December 2018 Anthem Missouri Provider Newsletter

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Anthem Accepts Electronic Prior Authorization Requests for Prescription Medications Online

Anthem accepts electronic medication prior authorization (ePA) requests for commercial health plans through covermymeds.com. This feature reduces processing time and helps determine coverage quicker. Some prescriptions are even approved in real time so that your patients can fill a prescription without delay. For example, medications such as celecoxib (Celebrex®), ezetimibe (Zetia®), fluocinolone acetonide (Synalar®), Victoza®, and long acting opioids are automatically approved when a member meets step therapy and/or clinical criteria (as applicable).

Electronic ePA offers many benefits:

- More efficient review process
- Ability to identify if a prior authorization is required
- Able to see consolidated view of ePA submissions in real time
- Faster turnaround times
- A renewal program that allows for improved continuity of care for members with maintenance medications
- Prior authorizations are preloaded for the provider before the expiration date.

Providers can submit ePA requests by logging in at covermymeds.com. Creating an account is FREE. For questions, please contact the provider service number on the member ID card.

Introducing the New Clinical Criteria Page for Injectable, Infused or Implanted Drugs

Beginning in January 2019, providers will be able to visit the Clinical Criteria tab of the Pharmacy Information page to review clinical criteria for all injectable, infused or implanted prescription drugs.

Injectable oncology medical specialty drug clinical criteria will be located on the new site at a later date in 2019.

Pharmacy Information Available at anthem.com

Visit anthem.com/pharmacyinformation for more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other

management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs.

The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate "*Marketplace, select Formulary*" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List." This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org, then select *Pharmacy Benefits*. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the Specialty Drug List or call us at 888-346-3731 for more information.

Anthem Streamlines Member ID Cards - Use Availity to Verify Members' Cost Shares and Benefits at Time of Service

In the June edition of our Network Update provider newsletter, Anthem Blue Cross and Blue Shield announced the introduction of a streamlined member identification (ID) card coming July 1, 2018, to help reduce confusion about members' cost shares. The updated member ID cards maintain the current style, but **specific cost share information (such as copayments, deductibles and coinsurance) will be absent from cards.** In addition, there may be alpha-numeric prefix and other changes to members' ID cards, so please check members' ID cards carefully. The new simpler and easier to read ID cards are available to groups over time as they renew coverage with Anthem.

Use Availity and EDI to verify eligibility, members' cost shares and benefits at time of service. Since the cost share information will no longer display on many of our ID cards, we urge providers to access **Availity** (our secure Web-based provider tool) and the **EDI** (Electronic Data Interchange) to verify member benefits and eligibility to obtain the most up-to-date cost share information in order to collect the applicable deductibles and coinsurance amounts at the time of service as appropriate. If a member presents an older ID card with outdated benefits at the provider office, it can create confusion about the member's cost share.

As always, please request that a member enrolled in our health benefit plans present their most current ID cards at the time of service. When filing claims to Anthem, enter the member's ID numbers exactly as the numbers appear on the card, including the alpha-numeric prefix, to help speed claims processing and reimbursement.

As the streamlined ID cards are adopted over time, it will help reduce misunderstandings around cost shares since real-time information is readily available via Availity about members' benefits and cost shares. Additionally, members will be encouraged to learn more about their benefits through Anthem's digital and online tools. Members can retain their cards for as long as they remain in the same product plan, regardless of changes to cost share information.

Electronic ID cards
As a reminder, members can now view, download, email, and fax an electronic version of their member ID cards using the Anthem Anywhere mobile app. And because our electronic ID cards look just like our physical ID cards, members can show either an electronic or physical ID card when obtaining services. Anthem member ID cards are also available through the Availity portal.

For questions, contact the provider service number on the back of members' ID cards.

Please note, this notice does NOT apply to National Accounts, the Federal Employee Program® (FEP), Medicaid or Medicare plans.

Availity to Serve as EDI Entry Point for Electronic Submissions

Anthem has designated Availity to operate and serve as your electronic data interchange (EDI) entry point or also called the EDI Gateway. The EDI Gateway is a **no-cost option** to our direct trading partners. With this change, Anthem continues our efforts to ensure consistency between your provider portal and the EDI Gateway.

As a mandatory requirement, all trading partners who currently submit directly to the Anthem EDI Gateway must transition to the Availity EDI Gateway. Availity is well known as a Web portal and claims clearinghouse. In addition, Availity functions as an EDI Gateway for multiple payers and is the single EDI connection for our company.

Your organization can submit and receive the following electronic transactions through Availity's EDI Gateway**:**

- 837- Institutional Claims
- 837- Professional Claims
- 837- Dental Claims
- 835 - Electronic Remittance Advice
- 276/277- Claim Status
- 270/271- Eligibility Request

If you wish to become a direct a trading partner with Availity, the setup is easy. Use the Availity Welcome Application to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions.

If you prefer to use your clearinghouse or billing company, please work with them to ensure connectivity.

Need Assistance?
The Availity Quick Start Guide will assist you with any EDI connection questions you may have.

835 Electronic Remittance Advice (ERA)
Effective June 1, 2018, please use Availity to register and manage account changes for ERA. If you were previously registered to receive ERA, you must register using Availity to manage account changes.

Electronic Funds Transfer (EFT)
To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™ enrollment tool, a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes. No other action is needed.

Contacting Availity
If you have any questions, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. ET.

Anthem to Enhance Claim Edits for Outpatient Facility Claims

Beginning in April 2019, Anthem will enhance its claims editing systems to include outpatient facility editing. These edits will:

- Help ensure correct coding and billing practices are being followed
- Help ensure compliance with industry standards such as Centers for Medicare & Medicaid Services (CMS), American Medical Association (AMA), National Uniform Billing Committee (NUBC), and national specialty and academy guidelines
- Reinforce compliance with standard code edits and rules (i.e., CPT, HCPC, ICD-10,

NUBC)

Anthem Works to Simplify Payment Recovery Process for National Accounts Membership

In our company's ongoing efforts to streamline and simplify our payment recovery process, we continue to consolidate our internal systems and will begin transitioning our National Accounts membership to a central system in 2019. While this is not a new process, we are transitioning the National Accounts membership to align with the payment recovery process across our other lines of business.

Currently, our recovery process for National Accounts membership is reflected in the EDI PLB segment on the electronic remittance advice (835). This segment will show the negative balance associated with the member account number. Monetary amounts are displayed at the time of the recovery adjustment.

As National Accounts membership transitions to the new system and claims are adjusted for recovery, the negative balances due to recovery are held for 49 days to allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remits ***only*** within the "Deferred Negative Balance" sections.

After 49 days, the negative balances due are reflected within the 835 as a corrected and reversed claim in PLB segments.

If you have any questions or concerns, please contact the E-Solutions Service Desk toll free at (800) 470-9630.

HEDIS® 2018 Commercial Results Are In

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) commercial data collection project for 2018. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS® scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS® results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS® project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate the HEDIS® process improvement by:

- Responding to our requests for medical records within five days, if possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient's medical record

Further information regarding documentation guidelines and administrative codes can be found on the HEDIS® page of our Provider Portal.

In addition, more information on HEDIS® can be found by visiting the provider portal at: *www.anthem.com > Provider > Choose State > Find Resources for your state > Health & Wellness (top menu) > Quality Improvement and Standards > HEDIS Information*. You will find reference documents entitled "HEDIS 101 for Providers" and "HEDIS Physician Documentation Guidelines and Administrative Codes".

To view the **HEDIS 2018 COMMERCIAL HMO and PPO Report**, click here.

Now is the time to review your patient's records to ensure that they have received their preventative care and/or immunizations before the end of the year.

Again, we thank you and your staff for demonstrating teamwork as we work together to improve the health of our members and your patients. We look forward to working with you again next HEDIS season.

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

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem is available to offer assistance in these difficult moments with our **Case Management Program**. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience

and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

To contact Case Management:

Commercial
Email: centregcmref@anthem.com
Phone: 1-888-662-0939 / 866-534-4348
Business Hours: Monday - Friday, 8:00 am - 7:00 pm CT

Federal Employee Program (FEP)
Phone: 1-800-711-2225
Business Hours: Monday - Friday, 8:00 am - 7:00 pm ET

ConditionCare Program Benefits Patients and Physicians

Anthem members have additional resources available to help them better manage chronic conditions.

The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of registered nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor’s orders and how to become a better self-manager of their condition.

Engagement methods vary by the individual’s risk level but can include:

- **Education** about their condition through mailings, email newsletters, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Care Managers and other health professionals.

Physician benefits:

- **Save time** by answering patients' general health questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient's progress in the program.

Please visit ***anthem.com/provider*** > *select Missouri* > *Find Resources for Missouri* > *Health & Wellness*, and select ***Condition Care*** to find more information about the program such as program guidelines, educational materials and other resources.

Also available is the Care Management Program Referral Form to be used to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call **1-877-681-6694**.
Our nurses are available Monday through Friday, 8:00 am to 9:00 pm, and Saturday, 9:00 am to 5:30 pm. CT

Integrated Care Model for Plans Purchased on the Health Insurance Marketplace Benefits Patients and Physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the Exchange) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the

physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Members or caregivers can refer themselves or family members using the information below.

To contact Case Management:
Email: centregcmref@anthem.com
Phone: 1-888-662-0939 / 866-534-4348
Business Hours: Monday - Friday, 8:00 am - 7:00 pm CT

Coordination of Care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:
1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available on the Provider website including a Coordination of Care template and cover letters for both

Behavioral Health and other Healthcare Practitioners. Access to the forms and cover letters are available at *anthem.com/providers* > select *your state* > *Find Resources for your state* > then select *Answers@Anthem*.

In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information. Access to the Toolkit is available at *anthem.com/providers* > select *your state* > *Find Resources for your state* > then select *Health and Wellness.*

Important Information about Utilization Management

Our utilization management (UM) decisions are based on written criteria, the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem's medical policies are available on Anthem's website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us at the toll-free numbers listed below. UM criteria are also available on the web. Just select "Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements" from the Provider home page at anthem.com.

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll free from 8:30 am - 5:00 pm, Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 am - 7:00 pm ET.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The phone numbers below are for physicians and their staffs. Members should call the member service number on their health plan ID card.

Our utilization management associates identify themselves to all callers by first name, title

and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

	To discuss UM Process and Authorizations	**To Discuss Peer-to-Peer UM Denials w/Physicians**	**To Request UM Criteria**
IN	1-800-345-4348, 1-877-814-4803 *Behavioral Health:* 1-866-582-2293 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-888 870 9342	1-877-814-4803
KY	1-800-568-0075 *KEHP:* 1-844-402-5347 *Behavioral Health:* 1-866-582-2293 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-877-814-4803	1-877-814-4803
MO	1-800-992-5498, 1-866-398-1922 *Behavioral Health:* 1-866-302-1015 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-800-992-5498, 1-866-398-1922 *CDHP/Lumenos:* 1-866-398-1922	1-800-992-5498, 1-866-398-1922
OH	1-800-752-1182 *Behavioral Health:* 1-866-582-2293 *Transplant:* 1-800-824-0581 *Autism:* 844-269-0538	1-877-814-4803	1-877-814-4803
WI	1-800-242-1527, 1-800-472-6909, 1-800-472-8909, 1-866-643-7087 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-800-242-1527, 1-800-472-6909, 1-866-643-7087	1-800-242-1527, 1-800-472-6909
FEP/ Nat'l	*FEP:* 1-800-860-2156 *Fax:* 1-800 732-8318 (UM) *Fax:* 1-877 606-3807 (ABD)	*FEP:* 1-800-860-2156 *Nat'l:* 1-800-821-1453	*FEP:* 1-800-860-2156 *Fax:* 1-800 732-8318 (UM) *Fax:* 1-877 606-3807 (ABD)

TTY Information

		TTY	**Voice**
IN	711 or	1-800-743-3333 (V/T)	1-800-743-3333 (V/T)
KY	711 or	1-800-648-6056 (T/ASCII)	1-800-648-6057 (V)
MO	711 or	1-800-735-2966 (TTY/ASCII)	1-866-735-2460 (V)
OH	711 or	1-800-750-0750 (V/T)	1-800-750-0750 (V/T)
WI	711 or	1-800-947-3529 (T)	1-800-947-6644 (V)

For language assistance, members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.

Members' Rights and Responsibilities

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem Blue Cross and Blue Shield has adopted a Members' Rights and Responsibilities statement. It can be found on our website. To access, go to the "Provider" home page at *anthem.com* > *Provider* > select your state > *Find Resources for* your state > then *Health & Wellness* > *Quality Improvement Standards* > *Member Rights & Responsibilities*.

Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

Vaginal Birth after Cesarean (VBAC) Certified Shared Decision Making Aid Available on the Web

As part of our commitment to provide you with the latest clinical information, we have posted a VBAC shared decision making aid to our provider portal. This is a tool for you to discuss with your patients to aid in making a decision regarding their treatment options. This has been reviewed and certified by the Washington Health Care Authority (HCA) and is available on our website. To access the aid, go to anthem.com and select *Provider* >select *your state* > choose *Find Resources in your state* > then select *Health & Wellness* > *Practice Guidelines* > then **Shared Decision Making Aid**.

Restructure of AIM Advanced Imaging Clinical Appropriateness Guidelines

AIM advanced imaging clinical appropriateness guidelines have been restructured to improve usability and to further link clinical criteria with supporting evidence. These structural enhancements resulted in no changes to existing clinical criteria or content.

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's *ProviderPortal*SM directly at providerportal.com. Online access is available

24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday - Friday, 8:30 am - 7:00 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, visit the AIM Specialty Health website to access and download a copy of the current guidelines.

Update to AIM Clinical Appropriateness Guidelines

Effective for dates of service on and after March 9, 2019, the following updates will apply to all of AIM's Clinical Appropriateness Guidelines, including Advanced Imaging, Cardiac, Sleep, Radiation Oncology and Musculoskeletal guidelines.

Clinical Appropriateness Framework
Replacing pretest requirements, this section will more accurately describe the guideline's purpose, which is to provide a summary of the fundamental components of a decision to pursue diagnostic testing. In order to support the full spectrum of AIM solutions, the terms "imaging request" or "diagnostic imaging" are replaced with "diagnostic or therapeutic intervention".

Ordering of Multiple Diagnostic or Therapeutic Interventions
Replacing ordering of multiple studies, this section expands its applicability to AIM solutions outside of diagnostic imaging. Terminology specific to imaging studies is replaced with the term "diagnostic or therapeutic intervention" to reflect a broader application of the principles included here.

Repeat Diagnostic Testing and Repeat Therapeutic Intervention
Replacing repeated imaging, these sections establish conditions in which duplication of the initial test or intervention may be warranted, and where such requests will require peer-to-peer discussion.

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's *ProviderPortal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.

- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday - Friday, 8:30 am - 7:00 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, visit the AIM Specialty Health website to access and download a copy of the current guidelines.

Updates to AIM Musculoskeletal Surgery Clinical Appropriateness Guidelines

Beginning with dates of review on and after January 1, 2019, the following updates will apply to AIM **Musculoskeletal Spine Surgery** Clinical Appropriateness Guidelines as indicated by section below:

- Cervical Decompression with or without Fusion
  - Added criteria for the appropriate use of laminectomy for cordotomy and biopsy, excision, or evacuation
  - Added indications for non-traumatic atlantoaxial instability
- Lumbar Laminectomy
  - Added criteria for the appropriate use of laminectomy for biopsy, excision, or evacuation
  - Added indication of Dorsal Rhizotomy

Beginning with dates of review on and after January 1, 2019, the following updates will apply to AIM **Musculoskeletal Interventional Pain Management** Clinical Appropriateness Guidelines as indicated by section below:

- Paravertebral Facet Injection/Nerve Block/Neurolysis
  - Exclusions: Radiofrequency neurolysis for sacroiliac (SI) joint pain is considered not medically necessary

These services or procedures were previously reviewed by Anthem, but will now be reviewed by AIM as part of the Musculoskeletal program. Visit the AIM Specialty Health website to view the CPT codes and access and download a copy of the current guidelines.

Ordering and servicing providers may submit prior authorization requests to AIM in one of the following ways:

- Access AIM ***Provider****Portal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday - Friday, 8:30 am - 7:00 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

Interactive Care Reviewer (ICR) New Features

Interactive Care Reviewer (ICR), Anthem's online authorization tool, is adding a new feature to further increase the efficiency of your authorization process. In mid-December, you can begin using ICR to request a clinical appeal for denied authorizations and check the status of a clinical appeal. This feature is available for authorization requests submitted through ICR, phone or fax.

Requesting a clinical appeal is easy:
Log on to ICR from the Availity Portal and locate the case using one of the search options, or from your ICR dashboard.

- Select the **Request Tracking ID** link to open the case. If the case is eligible for an appeal you will see the **Request Appeal** menu option on the **Case Overview** screen.
- Select **Request Appeal** to open the **Appeal Details** screen and complete the required fields on the appeal template. (You also have the option of uploading attachments and images to support your request.)
- Select Submit

Take the steps below to check the status of a clinical appeal:
Logon to ICR from the Availity Portal

- Select **Check Appeal Status** from the ICR top menu bar
- Type the **Appeal Case ID** and **Member ID** in the allocated fields
- Select **Submit**

The appeal status and detail of the decision will open on the bottom of the screen.

Need more information on how to navigate the new ICR Appeals feature?
Download the *ICR Clinical Appeals Reference Guide* located on the Availity Portal. Select: *Payer Spaces > Applications > Education and Reference Center > Communication and Education*. Find the link to the reference guide below the ICR menu.

Additional Training:
If you are new to ICR or want to get a refresher please attend our monthly ICR webinar. The next event is taking place on December 6 at 1:00 pm ET. **Register Here**

Bundled Services and Supplies (Professional)

Beginning with dates of service on or after March 1, 2019, Anthem will apply our always bundled edit to HCPCS code G0453 (Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)). For more information, review Section 1 of the policy dated March 1, 2019, along with the Bundled Services and Supplies Section 1 Coding list, on anthem.com/provider. To access the guidelines, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Reimbursement for Convenience Surgical Supply Kits: Professional

Anthem periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our members' benefit plans. Some providers are submitting claims for point-of-use convenience kits that are used in the administration of injectable medicines or other office procedures. These prepackaged kits contain not only the injectable medicine, but also non-drug components including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

Typically, the cost of a convenience kit exceeds the cost of its components when purchased individually. As a reminder, non-drug components included in the kits are inclusive of the practice expense for the procedure performed for which no additional compensation is available to the provider.

Please refer to Anthem's Global Surgery and/or Bundled Services and Supplies Reimbursement Policies located at anthem.com for additional information.

Clinical practice and preventive health guidelines available on anthem.com

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health and preventive health guidelines, which are 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 recent medical research.

All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website at anthem.com/provider. To access the guidelines, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Medical Polices and Clinical Guidelines Updates - December 2018

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were reviewed on September 13, 2018 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Below is a new Medical Policy effective March 1, 2019:

New Medical Policy	Effective March 1, 2019
MED.00125 Biofeedback and Neurofeedback	• Outlines the MN and INV&NMN indications for biofeedback and neurofeedback. Existing CPT codes 90875, 90876, 90901, 90911 will be reviewed for MN (medical necessity) criteria; HCPCS device code E0746 considered INV&NMN (Investigational and Not Medically necessary)

The below current Clinical Guidelines and/or Medical policies were reviewed and updates were approved.

Below are Medical Policy updates effective March 1, 2019:
requires precertification

Medical Policy Updates	Effective March 1, 2019

CG-ADMIN-02 Clinically Equivalent Cost Effective Services – Targeted Immune Modulators	• Added cost effective agent language for Cimzia to the Clinically Equivalent Cost Effective Services (CECE) for Crohn’s Disease or Ulcerative Colitis section • Added off-label indications for Remicade in immune checkpoint inhibitor-related toxicities to Table section • Added off-label indications for Actemra in chronic antibody mediated rejection (cAMR) in renal transplantation to Table section
*CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring	Revised title • Revision to the ambulatory EEG MN statement to include with or without video monitoring • Revision to NMN statement of ambulatory EEG by adding “Antiepileptic drug treatment withdrawal or modification in individuals because the risk of seizure precipitation would require immediate medical intervention” • Revision to the MN statement for attended EEG video monitoring in a healthcare facility by adding “withdrawal”
LAB.00030 Measurement of Serum Concentrations of Monoclonal Antibody Drugs and Antibodies to Monoclonal Antibody Drugs	Revised title • Expanded scope of policy to address all monoclonal antibody drugs • Revised position statement to state: "The measurement of serum concentrations of either of the following is considered investigational and not medically necessary under all circumstances: A. Monoclonal antibody drugs, including but not limited to tumor necrosis factor antagonist drugs; or B. Antibodies to monoclonal antibody drugs, including but not limited to tumor necrosis factor antagonist drugs
SURG.00011 Allogeneic, Xenographic, Synthetic, and Composite Products for Wound Healing and Soft Tissue Grafting	• Added several products to the INV&NMN section. Added existing codes 65778, 65779, 65780, V2790 for ocular indications, considered INV&NMN (investigational and not medically necessary)

*SURG.00103 Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	• Added iStent inject Trabecular Micro-Bypass System as MN when criteria met • Revised INV&NMN to include iStent inject Trabecular Micro-Bypass System for all indications not listed as MN • Revised MN and INV&NMN statements as a result of manufacturer's voluntary removal of the CyPass System from the market CPT Category III code 0474T (CyPass) changed to INV&NMN

Below are Coding updates effective March 1, 2019:

Coding Updates	Effective March 1, 2019
GENE.00016 Gene Expression Profiling for Colorectal Cancer	Added CPT code 0069U expression profiling test considered INV&NMN
GENE.00010 Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	Added CPT codes 0070U-0076U for CYP2D6 testing replacing 0028U (MN criteria); added pain panel 0078U considered INV&NMN
LAB.00029 Rupture of Membranes (ROM) Testing in Pregnancy	Added CPT code 0066U considered INV&NMN
MED.00111 Added HCPCS code C9750 considered INV&NMN	Added HCPCS code C9750 considered INV&NMN

View reimbursement policies online at anthem.com

To find Anthem’s professional and facility reimbursement policies online, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Reimbursement Policy Updates - December 2018

“Rule of Eight” Reporting Guidelines for Physical Medicine and Rehabilitation Services – Professional

Please note: We have updated the title of our *“Rule of Eight” Reporting Guidelines for Physical Medicine and Rehabilitation Services* reimbursement policy to *Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation Services.*

System updates for 2019 – Professional

As a reminder, our claim editing software will be updated monthly throughout 2019 with the most common updates occurring in quarterly in February, May, August and November of 2019. These updates will:

- reflect the addition of new, and revised codes (e.g. CPT, HCPCS, ICD-10, modifiers) and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, frequency edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

Modifier 79 –Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period –Professional
This coding tip is based on recent findings for claims processed with modifier 79 during a postoperative period. *Current Procedural Terminology* (CPT®) specifically states modifier 79 should be reported by the same individual when reporting unrelated procedures or services during the postoperative period. For example, this modifier is used when a patient presents with a problem that is unrelated to a previous surgery (yet within the postoperative period) and requires additional services by the **same provider/individual**. When modifier 79 is appended for a different provider (e.g. Nurse Practitioner or Physician Assistant) during the postoperative period the claim line will deny.

In addition to modifier 79, modifiers 58 and 78 are also based on **Same Physician or Other Qualified Health Care Professional** as documented below:

- 58 – Staged/Related Procedure/Service by the Same Physician/Other Qualified Health Care Professional during the Postoperative Period.
- 78 – Unplanned Procedure/Service by Same Physician/Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure during the Postoperative Period.

Reimbursement Policy Update - Scope of License (Professional)

In the December 2017 edition of *Network Update,* we announced a new Scope of License Policy which states that we will not reimburse services performed by a provider that are outside their state license requirements. We are updating our editing systems to deny services deemed to be outside of a specific specialty’s scope of license.

For more information about this policy, select your state to visit the Reimbursement Policy page: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

2019 FEP Benefit information available online

To view the 2019 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org > *select Benefit Plans > Brochure & Forms.*

Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2019, including information on the new PPO product, Blue Focus, being offered to federal employees effective January, 1, 2019. For questions please contact FEP Customer Service at the number below for your state:

IN – 1-800-382-5520
KY – 1-800-456-3967
MO – 1-800-392-8043
OH – 1-800-451-7602
WI – 1-800-242-9635

Coordination of Benefits for an FEP® member

Anthem Blue Cross and Blue Shield values the relationship we have with our providers, and always look for opportunities to help expedite the claim processing. When a Federal Employee visits the provider office, obtaining the most current medical insurance information will help to establish the primary carrier, and will alleviate claim denials and support accurate billing. For questions please contact the Federal Employee Customer Service at the number below for your state:

IN – 1-800-382-5520
KY – 1-800-456-3967
MO – 1-800-392-8043
OH – 1-800-451-7602
WI – 1-800-242-9635

Benefit change for Infliximab for Federal Employee Program (FEP)

Beginning January 1, 2019, Blue Cross and Blue Shield Federal Employee Program® (FEP) benefit procedures will change for the autoimmune infusion drug infliximab (brand names Remicade, Inflectra, and Renflexis). Members currently receiving the drug may be covered under either pharmacy or medical benefits. However, members who receive a first infusion on or after January 1, 2019 can only receive the drug under medical benefits. Members who receive it under pharmacy benefits prior to January 1, 2019 will continue receiving it under

pharmacy benefits. If you have any questions please contact FEP Customer Service at the number below for your state:

IN – 1-800-382-5520
KY – 1-800-456-3967
MO – 1-800-392-8043
OH – 1-800-451-7602
WI – 1-800-242-9635

New Medicare Advantage provider service phone number beginning January 1, 2019

Effective January 1, 2019, Medicare providers will have toll free phone numbers specifically designated for their service inquiries. These new provider numbers will be listed separately on the back of the member ID cards and should be used beginning January 1, 2019. The associates answering your provider service calls are trained to answer your questions and resolve your issues as quickly as possible. To ensure you receive the most efficient service, please refrain from using the member services line and use only 1-844-421-5662 or the provider services phone number listed on the back of the member ID card for individual Medicare Advantage calls beginning January 1, 2019.

2019 Medicare Advantage individual benefits and formularies

Summary of benefits, evidence of coverage and formularies for 2019 individual Medicare Advantage plans will be available at anthem.com/medicareprovider. An overview of notable 2019 benefit changes also is available at Important Medicare Advantage Updates at anthem.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information.

CMS Medicare Preclusion List effective April 1, 2019

The U.S. Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage and Part D organizations, including Anthem, will implement a new initiative, the Preclusion List, to protect the integrity of the Medicare Trust Funds. Beginning April 1, 2019, Medicare Advantage and Part D organizations will deny payment for items and services furnished by providers that CMS has placed on the Preclusion List. For more information, visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

When and how to initiate Medicare Advantage reopenings

When a claim must be corrected beyond the initial claim timely filing limit of one year from the **date of service**, a normal adjustment bill is not allowed. Providers must use the reopening process to correct the error. To learn when and how to initiate reopenings and adjustments, check Important Medicare Advantage Updates at anthem.com/medicareprovider

Individual Medicare plans move compound drugs off formulary beginning January 1, 2019

Beginning January 1, 2019, Individual Medicare Advantage plans will move compounded drugs to non-formulary with the exception of home infusion drugs. Group-sponsored Medicare Advantage members will continue to have compounded drug coverage; these drugs will require prior authorization. Compounded home infusion drugs will continue to be covered for both Individual Medicare and group-sponsored members without prior authorizations. Members and/or providers can request a non-formulary exception for compounded drugs.

Medicare Part B drugs may include Step Therapy beginning January 1, 2019

CMS updated its guidance to allow Medicare Advantage plans the option of implementing step therapy for Part B drugs as part of a patient-centered care coordination program beginning January 1, 2019. The goal is to lower drug prices while maintaining access to covered services and drugs for beneficiaries. Anthem will implement step therapy edits to promote clinically appropriate and cost effective drug options for our members. A patient-centered care coordination program will be created to ensure member access to necessary drugs, provide medication reviews and reconciliations, educate members regarding their medications, encourage medication adherence, and provide incentives to members who complete care coordination programs.

Keep up with Medicare news

Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Medicare Advantage Reimbursement Policy October Provider Bulletin
- Prior authorization requirements for Part B drugs: Moxetumomab Pasudotox, Cemiplimab and Fulphila
- July Medicare Advantage reimbursement policy

- Submit PA medication requests electronically; new phone number for MA prescription PAs
- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective Jan. 1, 2019
- Inpatient Readmissions
- Submit PA medication requests electronically; new phone number for MA prescription prior authorizations effective Sept. 1