Anthem BlueCross
P.O. Box 4330, Woodland Hills, CA 91365

July 30, 2015

IMPORTANT NOTICE: Physical and occupational therapy utilization management program begins November 1, 2015

Dear Participating Provider:

To assist in the management of chronic and permanent musculoskeletal conditions , effective November 1, 2015, Anthem Blue Cross ("Anthem") will implement a new prior authorization program for outpatient physical and occupational therapy services, subject to Department of Managed Health Care approval.

We have selected OrthoNet, LLC, a musculoskeletal management company, to administer this program. OrthoNet has experience in promoting best practices and evidence-based health care, while working with physical and occupational therapists as well as other providers of therapy services and their patients.

The program consists of a utilization management program in which outpatient physical and occupational therapy services will require prior authorization through OrthoNet following the initial evaluation. The rendering therapy provider/facility should contact OrthoNet since they will have the clinical details and information needed for the review.

OrthoNet will be using Anthem's physical and occupational therapy clinical UM guidelines (CG-REHAB-04, CG-REHAB-05) and OrthoNet's proprietary guidelines for medical necessity review. All of Anthem's Medical Policies and Clinical UM Guidelines may be accessed on Anthem's Web site at www.anthem.com/ca. OrthoNet will provide their guidelines used in determinations upon request.

Enclosed with this letter is a Fact Sheet which contains information on the program, specifics on the health benefit plans covered under the program, and the services involved. Claim submission and member benefit/eligibility verification processes will not change as a result of the new pre-authorization program. Continue to submit claims for these services to us. For benefits and eligibility verification utilize our self-service tools or contact Provider Customer Service.
Thank you for your support of this program and continued service to our members.

Sincerely,

Steven Scott
Vice President & Chief Operating Officer
California Commercial Business
Anthem Blue Cross

Anthem BlueCross

Outpatient Physical and Occupational Therapy Services Program Fact Sheet

Contact OrthoNet at 844-282-6994 before providing physical and occupational therapy services for Anthem Blue Cross members.
Note: the *initial evaluation* does not require pre-authorization.

- Effective November 1, 2015, Anthem Blue Cross (Anthem) will implement pre-authorization requirements for outpatient physical and occupational therapy services for certain health benefit plans in California. As more fully described below, OrthoNet will perform utilization review for these services. The initial evaluation does not require utilization review. In addition, providers are not required to obtain pre-authorization for members already in a course of treatment for services that are scheduled prior to November 1, 2015 for dates of service between November 1 and December 1, 2015.

- **Utilization Review:** Pre-authorization will be required for outpatient physical and occupational therapy services for Anthem members *except* for the following health benefit plans:

  - The following health benefit plans are ***excluded*** from the pre-authorization requirement for physical and occupational therapy services: Medicare Advantage, Medicaid, Medicare supplement, Medicare Part D, Federal Employee Program® (FEP®), and BlueCard.

- Beginning October 6, 2015, the OrthoNet call center will be available at **1-844-282-6994** to assist in processing pre-authorization requests for physical and occupational therapy services. The OrthoNet call center number will not be active prior to October 6, 2015. Providers must contact OrthoNet to determine the utilization review requirements for all Anthem members. OrthoNet will issue a pre-authorization number as applicable.

- Providers should submit requests for therapy visits using the *OrthoNet Therapy Request Form* available on OrthoNet's website at www.orthonet-online.com. Beginning October 6, 2015, please fax the completed form along with supporting clinical information to OrthoNet's Medical ~~Management Automated Fax Request line at 1-844-216-1599. The OrthoNet call center number will~~ not be active prior to October 6, 2015. The supporting clinical information may be supplied on OrthoNet's *PT/OT Initial Report Form, Functional Progress Chart*, or using your own forms or clinical notes that would supply the same information.

- OrthoNet will review the request and its supporting clinical data, verify member eligibility and benefits, and assign an authorization number or notification number as appropriate. Providers will be notified via fax of the authorization number and the number of visits approved (utilization review). Information about the status of the authorization request, approvals and number of visits approved will also be available on www.orthonet-online.com. *Please note: An authorization number is not a*

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guarantee of payment. Compensation is based on your agreement with Anthem and the terms of the member's health plan.

- In order for OrthoNet to promptly respond to your request, current objective clinical data needs to be supplied. Examples of this include, but are not limited to: strength, active range of motion, functional status, short and long term treatment goals, and a treatment plan. This information may be supplied on OrthoNet's PT/OT Initial Report Form, Functional Progress Chart, or on your own forms that would supply the same information.

- Anthem will handle all utilization management appeals.

- Anthem will continue to process all claims related to outpatient physical and occupational therapy services, and provide member benefit and eligibility information.

- Modifier GP must be appended to all physical therapy services and modifier GO must be appended to all occupational therapy services when submitting claims for services delivered under an outpatient occupational or physical therapy plan of care on a CMS-1500 form. If the applicable modifier is not appended to services delivered under an outpatient occupational or physical therapy plan of care, the claim will be denied.

- Services rendered as part of **emergency room** services or in the hospital **inpatient** setting, or in an **urgent care** setting at the time of the urgent care visit, are not subject to any utilization review program requirements. However, if a member receiving care in these settings is referred for physical or occupational therapy services at a future date, those therapy services are subject to any applicable program requirements.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C5-19-16
Baltimore, Maryland 21244-1850

JUL - 7 2015

Dear Medicare Provider:

On October 1, 2015, the United States transitions from ICD-9 to ICD-10 as the medical code set for medical diagnoses and inpatient hospital procedures. I am writing to remind you that while there is still time to get ready– and resources available to help you prepare – we are rapidly approaching the October 1 deadline. If you don't use a valid ICD-10 code starting on October 1, 2015, you will not be able to successfully bill for your services.

As a reminder, the International Classification of Diseases, or ICD, is used to standardize codes for medical conditions, diagnoses, and institutional procedures and has not been updated in this country for more than 35 years. The current code set, ICD-9, contains outdated, obsolete terms that are inconsistent with current medical practice. Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes will continue to be used for outpatient, ambulatory, and office-based procedure coding.

Starting on October 1, Medicare claims with a date of service on or after October 1, 2015 will only be accepted if they contain a valid ICD-10 code. The Medicare claims processing systems will not have the capability to accept ICD-9 codes for dates of service after September 30, 2015 or accept claims that contain both ICD-9 and ICD-10 codes.

We understand that moving to ICD-10 is a significant change, and CMS wants providers to be successful. In response to requests from the provider community, I directed CMS to release guidance that allows for additional flexibility in the claims auditing and quality reporting processes.

- For 12 months after ICD-10 implementation, Medicare review contractors **will not deny** physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015.

- For all quality reporting completed for program year 2015, Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) penalties during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes.

CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients if the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes).

- CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.

- CMS will name an **ICD-10 Ombudsman** to help receive and triage physician and provider issues.

The complete guidance can be found on the CMS website at www.cms.gov/ICD10.

If you are not yet ready for the transition to ICD-10, there is still time and CMS is ready to help. CMS's free help includes tools to help you succeed in preparing yourself and your office for ICD-10. To jumpstart your efforts, begin with the new **ICD-10 Quick Start Guide**. It, along with many other resources, is available at the CMS website at www.cms.gov/icd10. This summer, I urge you to take advantage of these tools.

Another valuable resource available on the CMS website is the "Road to 10," which is specifically geared toward addressing the needs of small physician practices, but is helpful for other provider types as well. The "Road to 10" includes primers for clinical documentation, clinical scenarios, and other specialty-specific resources to help with implementation. CMS has also released provider training videos that offer helpful ICD-10 implementation tips.

In addition to what CMS provides, health insurance plans, medical societies, coding organizations, and trade associations offer many free resources to expedite your ICD-10 transition.

As we work to modernize our nation's health care infrastructure, the coming implementation of ICD-10 will set the stage for improved patient care and public health surveillance across the country, leading to better identification of illnesses and earlier warning signs of epidemics and pandemics, such as Ebola. Over time, ICD-10 will improve coordination of a patient's care across providers, advance public health research and emergency response through detection of disease and adverse drug events, support innovative payment models that drive quality of care, and enhance fraud detection efforts.

Our nation's health care community has invested deeply in preparing for this transition. We've seen unprecedented cooperation across stakeholders, as providers, health plans, and vendors have worked together toward a smooth transition. I encourage you to get ready and continue in this spirit of cooperation as we complete the switch to ICD-10 – and beyond.

Sincerely,

Andrew M. Slavitt
Acting Administrator