy among diabetics is high. Nearly all patients with Type 1 diabetes develop retinopathy, and most patients with Type 2 diabetes eventually develop retinopathy to some degree as well.² It is also reported that 40 percent of diabetic patients will most likely develop glaucoma than non-diabetics.³ Effective management of diabetes reduces the risk of these complications and helps diabetics achieve normal glycemic levels.

The American Diabetes Association recommends that all patients with diabetes should have an annual dilated retinal exam (DRE) from an eye care specialist. This allows early detection of the disease and interventions such as laser photocoagulation surgery can help prevent vision loss.⁴

According to the 2009 National Committee for Quality Assurance (NCQA) benchmarks, the national average for DRE's was only 57 percent for those with a diagnosis of diabetes.⁵ Several reasons have been identified why diabetics fail to get tested for retinopathy each year, such as uncertainty about coverage for the exam. Many patients may not realize their medical benefits may cover yearly eye exams for retinopathy, even if they do not have vision insurance. Please ask patients to contact Customer Service at the 1-800 number on the back of their medical insurance ID cards to inquire about their diabetic eye exam benefit.

It may be helpful to also note that providers who use tools, such as flow charts and electronic medical records with reminders for preventive screening, have higher success rates in helping patients get needed tests and may have better quality of care scores.⁶

Visit anthem.com>health & wellness> provider toolkits to find resources such as flow sheets and patient educational materials that may be helpful in managing your patients' diabetes care.

Sources:

1. NCQA Quality Profiles, Focus on Diabetes, May 2005 edition
2. NCQA Quality Profiles, Focus on Diabetes, May 2005 edition
3. American Diabetes Association, Living with Diabetes, Eye Care- abstracted 6/2/10 from website: <http://www.diabetes.org/living-with-diabetes/complications/eye-care.html>
4. American Diabetes Association, Living with Diabetes, Eye Care- abstracted 6/2/10 from website: <http://www.diabetes.org/living-with-diabetes/complications/eye-care.html>
5. NCQA Quality Compass 2009
6. NCQA Quality Profiles, Focus on Diabetes, May 2005 edition

Every 20 seconds.....Osteoporosis causes a fracture.....order a bone scan

Each year, osteoporosis is responsible for 1.5 million fractures. That is 4,110 fractures every day – one every 20 seconds. Even more alarming, 71 percent of women with osteoporosis are not diagnosed, leaving them at increased risk for fractures.¹

How you can help

A very important step is ordering a BMD within three to six months post hip, vertebral, or distal radial fracture for your patients.² A woman who experiences a hip fracture is at a four-fold greater risk for having another hip fracture.³ Fragility fractures have a high probability of being related to osteoporosis.⁴ BMD is used to assess risk of future fractures, monitor changes over time, and to diagnose and identify severity of osteoporosis.

The National Osteoporosis Foundation has written “The Physicians’ Guide to Prevention and Treatment of Osteoporosis” that recommends testing for postmenopausal women and should begin no later than age 65.⁵ This guide also recommends talking with your patients about interventions to reduce future fracture risk including; adequate intake of calcium and vitamin D and participation in weight-bearing and muscle-strengthening exercises. Evaluation of secondary causes of osteoporosis should be completed prior to initiation of treatments. Patients taking FDA-approved medications should have laboratory and bone density re-evaluation after two years or more frequently when medically appropriate.⁶

The Medicare Advantage benefits include \$0 deductible for Bone Mass Preventive screening as long as the member stays within network. It is best to check your patient’s benefits to ascertain coverage.

Sources:

¹“Building a Strong Community from the Inside Out” toolkit- CA Medical Association Foundation April 2008

²Musculoskeletal Osteoporosis. (2008) **Screening and Treatment: National Osteoporosis Foundation. Physician’s Guide to Prevention and Treatment of Osteoporosis. Washington DC: National Osteoporosis Foundation. 2008**

³ National Osteoporosis Foundation, Fast Facts on Osteoporosis; www.nof.org/osteoporosis/diseasefacts

⁴“Bone Health & Osteoporosis: A Report of the Surgeon General” October 2004

⁵Musculoskeletal Osteoporosis. (2008) **Screening and Treatment: National Osteoporosis Foundation. Physician’s Guide to Prevention and Treatment of Osteoporosis. Washington DC: National Osteoporosis Foundation. 2008**

⁶Musculoskeletal Osteoporosis. (2008) **Screening and Treatment: National Osteoporosis Foundation. Physician’s Guide to Prevention and Treatment of Osteoporosis. Washington DC: National Osteoporosis Foundation. 2008**

View BlueCard® members' coverage guidelines and pre-certification requirements online – effective October 1, 2010

Anthem Blue Cross and Blue Shield in Virginia is pleased to announce the launch of a new feature on our provider website to make it easier for you to find information about coverage and pre-certification guidelines as you work to treat your out-of-area BlueCard patients. Effective October 1, 2010, you will be able to view medical policies that apply specifically to your out-of-area BlueCard patients who have coverage through Anthem or other Blue plans. In addition, you will have access to general pre-certification/pre-authorization requirements, along with the contact information to initiate pre-certification/pre-authorization requests for BlueCard members – all in a few easy steps from your computer.

Online Instructions

To access medical policy and pre-certification/pre-authorization requirements, go to the provider section of anthem.com and select a specific state – for example, Virginia, Indiana or Maine. Next, select the blue box labeled Medical Policy, Clinical UM Guidelines, and Pre-Certification on the left-hand side of the provider home page. Then, just click the appropriate link for either local plan members or BlueCard/out-of-area members. For out-of-area Blue members, you must enter the patient's three-letter alpha prefix that precedes the ID number. We hope this new Web functionality provides a valuable supplement to the information you currently receive when verifying patients' benefits and eligibility.

We believe in continuous improvement

Commitment to our members' health and their satisfaction with the care and services they receive is the basis for the **Anthem Blue Cross and Blue Shield's** Quality Improvement Program. Annually, Anthem prepares a quality program description that outlines the plan's clinical quality and service initiatives. We strive to support the patient-physician relationship that ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously 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 most current outcomes, visit our website at anthem.com.

Series to promote behavioral change and patient compliance continues:

Motivation interviewing – OARS technique with non-compliant hypertensive patient – part 4

With this edition of our *Network Update*, we continue our multi-part series on promoting behavioral change and patient compliance. In this fourth installment, we again emphasize the importance of motivational interviewing and the OARS technique (**O**pen-ended questions, **A**ffirmation of patient strengths, **R**eflective listening and **S**ummarization) in gauging patients' reactions and resistance to recommended treatment plans – particularly those chronically ill patients.

Successful behavior changes are typically fostered within a trusted, therapeutic and patient-centric clinical setting. The first three articles in this series focused on the tool required to promote positive behavioral lifestyle choices. The scenario below demonstrates the use of the OARS technique with a hypertensive patient who is non-complaint taking medications.

Putting the OARS technique in practice

(O - Open-ended question)

Provider

- o *Can you share with me what you feel is most difficult about taking your blood pressure medication?*

Patient

- o I feel really good. I don't like taking pills if I don't need to – plus they are expensive.

(A – Affirmation)

Provider

- o *I hear you saying that you don't feel you need these medications because you feel good and they are expensive.*

Patient

- o Yes

(R- Reflective listening)

Provider

- o *You feel that you may not need these medications because your blood pressure is under control.*

Patient

- o Yes, I feel good; I'm not dizzy or light-headed.

(S- Summarizing statement)

Provider

- o *I certainly understand your position. Perhaps, we can discuss the hidden dangers of uncontrolled blood pressure and why it's important to take your blood pressure medicine. In addition, I can prescribe a generic medication for you that's less costly than brand name drugs. What do you think?*

Patient

- o Is there a generic available?

Provider

- o *I will review your insurer's formulary to find an equivalent medicine and give you some additional information about blood pressure control. Would this help you?*

Patient

- o Yes, I think it would.

Provider

- o *Once we've addressed all your concerns, would you be willing to begin taking the medications as I've prescribed them?*

Patient

- o Yes, I can.

Provider

- o *I'd like to see you back in about a month or so for a follow-up to see how things are going. Can you commit to that?*

Patient

- o Yes, I believe I can do that. Thank you for listening to my concerns.

For additional information concerning the use of MI techniques, please cut and paste this online link into your Web browser:

<http://motivationalinterview.org/clinical/whatismi.html>

Anthem develops low back pain program to help support better care

Low back pain – it can hit suddenly and inexplicably. Patients want their physicians to do something, but what really works?"

The Program of Excellence for Low Back Pain was developed by Anthem Blue Cross and Blue Shield, with input from medical societies, leading experts and practicing physicians to help educate and support PCPs and the specialists who treat low back pain in delivering better care.

The program is based on the most recent evidence-based guidelines from the American College of Physicians and American Pain Society,¹ and it aligns with the measures from the NCQA Back Pain Recognition Program (BPRP). Physicians participating in the program develop an evidence-based treatment protocol to guide their treatment of patients with low back pain that includes:

- Taking a complete medical history at initial visit to assess for red flag conditions
- Collection of pain and functional status using standardized and validated tools
- Inclusion of shared decision-making in the patient education process

Advantages for participating physicians include:

- Education, tools and dialogue with Anthem's expert panel to develop top- notch treatment processes for low back pain patients
- Additional reimbursement for adherence to the program
- Maintenance of Certification credits through Anthem's designation as an Approved Quality Improvement program from the American Board of Internal Medicine
- Administrative fee reductions for recognition in the NCQA BPRP

While the program is only available in select pilot markets, information and program materials will be available online to all Anthem network physicians within the next few months. (Plans are under way with pilot markets in New Hampshire, California and Wisconsin. Other pilot sites will be announced later.) For more information, contact Sandra Marinace, Program Manager, Programs in Clinical Excellence at sandra.marinace@wellpoint.com.

Sources:

¹Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society on the diagnosis and treatment of low back pain (Ann Intern Med. 2007;147:478-49)

Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain: An Evidence-Based Clinical Practice Guideline from the American Pain Society (Spine; 34:10:1066-1077).

Medicare and Medicaid information

Physician Quality Reporting Initiative (PQRI) provider bonus payment

Medicare Advantage plans are required to reimburse eligible “deemed” or non-contracting physicians/practitioners at the same amount that Medicare would have paid for the service. This includes the bonus payments due to providers who are participating in the voluntary Physician Quality Reporting Initiative (PQRI). PQRI bonus payments are due only on Medicare Physician Fee Schedule services and are a specified percentage paid on 100 percent of the fee schedule allowed amount.

Providers qualifying as “eligible professionals” under the Medicare PQRI program are also entitled to incentive/bonus payments under the Medicare Advantage program if they meet the specified criteria. Additional information related to the program including incentive eligibility and how amounts are calculated may be accessed on the CMS website at www.cms.hhs.gov/pqri.

- PQRI bonus payments are issued on an annual basis. We are issuing bonus payments for the 2007 and 2008 PQRI reporting periods now. PQRI bonuses for the 2009 Reporting Period will be issued later in 2010 when CMS provides the list of eligible professionals.
- Bonus payments related to Medicare Advantage Private Fee-for-Service claims were issued by mid-April 2010 for both the 2007 and 2008 reporting periods.
- The PQRI program began July 1, 2007, so the initial reporting period is from July 1, 2007, through December 31, 2007. Subsequent reporting periods are on a calendar-year basis; however, providers may opt to participate on a 12-month or 6-month basis during a reporting period beginning with 2008.
- Eligible Professional status is determined by CMS (not the MA plan).
- All payments are issued at the Tax ID (TIN) level, including all rendering/performing practitioner NPI's eligible for that TIN. If a rendering/performing practitioner submits claims through more than one billing provider, a separate check will be issued to each eligible TIN. It is not guaranteed that the NPI is eligible for bonus payments with all their billing provider TINs; there must be an exact match against the CMS list of eligible professional TIN/NPI combinations for a bonus to be issued.
- The Explanation of Payments included with each check gives details of the claims included in the bonus payment and states that the payments are related to **“PQRI BONUS PAYMENT DUE ON CLAIMS PER CMS MEDICARE ADVANTAGE REGULATIONS. SEE www.cms.hhs.gov/pqri FOR ADDITIONAL INFORMATION.”**

Patient Protection and Affordable Care Act

The Centers for Medicare & Medicaid Services (CMS) is changing their timely filing criteria as per the Patient Protection and Affordable Care Act (PPACA). Prior to this change, the provider must have submitted their claims for services furnished during the first nine months of the calendar year on or before December 31 of the following year. For services furnished in the last three months of the calendar year, the provider must have submitted a claim by December 31 of the

second following year. CMS is eliminating this system and will now require providers to submit claims within one calendar year for claims with dates of service on or after January 1, 2010.

Anthem Blue Cross and Blue Shield's Medicare Advantage plans are required to follow CMS's new timely filing guidelines unless expressly noted within a provider's contract with Anthem Blue Cross and Blue Shield. All non-contracting provider's claims will be processed as per the new CMS guidelines.

Relevant timely filing dates

- Claims with dates of service prior to October 1, 2009, will be subject to pre-PPACA timely filing guidelines.
- Claims with dates of service October 1, 2009, through December 31, 2009, must be filed by December 31, 2010.
- Claims with dates of service on or after January 1, 2010, will be subject to denial if they are not filed within one calendar year from the date of service.

If you have further questions, please visit the CMS website at:
<http://www.cms.gov/MLNMMattersArticles/downloads/MM6960.pdf>

Anthem teams with MediConnect Global Inc.

In a continuing effort to promote change and improvement that will help strengthen the relationship with our members and providers, Anthem Blue Cross and Blue Shield is pleased to announce that we've teamed with MediConnect Global Inc. (MediConnect). MediConnect is a leading records retrieval and electronic document management company that specializes in medical records retrieval, digitization, coding and delivery via the Internet. MediConnect's Web-based workflows help reduce time and costs and improve efficiencies associated with record retrieval, coding and document management.

The Centers for Medicare & Medicaid Services (CMS) requires that we perform oversight activities related to the collection and reporting of member diagnosis data which must be supported by medical record documentation. As such, Anthem has engaged MediConnect to perform retrospective reviews of our Medicare Advantage members' medical records. MediConnect's role in record retrieval, review and coding will be instrumental in helping Anthem ensure risk adjustment payment integrity and accuracy.

If you have any questions regarding MediConnect Global Inc., contact your network manager.

Update: Formulary changes for Anthem HealthKeepers Plus (Medicaid/FAMIS Plus and FAMIS) plans

Recently, we made formulary changes for members with coverage under Anthem HealthKeepers Plus (Medicaid/FAMIS Plus and FAMIS plans). In May 2010, Spiriva was added to the Anthem HealthKeepers Plus formulary – prior authorization is no longer required for this drug. Secondly, effective July 23, 2010, the prescription drug Tretinoin no longer requires prior authorization for members younger than 36 years of age. Providers and members can call us toll free at **800-901-0020** if there are questions about the formulary changes.

Change to FAMIS MOMS Program

The Virginia Department of Medical Assistance Services (DMAS) administers the Family Access to Medical Security Insurance (FAMIS) and FAMIS MOMS Programs. Effective July 1, 2010, DMAS has directed that babies born to an Anthem HealthKeepers Plus FAMIS MOMS member can be enrolled in the Anthem HealthKeepers Plus product for their birth month plus two additional months. Mothers enrolled in the Anthem HealthKeepers Plus FAMIS MOMS program should notify Member Services toll free at 800-901-0020 to enroll their newborns. In addition, these mothers will need to notify the FAMIS CPU toll free at 866-87FAMIS (866-873-2647) immediately after the baby's birth in order for the baby to receive continued coverage. Participants will be responsible for a \$2 co-payment for services until Anthem HealthKeepers Plus Member Services receives the baby's complete enrollment information.

Important information about Anthem HealthKeepers Plus (Medicaid/FAMIS Plus and FAMIS) plans offered through our HMOs

The Virginia Department of Medical Assistance Services (DMAS) administers the Title XIX Medicaid, Title XXI Family Access to Medical Security Insurance (FAMIS) and FAMIS Plus programs. Several providers have expressed some confusion regarding the various programs in Virginia that support indigent persons and Anthem's role in these programs. Commonly referred to as Anthem HealthKeepers Plus – which is issued by Anthem's affiliated HMOs (HealthKeepers Inc., Peninsula Health Care Inc. and Priority Health Care Inc.) – the plans serve Medicaid/FAMIS Plus and FAMIS members. We've included some general information in this edition of our Network Update regarding Virginia's Medicaid programs and Anthem's role in these programs.

Funded by state and federal funds, Medicaid provides health care for individuals and families with low income and limited resources. Persons of any age can be eligible for Medicaid. Virginia has named its program for Medicaid-eligible children aged 19 and under – FAMIS Plus. DMAS also administers the Virginia Children's Health Insurance Program (CHIP) which is known as FAMIS and is a stand-alone program.

DMAS and MCOs

DMAS contracts with several managed care organizations (MCOs) in the state to provide coverage to persons eligible for Medicaid, FAMIS Plus or FAMIS. MCOs coordinate access to health care providers such as PCPs, specialists, hospitals, clinics, medical supply companies, transportation service providers, drug stores and other medical service providers. DMAS has five MCO plans in Virginia – Anthem's affiliated HMOs, AMERIGROUP, CareNet, Optima Family Care and Virginia Premier.

Medallion II (Medicaid/FAMIS Plus)

DMAS' managed care plan for Medicaid-FAMIS Plus eligible persons is called Medallion II. Anthem's affiliated HMOs participate in the Medallion II program that covers a comprehensive set of services. There are no copayments for Medallion II enrollees. Participants in the Medallion II program are not required to obtain specialty care reviews from a PCP for immunizations; family planning/OB/GYN services; mental health/mental retardation state plan option services; and school health services.

FAMIS Program

FAMIS is Virginia's Title XXI CHIP program which is available to children from low-income homes who are not eligible for Medicaid. Much like Medallion II, DMAS-contracted MCOs handle claims for members enrolled in this program. However, FAMIS benefits differ slightly from those in the Medallion II program. There are benefit limitations (some services are

excluded) and small co-payments – much like those associated with standard commercial group health plans. Co-payments range from \$2 to \$5 depending on services. Refer to members' ID cards for this information.

FAMIS MOMS is another program administered by DMAS for which MCOs provide coverage. This program expands coverage for certain low-income, pregnant women who are not eligible for Medicaid. Covered services, service limitations or authorization requirements for enrollees in the FAMIS MOMS program are the same as those for Medallion II enrollees. Please note that FAMIS MOMS enrollees have no copayments for covered services.

Pharmacy update

Specialty pharmacy update: introducing CuraScript Specialty Pharmacy

PrecisionRx Specialty Solutions (PRxSS) will become CuraScript, the Express Scripts Specialty Pharmacy, at the end of September. All Anthem members who obtained specialty medications from PRxSS should now obtain them from CuraScript. Anthem Blue Cross and Blue Shield in Virginia continues to manage specialty pharmacy drug programs, and members will keep their existing ID cards, Customer Service phone numbers, drug lists and benefit designs. Anthem members will be notified by letter of this change in September.

No action is required on your part due to this change. Prescriptions can still be submitted through phone or fax – the contact numbers remain the same. Our members continue to receive their specialty medication with the care and service they deserve. Refills on prescriptions less than one year old have been automatically transferred to CuraScript; though prescriptions may be filled and shipped from a different pharmacy location. CuraScript facilities are located in Indianapolis, Ind., Orlando, Fla. and New Castle, Del. Additionally, you can download CuraScript referral forms at curascript.com.

Anthem is committed to finding ways to make health care more affordable for our clients and members. Working with CuraScript Specialty Pharmacy will help us promote better health and value for all specialty patients.

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

Fall medical office seminars approaching – register today

Only a few more medical office seminars remain for the year, so please make plans today to attend a session scheduled throughout the state for **network-participating** physicians and their staffs – offered in central, eastern, northern or western regions of Virginia. Those health care professionals invited to attend include medical doctors (MDs), doctors of osteopathy (DOs), doctors of podiatric medicine (DPMs) and behavioral health professionals.

We 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. Our informative sessions cover a wide variety of topics – using a more global approach to the seminar material covered so that all provider types can benefit from the information provided.

We understand that it's often difficult to leave your office because of busy schedules. 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.

Seminar topics

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

- 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.
- Use of e-tools such as anthem.com and our secure portal, "Point of Care."
- Product and/or benefit changes for our PAR, PPO, HMO, Medicaid HMO and Medicare Advantage plans.
- The BlueCard® Program (out-of-area program) from the Blue Cross and Blue Shield Association.
- Updates for state (Commonwealth of Virginia), local (The Local Choice), and federal (Blue Cross and Blue Shield Service Benefit Plan or FEP) government programs.
- 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 FALL MEDICAL OFFICE SEMINARS
Central, Eastern, Northern and **Western** Regions of Virginia

REGION	DATE/TIME	LOCATION / ADDRESS	SEATS
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 Complete entire form; then FAX to (804) 354-2979</p> <hr style="width: 20%; margin: 0 auto;"/> <p>WESTERN REGION OF VIRGINIA ONLY Complete entire form; then FAX to (703) 227-5355</p>
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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.

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.