Anthem BlueCross BlueShield

Working together to improve the health of our members.

October 2017

Network Update

CENTRAL REGION

In this issue

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Network Update is produced bi-monthly by Anthem Blue Cross and Blue Shield's Marketing Communications Department.

anthem.com

CE1017
IN, KY, MO, OH, WI

Health Care Reform (including Health Insurance Exchange)

Updates and Notifications

Please be sure to check the Health Care Reform Updates and Notifications and Health Insurance Exchange sections of our website regularly for new updates on health care reform and Health Insurance Exchanges, at www.anthem.com>Tools for Providers (select state)>Health Care Reform/Health Insurance Exchange..

Sign up to receive immediate notification of new information.
Note that in addition to this newsletter and our website, we also use our email service, Network eUPDATE, to communicate new information. If you are not yet signed up to receive Network eUPDATEs, we encourage you to enroll now so you'll be sure to receive all information that we send about Exchanges. To sign up, visit anthem.com > Tools for providers (enter state)>Network eUPDATE.

Administrative Update

Important information about provider reimbursement penalties

Effective for dates of service beginning January 1, 2018 and after, Anthem will enforce its policy for handling late precertification for commercial claims. As a reminder, Anthem requires precertification prior to certain elective services in both the inpatient and outpatient settings. For an *emergency* admission, precertification is not required. However, you must notify us of the admission within the timeframe specified in the Provider Manual or as otherwise required by law. Failure to comply with these requirements can result in reimbursement penalties of 30% to providers and facilities. Additionally, enforcement of the policy will lead to greater consistency in our processes. Providers and facilities may not balance bill the member for any such reduction in payment.

Electronic member ID cards

Anthem has a mobile app called Anthem Anywhere that allows members to manage their benefits on their smart phones, including electronic copies of their ID cards. Anthem Anywhere mobile app allows members easy access to their ID card even when there is no internet connection.

Currently, members still receive hard copies of their ID cards, even if they utilize an electronic version. Starting in fall 2017, we will allow members the option to choose electronic cards only. If the member chooses this option, he/she will not receive a hard copy card. Members will continue to have the option of selecting a hard copy card if that is their preference.

We want to ensure a member's request for electronic ID card meets a provider's office needs. If presented with an electronic card, you may still obtain a copy of the ID card for your records.

Members who choose to use their mobile app will have the option to email or fax their ID Card from their phone, and providers can view (and print the card if needed) from the Availity Portal – NEW coming by January 1, 2018! Members are still required to have a copy of their card in one format or another, whether hard copy or electronic, in order for services to be rendered.

Anthem members who will have this option:

- Individual commercial members will have this option starting in fall 2017 for plans becoming effective on or after January 1, 2018. (This includes all plans on and off exchange.)
- Most Small Group members will have this option upon their group renewals starting in fall 2017 for plans becoming effective on or after January 1, 2018.
- Other membership including some Large Group, Federal Employee Program® (FEP®) and National Account members will have this option in late 2018.
- Further expansion to additional members is scheduled for 2019 and beyond.

See our *Electronic Member ID Cards – Quick Reference Guide* for more details and information on:

- Frequently Asked Questions
- Details on provider options for obtaining a copy of an electronic Member ID card
- Sample electronic Member ID cards

View our *Quick Reference Guide* online at anthem.com. Select Menu, and under the Support heading, select Providers. Choose your state from the drop down list, and Enter. From the Provider Home page, under the Self-Service and Support heading, select the link titled "Electronic Member ID Cards – Quick Reference Guide."

Visually enhanced member ID cards

Through recent market research and in an effort to further our continued commitment to our members, we will be introducing refreshed and visually enhanced member ID cards beginning in the fourth quarter of 2017. The redesigned ID card directs members' and providers' attention to key information by enhancing the data with the use of color; no new information was added to the ID card. The enhancements include:

- The field labelled 'Identification number' has been renamed 'member ID' for clarity, and the ID number is printed in blue for emphasis.
- Copays and other member specific information will be printed in blue.
- Member Service phone number has been enlarged and printed in blue.

Starting in September 2017, we will gradually issue the newly redesigned ID cards to members in new groups as well as those that renew with benefit changes. We will not perform a mass reissue of ID cards to our membership and, therefore, both the current ID card design and the new ID card design with blue accent will be present in the market.

Out-of-area medical record retrieval

Inovalon began sending medical records requests for out-of-area Blue Plan members in April 2017. Verscend will continue to send medical records requests through the end of 2017.

As a reminder, Verscend and Inovalon are the contracted vendors to gather medical records on behalf of Blue Cross and/or Blue Shield companies. Blue Plans utilize the vendors' services to retrieve medical records for non-Anthem Blue members or from providers in Anthem's Blue service area to support HEDIS®, risk adjustment and government required programs.

Both vendors are experienced health care analytics and services companies. They provide an efficient, centralized process, to coordinate medical record requests on behalf of Blue Cross and/or Blue Shield companies across the country and help reduce multiple requests for patient data.

As outlined in your contract, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Verscend in 2017 only and Inovalon beginning April 1, 2017, and later. Anthem is working diligently to ensure this process is followed.

Verscend and Inovalon are contractually bound to preserve the confidentiality of health plan members' protected health information (PHI) obtained from medical records, in accordance with HIPAA regulations. Please note that patient-authorized information releases are not required in order for you to comply with these requests for medical records.

Providers are permitted to disclose protected health information to health plans without authorization from the patient when both the provider and health plan had a relationship with the patient and the information relates to the relationship [45 CFR 164.506(c)(4)]. For more information regarding privacy rule language, please visit http://www.hhs.gov/ocr/privacy.

If you have any questions, please do not hesitate to call the Provider Service number on the back of the member's ID card.

New EDI edits for 837 Institutional claim diagnosis validation

Historically, Institutional claims diagnosis codes have been validated by the *Statement Through* date, regardless of whether the claim is Inpatient or Outpatient. Beginning August 18, 2017, a change occurred for Outpatient services diagnosis validation. The diagnosis codes are now validated using the *Statement From* date. This change did not impact the Inpatient services, they are still validated by the *Statement Through* date.

This change involves the following submitted diagnoses:

- Principal diagnosis
- Admitting diagnosis
- Patient reason for visit
- External cause of injury
- Other diagnosis.

If you have any questions, please contact your local E-Solution service desk at 800-470-9630.

MyAnthem portal to be retired December 2017

The MyAnthem provider portal is scheduled to be retired December 8, 2017. At that time, the Availity Portal (www.availity.com) will be your exclusive web portal for access to all Anthem electronic tools and resources.

As a reminder, here is some of the functionality available to you on the Availity Portal:

- Eligibility and Benefits
- Claims Status Inquiry
- Secure Messaging
- Remittance Advices
- Claims Submission
- Provider Online Reporting
- Fee Schedule
- Interactive Care Reviewer

- Education and Reference Center
- Online Provider Maintenance Form
- Patient 360
- Clear Claim Connection

If you would like more information on navigating in Availity, select Help & Training | My Learning Plan from the top navigation menu on the Availity home page to plot your learning journey. Availity also offers onboarding modules for new administrators and users. To locate these modules in the Availity Learning Center type "onboarding" in the search field.

For more information on Anthem features and navigation, select Payer Spaces| Applications| Education and Reference Center to find presentations and reference guides that can be used to educate provider staff on Anthem proprietary tools.

We encourage you to start using the Availity Portal today.

Use the Provider Maintenance Form to update your information

We continually update our provider directories to help ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice – updating address and/or phone number, adding or deleting a physician from your practice, closing your practice to new patients, etc. -- please notify us by completing the Anthem Provider Maintenance Form at anthem.com. Thank you for your help and continued efforts to keep our records up to date.

Federal Employee Plan (FEP)

Attention: Electronic claim submitters

Anthem values the relationship we have with our providers and are taking this opportunity to share important information on submitting necessary electronic claim data for re-submissions.

In an effort to reduce duplicate payments or claims rejecting for additional information, please review the following reminder on how to submit a Corrected CMS-1500 Claim Submission:

- Electronic claims need to contain the correct billing code to help identify when a claim is being submitted to correct or void a claim that has been previously processed.
    - Enter the Claim Frequency Type code (billing code) 7 for a replacement/correction (2300 CLM05-3).
    - Enter the Claim Frequency Type code (billing code) 8 to void a prior claim (2300 CLM05-3).
    - Complete box 22 (Resubmission code) to include a 7 (the "replace" billing code) to notify us of a corrected or replacement claim, or insert an 8 (the "void" billing code) to let us know you are voiding a previously submitted claim.
    - Enter the 'original' claim number as the Original Ref. No., or if that information is not available, enter the DCN (Document Control Number). (2300 REF02),

If you have any questions please contact E-Solutions by phone at (800) 470-9630 between 8 am – 4:30 pm ET, Monday – Friday, or by email: e-solutions.support@anthem.com

Health Care Management

Medical policy updates

The following Anthem medical policy was reviewed on August 3, 2017 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. This new policy will be implemented on January 1, 2018.

Policy Number	Policy Title and Description	Comments
LAB.00035	Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis	This document addresses the use of multi-biomarker disease activity (MBDA) blood testing that produces a score designed to assess rheumatoid arthritis (RA) disease activity.

The following revision to current medical policies or clinical guidelines will be implemented on January 1, 2018.

Policy Number	Policy Title and Description	Comments
SURG.00010	Treatments for Urinary Incontinence	MPTAC approved revision of policy which reflects the following: • Added ProACT™ adjustable continence therapy as INV&NMN. Existing HCPCS code C9746 (effective 07/01/17) for ProACT will be denied INV&NMN for all indications.

Specialty pharmacy updates

Prior authorization list

Effective for dates of service on and after January 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be included in our existing pre-service review process. Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM.

Medical Policy or Clinical Guideline	Code	Drug	Comments
DRUG.00058	J3490, J3590	Haegarda	New drug to existing policy
DRUG.00111	J3490, J3590	Tremfya	New drug policy

Level of care drug list

Effective for dates of service on and after January 1, 2018, the following specialty pharmacy code from new or current medical policies or clinical UM guidelines will be included in our existing level of care review process. Level of care review will be managed by AIM.

Medical Policy or Clinical Guideline	Code	Drug	Comments
CG-DRUG-64	Q5102	Renflexis	

Level of Care (Clinical Site of Care) drug list:
http://www.aimprovider.com/specialtyrx/pdf/ClinicalSiteofCareDrugList.pdf

View the level of care pre-service clinical review FAQs for more information.

AIM genetic testing expands to include additional health plans

Effective with dates of service on and after January 1, 2018, Anthem will expand the medical necessity review as a prior authorization of all genetic testing services to include Anthem's National Account and self-funded health plans with services medically managed by AIM. As a reminder, this program was effective for Anthem fully-insured members on July 1, 2017.

The medical policies and codes reviewed for Anthem plans managed by AIM include:

Medical Policy #	Medical Policy Title	Codes
GENE.00001	Genetic Testing for Cancer Susceptibility	81404, 81405, 81406, 81437, 81438, 81445, 81450, 81455, 81479, 0013U*, 0014U*
GENE.00002	Preimplantation Genetic Diagnosis Testing	89290, 89291
GENE.00003	Genetic Testing and Biochemical Markers for the Diagnosis of Alzheimer's Disease	81401, 81405, 81406, 83520, 84999, S3852
GENE.00004	Janus Kinase 2 (JAK2)V617F Gene Mutation Assay	81270, 81403
GENE.00005	BCR-ABL Mutation Analysis	81170, 81401
GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	81235, 88365
GENE.00007	Cardiac Ion Channel Genetic Testing	81406, 81413, 81414, 81404, 81405, 81406, 81407, 81408, S3861
GENE.00008	Analysis of Fecal DNA for Colorectal Cancer Screening	81528, 81479
GENE.00009	Gene-Based Tests for Screening, Detection and Management of Prostate Cancer	81313, 81479, 81599, 0005U
GENE.00010	Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	81225, 81479, 81381, 81226, 81400, 81401, 81227, 81350, 81355, G9143, 0015U*
GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	81519, 0008M, 81599, 84999, S3854, 0008M*
GENE.00012	Preconceptional or Prenatal Genetic Testing of a Parent or Prospective Parent	81200, 81209, 81220, 81221, 81222, 81223, 81224, 81241, 81242, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81260, 81290, 81330, 81401, 81412, S3841, S3842, S3844, S3845, S3846, S3849, S3853, 81403, 81404, 81405, 81406, S3800, 81479, 81415, 81416, 81417, 81425, 81426, 81427, 0012U*
GENE.00014	Analysis of KRAS Status	81275, 81276, 88363
GENE.00016	Gene Expression Profiling for Colorectal Cancer	81525, 81599, 84999
GENE.00017	Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)	81403, 81405, 81406, 81407, 81408, 81439, 81479, S3865, S3866
GENE.00018	Gene Expression Profiling for Cancers of Unknown Primary Site	81406, 81504, 81540, 81599

Medical Policy #	Medical Policy Title	Codes
GENE.00019	BRAF Mutation Analysis	81210, 88363, 81406
GENE.00020	Gene Expression Profile Tests for Multiple Myeloma	81479, 81599
GENE.00021	Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies	81228, 81229, S3870, 81405
GENE.00022	In Vitro Companion Diagnostic Devices	Specific coding does not apply
GENE.00023	Gene Expression Profiling of Melanomas	81599, 84999
GENE.00024	DNA-Based Testing for Adolescent Idiopathic Scoliosis	0004M
GENE.00025	Molecular Profiling for the Evaluation of Malignant Tumors	81425, 81445, 81450, 81455, 81479, 81599, 88363, 0013U*, 0014U*
GENE.00026	Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy	81507, 0009M, 81420, 81479, 81599, 81422
GENE.00027	The Panexia™ Test for Oncologic Indications	81406, 81479
GENE.00028	Genetic Testing for Colorectal Cancer Susceptibility	81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81317, 81318, 81319, 81403, 81435, 81436, 81201, 81202, 81203, 81401, 81406
GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	81162, 81211, 81212, 81213, 81214, 81215, 81216, 81217, 81432, 81433, 81445, 81455
GENE.00030	Genetic Testing for Endocrine Gland Cancer Susceptibility	81404, 81405, S3840, 81445, 81455, 81479
GENE.00031	Genetic Testing for PTEN Hamartoma Tumor Syndrome	81321, 81322, 81323
GENE.00032	Molecular Marker Evaluation of Thyroid Nodules	81545, 81599
GENE.00033	Genetic Testing for Inherited Peripheral Neuropathies	81324, 81325, 81326, 81403, 81404, 81405, 81406, 81440, 81479
GENE.00034	SensiGene® Fetal RhD Genotyping Test	81403
GENE.00035	Genetic Testing for TP53 Mutations (Li-Fraumeni Syndrome)	81404, 81405, 81445, 81455
GENE.00036	Genetic Testing for Hereditary Pancreatitis	81222, 81223, 81224, 81401, 81404, 81479
GENE.00037	Genetic Testing for Macular Degeneration	81401, 81405, 81408, 81479, 81599
GENE.00038	Genetic Testing for Statin-Induced Myopathy	81400
GENE.00039	Genetic Testing for Frontotemporal Dementia (FTD)	81406, 81479
GENE.00040	Genetic Testing for CHARGE Syndrome	81403, 81407
GENE.00041	Short Tandem Repeat Analysis for Specimen Provenance Testing	81479, 0007U*

Medical Policy #	Medical Policy Title	Codes
GENE.00042	Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome	81406
GENE.00043	Genetic Testing of an Individual's Genome for Inherited Diseases	81200, 81209, 81221, 81222, 81223, 81224, 81241, 81242, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81260, 81290, 81330, 81412, 81479, 81599, 81400, 81403, 81404, 81405, 81406, 81408, 81410, 81411, 81415, 81416, 81417, 81425, 81426, 81427, 81430, 81431, 81434, 81440, 81442, 81460, 81465, 81470, 81471, 81479, 81493, 81506, 81599, S3800, S3841, S3842, S3844, S3845, S3846, S3849, S3853, 0012U*
GENE.00044	Analysis of PIK3CA Status in Tumor Cells	81404
GENE.00045	Detection and Quantification of Tumor DNA Using Next Generation Sequencing in Lymphoid Cancers	81479, 81599
GENE.00046	Prothrombin G20210A (Factor II) Mutation Testing	81240
GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing	81291

*Review of 0007U, 0008M, 0012U, 0013U, 0014U and 0015U begins with AIM starting January 1, 2018.

Beginning January 1, 2018, please submit genetic testing prior authorization requests for these members to AIM using one of the following ways:

- Access AIM *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: 800-554-0580, Monday – Friday, 8:30 am – 7 pm ET.

To learn more about genetic testing prior authorization, visit aimprovider.com/genetictesting/. For questions regarding prior authorization requirements, please contact the provider service number on the back of the member ID card.

Please note, this program does not apply to the following plans: BlueCard® or Federal Employee Program® (FEP®).

CG-MED-53 will apply to cervical cancer screening and HPV testing

Effective January 1, 2018, the updated coverage guideline CG-MED-53 will apply to cervical cancer screening and human papillomavirus (HPV) testing.

- Cervical cancer screening with cytology, with or without HPV testing, for women under 21 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed (for example, organ transplant recipients or seropositive for the human immunodeficiency virus [HIV]).
- Cervical cancer screening with HPV testing, alone or in combination with cytology, for women younger than 30 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed.
- Cervical cancer screening with cytology with or without HPV testing, is considered medically necessary for women under 30 years of age who are chronically immunosuppressed.
- There is no change to the medical necessity criteria for cervical cancer screening with cytology without HPV testing for women ages 21 to 65 years.

This coverage guideline does not apply to Medicare Advantage and Medicare Supplement plans.

Pre-service clinical review of skilled nursing home health services

Effective with dates of service on and after January 1 2018, Anthem will review the skilled nursing home health services noted below for medical necessity. Medical necessity review will take place as a prior authorization and will apply to Anthem's fully insured health plans. You will be notified in advance of the expansion of this review to local self-funded groups at a later date. Ordering and servicing providers may submit prior authorization requests by contacting the phone number on the back of the member ID card.

Ohio providers: If you are currently participating with Anthem through a subcontracted relationship with a Network Administrator such as NorthCoast Health Care Management Services and/or Clinical Specialties Inc., please see the communications sent directly from your Network Administrator to understand what this means to you.

This program does not apply to the following plans: Medicare, Medicaid, National Accounts, and FEP.

CG-MED-23 is the clinical guideline that applies to home health services.

The following codes will be reviewed:

Revenue Code	Description
0550-0559	Skilled nursing (includes codes 0550, 0551, 0552, 0559)
0570-0579	Home health aide (includes codes 0570, 0571, 0572, 0579)
0580-0589	Home health, other visits (includes codes 0580, 0581, 0582, 0583, 0589)
0590-0599	Home health, units of service (includes codes 0590, 0599)
CPT/HCPS codes	**Description**
99600	Unlisted home visit service or procedure
S9122	Home health aide or certified nurse assistant, providing care in the home, per hour
S9123	Nursing care, in the home; by registered nurse, per hour.
S9124	Nursing care, in the home; by licensed practical nurse, per hour
T1001	Nursing assessment/evaluation
T1002	RN services, up to 15 minutes
T1003	LPN/LVN services, up to 15 minutes
T1004	Services of a qualified nursing aide, up to 15 minutes
T1021	Home health aide or certified nurse assistant, per visit
T1022	Contracted home health agency services, all services provided under contract, per day
T1030	Nursing care, in the home, by registered nurse, per diem
T1031	Nursing care, in the home, by licensed practical nurse, per diem

Ohio: Appropriate use of Emergency Room services

We know that providing tools and resources for our members is important to help them choose the most appropriate site for care. Our 24/7 Nurse Line and our Find A Doctor, Find Urgent Care and Estimate Your Cost tools all provide information to help members choose among physician offices, retail clinics, urgent care, and emergency rooms. Using the most appropriate site for care usually saves time and out-of-pocket costs.

In order to help minimize the effects of rising health care costs, Anthem has a policy based on the member's Certificate of Coverage that states that services for minor (non-emergency) conditions may not be covered when treated in the hospital emergency department – that such minor conditions may not be covered if more appropriate settings are available. The common symptoms that can be treated in less intensive settings can be found at www.anthem.com/findurgentcare. Per this policy, members who choose to receive non-emergency care in the ER could be responsible for the charges incurred. As a result, as of their group's renewal/effective date beginning January 1, 2018, if Ohio members choose to receive care for non-emergency ailments at the ER when a more appropriate setting is available, the claim may be reviewed and potentially denied.

We recognize our members' safety as well as the health care services they receive are decisions made between the health care provider and the patients. This flier reinforces the point and can be shared with our members.

We appreciate your partnership as we strive to ensure our members are seen in the most appropriate setting for their health care needs.

If you have questions, please contact your local Network Relations consultant.

Reminder: Hyaluron injections in the knee (CG-DRUG-29)

Clinical guideline CG-DRUG-29 addresses the use of intra-articular injections of hyaluronan. Effective for dates of service on and after December 1, 2017, intra-articular injections of hyaluronan are considered **not medically necessary** for the treatment of pain due to osteoarthritis of the knee and all other knee conditions.

The following codes will be subject to review under this clinical guideline:

Hyaluronic Acid	Euflexxa	J7323
Hyaluronic Acid	Gel-One	J7326
Hyaluronic Acid	Gel-Syn	J7328
Hyaluronic Acid	Genvisc	J7320
Hyaluronic Acid	Hyalgan	J7321
Hyaluronic Acid	Hymovis	J7322
Hyaluronic Acid	Monovisc	J7327
Hyaluronic Acid	Orthovisc	J7324
Hyaluronic Acid	Supartz	J7321
Hyaluronic Acid	Synvisc	J7325
Hyaluronic Acid	Synvisc-One	J7325

Please note: this initiative is not administered by AIM.

For questions, please contact the provider service number on the back of the member ID card.

Post-service reviews using AIM

Anthem uses AIM to administer pre-service clinical reviews for services noted below. AIM reviews requests in real time against evidence-based clinical guidelines and Anthem medical policy.

Effective January 1, 2018 providers will be notified via letter or remit message when claims are submitted without the appropriate pre-service review by AIM. As a result, providers will need to obtain a post-service clinical review for the service via the AIM *ProviderPortal*$_{SM}$.

To help prevent delays in claim processing and post-service reviews, ordering providers submit pre-service requests to AIM in one of the following ways:

- Access AIM *ProviderPortal*$_{SM}$ directly at www.providerportal.com, available 24/7 to process orders in real-time.
- Access AIM via the Availity Web Portal at www.availity.com.

As a reminder, AIM reviews the following services for clinical appropriateness:

- Advanced diagnostic imaging (e.g. CT, MRI/MRA)
- Cardiology tests and procedures (e.g. MPI, echocardiography, PCI, cardiac catheterization)
- Medical oncology treatments through the Cancer Care Quality Program
- Radiation oncology treatments (e.g. IMRT, brachytherapy)
- Sleep testing, treatment, and supplies
- Specialty pharmacy
- Genetic testing
- Musculoskeletal (e.g. spine and joint surgeries, pain management)

Services performed in an emergency or inpatient setting are excluded from AIM programs.

This update applies to local fully-insured Anthem members, with services medically managed by AIM. It does not apply to BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, Federal Employee Program® (FEP®), members who are covered under a self-insured (ASO) benefit plan.

For more information, please contact the phone number of the back of the member ID card.

Anthem adopts MCG Recovery Facility Care guidelines

Effective with dates of service on and after January 1, 2017, Anthem will transition from using the Anthem Clinical Guidelines CG-Rehab-09, CG-MED-31, and CG-MED-29 to using Milliman Care Guidelines (MCG) Recovery Facility Care guidelines for the review of prior authorization requests for inpatient rehabilitation and skilled nursing facility services. This change applies to commercial, FEP and National accounts. This change does not apply to Medicare or Medicaid plans at this time.

Providers should continue to call the phone number indicated on the back of the member ID card to request prior authorization review for these services. Additionally, you may initiate your request online using our Interactive Care Reviewer (ICR): Select Authorizations on the Availity Web Portal at www.availity.com.

For questions, please contact the provider service number on the back of the member ID card.

Medicare

PA required for new group-sponsored MA membership

Beginning Jan. 1, 2018, Anthem will expand the types of benefits available to new group-sponsored Medicare Advantage membership. Some services for these new group-sponsored Medicare Advantage (MA) members also will have new utilization management (UM) and prior authorization (PA) requirements.

Medicare Advantage members with alpha prefix ZDX and YGZ are group-sponsored Medicare Advantage members who are eligible for additional services and may require additional UM and PAs. Additional information is available at anthem.com/medicareprovider at Important Medicare Advantage Updates.

Current UM and PA requirements for group-sponsored Medicare Advantage membership will not change Jan. 1, 2018 for group-sponsored Medicare Advantage members with the following alpha prefixes: JQB, JQF, VGD, WSP, XDK, XKJ, YGJ, YLR, YLV, YRA and YRE.

Detailed PA requirements are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. As always, you may confirm member benefits via the Availity web portal or by calling the number on the back of the member ID card. Any updates regarding effective dates or other changes will be posted to Important Medicare Advantage Updates on anthem.com.

Liability assignment for eye refraction and self-administered drugs

Anthem would like to clarify liability assignment related to Statutorily Non-Covered Services of Eye Refraction (procedure code 92015) and Self-Administered Drug (procedure code A9270) when the service is denied on Medicare Advantage individual and group-sponsored claims.

For the liability assessment to be assigned appropriately, we require that the G modifier(s) be submitted on the claim form and the Notice of Denial of Medical Coverage letter be obtained prior to the service rendered. When the Notice of Denial of Medical Coverage letter is obtained, please submit both the GX and GY modifier on the claim.

This billing process is different from traditional Medicare, which only requires a GY modifier be appended to the procedure code.

The Centers for Medicare & Medicaid Services (CMS) considers Anthem Medicare Advantage contracted providers as plan “agents;” therefore related CMS regulations must be followed. Due to this, a GY modifier only submitted on the claim form will not ensure the correct liability assignment for the denied service. Please refer to the FAQ for Non-Covered Services at anthem.com/medicareprovider for additional details.

Improve MA member medication adherence

To help improve medication adherence among Anthem individual and group-sponsored Medicare Advantage members, Anthem will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. Ninety-day prescriptions help improve the adherence of our Medicare Advantage members by having them travel to their pharmacy less often. When medically appropriate, we request that you convert the member’s prescription to a 90-day supply to improve patient adherence and outcomes without compromising the quality of care. Please note that we do *not* intend to transfer these prescriptions to a mail-

order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.

Medicare Part D and Comprehensive Medication Reviews

CMS requires that plans with Medicare Part D benefits offer a Comprehensive Medication Review (CMR) as part of the Medication Therapy Management (MTM) program. A CMR is offered to members who have three or more chronic diseases and who are receiving eight or more maintenance medications. Anthem employs SinfoniaRx to contact our qualifying individual and group-sponsored Medicare Part D members to complete the interactive consultation. The CMR consists of a consultation followed by a written medication summary to help educate and support provider recommendations for medication adherence. Please ask these members if they have received a letter or postcard inviting them to participate in a Medication Review.

Include NPI on surgical procedure (UB04) bills

In October 2017 Anthem will edit for operating provider NPI when a surgical procedure code is billed for members having an individual Medicare Advantage or MMP plan. A surgical procedure code is a code within the range of 10021-69990 but excluding 10035, 10036, 15780-15783, 15786-15789, 15792, 15793, 20527, 20550-20553, 20555, 20612, 20615, 29581-29584, 36406, 36410, 36415, 36416, 44705, 47531, 47532, 50430, 50431, 59425, 59426, 59430, 62302-62305, 62320-62327, 62367-62370, 69209, 69210. When a surgical procedure code is billed the operating provider's NPI must be billed in box 77 on the facility UB04 CMS 1450 claim form for outpatient services. If a surgical procedure code is billed without an operating provider NPI the claim will be denied for missing NPI.

Reimbursement rates for critical access hospitals

Effective May 26, 2017, Anthem began using a rate database, sourced from CMS-published Medicare hospital cost reports, of CAH inpatient, swing bed and outpatient rates to price claims from non-contracted CAHs for individual Medicare Advantage and MMP members. Consequently, Anthem usually will not need a Medicare Administrative Contractor (MAC) rate letter to process claims from non-contracted CAHs for individual Medicare Advantage and MMP members. However, Anthem will require a MAC rate letter in the situations noted below. We look forward to handling your claims in a more-timely manner with this process change.

Anthem still will require a MAC rate letter or additional information from CAHs in the following situations.

- Non-contracted CAHs must submit a MAC rate letter for claims for Medicare Advantage group-sponsored members.
- Contracted CAHs compensated using Medicare rates must continue to submit MAC rate letters to their Anthem network managers as required by contract.
- All CAHs should update Anthem regarding a change in status in Method (from I to II or II to I). Note that Method II reimbursement applies to contracted CAHs only if specified in contract.

Network delegation for home health care services

Anthem will delegate its provider network for Home Health Care Services for most of our Medicare Advantage individual products to myNEXUS in 2018.

We want to ensure the transition is as seamless as possible for our members. If you are not currently contracted with myNEXUS and wish to continue providing home health care services to Anthem Medicare Advantage individual members and to stay current with delegation dates and learn more, visit the myNEXUS Contracting Homepage at https://www.mynexuscare.com/contracting/ Contact myNEXUS by email: contracting@mynexuscare.com or phone: (844) 411-9622).

Complete *OptiNet* assessments for out-of-state locations; drop-down menu changed

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM's online registration tool, *OptiNet*. *OptiNet* will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services. Areas of assessment include facility qualifications, technologist and physician qualifications, accreditation, equipment and technical registration. These data will be used to calculate modality scores for providers who render imaging services for our individual Medicare Advantage members. Some group-sponsored Medicare Advantage members will be included in this initiative beginning Jan. 1, 2018. Claims for group-sponsored Medicare Advantage membership with the alpha prefix ZDX and YGZ are included in this initiative. Other group-sponsored Medicare Advantage members with the following prefixes are not in scope for this policy update at this time: JQB, JQF, VGD, WSP, XDK, XKJ, YGJ, YLR, YLV, YRA and YRE. Please check Important Medicare Advantage Updates for updates.

Contracted providers who render services to Anthem Medicare Advantage members in other state counties that are contiguous to their home state (e.g. Contracted with Anthem WI rendering services in Lake county IIlinois) should complete the OptiNet registration. The OptiNet program has expanded to include these providers who render services in other state counties contiguous to their home state; these providers should register by Jan. 1, 2018.

All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

The provider registration is available online at www.providerportal.com. Please note that the drop down menu selection for participating Medicare Advantage providers has changed. Select Medicare Advantage/Medicaid from the drop down menu. This drop down is changing from Anthem MA.

If you have questions or need help completing the registration, please call AIM Customer Service at 800-252-2021 Monday-Friday 8 a.m. to 7 p.m. ET or send an email to Assessment@AIMSpecialtyHealth.com.

If you have already completed an *OptiNet* assessment, please ensure that you keep your registration up to date. Expiring data could lead to a negative impact in your modality scores.

Additional *OptiNet* information is available here.

IN, KY, OH, WI: Gift cards for diabetic retinal exams

To encourage individual and group-sponsored Medicare Advantage members to receive screening for diabetic retinal disease, eligible members in OH HMO, LPPO, RPPO and DSNP plans, WI LPPO plans and IN and KY RPPO plans will receive Visionary Rewards, an offer for a $50 VISA gift card for completing a retinal or dilated eye exam in 2017. The goal of the incentive is to improve HEDIS/Star measure (CDC-DRE) and improve member health outcomes while reducing cost of care through early detection and improving member satisfaction.

OH: New select MA network HMO for 2018

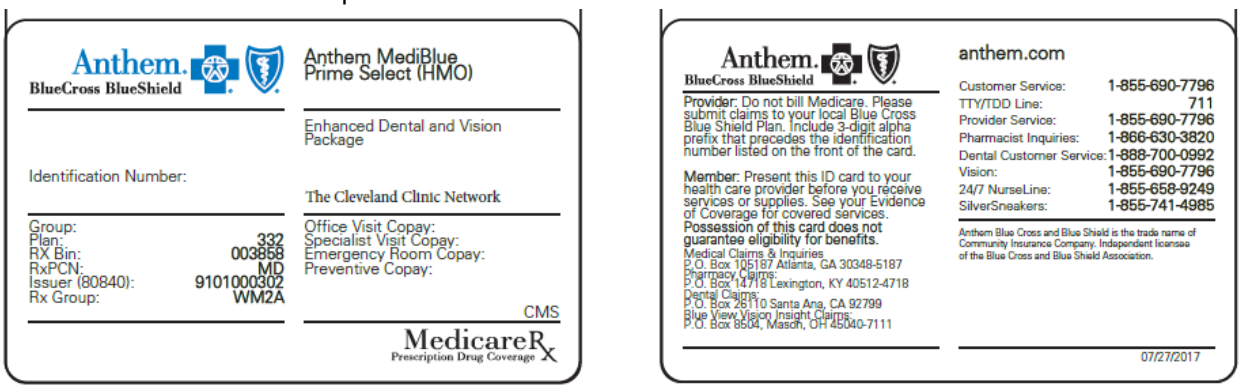
Blue Cross Blue Shield Healthcare Plan of Ohio, Inc. (BCBSHP) announces a new Medicare Advantage select network HMO plan in collaboration with Cleveland Clinic that will be effective on Jan. 1, 2018. The new plan will be

called The Cleveland Clinic Network and will initially be available to individual Medicare Advantage members who reside in Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit counties. As a result, we have built a new limited provider network that will support this new benefit plan, where Cleveland Clinic Healthcare Network will be the sole provider of health care for members enrolled in the Prime Select plan.

Current provider participation in other BCBSHP Medicare Advantage HMO plans will not be impacted by the new BCBSHP Cleveland Clinic Network plan. The current broad network BCBSHP HMO plan will continue to be available to members residing throughout Ohio, including Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit counties.

The Cleveland Clinic Network (HMO) plan members do not have any out-of-network benefits with the exception of emergency services and/or if Cleveland Clinic Healthcare Network provider refers the member to a specific physician for care. If you are not part of the Cleveland Clinic Healthcare Network and your patient presents you with a BCBSHP Cleveland Clinic Network ID card, please refer the patient to an in-network provider. It is important to always call and confirm eligibility and benefits before providing care to ensure coverage and accurate copayment/coinsurance collection. Providers can confirm member eligibility and benefit information through the Availity Portal at availity.com.

BCBSHP member ID card sample



Keep up with MA news

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

Medication Reconciliation Post-Discharge (MRP): billing codes for reimbursement
Prior authorization change for orthotics
August reimbursement update
Medicare risk adjustment training

68171MUPENMUB 08/07/2017

Pharmacy

Flu vaccine update

Flucelvax® Quadrivalent is a new flu vaccine that was recommended by Advisory Committee Immunization Practices (ACIP) for the 2017/2018 flu season. CPT® Procedure Code, *90756 - Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, antibiotic free, 0.5mL dosage, for intramuscular use*, is the code that was created to report this new vaccine. This code is effective January 1, 2018.

In the interim, from August 1, 2017 to December 31, 2017, our recommendation is to report the currently active HCPCS Level II Code, *Q2039 - Influenza virus vaccine, not otherwise specified*, since it is the most specific code available during this timeframe that could be used to report this vaccine. As always, when using not otherwise specified codes, be sure to continue to include the appropriate NDC with your claim submission.

Pharmacy information available at anthem.com

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, visit www.anthem.com/pharmacyinformation. The commercial drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October). To locate the "Marketplace Select Formulary" and pharmacy information for Health Plans offered on the Exchange Marketplace, go to Customer Support, select your state, Download Forms and choose "Select Drug List." Website links for the Federal Employee Program® (FEP®) formulary Basic and Standard Options are Basic Option: https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and Standard Option: https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated regularly as needed. FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org >Benefit Plans>Brochures and Forms>Medical Policies.

Quality

Improving the patient experience

Anthem is committed to working with our network physicians to make our members' health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Simply log onto our website at www.anthem.com and follow this path: Select "Menu," then under the Support heading, select Providers. Enter your state, then select Health & Wellness>Tools & Resources for Providers>Guide to Improving the Patient Experience.

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

2017 CAHPS member satisfaction experience survey results

Every year, Anthem sends out the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to our HMO/POS members. The survey provides Anthem members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. The CAHPS survey is used by all HMO/POS plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

The following tables (see next page) compare our results from 2016 with those in 2017. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

When you're reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.

2017 Anthem Blue Cross and Blue Shield
CAHPS® Member Satisfaction Survey Results

NCQA Quality Compass Percentile Legend [4]	10th	25th	50th	75th	90th

Rating of Physician									
	Rating of Personal Doctor [1]			Rating of Specialist Seen Most Often [1]			Rating of All Health Care Provided in Past 12 Months [1]		
Plan	2016	2017	Score Trend	2016	2017	Score Trend	2016	2017	Score Trend
IN HMO/POS	84%	82%	↓	80%	89%	↑	77%	74%	↓
KY HMO/POS	84%	89%	↑	84%	83%	↓	75%	71%	↓
MO HMO/POS	82%	87%	↑	83%	84%	↑	79%	82%	↑
OH HMO/POS	81%	83%	↑	79%	NA	---	78%	72%	↓
WI HMO/POS	85%	86%	↑	78%	NA	---	78%	75%	↓

Getting Care Quickly									
	Got appointment for urgent care as soon as needed [2]			Got appointment for *check-up or routine care* as soon as needed? [2]			Got help or advice needed when calling doctor after regular office hours [2]		
Plan	2016	2017	Score Trend	2016	2017	Score Trend	2016	2017	Score Trend
IN HMO/POS	NA	NA	---	NA	79%	---	71%	50%	↓
KY HMO/POS	NA	NA	---	83%	73%	↓	85%	63%	↓
MO HMO/POS	85%	91%	↑	85%	84%	↓	69%	72%	↑
OH HMO/POS	NA	NA	---	NA	NA	---	NA	60%	---
WI HMO/POS	89%	NA	---	80%	86%	↑	80%	100%	↑

Doctor's Communication with Patients						
	How often personal doctor explained things understandably to you? [2]			How often personal doctor listened carefully to you? [2]		
Plan	2016	2017	Score Trend	2016	2017	Score Trend
IN HMO/POS	97%	98%	↑	93%	96%	↑
KY HMO/POS	96%	97%	↑	95%	96%	↑
MO HMO/POS	95%	96%	↑	95%	98%	↑
OH HMO/POS	NA	NA	---	NA	NA	---
WI HMO/POS	98%	98%	=	97%	98%	↑
	How often personal doctor showed respect for what you had to say? [2]			How often personal doctor spent enough time with you? [2]		
Plan	2016	2017	Score Trend	2016	2017	Score Trend
IN HMO/POS	96%	98%	↑	92%	91%	↓
KY HMO/POS	94%	98%	↑	91%	92%	↑
MO HMO/POS	95%	98%	↑	93%	96%	↑
OH HMO/POS	NA	NA	---	NA	NA	---
WI HMO/POS	98%	98%	=	95%	96%	↑

Shared Decision Making									
	Doctor discussed reasons to take a medicine? [3]			Doctor discussed reasons you may want not to take a medicine? [3]			Doctor asked what you thought was best for you? [3]		
Plan	2016	2017	Score Trend	2016	2017	Score Trend	2016	2017	Score Trend
IN HMO/POS	93%	90%	↓	77%	65%	↓	76%	76%	=
KY HMO/POS	97%	96%	↓	71%	67%	↓	73%	79%	↑
MO HMO/POS	92%	94%	↑	73%	75%	↑	75%	78%	↑
OH HMO/POS	NA	NA	---	NA	NA	---	NA	NA	---
WI HMO/POS	95%	NA	---	71%	NA	---	86%	NA	---

Continuity of Care & Health Promotion						
	How often did your personal doctor seem informed about care you received from other health providers? [2]			Did you and your doctor discuss ways to prevent illness? [3]		
Plan	2016	2017	Score Trend	2016	2017	Score Trend
IN HMO/POS	74%	88%	↑	70%	70%	↓
KY HMO/POS	80%	83%	↑	71%	68%	↓
MO HMO/POS	87%	83%	↓	74%	76%	↑
OH HMO/POS	NA	NA	---	NA	65%	↓
WIHMO/POS	87%	NA	---	74%	74%	=

1 Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 Percent responding "Usually" or "Always."
3 % responding "Yes"
4 Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

*The source of data contained in this report is Quality Compass ® 2017 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

Clinical practice and preventive health guidelines

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 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. To access the guidelines, go to www.anthem.com. Select "Menu," then under the Support heading, select Providers. Enter state, then select Health & Wellness>Practice Guidelines.

Reimbursement

Professional reimbursement policy updates

Anthem (the "Health Plan") reviews its professional reimbursement policies annually to determine if changes or revisions are required. See below for clarification and detail of recent changes.

IN, KY, WI: Acupuncture when Billed with Evaluation and Management Services
A new policy titled "Acupuncture when billed with Evaluation and Management Services" will be effective for claims processed on and after January 1, 2018. E/M services performed by a physician or other health care professional and billed with Acupuncture services will not be eligible for reimbursement. Please review the policy for additional information.

Bundled Services and Supplies

For dates of service on or after December 1, 2017, we will begin to reimburse the Psychiatric Care Collaborative Management Healthcare Common Procedure Coding System (HCPCS Level II) codes G0502, G0503, and G0504. These codes describe behavioral health care coordination that is directed by the primary care team and is reported by primary care providers for their collaboration with a qualified behavioral health provider, such as a psychiatrist, licensed clinical social worker, etc. Additional information is available in the article titled "Integrated medical and behavioral healthcare reminders and updates" on page 28 of this newsletter.

In accordance with Section 1 of our policy (always bundled services) which indicates HCPCS G codes for CMS programs are considered always bundled services, effective with dates of service January 1, 2018, HCPCS codes G9143 (warfarin responsiveness testing), G9147 (outpatient intravenous insulin treatment (OIVIT)), G9156 (evaluation for wheelchair requiring face-to-face visit with physician), and G9157 (transesophageal doppler used for cardiac monitoring) will not be eligible for reimbursement.

Bundled Services and Supplies Code List

Beginning with claims processed on or after November 18, 2017, we have updated our Bundled Services and Supplies Section 1 code list to reflect that transitional care codes 99495 and 99496 are eligible for separate reimbursement.

Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For 99496, the face-to-face visit must occur within 7 calendar days of the date discharge and medical decision making must be high complexity. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge and medical decision making must be of at least moderate complexity.

Only one individual may report these services and only once per patient within 30 days of discharge.

Bundled Services and Supplies and Modifier 59, XE, XP, XS, & XU

We consider the use of technology used to assist in the performance of a procedure to be part of the surgical procedure. Therefore, beginning with dates of service on or after January 1, 2018, ultrasonic guidance (CPT code 76942) will not be eligible for separate reimbursement when reported with trigger point injection services (CPT codes 20552 and 20553); modifiers will not override this edit.

Claim Editing Overview: Professional and Technical Components

As a reminder, a global diagnostic procedure code includes reimbursement for both the professional (26) and technical components (TC); therefore, according to our policy, when both components are performed by the same provider, the appropriate code must be reported as a global service without the 26/TC modifiers. This will help ensure proper reimbursement for the global diagnostic procedure performed.

Effective with dates of service on or after January 1, 2018, we will be updating our policy to indicate that when the professional and the technical components of a global diagnostic procedure are performed by the same provider or an associate provider in the same practice for the same patient, the service must be reported as a global procedure.

IN, KY, WI: Drug Screen Testing

Beginning with the dates of service on or after January 1, 2018, G0480, G0481, G0482, or G0483 (definitive drug testing) will not be eligible for separate reimbursement when reported on the same date of service as 80307 (presumptive drug testing by instrumented chemistry analyzers) for the same patient by an independent clinical laboratory.

In addition, to be considered for reimbursement, additional documentation must be provided specifying the rationale for the drug classes being tested for to support performing the higher level definitive drug testing codes G0482 (15-21 drug classes) and G0483 (22 or more drug classes).

New language has been added to the "Description" section of the policy to further clarify our drug screen testing guidelines. Presumptive drug testing is done either on a random basis or for cause, however the latter should be documented in the medical record.

Durable Medical Equipment

On October 1, 2017, we are updating the Continuous Rental section of our policy to indicate that pressure/automatic positive airway pressure (CPAP/APAP) devices, bi-level positive airway pressure (BPAP) devices, and corresponding humidifiers will be designated as continuous rental items. As a reminder, continuous rental items reported with durable medical equipment (DME) purchase modifiers will not be eligible for reimbursement.

KY, OH, WI: Evaluation and Management Services and Related Modifiers -25 & -57

Beginning with claims processed on or after January 1, 2018, evaluation and management services that are eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery ("0" or "10" day global period) will be reduced by 50%. As a reminder, please review the guidelines on reporting Modifier 25 in our reimbursement policy.

Frequency Editing

Beginning with claims processed on or after November 18, 2017, we are revising our current frequency limit of 3 units per 90 days to 3 units per 84 days for HCPCS code G0249 (provision of test materials and equipment for home INR monitoring ... includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests).

For claims processed on or after January 1, 2018, HCPCS code A9276 (sensor; invasive, disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply) will have a unit limit of 1 per three (3) days of service. Modifiers will not override this frequency limit edit.

Global Surgery

Currently our Global Surgery Reimbursement Policy lists examples of services the Health Plan considers to be routine post-surgical care. For claims with dates of service on or after January 1, 2018, the Health Plan will include the following services it considers routine post-surgical care when performed during the aftercare period for the primary procedure.

- Bladder irrigation 51700 post bladder surgery 51550-51597, 52500, 52601, 52630, 52640, 52647, 52648, 52649, 55801-55845 and 0421T usual and customary to irrigate the bladder

KY, MO, OH: Laboratory and Venipuncture Services

For claims processed on and after January 1, 2018, when routine venipuncture CPT code 36415 is reported with evaluation and management (E&M) office visit codes (99201-99205 and 99211-99215), it is included in the reimbursement for office visit E&M services and is not eligible for separate reimbursement.

CPT code 36415 is eligible for separate reimbursement when reported with a laboratory service. Modifiers will not override the edit.

Laboratory and Venipuncture Services and Modifier Rules

According CPT Appendix A, modifier 92 (alternative laboratory platform testing) should only be reported with CPT codes 86701, 86702, 86703, and 87389 (HIV testing). Therefore, beginning with claims processed on or after

October 22, 2017, a laboratory service reported with modifier 92 that is not one of the CPT identified codes will not be eligible for reimbursement.

Multiple Surgery Reimbursement

For claims processed on or after November 18, 2017, we will apply multiple surgical rules to HCPCS surgical "S" codes that are eligible for reimbursement. Please refer to our Multiple Surgery and Bilateral Processing Reimbursement Policy for details on our multiple surgical rules.

Physical and Manipulative Maintenance Services

As of October 1, 2017, we are retiring our Physical and Manipulative Maintenance Services Reimbursement Policy; however, these physical and manipulative maintenance services should continue to be reported with HCPCS code S8990. As a reminder, providers are encouraged to continue to verify benefits for our members.

Routine Obstetrical Services

According to our policy, evaluation and management (E/M) services are included in the reimbursement for global obstetrical care when reported with a normal pregnancy and/or delivery diagnosis. Beginning with dates of service on or after October 1, 2017, ICD-10 is deleting antenatal screening code Z36 and replacing Z36 with more specific codes for antenatal screening--Z36.1-Z36.5, Z36.81-Z36.89, Z36.8A, and Z36.9. As part of our policy maintenance, based on the ICD-10 changes, we are updating our policy to include these expanded antenatal screening diagnosis codes and delete Z36. Please refer to our policy for further information.

Telehealth Services

Our Telehealth Services Reimbursement Policy received a review and has some minor language updates and clarifications, effective October 1, 2017; however, the updates do not change the policy position or criteria.

Coding Tip: Annual wellness visits

The Centers for Medicare & Medicaid Services (CMS) developed two codes to describe annual wellness visits (AWV)—G0438 (annual wellness visit, initial visit), which is used to report an initial wellness visit after the first 12 months of Medicare coverage, and G0439 (annual wellness visit, subsequent visit), which is used to report subsequent AWVs. Based on the description of these codes and in agreement with CMS guidelines, G0438 is to be reported only once per patient for the initial AWV and all subsequent AWVs are to be reported with HCPCS code G0439 regardless of the provider, provider group, or provider location.

Coding Tip: procedure unbundling

When two or more procedure codes are used to describe a service when a single, more comprehensive procedure code exists that more accurately describes the complete service performed, the comprehensive code that most accurately describes the documented service should be reported. Reporting the most comprehensive code will decrease denials and ensure proper adjudication of the procedure performed.

Reminder – 3D rendering services

As a reminder, in accordance with our Three Dimensional (3D) Radiology Services and Bundled Services and Supplies Reimbursement Policies, 3D rendering services (76376 and 76377) are not eligible for reimbursement.

Notice of reimbursement policy modifications due to these updates will continue to be published in *Network Update*.

Facility reimbursement policy updates

KY, MO, WI: Multiple Diagnostic Imaging

Anthem will apply multiple imaging reimbursement rules to the technical component of diagnostic imaging procedures effective for claims processed on and after January 1, 2018. These rules apply across diagnostic imaging families, and modalities of radiology procedures and are not limited to contiguous body areas. Multiple imaging reimbursement rules are applied to the maximum allowance for the Technical Component (TC) of the following diagnostic imaging procedures rendered on the same date of service and eligible for reimbursement: Ultrasound, Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Imaging (MRI), and Magnetic Resonance Angiography (MRA).

When two or more imaging procedures are performed in the same facility on the same patient during the same imaging session and reported as TC only, reimbursement is:

- 100% of the highest facility allowance for the first imaging procedure for the date of service.
- 50% of the facility allowance for each subsequent imaging procedure for that date of service.

Please review the policy in its entirety for more detailed information.

Facility Readmission Policy

Effective January 1, 2018, Anthem does not allow separate reimbursement for claims that have been identified as a readmission to the same facility, or another facility that (i) operates under the same Facility Agreement, (ii) has the same tax identification number as Facility, or (iii) is under common ownership as Facility. This policy documents the Health Plan's guidelines used to identify a readmission and the Health Plan's guidelines for reimbursement related to a readmission.

For purposes of this policy, a readmission is defined as:

- Admission to the same facility, or another facility that (i) operates under the same Facility Agreement, (ii) has the same tax identification number as Facility, or (iii) is under common ownership as Facility, within 30-days from discharge of the original admission, and
- Such subsequent admission is for the same, similar or related diagnosis or for a complication arising out of the first admission, and
- Original admission is reimbursed using DRG or Case Rate methodology

Anthem will utilize clinical coding criteria or, when appropriate, licensed clinical medical review to determine if the subsequent admission is for, including but not limited to:

- The same or closely-related condition or procedure as the prior discharge
- An infection or other complication of care
- A condition or procedure indicative of a failed surgical intervention
- An acute decompensation of a coexisting chronic disease
- A need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow up period

Reimbursement: Facility shall not be reimbursed for the readmission. Facility shall only be reimbursed for the original admission. In no circumstances shall the admissions be combined to qualify for outlier reimbursement.

Anthem reserves the right to reject or deny the claim or to recoup and/or recover monies previously paid on a claim that falls within the guidelines of this Policy.

Exclusions,

- Admissions for chemotherapy or immunotherapy treatment
- Admissions to a psychiatric/substance abuse unit or facility
- Admissions to an inpatient rehabilitation unit
- Elective admissions or staged procedures following commonly accepted practices
- Readmission after a patient is discharged from the hospital against medical advice
- Admissions for covered transplant services during the global case rate period for the transplant

This policy will not supersede any individual facility contract provisions or state or federal guidelines.

View Anthem reimbursement policies

To view Anthem's reimbursement policies, sign onto the Availity Portal at availity.com. From the Availity Home page, select Payer Spaces, Anthem, then the "Resources" tab, then Provider Portal (Anthem). Click the Administrative Support tab, then the link labeled Procedures for Professional Reimbursement or Procedures for Facility Reimbursement.

Note: To view online reimbursement policies, you must be registered for access to Availity. If you are not registered yet, go to availity.com/providers/registration-details/ and follow the prompts.

Specialty Services – Behavioral Health

Integrated Medical and Behavioral Health reminders and updates

In our ongoing efforts to encourage the coordination and integration of care between medical and behavioral health providers Anthem continues to expand opportunities for primary care. Anthem currently reimburses for screening and assessment for behavioral health and substance use through billing the following codes:

- G0396 /99408 - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes
- G0397 / 99409 - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention, greater than 30 minutes
- G0442 - Annual alcohol misuse screening, 15 minutes ≤ G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0443 - Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
- G0444 - Annual depression screening, 15 minutes

In addition to screenings and assessments, Anthem supports behavioral counseling for specific chronic conditions while in the primary care office. These services include:

- G0446 - Annual, face-to-face intensive behavioral therapy for cardiovascular disease, 15 minutes
- G0447 - Face-to-face behavioral counseling for obesity, 15 minutes
- G0473 - Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes

In January 2017 Anthem initiated a medical/behavioral integration metric-based quality performance programs incentivizing behavioral health providers to engage in local care collaboratives with primary care. In this program, the behavioral health providers are measured on timely appointment and access for primary care referrals, engagement in behavioral health treatment, avoidable ER visits, and improvement on three highly co-morbid conditions (diabetes, hypertension and cardiac), among a few other metrics. Anthem continues to expand this program.

Finally, effective December 1, 2017, Anthem will begin to reimburse the new Psychiatric Care Collaborative codes (G0502, G0503 and G0504). These codes are reportable by primary care for their collaboration with a qualified behavioral health provider, such as a Psychiatrist, Licensed Clinical Social Worker, etc. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations. These codes are intended to represent the care and management for patients with behavioral health conditions that often require extensive discussion, information-sharing, and planning between a primary care physician and a specialist.

Medicaid Notifications

Indiana Medicaid

Electronic PA for medications

Starting October 1, 2017, electronic prior authorization for medications is available

What is electronic prior authorization (ePA)?
ePA offers providers the ability to complete prior authorization requests for medications via a web portal.

How do ePA cases differ from phone/fax cases?

- ePA cases are simply initiated differently from other PA cases. Once ePA cases are submitted, it follows the same process as phone/fax cases.
- This electronic alternative allows providers a self-service option for initiating and managing PA requests.
- If the necessary information to meet clinical criteria is submitted during the ePA process, an immediate approval decision can be completed and communicated back to the provider.

Why ePA?

- ePA is speedy, simple and smart.
- It saves time; submitting ePA requests is faster than phone/fax requests, and there is no paperwork to manage.
- It is easy to use; 70% of physicians already ePrescribe, and ePA is the next step.
- The ability to receive automatic approvals with ePA expedites the process and, subsequently, fosters a positive member experience.
- ePA is currently available for Anthem Blue Cross and Blue Shield providers through CoverMyMeds® for commercial and health care exchange members in all states, Medicare members in all states, and Medicaid members in California, Kansas, Louisiana and South Carolina and Texas.

How do I submit an ePA?

- Visit the CoverMyMeds website (https://www.covermymeds.com).
- Through your electronic medical records tool, utilize the ePA functionality if it exists.

If I have issues or questions with ePA through CoverMyMeds, how do I receive assistance?
For assistance, reach out to CoverMyMeds via one of the following methods:

- Online: https://www.covermymeds.com/main/help
- Phone: 1-866-452-5017

Hemophilia factor injections to require PA

Effective September 1, 2017, Anthem requires prior authorization (PA) for hemophilia factor injections for Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect members when provided in the outpatient setting. Federal and state law as well as state contract language including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- J7175 — injection of factor x (human), 1 international unit (IU)
- J7179 — injection of von willebrand factor (recombinant), vonvendi, 1 IU
- J7202 — injection of factor ix (albumin fusion protein, recombinant), idelvion, 1 IU
- J7207 — injection of factor viii, (antihemophilic factor, recombinant), pegylated, 1 IU

- J7209 — injection of factor viii, (antihemophilic factor, recombinant), nuwiq, 1 IU

To request PA, you may use one of the following methods:

- Web: Interactive Care Reviewer tool via https://www.availity.com
- Fax: 1-866-406-2803
- Phone: Hoosier Healthwise and Hoosier Care Connect: 1-866-408-7187 or HIP: 1-866-398-1922

For detailed PA requirements, please refer to our website (www.anthem.com/inmedicaiddoc > Prior Authorization & Claims > Prior Authorization Lookup Tool) or call Provider Services: Hoosier Healthwise: 1-866-408-6132; Healthy Indiana Plan: 1-844-533-1995; Hoosier Care Connect: 1-844-284-1798.

Wheelchair component or accessory not otherwise specified to require PA

Effective October 1, 2017, Anthem requires PA for wheelchair components or accessories, not otherwise specified (NOS) for Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect members. Federal and state law as well as state contract language including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following code: K0108 — wheelchair component or accessory, NOS

To request PA, you may use one of the following methods:

- Phone: Hoosier Healthwise -- 1-866-408-6132, HIP -- 1-844-533-1995, Hoosier Care Connect -- 1-844-284-1798
- Fax: 1-866-406-2803
- Web: Interactive Care Reviewer tool via https://www.availity.com

Detailed PA requirements are available to contracted providers by logging in to ProviderAccess using your Availity credentials. On the left-side navigation, select Services Requiring Prior Authorization. Noncontracted providers may call Provider Services.

Multiple delivery services

(Policy 06-044, effective 03/01/2018)

Anthem allows reimbursement for multiple births by a same-delivery or combined-delivery method. For vaginal or cesarean deliveries involved in multiple births and performed using a same-delivery or combined-delivery method, professional reimbursement is based on the following rules:

- Vaginal Deliveries — Vaginal deliveries involved in multiple births should be billed with Modifier 51. Multiple procedure guidelines will apply. Please see Multiple and Bilateral Surgery Reimbursement Policy for more information.
- Cesarean Deliveries — Cesarean deliveries involved in multiple births should be billed with Modifier 22. Multiple procedure guidelines will not apply. Please see Modifier 22 Reimbursement Policy for more information.

For additional information, refer to Multiple Delivery Services Reimbursement Policy at www.anthem.com/inmedicaiddoc.

Access to Disease Management programs

Anthem Disease Management programs are designed to assist PMPs and specialists in managing the care of Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members with chronic health care needs. Members are provided with care management and education by a team of highly qualified disease management professionals whose goal is to create a system of coordinated health care interventions and communications for enrolled members.

Case managers provide support to members with:

- Behavioral health conditions
- Chronic kidney disease
- Diabetes
- Heart conditions
- HIV/AIDS
- Pregnancy
- Pulmonary conditions
- Substance use disorder

Additionally, in order to improve condition-specific outcomes, case managers use motivational interviewing to identify and address health risks such as tobacco use and obesity. Licensed nurse case managers are available Monday through Friday from 8:30 am -- 5:30 pm local time, and our confidential voicemail is available 24/7. To contact our Disease Management team, call 1-888-830-4300.

Additional information about our Disease Management programs can be found on our provider website, www.anthem.com/inmedicaiddoc > Provider Support > Helping Members > Disease Management Centralized Care Unit (DMCCU). Members can obtain information about our Disease Management programs by visiting www.anthem.com.

Update regarding digital breast tomosynthesis

Beginning February 20, 2017, Anthem no longer applies medical policy to digital breast tomosynthesis (DBT or 3-D mammography) services provided to members in its individual, small group, group and employer-sponsored plans, and its Medicaid plans when the State Medicaid programs provide coverage for this service. Dates of service before February 20, 2017 may still be reviewed using the medical policy. Under an existing rule by CMS, Medicare plans provide benefits for DBT. Providers should verify eligibility and benefits (including appropriate copays or coinsurance amounts) for all members prior to rendering services.

Anthem previously reviewed DBT under medical policy RAD.00060, which has been archived and is no longer in effect on and after February 20, 2017. When a medical policy no longer exists, coverage is guided by members' plan benefits.

Kentucky

Hemophilia factor injections to require prior authorization

Effective September 1, 2017, Anthem now requires prior authorization (PA) for hemophilia factor injections when provided in the outpatient setting. Federal and state law as well as state contract language including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- J7175 — injection of factor x (human), 1 international unit (IU)
- J7179 — injection of von willebrand factor (recombinant), vonvendi, 1 IU
- J7202 — injection of factor ix (albumin fusion protein, recombinant), idelvion, 1 IU
- J7207 — injection of factor viii, (antihemophilic factor, recombinant), pegylated, 1 IU
- J7209 — injection of factor viii, (antihemophilic factor, recombinant), nuwiq, 1 IU

To request PA, you may use one of the following methods:

- Web: Interactive Care Reviewer tool via https://www.availity.com
- Fax: 1-800-964-3627
- Phone: 1-855-661-2028

For detailed PA requirements, please refer to our website (https://mediproviders.anthem.com/ky > Precertification) or call Provider Services at 1-855-661-2028.

Multiple delivery services

(Policy 06-044, effective 03/01/2018)

Anthem Medicaid allows reimbursement for multiple births by a same-delivery or combined-delivery method. For vaginal or cesarean deliveries involved in multiple births and performed using a same-delivery or combined-delivery method, professional reimbursement is based on the following rules:

- Vaginal Deliveries — Vaginal deliveries involved in multiple births should be billed with Modifier 51. Multiple procedure guidelines will apply. Please see Multiple and Bilateral Surgery Reimbursement Policy for more information.
- Cesarean Deliveries — Cesarean deliveries involved in multiple births should be billed with Modifier 22. Multiple procedure guidelines will not apply. Please see Modifier 22 Reimbursement Policy for more information.

For additional information, refer to Multiple Delivery Services Reimbursement Policy at https://mediproviders.anthem.com/ky.

Medical policy update

On February 2, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following Medical Policies applicable to Anthem Medicaid. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the listing below.

The Medical Policies were made publicly available on the Anthem provider website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Effective date	Medical Policy number	Medical Policy title	New or revised
2/16/2017	DRUG.00068	Vedolizumab (Entyvio®)	Revised

Clinical utilization management guidelines update

On February 2, 2017, the MPTAC approved the following clinical utilization management (UM) guidelines applicable to Anthem. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the clinical UM guidelines adopted by the Medical Operations Committee for the Government Business Division on March 21, 2017.

On February 2, 2017, the clinical guidelines were made publicly available on the Anthem Medical Policies and Clinical UM Guidelines subsidiary website. Visit www.anthem.com/cptsearch_shared.html to search for specific guidelines.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	New or revised
2/16/2017	CG-DRUG-28	Alglucosidase alfa (Lumizyme®)	Revised

Vaccines added to the pharmacy benefit

Anthem added coverage for several vaccines to its pharmacy benefit effective May 26, 2017. These vaccines were previously limited to coverage through the medical benefit for Anthem. These vaccines may now be administered to patients at any participating in-network pharmacy. The additional vaccines are listed on the next page.

National drug code number	Label name
49281040015	Adacel® tetanus and diphtheria toxoids and acellular pertussis (TDAP) syringe
49281040088	Adacel® TDAP syringe
49281040010	Adacel® TDAP vial
49281040058	Adacel® TDAP vial
58160084232	Boostrix® TDAP vaccine syringe
58160084252	Boostrix® TDAP vaccine syringe
58160084201	Boostrix® TDAP vaccine vial
58160084211	Boostrix® TDAP vaccine vial
58160084243	Boostrix® vaccine syringe
54569638600	Boostrix® vaccine vial
49281028610	Daptacel® diphtheria and tetanus toxoids and acellular pertussis (DTAP) vaccine
49281028658	Daptacel® DTAP vaccine
00006412101	Gardasil® 9 syringe
00006412102	Gardasil® 9 syringe
00006411901	Gardasil® 9 vial
00006411903	Gardasil® 9 vial
00006404500	Gardasil® vial
00006404501	Gardasil® vial
00006404541	Gardasil® vial
00006483701	Pneumovax® 23 syringe
00006483702	Pneumovax® 23 syringe
00006483703	Pneumovax® 23 syringe
00006473900	Pneumovax® 23 vial
00006473901	Pneumovax® 23 vial
00006494300	Pneumovax® 23 vial
00006494301	Pneumovax® 23 vial
00005197101	Prevnar® 13 syringe
00005197102	Prevnar® 13 syringe
00005197105	Prevnar® 13 syringe
54569661300	Prevnar® 13 syringe
00006410901	Gardasil® syringe
00006410902	Gardasil® syringe
00006410909	Gardasil® syringe
54569582201	Gardasil® vial

If you have questions about this communication, please contact Provider Services at 1-855-661-2028.

What is HEDIS?

Providers play a critical role in the outcome of HEDIS measures. This in turn helps our members develop healthy behaviors and become active participants in their care. Additionally, proper and thorough documentation in medical records as well as accurate claims coding for member encounters helps keep patients aligned with best practice guidelines and the National Committee for Quality Assurance standards.

To increase HEDIS scores as well as your pay for performance scores, we have listed some helpful tips below.

HEDIS measure:	Tip(s):
Adult BMI Assessment (ABA)	Be sure to capture BMI values/percentiles for patients. For adults, document BMI values. For children and adolescents (up to 21 years of age), document BMI percentiles.
Controlling Blood Pressure (CBP)	For members who have a diagnosis of hypertension prior to June 30, document the patients' blood pressure.
Comprehensive Diabetes Care (CDC)	The following must be completed at least once annually and documented appropriately: Blood pressure Hemoglobin A1c testing Screening/treatment of nephropathy (urine test, treatment with an angiotensin converting enzyme inhibitor or angiotensin II receptor blocker, or a visit to a nephrologist) Retinal eye exam
Cervical Cancer Screening (CCS)	Assess all women 21 to 64 years of age for Papanicolaou (PAP) screenings. Provide a cervical cytology every three years for women 21 to 64 years of age or provide cervical cytology and human papillomavirus cotesting every five years for women 30 to 64 years of age. Acceptable documentation for this measure includes documentation from a doctor on the date/year of the PAP test and results or lab results in the member's chart. If a hysterectomy must be documented, be sure to include the type of hysterectomy the patient received and the year. Any contraindications must be clearly documented within the medical record.
Frequency of Prenatal Care (FPC)	Track the occurrence and regularity of all prenatal care rendered. Required documentation includes American Congress of Obstetricians and Gynecologists forms, lab results, and ultrasound testing. Education provided to the patient should be clearly noted in the medical record and include a copy of the material(s).
Prenatal and Postpartum Care (PPC)	Care in the first trimester and postpartum (between 21 to 56 days after delivery) are compulsory components for this measure.
Lead Screening in Children (LSC)*	Assess children for lead poisoning by their second birthday. Provide a report and document the lab results.
Childhood Immunization Status (CIS)*	Immunization records should be updated and complete. Note influenza and human papillomavirus (HPV) vaccinations in medical records. Parental refusal and/or contraindications for any vaccinations should be clearly noted in medical records. Childhood immunizations should be completed by the member's 2nd birthday.
Immunizations for Adolescents (IMA)*	This measure determines the number of members who receive diphtheria, tetanus and pertussis, meningococcal, and HPV vaccines between the ages of 11 and 13. Males and females should complete all adolescent vaccinations in this time period. Parental refusal and/or contraindications for any vaccinations should be clearly noted in medical records.

HEDIS measure:	Tip(s):
Weight Assessment and Counseling for Nutrition and Activity forChildren/Adolescents (WCC)*	For members 3 to 17 years of age, the necessary components for this measure include height, weight and BMI percentile. Additionally, there must be documentation of counseling for both physical activity and nutrition. A simple checklist typically does not suffice; there must be evidence a discussion was held with the member/the member's parents.
Well-Child Visits in the First 15 months of Life (W15) Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) Adolescent Well-Care Visits (AWC)	For each of these measures, there are five requirements, and documentation for all must be included in medical records: Health history including allergies, medications and immunization records Physical exam Assessment of physical development (as appropriate per age) Assessment of mental development (as appropriate per age) Anticipatory guidance (directed at preventive health and safety of the member) — Please note, this is not the same as health education provided for a specific diagnosis during a sick visit.

* If you need information or examples of complete documentation, please contact EPSDT Program Manager Mary Maupin by email at mary.maupin@anthem.com.

Global surgical package for professional providers

(Policy 06-041)

Anthem Blue Cross and Blue Shield Medicaid would like to remind providers that included in the global surgical package are visits occurring during the postoperative period that are related to recovery from the surgery regardless of the location. The Global Surgical Package for Professional Providers reimbursement policy includes additional information on what is included in the global surgical package and what is separately reimbursable. For additional information, please refer to the reimbursement policy at https://mediproviders.anthem.com/ky.

Wisconsin Medicaid

Hemophilia factor injections to require PA

Effective September 1, 2017, Anthem now requires prior authorization (PA) for hemophilia factor injections for BadgerCare Plus members when provided in the outpatient setting. Federal and state law as well as state contract language including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following codes:

- J7175 — injection of factor x (human), 1 international unit (IU)
- J7179 — injection of von willebrand factor (recombinant), vonvendi, 1 IU
- J7202 — injection of factor ix (albumin fusion protein, recombinant), idelvion, 1 IU
- J7207 — injection of factor viii, (antihemophilic factor, recombinant), pegylated, 1 IU
- J7209 — injection of factor viii, (antihemophilic factor, recombinant), nuwiq, 1 IU

To request PA, you may use one of the following methods:

- Web: Interactive Care Reviewer tool via https://www.availity.com
- Fax: 1-800-964-3627
- Phone: 1-855-558-1443

For detailed PA requirements, please refer to our provider website (https://mediproviders.anthem.com/wi > Precertification) or call Provider Services at 1-855-558-1443.

Transportation Services: Ambulance and Nonemergent Transport

(Policy 07-036, effective 01/01/18)

Anthem allows reimbursement for medical transport to and from covered services or other services. This policy provides reimbursement guidelines for ambulance services and transportation modifiers. Separately reimbursable from the ambulance base rate is oxygen.

Note: NEMT services are provided through a state vendor, not Anthem.

For additional information, please refer to the Transportation Services: Ambulance and Nonemergent Transport reimbursement policy at https://mediproviders.anthem.com/wi > Claims > Reimbursement Policies. Due to the complex nature of transportation services, Anthem recommends that providers also review state guidelines for coverage requirements.

Global Surgical Package for Professional Providers

(Policy 06-041)

Anthem would like to remind providers that included in the global surgical package are visits occurring during the postoperative period that are related to recovery from the surgery regardless of the location. The Global Surgical Package for Professional Providers reimbursement policy includes additional information on what is included in the global surgical package and what is separately reimbursable. The policy can be accessed from the Anthem provider portal at the following link: https://mediproviders.anthem.com/wi > Claims > Reimbursement Policies.

Diagnosis-Related Group (DRG) Inpatient Facility Transfers

(Policy 13-002, effective 01/01/2018)

Anthem allows payment for services rendered by both the sending and the receiving facility when a patient is admitted to one acute care facility and subsequently transferred to another acute care facility for the same episode of care. Anthem will use the following criteria:

- Transferring facility will receive a calculated per diem rate based on length of stay not to exceed the amount that would have been paid if the patient had been discharged to another setting.
- Receiving facility will receive the full DRG amount.

Note: Anthem Blue Cross and Blue Shield does not reimburse claims assigned with a DRG for neonate transfer.

Refer to the Diagnosis-Related Group (DRG) Inpatient Facility Transfers reimbursement policy at https://mediproviders.anthem.com/wi.

Medical policy update

On May 4, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Anthem. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The medical policies were made publicly available on the Anthem provider website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Effective date	Medical Policy number	Medical Policy title	New or revised
5/18/2017	DRUG.00099	Cerliponase Alfa (Brineura™)	New
5/18/2017	DRUG.00107	Avelumab (Bavencio®)	New
5/18/2017	DRUG.00109	Durvalumab (IMFINZI™)	New
6/28/2017	MED.00121	Implantable Interstitial Glucose Sensors	New
6/28/2017	MED.00122	Wilderness Programs	New
6/28/2017	SURG.00148	Spectral Analysis of Prostate Tissue by Fluorescence Spectroscopy	New
6/28/2017	SURG.00149	Percutaneous Ultrasonic Ablation of Soft Tissue	New
6/28/2017	SURG.00150	Leadless Pacemakers	New
5/18/2017	DME.00040	Automated Insulin Delivery Devices	Revised
5/18/2017	DRUG.00002	Tumor Necrosis Factor Antagonists	Revised
5/18/2017	DRUG.00038	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	Revised
5/18/2017	DRUG.00041	Rituximab (Rituxan®) for Non-Oncologic Indications	Revised
5/18/2017	DRUG.00047	Brentuximab Vedotin (Adcetris®)	Revised
6/28/2017	DRUG.00062	Obinutuzumab (Gazyva®)	Revised
5/18/2017	DRUG.00066	Antihemophilic Factors and Clotting Factors	Revised
5/18/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised

5/18/2017	DRUG.00075	Nivolumab (Opdivo®)	Revised
5/18/2017	DRUG.00083	Elotuzumab (Empliciti™)	Revised
5/18/2017	DRUG.00088	Atezolizumab (Tecentriq®)	Revised
5/18/2017	DRUG.00104	Nusinersen (SPINRAZA™)	Revised
5/18/2017	GENE.00032	Molecular Marker Evaluation of Thyroid Nodules	Revised
5/18/2017	GENE.00035	Genetic Testing for TP53 Mutations	Revised
6/28/2017	SURG.00121	Transcatheter Heart Valves	Revised
5/18/2017	THER-RAD. 00004	External Beam Intraoperative Radiation Therapy	Revised
5/18/2017	TRANS.00024	Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome	Revised

Clinical utilization management guidelines update

On May 4, 2017, the MPTAC approved the following clinical utilization management (UM) guidelines applicable to Anthem. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the clinical UM guidelines adopted by the Medical Operations Committee for the Government Business Division on June 5, 2017.

On May 4, 2017, the clinical guidelines were made publicly available on the Anthem Medical Policies and Clinical UM Guidelines subsidiary website. Visit www.anthem.com/cptsearch_shared.html to search for specific guidelines.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	New or revised
6/28/2017	CG-REHAB-10	Level of Care: Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services	New
5/18/2017	CG-DRUG-34	Docetaxel (Docefrez™, Taxotere®)	Revised
5/18/2017	CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	Revised
6/28/2017	CG-DRUG-60	Gonadotropin Releasing Hormone Analogs for the Treatment of Oncologic Indications	Revised
6/28/2017	CG-SURG-09	Temporomandibular Disorders	Revised
5/18/2017	CG-SURG-55	Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation	Revised
5/18/2017	CG-THER-RAD-01	Fractionation and Radiation Therapy in the Treatment of Specified Cancers	Revised

Multiple Delivery Services

(Policy 06-044, effective 03/01/2018)

Anthem allows reimbursement for multiple births by a same-delivery or combined-delivery method. Professional reimbursement is based on multiple procedure guidelines for the following:

- Vaginal or cesarean deliveries involved in multiple births
- Multiple deliveries performed using a same-delivery or combined-delivery method

Vaginal and cesarean deliveries involved in multiple births should be billed with Modifier 51. Please see Multiple and Bilateral Surgery Reimbursement Policy for more information.

For additional information, refer to Multiple Delivery Services Reimbursement Policy at https://mediproviders.anthem.coml/wi.

Modifier 62: Co-Surgeons

(Policy 06-027, originally effective 12/15/17)
Anthem allows reimbursement of procedures eligible for co-surgeons when billed with Modifier 62. Each surgeon must bill the same procedure code(s) with Modifier 62. Reimbursement to each surgeon is based on 62.5% of the applicable fee schedule or contracted/negotiated rate. Co-surgeons may be from the same or different specialties and must perform the procedure during the same operative session.

For more information, please refer to Modifier 62: Co-Surgeons Reimbursement Policy at https://mediproviders.anthem.com/wi

Anthem adopts Milliman Care Guidelines for inpatient rehabilitation, subacute rehabilitation and skilled nursing facility clinical reviews

Effective for dates of service on and after January 1, 2018, Anthem will transition from using the Anthem Clinical Utilization Management Guidelines CG-REHAB-09, CG-MED-29 and CG-MED-31 to using Milliman Care Guideline (MCG) Recovery Facility Care Guidelines for the review of prior authorization requests for inpatient rehabilitation and skilled nursing facility services.

Providers should continue to call the telephone number indicated on the back of the member ID card to request prior authorization review for these services. Additionally, you may initiate your request online using our Interactive Care Reviewer (ICR): Select Authorizations on the Availity Web Portal at www.availity.com.

For questions, please call Provider Services at 1-855-558-1443.