Anthem BlueCross BlueShield

Working together to improve the health of our members.

August 2018

Network Update

CENTRAL REGION

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

The information in this newsletter is for informational purposes only and should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for our members and enrollees is the responsibility of physicians and providers.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT). Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

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CE0818
IN, KY, MO, OH, WI

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Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation ("Compcare") or Wisconsin Collaborative Insurance Company ("WCIC"); Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

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 at anthem.com for new updates on health care reform and Health Insurance Exchanges.

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. Sign up here.

Administrative Update

Additional support available for members with rare conditions

Anthem is working with Accordant Health Services to provide targeted disease management services for members with rare medical conditions, including:

- Epilepsy (Seizures)
- Rheumatoid Arthritis (RA)
- Human Immunodeficiency Virus (HIV)
- Multiple Sclerosis (MS)
- Crohn's Disease (CD)
- Ulcerative Colitis (UC)

- Parkinson's Disease (PD)
- Systemic Lupus Erythematosus (SLE or Lupus)
- Myasthenia Gravis (MG)
- Sickle Cell Disease (SCD)
- Cystic Fibrosis (CF)
- Hemophilia
- Scleroderma
- Polymyositis
- Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
- Amyotrophic Lateral Sclerosis (ALS)
- Dermatomyositis
- Gaucher Disease

Members in your care who may benefit from additional outreach and information may receive letters or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention.

If you would like to refer a member to this program, please contact AccordantCare at:
Phone or Fax: 1-866-247-1150
Web: https://referral.accordant.com
Plan name: AnthemReferrals
Password: ref1088Anthem

Billing colonoscopy and related anesthesia services

The Affordable Care Act (ACA) requires many health plans to cover recommended preventive care services without member cost sharing when the services are rendered by an in-network provider and/or facility. Screening colonoscopies (even when polyps are removed) are included as a covered preventive care service. Since colonoscopies are rendered for both screening and diagnostic purposes, it is very important for providers to use appropriate coding guidelines when reporting colonoscopies. When inappropriate CPT and ICD-10 codes are submitted on claims, it can result in incorrect provider payment and/or incorrect member cost sharing.

The following services are covered with no member cost share:

- The colonoscopy screening procedure.
- Anesthesia charges when anesthesia is billed with the appropriate screening CPT code (even when polyps are removed).
- Other associated facility charges when the colonoscopy is billed with an appropriate screening diagnosis code.
- When polyps are removed during a screening colonoscopy - the removal, examination and analysis of the polyps.

In the instance where a screening colonoscopy starts out as screening but turns into a diagnostic procedure due to polyps being removed, Anthem follows CPT guidelines for our Commercial members, not Medicare guidelines. The CPT® 2018 Professional Edition manual shares the following information regarding the billing of anesthesia for any screening colonoscopy: “Report 00812 to describe anesthesia for any screening colonoscopy regardless of ultimate findings.”

Billing update for professional delivery claims

To better assess measures of quality for our members, for all physician delivery claims, Anthem will begin requiring documentation of a newborn's gestational age at the time of delivery.

Beginning with dates of service on and after November 1, 2018, all professional delivery claims (59400, 59409, 59410, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620 and 59622) will require an ICD-10 Z3A code indicating the newborn's gestational age at the time of delivery. If the code is not found on the claim, the claim will be denied with the following reason: "*Delivery diagnoses incomplete without report of pregnancy weeks of gestation. You may resubmit the corrected claim with the appropriate ICD-10 code for payment*."

Anthem applies daily morphine equivalent dosing limit

Beginning with prescriptions filled on and after September 1, 2018, Anthem will apply a daily morphine equivalent dosing limit of 90mg. This change is part of our continued efforts to help improve patient safety and reduce the misuse and abuse of opioid analgesics.

Current users of short-acting or long-acting opioid analgesics will only be impacted by this change should they have a change in their prescription requesting an increase in dosage that exceeds the new limitation.

Members receiving palliative care and needing short-acting or long-acting opioid analgesics, with a diagnosis of cancer-related pain or a diagnosis of a terminal condition, will automatically be approved through the prior authorization process.

Note: This update does not apply to Medicare plans.

Your state's pharmacy information page provides details on prior authorization criteria, or any other requirements, restrictions or limitations that may apply; to view it, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin. For more information, please contact the provider service number on the back of the member ID card.

Enhanced automated claim edits

Effective for professional claims (CMS-1500) processed on or after November 18, 2018, Anthem will enhance our editing systems to automate edits supported by correct coding guidelines, as documented in industry sources such as CPT, HCPCS Level II, and International Classification of Diseases 10 (ICD-10). As a result, there will be greater focus on identifying incorrect or inappropriate billing of services by multiple providers within the same tax identification number for the same patient on the same day. This enhanced editing automation will promote faster claim processing and reduce follow-up audits and/or record requests for claims not consistent with correct coding guidelines.

Below are examples of claim edits that will be automated:

- Accurate reporting of modifiers, including LT, RT, 54, 55, 56, 62,76, 77, 78, 79, 80, 81, 82, and AS, which are often reported for the billing of services rendered by the same provider or multiple providers.
- Ensuring global, professional (modifier 26) and technical components (modifier TC) are billed appropriately by one or more providers in facility and office settings.
- Assessing whether services considered once in a lifetime have been billed more than once.
- Ensuring the reporting of procedures and the associated diagnosis codes are correctly reported together.

Submit solicited medical attachments via Availity

To process a claim for an Anthem member, has your office received a request for additional information? Those records can now be submitted electronically using the Medical Attachments feature on the Availity Portal.

The Medical Attachments feature makes submitting electronic documentation in support of a claim simple and streamlined. You can use your tax identification number (TIN) or your NPI to register and submit *solicited* (requested by Anthem) medical record attachments.

Our *solicited* Medical Attachments feature supports an unlimited number of document attachments for each submission, and can handle .tiff, .jpg and .pdf attachments. Once your office receives a letter requesting additional documentation, you can send up to 10 attachments through the portal for each claim. The maximum file size is 10MB per attachment and file sizes larger than 10MB can be split into smaller ones.

To access *solicited* Medical Attachments for your office, Availity adminstrators should complete the following steps: From My Account Dashboard, select Enrollments Center>Medical Attachments Setup, follow the prompts and complete the following sections:

1. Select Application>choose Medical Attachments Registration.
2. Provider Management>Select Organization from the drop-down. Add NPIs and/or Tax IDs. Multiples can be added separated by spaces or semi-colons.
3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name.

To use Medical Attachments, Availity users should complete the following steps:

1. Log in to www.availity.com.
2. Select Claims and Payments > Medical Attachments >Send Attachment tab.
3. Complete all required fields on the form.
4. Attach supporting documentation.
5. Select Submit.

To access additional training for this Availity feature:

1. Log in to the Availity Portal at www.availity.com.
2. At the top of any Availity portal page, choose *Help and Training > Get Trained* (Make sure you do not have a pop-up blocker turned on or the next page may not open.)
3. In the Catalog, click Sessions.
4. Scroll through Your Calendar to view the upcoming live events.
   - ✓ Tuesday, 08/14/2018, 3:00 p.m. to 4:00 p.m. ET
   - ✓ Wednesday, 08/29/2018, 12:00 noon to 1:00 p.m. ET
   - ✓ You can also search the ALC Catalog by a special keyword set up just for you. The keyword is MEDATT.

Check out the new enhancements to ICR

The Interactive Care Reviewer (ICR)* tool offers a streamlined process to request inpatient and outpatient procedures as well as locate information on previously submitted requests for Anthem members via the Availity portal.

Our ICR tool provides many benefits, including fax reduction, authorization determination and a comprehensive view

of all your authorization requests. In addition, the ICR tool has recently completed some enhancements to improve convenience and efficiency, including:

- The number of *Favorites* that can be saved increased to 25 for all provider types, including requesting, servicing, facility DME, and refer to providers.
- The *Authorization Referral Inquiry* tab at the top of the dashboard is now the *Check Case Status* tab and includes the ability to view any submitted cases that are associated with the tax IDs on the request. This includes submission by phone, fax, and etc. Also under the tab, the *Search by Reference Referral Number* changed to *Search by Reference/Authorization Request Number* and includes the ability to search by reference request number or authorization request number and a tax ID associated with the case.
- *Search Organization Requests* is now *Search Submitted Requests* and includes the ability to search for any ICR case requested by your organization or a request that your organization is associated with. This includes requests with a status of review not required.

To learn more about the ICR tool, attend an ICR webinar by registering here.

*Note: ICR is not currently available for Federal Employee Program® (FEP®), BlueCard®, and some National Account members; requests involving transplant services; or services administered by AIM Specialty Health® or OrthoNet. For these requests, follow the same authorization process that you use today.

Availity is our designated EDI gateway

Availity is Anthem's designated EDI Gateway. All EDI submissions currently received via the Anthem EDI Gateway are now available on the Availity EDI Gateway. There is no impact to the provider's participation status with Anthem and no impact on how claims adjudicate.

If you are connected to Availity, you can use your same connection for your EDI submissions. If you are using another clearinghouse, contact it to validate transition dates. If your clearinghouse notifies you of changes regarding connectivity, workflow, or the financial cost of EDI transactions, there is a no-cost option available to you – you can submit claims directly through Availity.

Your organization can register with Availity to submit the following transactions:

- 837- Institutional
- 837- Professional
- 837- Dental
- 835- Electronic Remittance Advice
- 276/277- Claim Status, real-time
- 270/271- Eligibility, real-time

Next steps:

- Anthem and Availity will continue to communicate and provide assistance with this transition going forward.
- Availity will be working directly with all trading partners.
- We recommend that you register with Availity for your EDI transmissions which gives you a free, fully subsidized option.

How to register with Availity:

- If your organization is not already registered with Availity, go to www.availity.com, click REGISTER and then follow the steps.
- Look for emails from Availity containing your log in credentials.

- If your organization is already registered with Availity, you can log in and click My Providers | Enrollments Center if you need to complete a new 835 enrollment or make changes.

We look forward to delivering a smooth transition to the Availity EDI Gateway. If you have any questions, please contact Availity Client Services at 1-800-282-4548 Monday through Friday 8 a.m. to 7:30 p.m., ET.

Training available

If you would like more information on transitioning to Availity's Gateway solutions, sign up for an upcoming webinar:

1. Log in to the Availity Portal.
2. Click Help & Training | Get Trained.
3. In the Catalog, click Sessions.
4. Scroll through Your Calendar to view upcoming live events. Select *Introduction to Availity EDI Gateway services for Anthem provider organizations* webinar.

Tip: You can also search the ALC Catalog by a special keyword set up just for you. The keyword is song.

See below for the current webinar schedule:

- Monday, 8/20/2018, 3 - 4 p.m. ET
- Thursday, 8/23/2018, 1 - 2 p.m. ET
- Tuesday, 9/25/2018, 12 noon – 1 p.m. ET
- Thursday, 9/27/2018, 3 - 4 p.m. ET

Member EOB gets a makeover

By the end of 2018, Anthem members will begin receiving a new explanation of benefits (EOB) that is designed to help members better understand their health care benefits and out-of-pocket expenses. The EOB will look more like a health care summary but will continue to include important information about services rendered, the amount paid to the provider, and the member out-of-pocket expense.

The new EOB will also include:

- Ways members can save on health care expenses
- A preventive care checklist, sharing important screenings that were missed
- A summary of the member's most recent claims

Learn more about our newly designed EOB here.

MyDiversePatients.com

We've heard it all our lives: To be fair, you should treat everybody the same. But the challenge is that everybody is not the same—and these differences can lead to critical disparities not only in how patients access health care, but their outcomes as well.

The reality is burden of illness, premature death, and disability disproportionately affects certain populations.[1] MyDiversePatient.com features robust educational resources to help support you in addressing these disparities. You will find:

- CME learning experiences about disparities, potential contributing factors and opportunities for you to enhance care.
- Real life stories about diverse patients and the unique challenges they face.
- Tips and techniques for working with diverse patients to promote improvement in health outcomes.

While there's no single easy answer to the issue of health care disparities, the MyDiversePatients.com vision is to start reversing these trends...one patient at a time. Accelerate your journey to becoming your patients' trusted health care partner by visiting MyDiversePatient.com today.

[1] Centers for Disease Control and Prevention. (2013, Nov 22). CDC Health Disparities and Inequalities Report — United States, 2013. *Morbidity and Mortality Weekly Report*. Vol 62(Suppl 3); p3.

IN, KY, OH, WI: New sort option for Care and Cost Finder

Anthem's Care and Cost Finder tool provides many of our members with the ability to search and compare cost and quality measures for in-network providers using the secure member portal at anthem.com. The Care and Cost Finder tool currently offers multiple sorting options, such as sorting providers based on distance or name.

Beginning October 14, 2018, Care and Cost Finder will have a new sorting option called "Personalized Match." The sorting option is based on algorithms which will use a combination of provider location, quality, cost results and member information to intelligently sort and display results for a member's search. The sorting results will take into account member factors such as the member's medical conditions and medications, as well as provider factors such as areas of specialty, quality and efficiency measures, volumes of patients treated across various disease conditions, and outcome-based quality measures. These member and provider features will be combined to generate a unique ranking of providers for each member conducting the search. Providers with the highest overall ranking within the search radius will be displayed first, with other providers displayed in descending order, based on overall rank and proximity to the center of the search radius.

Members will continue to have the ability to sort from a variety of sorting orders (such as distance), and this enhancement in sorting methodology will have no impact on member benefits.

You may review a copy of the new sorting methodology here.

If you have general questions about the Care and Cost Finder tool or this new sorting option, please contact Provider Customer Service. If you would like detailed information about quality or cost factors used as part of this unique sorting, or you would like to request reconsideration of those factors, you may do so by emailing personalizedmatchsorting@anthem.com or by calling 833-292-5250.

Anthem will continue to focus and expand our consumer tools and content to assist members in making more informed and personalized health care decisions.

IN, MO, OH, WI: Anthem Community Care

Effective July 16, 2018 for Indiana; August 1, 2018 for Ohio; and September 4, 2018 for Missouri and Wisconsin; Anthem will integrate Community Health Workers utilized by Preferred Community Health Partners (PCHP) into our current care management program to provide enhanced care transition for Anthem members with complex needs. Members will include, but are not limited to, those with the following:

- Hospital readmissions
- Frequent ER visits
- No engagement with PCP within three months or more
- Readmission risk score >24
- Multiple diagnoses
- Identified social determinants of health

PCHP does not replace Case Management, the care or the care management provided by PCPs and specialists. Instead, it provides an extra layer of support with Community Health Workers as an extension of care management to help our members navigate the complex health care system.

Services are meant to complement members' efforts to improve health outcomes. PCHP will make an initial outreach to identified members to determine the appropriate level of services. PCHP will not provide any clinical services. A PCHP Community Health Worker may reach out to your practice to introduce themselves and establish a relationship with the physician. They may also discuss developing a mechanism by which to share information regarding patients that have been identified for complex care services.

For questions regarding PCHP and complex care services, please contact the number for your state:
Indiana: 1-317-287-5990
Missouri/Wisconsin: 1-303-831-2427
Ohio: 1-800-831-7161

Reminder: FEP® mailing address

As a reminder, if you are not using an electronic submission option, we ask that you use the following address for FEP paper claims, correspondence and grievance and appeals:

Federal Employee Program
PO Box 105557
Atlanta, GA 30348-5557

If you have questions, please contact FEP customer service at the following number for your state:
IN – 1-800-382-5520, KY – 1-800-456-3967, MO – 1-800-392-8043, OH – 1-800-451-7602, WI – 1-800-242-9635.

Reminder: Use the Provider Maintenance Form

Anthem contracted providers are required to update their demographic information when changes occur to their practice, including:

- Change of address/location
- Name change
- Tax ID changes
- Provider leaving a group or a single location
- Change in phone/fax numbers
- Closing a practice location

As a reminder, our Find a Doctor online tool is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To help ensure we have the most current and accurate information, please take a moment to access the Find a Doctor tool and review how you and your practice are being displayed. To report discrepancies, please make any necessary corrections using the Provider Maintenance Form.

To update your information, please continue to use the current Provider Maintenance Form at anthem.com. In addition, the PMF can be found on the Availity Portal by selecting your state > Payer Spaces > Anthem Blue Cross and Blue Shield > Resources > Provider Maintenance Form.

Health Care Management

Medical policy and clinical guideline updates

Anthem medical polices were reviewed on May 3, 2018 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

The medical policy, THER-RAD.000002 Proton Beam Radiation Therapy, will be archived, effective November 1, 2018. (This policy will be applied as a part of AIM Clinical Guidelines beginning November 1, 2018.)

In addition, the following chart shows content converted to clinical guidelines, effective June 28, 2018.

New Clinical Guideline	Content Moved From Clinical Guideline and/or Medical Policy
CG-DME-44 Electric Tumor Treatment Field (TTF)	• Content moved from DME.00035 Electric Tumor Treatment Field (TTF) • No change to position statement / clinical indications
CG-MED-72 Hyperthermia for Cancer Therapy	• Content moved from MED.00026 Hyperthermia for Cancer Therapy • No change to position statement / clinical indications
CG-SURG-76 Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty	• Content moved from SURG.00001 Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty • No change to position statement / clinical indications
CG-SURG-77 Refractive Surgery	• Content moved from SURG.00009 Refractive Surgery • No change to position statement / clinical indications
CG-SURG-78 Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies	• Content moved from SURG.00065 Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies • No change to position statement / clinical indications
CG-SURG-79 Implantable Infusion Pumps	• Content moved from SURG.00068 Implantable Infusion Pumps • No change to position statement / clinical indications
CG-SURG-80 Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors	• Content moved from RAD.00011 Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors • No change to position statement / clinical indications

PA required for upper gastrointestinal endoscopy

Beginning with dates of service on and after November 1, 2018, Anthem will expand precertification requirements to include upper gastrointestinal (GI) endoscopy, also referred to as esophagogastroduodenoscopy (EGD). AIM Specialty Health® (AIM), a separate company, will administer this EGD review on behalf of Anthem.

EGD procedures will be reviewed against clinical guideline CG-MED-59, Upper Gastrointestinal Endoscopy, for clinical appropriateness and to help ensure care aligns with established evidence-based medicine. A complete list of EGD CPT codes requiring precertification is available on the AIM Surgical Procedures website. Note: Procedures performed in an inpatient or observation setting or on an emergent basis will not be reviewed under CG-MED-59.

Submit a request for review

Starting October 17, 2018, ordering providers may submit precertification requests to AIM for dates of service November 1, 2018 and after in one of several ways:

- Access AIM *ProviderPortal*℠ 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 a.m.–7:00 p.m. ET

Note: This review does not apply to BlueCard®, Federal Employee Program® (FEP®), Medicaid, Medicare Advantage, and Medicare Supplemental plans. To find all precertification requirements for Anthem members, see Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements at anthem.com. **Providers should continue to verify eligibility and benefits for all members prior to rendering services.**

For questions, please contact the Provider Service number on the back of the member ID card.

Update: AIM Radiation Oncology Clinical Appropriateness guidelines

Effective for dates of service on and after November 1, 2018, AIM will apply AIM's Radiation Oncology Clinical Appropriateness Guidelines to prior authorization requests for proton beam radiation therapy. These guidelines will replace certain Anthem radiation oncology medical policies and clinical guidelines, which are being archived. This update applies to Anthem plans with radiation oncology services medically managed by AIM.

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

- Access AIM's *ProviderPortal*℠ 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 a.m.–7:00 p.m. ET.

Note: This program does not apply to FEP or National Accounts.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Update: AIM Advanced Imaging Clinical Appropriateness guidelines

Beginning with dates of service on and after October 29, 2018, the following updates will apply to AIM Advanced Imaging Clinical Appropriateness Guidelines.

CT Chest guideline:

- Expanded list of diagnostic testing abnormalities that may be followed up with CT to include endoscopy, fluoroscopy, and ultrasound in addition to specific chest radiography findings
- Lengthening of timeframe required prior to imaging for chronic cough from 3 to 8 weeks, and more specifics of preliminary workup required prior to imaging
- Lower threshold for defining unexplained weight loss, and more explicit definition of preliminary workup required prior to imaging
- Allowance for use of imaging in the staging of malignancy prior to biopsy confirmation
- Allowance for imaging of suspected pulmonary embolism in pregnancy
- New criteria for appropriate imaging of chest wall mass

CT Angiography (CTA) Chest guideline:

- Allowance for imaging of suspected pulmonary embolism in pregnancy

CT Abdomen/CT Pelvis/CT Abdomen & Pelvis guideline:

- Lower threshold for defining unexplained weight loss, and more explicit definition of preliminary workup required prior to imaging

MRI Chest guideline:

- Inclusion of imaging of suspected pectoralis muscle tear
- New criteria for appropriate imaging of chest wall mass

MRI Abdomen guideline:

- Addition of hemochromatosis as an indication for imaging in pediatric patients

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

- Access AIM *ProviderPortal* 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 a.m.–7:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Changes to Specialty Pharmacy clinical site of care drug list

Drugs removed from specialty pharmacy clinical site of care (level of care) drug list

Effective immediately, the following specialty pharmacy codes from new or current coverage guidelines will be removed from our existing specialty pharmacy clinical site of care review process. Note: These drugs will continue to require pre-service clinical review for medical necessity.

Medical Policy or Clinical Guideline	Drug	Code
CG-DRUG-100	Actimmune®	J9216
DRUG.00086	Increlex®	J2170
CG-DRUG-60	Firmagon®	J9155

Drugs added to specialty pharmacy clinical site of care drug list

Effective for dates of service on and after November 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be included in our existing specialty pharmacy clinical site of care review process. Anthem's pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

View the Clinical Site of Care drug list and Clinical Site of Care pre-service clinical review FAQs for more information.

Medical Policy or Clinical Guideline	Drug	Code
CG-DRUG-78	Hemlibra™	Q9995
CG-DRUG-89	Sublocade™	Q9991 Q9992
CG-DRUG-89	Probuphine®	J0570
CG-DRUG-05	Retacrit®	Q5106

Anthem expands Specialty Pharmacy prior authorization list

Effective for dates of service on and after November 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be included in our pre-service review process. Anthem's pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Medical Policy or Clinical Guideline	Code	Drug	Comments
DRUG.00098	C9031, A9699, J9999	Lutathera®	New Policy
DRUG.00111	J3590	Ilumya™	New Drug to Existing Policy
CG-DRUG-05	Q5105, Q5106	Retacrit®	New Drug to Existing Guideline
CG-DRUG-16	J3590	Fulphila™	New Drug to Existing Guideline

AIM Level of Care Musculoskeletal Surgery Clinical Appropriateness guidelines

Beginning with dates of review on and after November 1, 2018, the following updates will apply to AIM Level of Care Musculoskeletal Surgery Clinical Appropriateness guidelines:

- Addition of criteria for observation in surgical settings, ambulatory surgical centers, and hospital outpatient departments
- Addition of staff, equipment, and resource capabilities in outpatient surgery
- Modifications to the inpatient admission criteria

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

- Access AIM *ProviderPortal* 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 a.m.–7 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

IN: New Musculoskeletal Program is effective August 30, 2018

Effective August 30, 2018, Anthem will transition medical necessity review of certain elective surgeries of the spine and joints, as well as interventional pain treatment for Anthem fully insured members, to AIM Specialty Health®(AIM). Currently, TurningPoint Healthcare Solutions, LLC is performing medical necessity reviews for spine and joint in Indiana. These reviews will transition to AIM, plus interventional pain management reviews will be added. For full details, go here.

Medicare

MA members offered incentives for screenings

We have several incentive programs this year to encourage Medicare Advantage (MA) members to obtain preventive screenings. Members may be rewarded when they complete their annual routine physical with their PCP. Eligible members will receive a gift card for competing their screening mammogram, a colorectal cancer screening or their diabetes retinal exam. Our members may ask that you confirm these screenings.

DME providers and physicians: wheelchair PA information

To help our members receive the DME equipment they need and help ensure no disruption in care, it is important to document that the physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. Additional details on this requirement and other information to help ensure your prior authorization request for a wheelchair is processed efficiently will be available at Important Medicare Advantage Updates at anthem.com/medicareprovider.

Electronic PA available for Medicare; new contact number for Medicare PA requests

Anthem accepts electronic medication prior authorization requests for Medicare plans. You may submit Medicare ePA requests by logging in at covermymeds.com. If you must initiate a new PA request by fax or phone, please note that the contact number for Medicare prior authorizations will change Sept. 1, 2018.

Effective Sept. 1, 2018	New fax Number	New phone number
Medicare prior authorizations	844-521-6938	833-293-0661

If you have other questions, please contact the provider service number on the back of the member ID card.
Note: For details on submitting electronic PA requests, see page 16 of this newsletter.

CMS issues regulatory changes for narcotics

The Centers for Medicare & Medicaid Services recently issued regulations related to opioid analgesics to help improve patient safety and reduce the misuse of opioid analgesics: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

Beginning Jan. 1, 2019, all short- and long-acting opioids will reject at the point of sale if prescribed for more than seven days. This edit applies to members who do not have an opioid prescription in the previous 60 days. The edit excludes members with cancer or members in hospice.

These edits are intended to allow those with intractable pain an opportunity to maintain their pain control while helping reduce the potential for misuse or addiction among those who are experiencing acute pain.

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:
Inpatient Readmissions Medicare Advantage Update
Prior authorization requirements for Part B drugs Retacrit, Damoctocog and Ilumya
Medical Policy Update
Prior authorization requirements for Part B drugs: Azedra and Poteligeo

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Pharmacy

Anthem to update drug lists supporting commercial health plans

Effective with dates of service on and after October 1, 2018, and in accordance with Anthem's Pharmacy and Therapeutic (P&T) process, we will update the drug lists that support commercial health plans. Note: This update does not apply to the Select Drug List and does not impact Medicaid and Medicare plans. To ensure a smooth transition and minimize member costs, please review these changes and consider prescribing a drug on formulary or on a lower tier, if appropriate. View a summary of changes here.

Submit PA medication requests electronically

Anthem accepts medication prior authorization requests submitted electronically. This feature reduces processing time. Some requests are even approved in real time so that your patients can fill a prescription without delay.

Electronic prior authorization (ePA) offers many benefits:

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

Submit ePA requests by logging in at covermymeds.com. Creating an account is FREE.

While ePA helps streamline the prior authorization process, providers can also initiate a new prior authorization request by fax or phone. Note: the contact numbers for the following plans have changed, effective July 15, 2018.

Market	New fax number	New phone number
Indiana on the exchange	844-471-7938	833-293-0660
Kentucky on the exchange	844-471-7939	
Missouri on the exchange	844-471-7940	
Ohio on the exchange	844-471-7942	
Wisconsin on the exchange	844-474-3340	
Indiana off the exchange	844-521-6940	833-293-0659
Kentucky off the exchange	844-521-6947	
Missouri off the exchange	844-534-9053	
Ohio off the exchange	844-534-9055	
Wisconsin off the exchange	844-534-9056	

Also, as noted on page 15, beginning September 1, 2018, the fax and phone number for all Medicare plans will change to: 844-521-6938 (fax), 833-293-0661 (phone). For questions, please contact the Provider Service number on the member ID card.

Pharmacy information available at anthem.com

IN, OH and WI: 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 anthem.com/pharmacyinformation. The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October). FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the 2018 Specialty Drug List or call us at 888-346-3731 for more information.

KY and MO: 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 anthem.com/pharmacyinformation. The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October). To locate "Marketplace Select Formulary" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List." This drug list is also reviewed and updated regularly as needed. FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the 2018 Specialty Drug List or call us at 888-346-3731 for more information.

Quality

Provider transparency update

A key goal of Anthem's provider transparency efforts is to improve quality while controlling health care costs. One of the ways this is done is by giving primary care physicians (PCPs) in the Enhanced Personal Health Care (EPHC) Program quality and/or cost information about the health care providers to which the PCPs refer their Attributed Members (the "Referral Providers"). If a Referral Provider is higher quality and/or lower cost, this component of the program should result in their getting more referrals from PCPs. The converse should be true if Referral Providers are lower quality and/or higher cost. Additionally, employers and group health plans (or their representatives or vendors) may also be given quality/cost information so that they can better understand how their health care dollars are being spent. This will give them the opportunity to educate their employees and plan members about the benefits of using higher quality and/or lower cost health care provider on.

Cost Opportunity Report

The Cost Opportunity Report is available for EPHC providers to access via Provider Care Management Solutions (PCMS).

- The Cost Opportunity Report is available for EPHC providers to access via Provider Care Management Solutions (PCMS).
- The report was created to help users quickly identify meaningful and actionable opportunities to optimize costs and help achieve shared savings targets within the EPHC Program.
- By providing a standard set of potential cost opportunity metrics, the Cost Opportunity Report can be used to help evaluate the relative success of providers within the EPHC Program.
- Metrics are selected based on size of financial opportunity, ability of PCPs to affect changes, mix of impacted service types, mix of utilization and unit price impact.
- Metrics are reviewed on a periodic basis and may be added, changed or removed.

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Anthem will share data on which it relied in making these quality/cost evaluations upon request, and will discuss it with Referral Providers, including any opportunities for improvement. For questions or support, please refer to your local network representative or Care Consultant.

Vaginal birth after Cesarean: New tool helps with decision-making

A VBAC shared decision-making aid has been posted online at anthem.com. It has been reviewed and certified by the Washington Health Care Authority (HCA) and may serve as a guide when you are discussing treatment options with patients. To access the aid, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

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 anthem.com. 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, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Reimbursement

Professional reimbursement updates

Bundled Services and Supplies

Beginning with dates of service on or after November 1, 2018, Anthem has added information to Section 1 of our policy that charges for copies of x-rays or DVDs are considered always bundled services and not eligible for separate reimbursement.

Once per Lifetime Procedures

Anthem's Once per Lifetime Procedures policy received a biennial review and we are removing modifier 58 from the policy. Modifier 58 is used to report a staged or related procedure by the same physician during the postoperative period and would not be used for a once per lifetime procedure if that procedure was previously performed on the patient.

OH: Facility reimbursement update

As was previously announced in the April 2018 *Network Update*, inpatient stay claims reimbursed at a percent of charge with billed charges above $40,000 require an itemized bill to be submitted with the claim. This notice is to inform providers that Anthem has engaged Equian to administer the review of these claims.

View reimbursement policies online at anthem.com

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

Specialty Services – Behavioral Health

Anthem engages with Alliant Health Solutions

As was previously communicated in the December 2017 issue of *Network Update*, Anthem has established a contractual relationship with Alliant Health Solutions to assist the organization in validating provider compliance with applicable reimbursement policies and identify instances of incorrect billing for behavioral health services. Alliant has initiated the work and your compliance is required should you receive a request for information. Alliant is a behavioral health audit and review company and will examine Anthem outpatient behavioral health claims data. Utilizing systematic sampling methodology and a broad range of algorithms, the audits and findings will be customized to support Anthem's expectations as outlined in Anthem's Provider Manuals and related policies and procedures. Alliant findings may result in provider audits and record reviews, education and other direct outreach.

Medicaid Notifications

Indiana Medicaid

Standards for access to care

Meeting patient expectations regarding timely appointments is an important part of quality care and excellence in patient experience. The National Committee for Quality Assurance and Indiana Family and Social Services Administration have established guidelines to set member and provider expectations for access to care. As a reminder, follow the guidelines below when providing care for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members.

Type of visit	Appointment standards
Emergency examinations	Immediate access during office hours
Urgent examinations	Within 24 hours of request
Non-urgent sick visits	Within 72 hours of request
Non-urgent routine exams	Within 21 days of request
Specialty care examinations	Within three weeks of request
Outpatient behavioral health examinations	Within 14 days of request
Routine behavioral health visits	Within 10 days of request
Outpatient treatment after hospitalization	Within seven days of discharge
Post-psychiatric inpatient care	Within seven days of discharge

After-hours services

Our members have access to quality health care 24/7. That means primary medical providers (PMPs) must have a system in place to ensure that members can call after hours with medical questions or concerns. PMPs must adhere to the following after-hours procedures.

Answering service or after-hours personnel must:

- Forward member calls directly to the PMP or on-call provider or advise that the provider will contact the member within 30 minutes.
- Ask the member if the call is an emergency. In the event of an emergency, immediately direct the member to dial 911 or proceed directly to the nearest hospital emergency room.
- Have the ability to contact a telephone interpreter for members with language barriers.
- Return all calls.

Answering machine messages:

- May be used in the event that staff or an answering service is not immediately available.
- Must instruct members with emergency health care needs to dial 911 or proceed directly to the nearest hospital emergency room.
- Must provide instructions on how to contact the PMP or on-call provider in a non-emergency situation.
- Must provide instructions in English, Spanish and any other language appropriate to the PMP's practice.

PA required for Cabazitaxel

Effective September 1, 2018, prior authorization (PA) requirements will change for injectable drug Cabazitaxel (Jevtana) to be covered by Anthem for Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan members.

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, 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:

- Cabazitaxel (Jevtana) — injection, 1 mg (J9043)

To request PA, you may use one of the following methods:
Web: availity.com
Fax:

- 1-866-406-2803 (Inpatient, new emergent)
- 1-844-765-5156 (Inpatient concurrent emergent/new urgent)
- 1-844-765-5157 (Outpatient)

Phone:

- 1-866-408-6132 (Hoosier Healthwise)
- 1-844-284-1798 (Hoosier Care Connect)
- 1-844-533-1995 (Healthy Indiana Plan)

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at availity.com. Contracted and noncontracted providers who are unable to access Availity may call us for PA requirements at 1-866-408-6132 (for Hoosier Healthwise), 1-844-284-1798 (for Hoosier Care Connect) or 1-844-533-1995 (for Healthy Indiana Plan).

ICR update

The Interactive Care Reviewer (ICR) tool offers a streamlined process to request inpatient and outpatient procedures as well as locate information on previously submitted requests for Anthem members via the Availity Portal.

What benefits does the ICR tool provide?

- Free and easy to use
- Access almost anywhere
- Preauthorization determinations
- Inquiry capability
- Fax reduction
- Ability to view decision letter
- Ability to save favorites
- Comprehensive view of all your preauthorization requests

How do I gain access to the ICR tool?
You can access the ICR tool through Availity. (Select Authorizations & Referrals from the *Patient Registration* drop-down menu in the upper left of the page.)

If you have not yet registered for Availity, go to availity.com and select Register at the top of the page. Select your Organization Type from the available options at the bottom of the page and follow the registration wizard.

How can I learn more about ICR?
Learn more about ICR by attending one of the monthly webinars. Register for the next webinar here.

Whom can I contact with questions?
For questions regarding our ICR tool, please contact your local Provider Network Relations representative.

For questions on accessing our tool via Availity, call Availity Client Services at 800-282-4548. Availity Client Services is available Monday to Friday from 8 a.m. to 7 p.m. ET (excluding holidays) to answer your registration questions.

Note: ICR is not currently available for Federal Employee Program, BlueCard® and some National Account members. ICR is also not currently available for requests involving transplant services or services administered by AIM Specialty Health® or OrthoNet LLC. For these requests, follow the same preauthorization process you use today.

The information above applies to the Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect programs.

Topical corticosteroids hot tip

This table is to assist prescribers in identifying topical corticosteroids included on all Anthem formularies. It does not represent all commercially available topical corticosteroids.

When prescribing medications, always select "substitution permissible by law" (where applicable) to ensure your patients benefit from generic medications when available.

Therapeutic class	Formulary product	Relative cost per prescription*
Topical corticosteroids — low potency	Hydrocortisone Cream Hydrocortisone Ointment	$
Topical corticosteroids — medium potency	Triamcinolone Cream Triamcinolone Ointment	$
Topical corticosteroids — high potency	Fluocinonide-E Cream	$$
Topical corticosteroids — very high potency	Clobetasol Cream Clobetasol-E Cream Clobetasol Gel Clobetasol Ointment	$$$

* Relative cost per prescription is intended to be directional in nature. Costs may change based on market dynamics. This information is meant to be used as a guide and should not take the place of clinical decision making by a prescriber regarding treatment.

Formulary status or drug availability may change. There may be additional qualifications needed for access to some drugs, such as a prior authorization or step therapy.

This document does not guarantee benefit coverage for any medication(s) as member coverage may vary.

PA required for electrical stimulation device

The electrical stimulation device will require prior authorization (PA) effective August 1, 2018.

Please use the Precertification Lookup Tool for authorization requirements at www.anthem.com/inmedicaiddoc > Prior Authorization & Claims > Prior Authorization Lookup Tool.

Noncompliance with the new requirements may result in denied claims. The following code will require PA:
E0766 — Electrical stimulation device used for cancer treatment, includes all accessories, any type

To request PA, you may use one of the following methods:
Web: https://www.availity.com
Fax:

- 1-866-406-2803 (Inpatient, new emergent)
- 1-844-765-5156 (Inpatient concurrent emergent/new urgent)
- 1-844-765-5157 (Outpatient)

Phone:

- 1-866-408-6132 (Hoosier Healthwise)
- 1-844-284-1798 (Hoosier Care Connect)
- 1-844-533-1995 (Healthy Indiana Plan)

Federal law, state law and state contract language (including definitions and specific contract provisions/exclusions) take precedence over these PA rules and must be considered first when determining coverage.

If you have questions about this communication or need assistance with any other item, call Provider Services at 1-866-408-6132 for Hoosier Healthwise, 1-844-284-1798 for Hoosier Care Connect and 1-844-533-1995 for Healthy Indiana Plan.

PA required for lower extremity vascular intervention codes

Effective September 1, 2018, lower extremity vascular intervention codes will require prior authorization (PA) by Anthem.

Please refer to the Prior Authorization Lookup Tool for detailed PA requirements by visiting www.anthem.com/inmedicaiddoc and choosing Prior Authorization Lookup Tool from the *Prior Authorization & Claims* menu.

PA requirements will be added to the following codes:

Code	Description
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

To request PA, please use one of the following methods:

Web: availity.com

Fax:

- 1-866-406-2803 (Inpatient, new emergent)
- 1-844-765-5156 (Inpatient concurrent emergent/new urgent)
- 1-844-765-5157 (Outpatient)

Phone:

- 1-866-408-6132 (Hoosier Healthwise)
- 1-844-284-1798 (Hoosier Care Connect)
- 1-844-533-1995 (Healthy Indiana Plan)

Noncompliance with the new requirements may result in denied claims. Federal and state law, as well as state contract language including definitions, and specific contract provisions and exclusions, take precedence over these PA rules and must be considered first when determining coverage.

If you have questions about this communication or need assistance with any other item, contact your local Provider Services representative or call Provider Services at 1-866-408-6132 (for Hoosier Healthwise), 1-844-284-1798 (for Hoosier Care Connect) or 1-844-533-1995 (for Healthy Indiana Plan).

Newborn claims processing

Effective November 1, 2018, Anthem will update the claims processing system to help ensure accurate payment of newborn claims in accordance with Indiana normal newborn diagnosis-related group (DRG) requirements and Anthem's inpatient authorization requirements.

All newborn inpatient stays must have sufficient documentation provided to support an admission to an area beyond the newborn nursery, such as a neonatal intensive care unit (NICU) or for the higher level of care associated with the more complex newborn DRG. Documentation to support the higher level admission includes authorization or medical records.

Failure to provide the appropriate documentation will result in the claim being processed based on the normal newborn rate. Please note that current authorization guidelines for normal newborn and higher level of care baby inpatient stays will be applied.

For more information about this update, go here.

Coding for pregnancy

Pregnancy demonstrates a woman's amazing creative and nurturing powers while providing for the future. Early and regular prenatal care is vital to the health of the baby and the mother.

Pregnancy facts

- In 2016, 7.2% of women who gave birth smoked cigarettes during pregnancy. Prevalence of smoking during pregnancy was highest for women aged 20 through 24 (10.7%), followed by women aged 15 through 19 (8.5%) and 25 through 29 (8.2%).[1]
- Hypertensive disorders affect up to 10% of pregnancies in the United States.[2]
- Ectopic pregnancy affects 1 to 2% of all pregnancies and is responsible for 9% of pregnancy-related deaths in the United States.[3]

For detailed information on pregnancy coding (risk factors, HEDIS® quality measures for prenatal and postpartum care, and ICD-10-CM: general coding and documentation), please view the full pregnancy coding guide on our provider website here.

Resources

[1]Cigarette Smoking During Pregnancy: United States, 2016. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db305.htm.

[2]Hypertension in pregnancy. Retrieved from https://www.acog.org/Clinical-Guidance-and-Publications/Task-Force-and-Work-Group-Reports/Hypertension-in-Pregnancy.
[3]Barash J.H., Buchanan E.M., Hillson C. Diagnosis and Management of Ectopic Pregnancy. Retrieved from https://www.aafp.org/afp/2014/0701/p34.html.

Important information about UM

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

You can request a free copy of our UM criteria from our Medical Management department. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the numbers listed below. To access UM criteria online, go to https://mediproviders.anthem.com/in/Pages/prior-authorization.aspx.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests by fax:

- Inpatient medical: 1-866-406-2803
- Outpatient medical: 1-866-406-2803
- Pharmacy: 1-866-406-2803
- Behavioral Health inpatient: 1-877-434-7578
- Behavioral Health outpatient: 1-866-877-5229

Or by phone:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-844-533-1995
- Hoosier Care Connect: 1-844-284-1798

If you have questions about utilization decisions or the UM process, call our Clinical team at the number below:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-844-533-1995
- Hoosier Care Connect: 1-844-284-1798

Member's rights and responsibilities statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem has adopted a *Member's Rights and Responsibilities Statement,* which is located in your *Provider Manual*.

To access the statement, go to https://mediproviders.anthem.com/in/pages/home.aspx > Provider Support > Member & Health Education. If you need a physical copy of the statement, call us at:

- Hoosier Healthwise: 1-866-408-6132
- Healthy Indiana Plan: 1-844-533-1995
- Hoosier Care Connect: 1-844-284-1798

Member copayments and balance billing

Anthem wants to remind our Medicaid participating providers they may not balance bill or direct bill Medicaid members. Members cannot be charged for covered services above the amount Anthem pays to the provider or be direct billed for the cost of services. Providers who accept Medicaid in any other state are still prohibited from balancing billing or direct billing Medicaid members. Providers may only bill members for copays if a copay applies. Member copays are identified on the Anthem ID card for Healthy Indiana Plan and Hoosier Care Connect members.

Out-of-network providers and non-Indiana Health Coverage Programs (IHCP) registered providers may not balance bill members. Following state requirements, providers are to enroll in the IHCP to receive reimbursement for providing services to our members.

An IHCP provider may bill a member only when the following conditions have been met:

- The service is noncovered or the member has exceeded program limitations and the member signed a waiver prior to each service that meets federal standards for Medicaid members.
- The provider documents that the member was informed (via a waiver prior to receiving the service) that he or she was receiving a noncovered service, and the member voluntarily signed the waiver to receive the service.

Please note: A general waiver must identify the specific procedure to be performed and its cost. The member must sign the waiver prior to receiving the service. Any provider that fails to obtain a waiver that meets federal and IHCP standards for each individual service forfeits the ability to bill the member. For more information, see the IHCP Provider Reference Modules by visiting here.

Providers may balance bill a member when prior authorization of a covered service is denied; however, the provider must:

- Establish that authorization was requested and denied prior to rendering service.
- Request to review Anthem's authorization decision.
- Notify the member that the service requires prior authorization and that Anthem has denied authorization. If out-of-network, the provider must also explain to the member that covered services may be available without cost when provided by an in-network provider. In such cases, authorization of service will still be required.
- Inform the member of his or her right to file an appeal if he or she disagrees with the decision to deny authorization.
- Inform the member of his or her responsibility for payment for receiving unauthorized services:
- If the provider chooses to use a waiver to establish member responsibility for payment, the waiver must meet the following requirements:
- Only after the member has received appropriate notification should the waiver be signed.
- The waiver should not contain any language or condition to the effect that the member is responsible for payment if the authorization is denied.
- Providers may not use nonspecific patient waivers — a waiver must be obtained for each encounter or member visit that falls under the scenario of noncovered services.
- The waiver must specify the date services are provided and the services that fall under the waiver's application.

- The provider has the right to appeal any denial of Anthem payment resulting from a denial of authorization.
- POWER Account funds cannot be used for member copays.

Please note: Providers are required to hold members liable for copays.

This information applies to Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.

Use the Provider Maintenance Form to update your information

Providers should now submit changes to their practice profile using our online *Provider Maintenance Form*. The form is available on both the provider website and the Availity Portal.

Online update options include:

- Adding address location.
- Name change.
- Provider leaving a group or a single location.
- Changing phone/fax number.
- Closing a practice location.
- Many more options.

Visit the resource page at www.anthem.com/inmedicaiddoc to view more change options. The new online form can be found at www.anthem.com/inmedicaiddoc > The Anthem Network > Join Our Network > Provider Maintenance Form. The *Provider Maintenance Form* is also located on the Availity Portal and can be found at availity.com > Indiana > Payer Spaces > Anthem Blue Cross and Blue Shield > Resources > *Provider Maintenance Form.*

Important information about updating your practice profile:

- Change requests should be submitted using the online Provider Maintenance Form.
- Submit the change request online. There is no longer a need to print and mail, fax or email demographic updates. You will receive an autoreply email acknowledging receipt of your request and another email when your submission has been processed.
- For change(s) that require(s) submission of an updated *W-9* form or other documentation, attach them to the form online prior to submitting.
- Change requests should be submitted with advance notice.
- Contractual agreement guidelines may supersede the effective date of the request.

You can check your directory listing in the Anthem online provider directory. The Anthem provider directory is used by consumers, members, brokers and providers to identify in-network physicians and other health care providers supporting Anthem members. To ensure Anthem has the most current and accurate information, please take a moment to access the online provider directory at www.anthem.com/inmedicaiddoc and review how you and your practice are being displayed.

EDI migration to Availity

Recently, Anthem partnered with Availity as our designated Electronic Data Interchange (EDI) gateway and E-Solutions Service Desk. As a result, Anthem will not renew existing contracts with clearinghouse vendors and, beginning January 1, 2019, Availity will manage all EDI trading partner relationships on behalf of Anthem for our Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect programs. This new partnership will not interrupt your current services.

If you currently transmit 837 claims using a clearinghouse, you should contact your clearinghouse as soon as possible to confirm your EDI submission path for Anthem transactions has not changed. If your clearinghouse notifies you of changes regarding connectivity, workflow or the financial cost of EDI transactions, there is a no-cost option available to you – You can submit claims directly through Availity.

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If you choose to submit directly through Availity but are not yet a registered user, go to availity.com and select REGISTER. The registration wizard will lead you through the enrollment process. Once complete, you will receive an email with your login credentials and next steps for getting started. If you have any questions or concerns please contact Availity at 1-800-AVAILITY (1-800-282-4548).

It is our priority to deliver a smooth transition to Availity for our EDI services. If you have questions please contact your Provider Relations representative or Provider Services at one of the following numbers:

- Hoosier Healthwise: 1-866-408-6132
- HIP: 1-844-533-1995
- Hoosier Care Connect: 1-844-284-1798

Medical Recalls

(Policy 06-111 — effective 11/01/2018)
In applicable circumstances, the appropriate modifier, condition code or value code (identified below) should be used to identify a medically recalled item. This will assist Anthem in identifying medically recalled items and support correct coding guidelines.

Applicable condition codes are 49 and 50. Condition code 49 signifies products replaced within the product lifecycle due to the product not functioning properly, and condition code 50 is used for product replacement for known recall of a product.

When a credit or cost reduction is received by the provider for the replacement device, applicable modifiers are FB and FC. Modifier FB is used when items are provided without cost to the provider, supplier or practitioner, and modifier FC is used when a partial credit is received by the provider, supplier or practitioner for the replacement device.

Note: In circumstances where we have reimbursed the provider for repair or replacement of items or procedures related to items due to a medical recall, we are entitled to recoup or recover fees from the manufacturer and/or distributor as applicable. In circumstances where we have reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, we are entitled to recoup or recover fees from the provider.

Please refer to CMS and/or your state's guidelines, and the Medical Recalls reimbursement policy for additional details at anthem.com/inmedicaiddoc.

Chimeric antigen receptor T-cell (CAR-T) therapy requires PA

Chimeric antigen receptor T-cell (CAR T) therapy, including immunotherapy and all inpatient stays, will continue to require a prior authorization (PA) regardless of the place of service in which it is given.

CAR T codes require PA, and all requests must be reviewed by Anthem Blue Cross and Blue Shield for PA regardless of place of service or if billed with an unlisted code.

Please refer to the Prior Authorization Lookup Tool for detailed PA requirements by visiting www.anthem.com/inmedicaiddoc and choosing Prior Authorization Lookup Tool from the *Prior Authorization & Claims* menu.

CAR T therapy is currently represented by the following codes:

- Q2040 — Tisagenlecleucel (brand name: Kymriah™), up to 250 million CAR-positive viable T-cells, including leukapheresis and dose-preparation procedures, per infusion.
- Q2041 — Axicabtagene Ciloleucel, up to 200 million autologous anti-CD19 CAR T-cells, including leukapheresis and dose-preparation procedures, per infusion (new code was effective April 1, 2018).

CAR T therapy in any form will continue to require PA. Please use one of the following methods to submit a request:

- Web: https://www.availity.com
- Fax:
  - 1-866-406-2803 (Inpatient, new emergent
  - 1-844-765-5156 (Inpatient concurrent emergent/new urgent)
  - 1-844-765-5157 (Outpatient)
- Phone:
  - 1-866-408-6132 (Hoosier Healthwise)
  - 1-844-284-1798 (Hoosier Care Connect)
  - 1-844-533-1995 (Healthy Indiana Plan)

Noncompliance with these requirements may result in denied claims. Federal and state law, as well as state contract language including definitions, and specific contract provisions and exclusions, take precedence over these PA rules and must be considered first when determining coverage.

If you have questions about this communication or need assistance with any other item, contact your local Provider Services representative or call Provider Services at 1-866-408-6132 (for Hoosier Healthwise), 1-844-284-1798 (for Hoosier Care Connect) or 1-844-533-1995 (for Healthy Indiana Plan).

Kentucky

PA required for pemetrexed

As of August 1, 2018, prior authorization (PA) requirements changed for pemetrexed (ALIMTA®) covered by Anthem Blue Cross and Blue Shield Medicaid. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, 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 were added to the following:

- Pemetrexed (ALIMTA) — 10 mg injection (J9305)

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

- Web: availity.com
- Fax: 1-800-964-3627
- Phone: 1-855-661-2028

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at availity.com. Providers who are unable to access the Availity Portal may call us at 1-855-661-2028 for PA requirements.

Eight injectable drugs will require PA

Effective June 1, 2018, Anthem Blue Cross and Blue Shield Medicaid will require prior authorization (PA) for eight injectable drugs. Please refer to the *Precertification Lookup Tool* for detailed authorization requirements.

Noncompliance with the new requirements may result in denied claims. PA requirements will be added to the following codes:

- J0565 — Injection, bezlotoxumab, 10 mg
- J1428 — Injection, eteplirsen, 10 mg
- J2326 — Injection, nusinersen, 0.1 mg
- J2350 — Injection, ocrelizumab, 1 mg
- J9022 — Injection, atezolizumab, 10 mg
- J9023 — Injection, avelumab, 10 mg
- J9285 — Injection, olaratumab, 10 mg
- Q2040 — Tisagenlecleucel

Please use one of the following methods to request PA:

- Web: availity.com
- Fax: 1-800-964-3627
- Phone: 1-855-661-2028

Federal and state law, as well as state contract language including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage.

If you have questions about this communication or need assistance with any other item, call Provider Services at 1-855-661-2028.

Maternity notification form

We are asking providers to go here to access the *Maternity Notification Form*.

Please complete the form and fax it to us as soon as possible after the patient's first prenatal visit during current pregnancy.

Our goal is to identify and address risk factors of expectant mothers as early in pregnancy as possible. We can help pregnant members manage chronic and behavioral health conditions during pregnancy.

Thank you for your support in helping our newly expectant members.

Physical and behavioral health collaborative care

The integration of physical and mental health care is an important aspect of the collaborative care model, where primary care providers and behavioral health providers team up to provide clinically and cost-effective care for our members. Implementation of evidence-based collaborative care for Anthem Blue Cross and Blue Shield Medicaid could substantially improve mental and physical health outcomes, as well as the functioning, safety and well-being of the patient.

Key elements for coordinated care include the following:

- Providing ongoing communication and coordination between PCPs and specialty providers
- Screening for co-occurring disorders
- Providing referrals for assessment and treatment to PCPs or specialty providers
- Involving patients and caregivers in the development of patient-centered treatment plans
- Offering case management or disease management programs to support coordination among providers
- Document the coordination efforts among providers in the individual member's medical record

Join us in this collaborative effort so we can make Kentucky a leader in coordination of care.

Primary care and behavioral health providers working together

Why PCPs and behavioral health providers should work together

- Physical and behavioral health go hand in hand. Comorbid conditions can complicate treatment of and recovery from both physical and behavioral health issues. A member is more likely to stick to a medical treatment plan if his or her behavioral health needs are properly met and vice versa.
- Collaboration leads to well-informed treatment decisions. Providers work together to develop compatible courses of treatment, increasing the chances for positive health outcomes and avoiding adverse interaction.
- Sharing relevant case information in a timely, useful and confidential manner is an Anthem Blue Cross and Blue Shield Medicaid requirement. We abide by standards set by the National Committee for Quality Assurance (NCQA) requiring health plans to ensure coordination of care between PCPs and behavioral health providers.

When PCPs and behavioral health providers should exchange health information

- When the member first accesses a physical or behavioral health service
- When a change in the member's health or treatment plan requires a change to the other provider's treatment plan (for example, when a member who has been taking lithium becomes pregnant)
- When the member discontinues care
- When the member is admitted to or discharged from the hospital
- When a member is admitted and a consultation is warranted
- Once a quarter if not otherwise required
- When a member has a physical exam and/or laboratory or radiological tests

Tips and tools for screening and follow-up care

When screening for substance abuse and depression, use standard screening tools or these brief screening questions. If your patient's answer to any of these questions is yes, refer the patient for a complete behavioral health evaluation. Contact us if you need help making this referral. Screenings should be completed annually.

In the last year, did you ever drink or use drugs more than you meant to?	Yes ☐ No ☐
Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	Yes ☐ No ☐
Over the past two weeks, have you felt down, depressed or hopeless?	Yes ☐ No ☐
Over the past two weeks, have you felt little interest or pleasure in doing things?	Yes ☐ No ☐

Doing well means doing well together for our members

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a program developed by NCQA to measure how effectively health plans and providers deliver preventive care. There are things we can do together to keep our members healthy.

- Follow-up visits after substance abuse diagnoses: People who stay in treatment for 90 or more days are less likely to use drugs after they are discharged. If treatment time is increased to 180 days, the likelihood of drug use after discharge falls more than 50%.
- Per HEDIS requirements, all patients with newly diagnosed substance abuse should be seen at least once within 14 days of being diagnosed and at least two or more times within 30 days of the initial visit.
- It's important to make sure patients begin treatment immediately upon diagnosis of substance abuse. If you need help arranging treatment for a newly diagnosed patient, call Provider Services at 855-661-2028.

Antidepressant medication management

Depressive disorders can have a significant negative impact on patients' quality of life and health care outcomes, and they are often diagnosed and initially treated in primary care. You should regularly monitor patients you're treating with antidepressant medications. Patients should also be maintained on these agents to allow for adequate trials.

We strive to meet the HEDIS goals for assessing the adequacy of the medication trials for members 18 years of age and older diagnosed with a new episode of major depression and treated with and kept on antidepressant medication:

- Effective Acute Phase Treatment — The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment — The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).
- We are here to help you ensure an adequate medication trial for patients whose treatment plan includes medication. Please call Provider Services at 1-855-661-2028 if you need help.

Follow-up visits after ADHD diagnosis

ADHD is a complicated disorder where treatment often involves a combination of counseling and medication. If treatment involves medication, it is very important to monitor this closely. We have adopted the HEDIS follow-up goals for medication follow-up:

- At least one follow-up visit with a practitioner within a month of the first prescription of ADHD medication for all 6- to 12-year-old children diagnosed with ADHD.
- At least two more follow-up visits in nine months for children who remain on the medication for at least 210 days.
- We can help you arrange follow-up visits for children with ADHD — just give Provider Services a call at 1-855-661-2028.

We're here to help!
We encourage you to use the *Coordination of Care Form* to cover all the bases when sharing information with your fellow providers. Log on to our secure provider website to access the form at https://mediproviders.anthem.com/ky.

If you have more questions or need help with a referral, contact your local Provider Relations representative or call Provider Services toll free at 1-855-661-2028.

Important information about UM

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

You can request a free copy of our UM criteria from our Medical Management department. Within seven calendar days of the date of denial, providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the numbers listed below.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and with Anthem Blue Cross and Blue Shield Medicaid when initiating or returning calls regarding UM issues.

You can submit precertification requests by:

- Calling us at 1-855-661-2028.
- Faxing to 1-800-964-3627.
- Submitting online at availity.com.

If you have questions about utilization decisions or the UM process, call our Clinical team at 1-855-661-2028 Monday through Friday from 7 a.m. to 7 p.m. local time.

Member's rights and responsibilities statement

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem Blue Cross and Blue Shield Medicaid has adopted a *Member's Rights and Responsibilities Statement,* which is located in your *Provider Manual*.

If you need a physical copy of the statement, call Provider Services at 1-855-661-2028.

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Medical Recalls

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In applicable circumstances, the appropriate modifier, condition code or value code (identified below) should be used to identify a medically recalled item. This will assist Anthem Blue Cross and Blue Shield Medicaid in identifying medically recalled items and support correct coding guidelines.

Applicable condition codes are 49 and 50. Condition code 49 signifies products replaced within the product lifecycle due to the product not functioning properly, and condition code 50 is used for product replacement for known recall of a product.

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Note: In circumstances where we have reimbursed the provider for repair or replacement of items or procedures related to items due to a medical recall, we are entitled to recoup or recover fees from the manufacturer and/or distributor as applicable. In circumstances where we have reimbursed the provider the full or partial cost of a replaced device and the provider received a full or partial credit for the device, we are entitled to recoup or recover fees from the provider.

Please refer to CMS and/or your state's guidelines, and the Medical Recalls reimbursement policy for additional details.

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Anthem Kentucky Managed Care Plan, Inc., independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Wisconsin Medicaid

Anthem adopts 22nd edition of MCG care guidelines

Effective with dates of service on and after May 7, 2018, Anthem Blue Cross and Blue Shield will begin using the 22nd edition of the MCG care guidelines.

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-855-558-1443.

PA required for Cabazitaxel

Effective September 1, 2018, prior authorization (PA) requirements will change for the following injectable drug Cabazitaxel (Jevtana) to be covered by Anthem. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, 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:

- Cabazitaxel (Jevtana) — injection, 1 mg (J9043)

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

- Web: availity.com
- Fax: 1-800-964-3627
- Phone: 1-855-558-1443

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at availity.com. Contracted and noncontracted providers who are unable to access Availity may call us at 1-855-558-1443 for PA requirements.

PA required for mepolizumab and reslizumab

Effective September 1, 2018, prior authorization (PA) requirements will change for injectable/infusible drugs mepolizumab (Nucala®) and reslizumab (Cinqair®). Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, 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:

- Mepolizumab (Nucala) — injection, 1 mg (J2182)
- Reslizumab (Cinqair) — injection, 1 mg (J2786)

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

- Web: availity.com
- Fax: 1-800-964-3627
- Phone: 1-855-558-1443

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal at availity.com. Providers who are unable to access Availity may call us at 1-855-558-1443.

ICR update

The Interactive Care Reviewer (ICR) tool offers a streamlined process to request inpatient and outpatient procedures as well as locate information on previously submitted requests for Anthem members via the Availity Portal.

What benefits does the ICR tool provide?

- Free and easy to use
- Access almost anywhere
- Preauthorization determinations
- Inquiry capability
- Fax reduction
- Ability to view decision letter
- Ability to save favorites
- Comprehensive view of all your preauthorization requests

How do I gain access to the ICR tool?

You can access the ICR tool through Availity. (Select **Authorizations & Referrals** from the *Patient Registration* drop-down menu in the upper left of the page.)

If you have not yet registered for Availity, go to availity.com and select **Register** at the top of the page. Select your **Organization Type** from the available options at the bottom of the page and follow the registration wizard.

How can I learn more about ICR?

Learn more about ICR by attending one of the monthly webinars. Register for the next webinar here.

Whom can I contact with questions?

For questions regarding our ICR tool, please contact your local Provider Network Relations representative.

For questions on accessing our tool via Availity, call Availity Client Services at 1-800-282-4548. Availity Client Services is available Monday to Friday from 8 a.m. to 7 p.m. ET (excluding holidays) to answer your registration questions.

Note: ICR is not currently available for Federal Employee Program, BlueCard® and some National Account members. ICR is also not currently available for requests involving transplant services or services administered by AIM Specialty Health® or OrthoNet LLC. For these requests, follow the same preauthorization process you use today.

Newborn claims processing

Effective November 1, 2018, Anthem will update the claims processing system to ensure accurate payment of newborn claims in accordance with Wisconsin normal newborn diagnosis-related group (DRG) requirements and Anthem's inpatient authorization requirements.

All newborn inpatient stays must have sufficient documentation provided to support an admission to an area beyond the newborn nursery, such as a neonatal intensive care unit (NICU) or for the higher level of care associated with the more complex newborn DRG. Documentation to support the higher level admission includes authorization or medical records.

Failure to provide the appropriate documentation will result in the claim being processed based on the normal newborn rate. Please note that current authorization guidelines for normal newborn and higher level of care baby inpatient stays will be applied.

For more information about this update, please go here.

Coding for obesity

Obesity is a serious issue in the United States. The obesity rate is rising. Obesity has significant health consequences, contributing to increased incidence of several diseases, including metabolic syndrome, high blood pressure, diabetes, heart disease, high blood cholesterol, sleep disorders and cancers.

For detail information on obesity HEDIS® measurements and coding, please view the full update here.

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

Vaccines for Children program

(Policy 05-022, effective 09/01/2018)

Anthem Blue Cross and Blue Shield allows reimbursement of the administration fee for vaccinations provided by the Vaccines for Children (VFC) Program for eligible members under the age of 19. Providers are required to report the procedure code of the actual vaccine administered. Medicaid providers who participate in the VFC Program and immunize children shall comply with all of the reporting requirements and procedures.

For additional information, please review the Vaccines for Children Program reimbursement policy at mediproviders.anthem.com/wi.

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Medical recalls

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