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Anthem news

New online provider forms are live!

We are pleased to announce that our three new provider eforms are now available on anthem.com! These forms have replaced former versions of our paper forms. The new Provider Maintenance Form can be accessed online at anthem.com > Providers > state > Answers@Anthem > Forms > Provider Maintenance Form. The new CAQH ID Number Request Form and New Provider Application Form are located on our new Join Our Networks webpage at anthem.com > Providers > state > Join Our Networks.

The Provider Maintenance Form should be used to request demographic and practice changes for existing participating providers. The New Provider Application Form should be used for new providers requesting participation in the Anthem networks or for existing non-participating providers who wish to join the Anthem networks. The CAQH Request ID Form should be used for new providers who do not have a CAQH ID and need to be sponsored by Anthem.
We are excited about these new forms, and we expect that they will result in faster processing of new provider participation requests for our Anthem networks as well as demographic change requests for participating providers.

The New Provider Application Form has 3 sections – Credentialed Providers, Ancillary Providers, and Non-Credentialed Providers. Note that the Credentialed Provider section requires minimal provider data because we will use the data contained on the CAQH application to credential and build the provider record in our systems; therefore, it is more important than ever that a provider’s CAQH information be accurate and kept current.

Please make note that beginning April 1, 2015, we will require the use of the new online forms and will no longer accept the old paper formats. If you have any questions about these new forms, please contact the Provider Call Center at 800-832-6011.

**Health care reform update**

**Health care reform updates on anthem.com**

Please be sure to check the Health Care Reform Updates and Notifications and Information about Health Insurance Exchanges sections of our website regularly for the latest updates on health care reform and health insurance exchanges.

**Administrative and policy update**

**ICD-10 updates: clinical documentation improvement**

Now is the time to focus on clinical documentation improvement (CDI). ICD-10 offers greater specificity than ICD-9, allowing documentation to be translated into an accurate and clear clinical picture. One of the best ways to prepare for the upcoming ICD-10 deadline is by improving your clinical documentation now. Visit our ICD-10 webpage for additional information and resources on this topic.

Coming in April 2015! We will be launching a free scenario-based coding practice tool designed to give professional providers and their coders the opportunity to test their knowledge of the ICD-10 codes set by applying it to medical scenarios. Look for more details in the next edition of Network Update.

**Update to claims processing edits and reimbursement policies**

On February 1, 2015, we will update our Anthem Online Provider Services (AOPS) website with the following new and/or revised reimbursement policies. The updates below identify if the article pertains to professional or facility provider billing.

**Anesthesia Services - professional**

In our policy dated February 1, 2015, we have added language to Section II. a. that we require the servicing modifier QK be listed in the first modifier field of the claim line when applicable in order to apply the correct percentage amount.

In addition, we have clarified some of the language in the policy; however, there is no change to the policy criteria. For example, section VIII for “Pain Management” is now titled “Postoperative Pain Management” and we have updated the title of the policy to “Anesthesia Services.” Please refer to the full text of the policy for further information.
Assistant Surgeon Coding and Assistant Surgeon Services

The Assistant Surgeon Coding table has been updated to add the new Current Procedural Terminology (CPT®) and Health Care Common Procedure Coding System (HCPCS Level II) codes effective January 1, 2015 as well as updates to existing codes per policy methodology that are not eligible for reimbursement for assistant at surgery services reported with modifiers 80, 81, 82, or AS: 15956, 20604, 20606, 20611, 20697, 20983, 22510-22515, 33270-33273, 33946-33949, 37191-37193, 40525, 40654, 43180, 44384, 44401-44408, 45346, 45347, 45349, 45350, 45355, 45355, 45383, 45387, 69400, 69401, 0226T, 0227T and 0319T-0325T.

The following codes were deleted from CPT as of January 1, 2015 and have been removed from the Assistant Surgeon Coding table: 21800, 22520-22525, 29020, 29025, 29715, 33961, 36469, 36822, 44383, 45339, 45345, 45355, 45383, 45387, 69400, 69401, 0226T, 0227T and 0319T-0325T.

The following codes are being removed from the denied list as they are allowed by the American College of Surgeons: 20101 and 21338.

In addition we have updated the effective date of our Assistant Surgeon Services policy to align with the effective date of our Assistant Surgeon Coding table.

Bundled Services and Supplies - professional

For claims processed on or after February 16, 2015, the following codes will be included in Section 1 of our policy to reflect that these services will not be eligible for reimbursement. Unless otherwise noted, these codes became effective 1/1/2015:

- 34839 (physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time)
- 99490 (chronic care management), 99497, and 99498 (advance care planning)
- 77061, 77062, 77063, and G0279 (digital breast tomosynthesis (DBT)); this information is also included in our Three-Dimensional (3D) Radiology Services Reimbursement Policy
- G0276 (blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial) (code effective date retroactive to January 9, 2015)
- G0472 (hepatitis C antibody screening for individual at high risk and other covered indication(s))(code effective date retroactive to June 2, 2014)
- G0473 (face-to-face behavioral counseling for obesity, group (2-10), 30 minutes)
- G6030-G6058 (drug screening)

As we advised in our August 2014 Network Update, we are reviewing and adding Healthcare Common Procedure Coding System (HCPCS Level II) “S” codes to our always bundled services edit. Unless there are specific, specialized contracts or criteria for a provider to report their services using a HCPCS temporary “S” code, we will consider “S” codes to be always bundled codes. Therefore, effective with dates of service on or after May 1, 2015 codes S0257, S1015, S1016, S3005, S4005, S4011, S4016, S4022, S4025, S4027, S4028, S4035, S4037, S4040, S4042, S8096, S8097, S8100, S8101, S9900, and S9901 will not be eligible for reimbursement.

In addition, we are adding HCPCS code G0431 and G0434 to our always bundled services edit for dates of service on or after May 1, 2015. This information will be included in Section 1 of our policy.
For claims processed on or after February 16, 2015, Section 2 of our policy will be updated to reflect that supplies and/or professional services such as an IV pole (HCPCS code E0776), infusion supplies (A4221, A4222 and E0781) and/or home therapy professional pharmacy services (S9810) will not be eligible for separate reimbursement when reported with a per diem home infusion therapy service (for example S5492-S5502, S9061, S9325-S9379, S9490-S9504, S9537-S9590) that includes supplies or home therapy professional services. Modifiers will not override this edit; therefore, this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

We are adding information to Section 2 of the policy that for claims processed on or after February 16, 2015, HCPCS code A4250 (urine test or reagent strips or tablets (100 tablets or strips)) will not be eligible for separate reimbursement when reported with CPT codes 81000-81003 (urinalysis). Modifiers will not override this edit therefore this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

For dates of service on or after May 1, 2015, Section 2 of our Bundled Services and Supplies Reimbursement Policy will be updated to reflect that when reported with electrical stimulator supplies (A4595) on the same date of service and/or within a 30 day period, electrodes (A4556) and lead wires (A4557) will not be eligible for separate reimbursement. Modifiers will not override this edit; therefore, this information will be included in our Modifier 59 (Distinct Procedural Service) Reimbursement Policy.

**Documentation Guidelines for Psychotherapy Services – professional**

A new policy outlining our documentation guidelines for reporting psychotherapy services will be effective February 1, 2015.

**Duplicate Reporting of Diagnostic Services – professional**

We will be posting a new policy titled Duplicate Reporting of Diagnostic Services. Effective for claims processed on or after March 16, 2015, if the ordering provider and the provider who actually performed the diagnostic services both report the same CPT/HCPCS code for the same patient on the same date of service, only the first claim processed will be eligible for reimbursement. ClaimsXten®, our claim editing system, will consider subsequent claims from any provider reported for the same diagnostic services for the same patient on the same date of service to be a duplicate service and the subsequent same service will not be eligible for separate reimbursement. For example: when the ordering provider sends a specimen to the laboratory, and the ordering provider and the laboratory both report the same CPT or HCPCS code, only the first claim processed will be eligible for reimbursement.

**Frequency Editing - professional**

Beginning with dates of service on or after May 1, 2015, we will apply a frequency limit of 2 units per 30 day period for electrodes per pair (A4556) and a frequency limit of 4 units per 365 days for lead wires per pair (A4557). We will also be removing the frequency limit information for HCPCS codes G0431 and G0434. Refer to our article for Bundled Services and Supplies for further information on G0431 and G0434.

**Surgical Pathology and Related Prostate Needle Biopsy – professional**

Effective January 1, 2015, HCPCS codes G0417-G0419 have been deleted and the definition of HCPCS code G0416 has been revised to remove the reference to 10-20 specimens. Our policy dated January 1, 2015 reflects these changes.

**Coding Tip: Vaccine Administration and Skin Tests - professional**

According to CPT Guidelines for Immunization Administration for Vaccines/Toxoids, it is stated to, “...report vaccine immunization codes, 90460, 90461, 90471-90474 in addition to the vaccine toxoid code(s) 90476-90749.” Therefore, vaccine administration codes should only be used to report the administration of vaccines and toxoids reported with codes that fall within the range of 90476-90749 and should not be reported for skin testing of bacterial, viral, or fungal extracts. (See the CPT Professional Edition Medicine Section—Immunization Administration for Vaccines/Toxoids.)
**FEP® to implement AIM Imaging Management Solution Program effective May 1, 2015**

We are dedicated to meeting the evolving needs of our members and we are pleased to announce that our Imaging Management Solution program will include the Federal Employee Program® beginning May 1, 2015.

Federal Employee plan members will participate in the Image Cost and Quality feature of the AIM Imaging Solution Program for outpatient and non-emergent radiology services.* After clinical appropriateness of the imaging service is confirmed and the choices are identified, a proactive call is made to the member to aide in scheduling the service at a “best value” site. This service guides our members to facilities offering high quality, affordable imaging services.

The following services are included in the AIM Imaging Cost and Quality program:

- Computed Tomography (CT) - joints, spine, abdomen, pelvis
- Magnetic Resonance Imaging (MRI) - joints, spine, abdomen, pelvis
- Nuclear Cardiology
- Positron Emission Tomography (PET)
- Resting Transthoracic Echocardiography (TTE)
- Stress Echocardiography (SE)
- Transesophageal Echocardiography (TEE)

Providers should contact AIM to obtain an order number before scheduling or performing any elective outpatient imaging service. AIM will begin taking calls for FEP on April 20, 2015 for dates of service May 1, 2015 or after.

To submit your request for an FEP member, contact AIM Specialty Health® (AIM) via their ProviderPortalSM at www.aimspecialtyhealth.com/goweb. You may also contact AIM at the dedicated FEP line of business number at 866-789-0397, Monday - Friday 6:00 a.m. –  6:00 p.m.

For the following imaging services, advanced benefit determinations are available by contacting FEP Utilization Management at 800-860-2156, or by fax 877-606-3807.

- Computed Tomography Angiography (CTA)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) Scans
- Nuclear Cardiology

*Services performed in conjunction with the emergency room services, inpatient hospitalization, or urgent- care facilities are excluded.

**FEP advanced benefit determination process**

Advance benefit determination (ABD) is a voluntary process offered to physicians and/or their representatives to prospectively submit a request for FEP member-specific services to the utilization management staff for medical necessity review and benefit determinations. ABDs are assigned a reference/authorization number when the review determines the medical necessity criteria have been met and/or benefits are available. This reference/authorization number will be included in the top right corner of the letter sent to the provider. The letter includes direction for the provider regarding how to use the
reference/authorization number for claims submission. If the ABD is approved, the provider can include the reference/authorization number on the post-service claim and the claim will be processed. This eliminates the need for the provider to submit the approval letter with each claim. The following note is included in the approval letter:

Note: To help ensure efficient and timely payment of claims when submitted, please include the authorization number from this letter on your claim.

**FEP® UM/CM call center hours changing effective March 1, 2015**

Effective March 1, 2015, the Federal Employee Program Utilization and Case Management Department is changing its hours of operation. The new hours of operation for the call center will be 8:00 a.m. to 6:00 p.m.

**2015 CPT/HCPCS code updates and reimbursement treatment**

On January 1, 2015, the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) released new CPT® and HCPCS codes. As we advised in a Network eUPDATE provider email on December 29, 2014, many codes released as part of their updates will be accepted by Anthem; however, the following new 2015 codes will not be eligible for reimbursement for our Commercial products only (which includes our Health Insurance Exchange Plans sold on or off the Exchange):

- Codes G6030 – G6058 (definitive drug testing) – Reimbursement will only be provided for the applicable new 2015 CPT codes.
- Code G0276 (blinded procedure for lumbar stenosis, clinical trial) – This code would only be payable for Medicare patients in their CED project.
- Code G0472 (hepatitis C antibody screening for high risk) – Reimbursement will only be provided for the applicable existing CPT code.
- Code G0473 (group behavioral obesity counseling) – Reimbursement will only be provided for the applicable existing CPT code.
- Code 99490 (chronic care management service) – Chronic care management services are an integral component of our value based payment innovation programs.
- Codes 99497 - 99498 (advance care planning service) – Advance Care Planning services are an integral component of our value based payment innovation programs.
- Code 34839 (physician planning for endograft) – Physician planning for surgery is an integral component of the surgical procedure.

**Increasing communications from us via email**

We are increasing the number of communications sent to you via email. Unless you have noted Anthem as a safe sender, our emails to you may be automatically filed in your junk email folder. Be sure to regularly check your junk email folder to ensure that you are aware of any email we send to you. We suggest that you consider adjusting your email settings to allow our emails to go directly to your inbox.

**BMI facility reimbursement policy**

As part of our ongoing commitment to share current administrative, billing, and reimbursement policies with you, we've posted a Facility Policy titled Documentation and Reporting Guidelines for the Diagnosis of Body Mass Index ≥ 40 that will...
Enhancements to AIM clinical appropriateness guidelines for advanced imaging effective May 2015

On May 4, 2015, we will implement changes to our clinical appropriateness guidelines for radiology, cardiology and oncologic PET for our commercial and Medicare Advantage Plans. A summary of those changes is provided below.

- **Head & Neck Appropriate Use Criteria**
  - Expansion of criteria for MRI and CT brain allowing for evaluation prior to discontinuation of antiepileptic medications when a patient has not had a prior MRI
  - Expansion of existing criteria for MRI and CT brain for evaluation of sensorineural hearing loss
  - Addition of new criteria for MRI, MRA, CT, and CTA brain for evaluation of tinnitus
  - Addition of new criteria for MRI orbit, CT maxillofacial, and CT neck (soft tissue) for evaluation of osteonecrosis of the jaw

- **Chest Appropriate Use Criteria**
  - Infectious and inflammatory criteria for CT chest are further differentiated at the condition level
  - Addition of several new criteria for CT chest include bronchopleural fistula, complications of pneumonia and paraneoplastic syndrome with unknown primary tumor or origin

- **Abdomen & Pelvis Appropriate Use Criteria**
  - Addition of new criteria for MRI and CT abdomen for evaluation of iron deposition/overload in patients with hemochromatosis when they are candidates for chelation therapy
  - Addition of new criteria for CTA abdomen and pelvis for evaluation of visceral artery aneurysms

- **Musculoskeletal Appropriate Use Criteria**
  - Clarification of criteria for MRI and CT spine when evaluating cord compression
  - Removal of criteria allowing CT cervical and thoracic spine evaluation for MS, myelopathy and spinal cord infarct (note: these are still available under MRI)
  - Revision of criteria for MRI upper extremity evaluation of nonspecific upper extremity pain

- **Oncologic PET Appropriate Use Criteria**
  - Enhancement of clinical criteria for thyroid cancer

- **Cardiology Appropriate Use Criteria**
  - Addition of new criteria allowing stress echo and MPI evaluation of patients awaiting solid organ transplantation
  - Clarification of criteria for stress echo and MPI evaluation of patients who have undergone percutaneous coronary intervention (PCI) greater than three years ago
  - Clarification of criteria for stress echo, resting echo and MPI evaluation for cardiac arrhythmias redefining frequent premature ventricular contractions
  - Modification of criteria for resting echo reevaluation of patients who have undergone implantation of a bioprosthetic valve to allow imaging seven years after the procedure and then annually thereafter

- **New Pediatric Guidelines**
In addition to the changes above, AIM has developed a set of radiology guidelines that are specific to pediatric members. These guidelines include:

- Pediatric Abdomen & Pelvis
- Pediatric Chest
- Pediatric Head & Neck
- Pediatric Musculoskeletal
- Fetal MRI

The guidelines listed above bring together criteria from AIM’s adult guidelines applicable to pediatrics with new criteria specific to pediatric members.

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click here to access and download a copy of the current guidelines.

Expanded list of outpatient procedures for predetermination

Our standardized review process for certain outpatient procedures allows providers to determine the member’s benefits before rendering the service/procedure. Below are some upcoming additions to the list of services for which we recommend predetermination of benefits effective May 1, 2015 for all Anthem local plans. Note: Does not apply to BlueCard®, Anthem secondary, National Accounts, Medicare supplemental, Medicare Advantage, Federal Employee Plan® (FEP), or Taft-Hartley.

**Predetermination is recommended for the following new medical policies and clinical guidelines services effective May 1, 2015**

- SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and other Genitourinary Conditions. Codes added for clinical review: 52441 and 52442.
- SURG.00033 Implantable Cardioverter-Defibrillator (ICD). Codes added for clinical review: 33270, 33271, 33272, 33273, 93260, 93261 and 93644.
- SURG.00055 Cervical Artificial Intervertebral Disc. Codes added for clinical review: 22858 and 0375T.
- CG-SURG-09 Temporomandibular Disorders. Codes added for clinical review: 20606 and S8262
- MED.00005 Hyperbaric Oxygen Therapy (Systemic/Topical). Code G0277 added for clinical review: replaces C1300
- SURG.00067 Percutaneous Spinal Procedures (Vertebroplasty, Kyphoplasty, Sacroplasty). Codes added for clinical review: 22510, 22511, 22512, 22513, 22514 and 22515

Note:
It is important to identify whether the request is for outpatient or inpatient on your faxed request for review. In addition, if the provider does not initiate the predetermination process, records may be requested for post service review based on the same criteria listed in the applicable medical policy or clinical guideline.

To obtain a copy of any clinical guideline or medical policy, visit anthem.com > Providers > select state > enter > Medical Policies and Clinical UM Guidelines.
Medical necessity review of lumbar spinal surgeries

We have updated our current lumbar spinal surgery medical necessity review list effective May 1, 2015 to add an additional code. The spine surgeries that will be reviewed include but are not limited to fusion surgeries, excision of disc, and decompression surgery. We utilize medical policy, Clinical Guidelines and Milliman CareGuidelines (MCG) which provide review criteria for these procedures.

New code added effective May 1, 2015

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63267</td>
<td>Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar</td>
</tr>
</tbody>
</table>

This change applies only to Anthem’s local plans. Note: Does not apply to BlueCard®, Anthem secondary, National Accounts, Medicare supplemental, Medicare Advantage, Federal Employee Plan (FEP®), or Taft-Hartley.

Although a predetermination is not required, we encourage providers to obtain one prior to performing any of the procedures on our revised list. Please be aware that records documenting the medical history and results of treatment and radiographic evaluations will be needed as part of this review whether done as a predetermination or as part of the claim submission. It is important to note that if a review of a spine surgery claim results in a denial of benefits due to medical necessity, the claim will be denied and will not be billable to the member.

Please note: This review does not replace any existing medical policies currently in place for other types of spine surgery not listed above.

Predetermination available for additional specialty pharmacy drugs beginning May 1, 2015

We will be offering predetermination for clinical review for the following specialty pharmacy drugs beginning May 1, 2015. Note that these drugs are being added to the existing list of drugs for which predetermination is already available. These changes will apply only to Anthem’s local plans. Note: Does not apply to BlueCard®, Anthem secondary, National Accounts, Medicare supplemental, Medicare Advantage, Federal Employee Plan® (FEP), or Taft-Hartley.

New drugs added to Medical Policy effective May 1, 2015

- **DRUG.00065** Recombinant Coagulation Factor IX, Fc Fusion Protein (rFIXFc) (Alprolix™). Code J7199 added for clinical review.
- **DRUG.00067** Ramucirumab (Cyramza™). Code J3590 added for clinical review.
- **DRUG.00068** Vedolizumab (Entyvio™). Code J3590 added for clinical review.
- **DRUG.00069** Recombinant Antihemophilic Factor, Fc Fusion Protein (Eloctate™). Code J7199 added for clinical review.
- **DRUG.00070** Siltuximab (Sylvant™). Code J3590 added for clinical review.
- **DRUG.00071** Pembrolizumab (Keytruda®). Code J9999 added for clinical review.
- **DRUG.00066** Antihaemophilic Factor and Clotting Factors. Codes added for clinical review: J7178, J7180-J7183, J7185-J7187, J7189-J7195, J7198 and J7200.
- **DRUG.00017** Hyaluronan Injections in Joints other than the Knee (Monovisc). Code J7327 added for clinical review.
- **CG-DRUG-38** Pemetrexed Disodium (Alimta®). Changes: additional clinical criteria added for code J9305.
CG-DRUG-03 Beta Interferons or Glatiramer Acetate for Treatment of Multiple Sclerosis. Code added for clinical review: J3490 (Plegridy).

If a predetermination is not requested, the claim will be reviewed post service for medical necessity. Please contact Utilization Management for a predetermination via one of the following options:

Fax: Predetermination fax form available on provider website: anthem.com > Providers > select State > Answers@Anthem > Forms > Predetermination forms.

Phone: 800-392-1016

New audit vendor effective January 1, 2015

On January 1, 2015, Anthem added an additional audit vendor, Connolly, Inc., to conduct market diagnosis related group (DRG) audits. Connolly is working with the current audit vendor in your state. The addition of Connolly is expected to be completed by March 31, 2015.

We are working with Connolly and your state’s current audit vendor to help ensure that they do not submit duplicate requests/contact with you.

No cost cultural competency trainings for providers - CME/CEU credits awarded

Your patients are becoming more racially, culturally and linguistically diverse. As such, there is an increased emphasis on cultural competence training for physicians, nurses, and other healthcare professionals who interact with these patients on a daily basis. Research shows that clinicians that are provided with multicultural training are better able to serve these growing patient populations, and are more likely to improve patient satisfaction, adherence, and patient outcomes, as well as increase their market share from some of the nation’s fastest growing communities.

We are excited to offer providers the following two culturally and linguistically targeted e-learning courses: 1) Viewpoints: Clinical Competence in a Globally Mobile World and 2) Language Access and the Law: Caring for the Limited English Proficient (LEP) Patient. These courses are offered to providers and appropriate office staff at no cost and provide AMA Category 1 CME/CEU credits.

To learn more about how to register for and complete these free trainings, visit our course summaries web page.

Inovalon requests for 2015

Just as in 2014, we have engaged Inovalon – an independent company that provides secure, clinical documentation services – to help us comply with provisions of the Affordable Care Act that require us to assess members’ relative health risk level. In the coming weeks and months, Inovalon will begin sending letters to providers as part of a new risk adjustment cycle, asking for their help with completing health assessments for some of our members.

If you worked with Inovalon in 2014, many thanks for your help. This year will bring a new round of assessments. As always, if you have questions about the requests you receive, you can reach Inovalon directly at 877-448-8125.
Guidance for provider grievances

As a provider, you have the right to submit grievances for any issues you are experiencing with us. The complaints against the plan can be for unsatisfactory interactions, inappropriate responses, staff behavior, delays, phone access, and insufficient reasons for denial. You can also file complaints about a remittance advice if it seems unclear, inaccurate, if there are HIPAA concerns, or any other issues. You may also submit complaints about our Availity system or membership issues such as eligibility information on a card. You would submit these complaints as you do today through the standard dispute/appeals process.

Electronic data interchange (EDI)

Electronic claim resubmission reminders

When submitting an 837 claim resubmission and requesting an adjustment, please be sure to use the appropriate frequency code and ORN (original reference number):

- Frequency 5: claim has late charges only, which could include adding a line with late charges
- Frequency 7: replacement of a prior claim; not to be used in lieu of late charges
- Frequency 8: complete void/cancel of prior claim

At any time when an 837 resubmission is submitted, the ORN (original reference number) must always be submitted. Please refer to the HIPAA 5010 TR3 and or NUBC documentation.

Medicare Advantage (MA) update

PCPs - no need to call to obtain referrals for Medicare Advantage HMO members

We value the role that primary care physicians play in helping to coordinate care for our Medicare Advantage HMO members. As such, we ask that you serve as their primary contact for referring them to other specialist and providers and that you document such referrals in individual member’s medical records.

To help ensure the highest level of benefits and coordination of care for Anthem members and streamline the approval process for your office, it’s important that you refer members to in network providers whenever possible. When you do, you will not need to contact us for preapproval of those referrals. Additionally, keep the following in mind:

- For in-network providers, members do not need a new referral simply because they are being seen in a new calendar year.
- Referrals from a PCP are not required for emergency care or urgently needed care.
- Certain routine care can be obtained without having an approval in advance from their PCP, such as routine women’s health care (breast exams, screening mammograms, Pap tests and pelvic exams) and routine dental and vision care.

Please visit our website for more detailed information on when precertifications are required or contact Provider Services at the number on the back of the member's ID card. You can find Important Medicare Advantage Updates here.
Anthem Blue Cross and Blue Shield is an HMO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Reminder: clinical information required for Medicare Advantage members

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Medicare Advantage members. These members rely on their health care professionals and their health plan to help coordinate this important aspect of their care. To do this, timely communication is essential. Please refer to your provider agreement and the Medicare Advantage HMO & PPO Provider Guidebook to help ensure that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review when clinical information is needed.

Please note that Anthem Medicare Advantage plans administer Medicare coverage for our Medicare Advantage members and follow Medicare guidelines. If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

Medicare Advantage member identification prefixes updated for 2015

On January 1, 2015, individual (non-group) Medicare Advantage members' claims were moved to a new claims processing system, and member identification prefixes were updated as part of that transition. Please submit services rendered in 2014 with the 2014 prefix and 2015 services with the new 2015 prefix to help ensure claims are delivered to the appropriate claims system for processing.

The 2015 member identification prefixes for individual Medicare Advantage plans are listed below.

2015 Individual Medicare Advantage plans

<table>
<thead>
<tr>
<th>Prefix</th>
<th>State</th>
<th>Plan Type</th>
<th>Plan Name</th>
<th>Provider and member service</th>
<th>CMS contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>VOI</td>
<td>CT</td>
<td>MA HMO</td>
<td>MediBlue HMO</td>
<td>866-673-4157</td>
<td>H5854</td>
</tr>
<tr>
<td>VHJ</td>
<td>CT</td>
<td>MA PPO</td>
<td>Anthem MediBlue Preferred (PPO)</td>
<td>855-558-1437</td>
<td>H2836</td>
</tr>
<tr>
<td>VOU</td>
<td>CT</td>
<td>MA HMO/SNP</td>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>866-673-4157</td>
<td>H5854</td>
</tr>
<tr>
<td>VOQ</td>
<td>ME</td>
<td>MA LPPO</td>
<td>Medicare Advantage LPPO - Maine</td>
<td>855-304-1785</td>
<td>H6786</td>
</tr>
<tr>
<td>VOM</td>
<td>ME</td>
<td>MA HMO</td>
<td>Med Advantage HMO - Maine</td>
<td>855-310-2472</td>
<td>H8432</td>
</tr>
<tr>
<td>VOS</td>
<td>ME</td>
<td>MA HMO/SNP</td>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>855-310-2472</td>
<td>H8432</td>
</tr>
<tr>
<td>YGU</td>
<td>NH</td>
<td>MA HMO</td>
<td>Med Advantage HMO - New Hampshire</td>
<td>855-310-2473</td>
<td>H3536</td>
</tr>
<tr>
<td>VON</td>
<td>NH</td>
<td>MA LPPO</td>
<td>Medicare Advantage LPPO - New Hampshire</td>
<td>855-304-1787</td>
<td>H7728</td>
</tr>
</tbody>
</table>
Sample ID cards are available at the Medicare Advantage public provider portal.

Group-sponsored Medicare Advantage plan members are not affected by these changes. Members with the following member identification prefixes on their member card will represent group sponsored business only and will remain on the current claims processing platform:

JQF, JWM, VZM, VZP, WGK, WSP, XDK, XDT, XGH, XGK, XKJ, XVJ, XVL, YCG, YGJ, YGS, YLR, YLV, YRA, YRE and YRU

OrthoNet authorization phone and fax numbers updated; use for medical necessity reviews and professional service coding reviews

We are collaborating with OrthoNet, LLC to conduct medical necessity reviews for physical therapy, occupational therapy and spine and back pain management for our individual Medicare Advantage members.

What does this mean to you?
As previously published, effective January 1, 2015, the following services/treatment requests must be reviewed by OrthoNet for precertification.

- Physical therapy (applies to professional and outpatient services)
- Occupational therapy (applies to professional and outpatient services)
- Spine and back pain management procedures (applies to professional, inpatient and outpatient services):
  - Epidurals
  - Facet blocks
  - Pain pumps
  - Neurostimulators
  - Spinal fusion
  - Spinal decompression
  - Vertebro/kyphoplasty

In addition, OrthoNet will conduct post service prepayment coding review of professional services, including:

- Orthopedic surgery
- Plastic surgery
- Neurosurgery
- Sports medicine
- Podiatry
- Hand surgery
- Neurology
- Pain management
- Psychiatry/physical medicine and rehabilitation (PM&R)
- ENT
- General surgery
- Dermatology
- Cardiology
Urology

Percutaneous coronary intervention (PCI)

Precertification numbers

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Telephone number</th>
<th>Fax number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical and occupational therapy</td>
<td>844-340-6418</td>
<td>844-340-6419</td>
</tr>
<tr>
<td>Spine and back pain management</td>
<td>844-788-4805</td>
<td>844-788-4806</td>
</tr>
</tbody>
</table>

A complete list of precertification requirements can be found at the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal at www.anthem.com/medicareprovider.

Medicare Advantage CMS 1500 claims require CLIA & ADI information effective July 1, 2015

Effective July 1, 2015, Individual Medicare Advantage professional claims billed on a CMS 1500 claim form without CMS required criteria will be denied. The denials will include:

- Advanced diagnostic imaging (ADI) supplier not accredited for the service being billed
- Clinical laboratory improvement amendment (CLIA) certification is missing or invalid, based on the laboratory code billed. CLIA certification should be billed in Box 23 on the claim form. Starting in March, an informational message will be included on your remittance when you bill a laboratory code that requires certification reminding you that beginning July 1, 2015, claims will be denied when CLIA certification is not included.

Please ensure your billing staff is aware of these changes. If you have any questions, please contact the Provider Services number on the back of the member’s ID card.

Routine physical exams are covered in 2015

Our Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2015 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers will be subject to member co-pay as applicable by the member’s plan.

Our Medicare Advantage plans also will continue to provide benefits for the following Medicare covered services:

- Initial preventive physical exam (IPPE) also known as the “Welcome to Medicare Preventive Visit”
- Annual wellness visit (AWV)

The IPPE and AWV are not routine physical exams. Please refer to the chart below to help ensure accurate coding for each type of exam.
<table>
<thead>
<tr>
<th>The Welcome to Medicare Visit (IPPE) G0402</th>
<th>The Annual Wellness Visit (AWV initial and subsequent) G0438 &amp; G0439</th>
<th>Routine Physicals/Preventive Medicine Services (99381-99397) Continued coverage in 2015 by Anthem Medicare Advantage Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0402 - Welcome to Medicare Visit/Initial Preventive Physical Exam A preventive evaluation and management service; a face-to-face evaluation. This exam is a preventive physical exam and not a comprehensive physical checkup. This service is limited to new beneficiaries during the first 12 months of Medicare enrollment. This is a once in a lifetime benefit.</td>
<td>G0438 - Initial Annual Wellness Visit (AWV): Services limited to beneficiary during the second year the member is eligible for Medicare Part B. Only one first AWV per beneficiary per lifetime. Includes a personalized prevention plan of services; face-to-face visit. G0439 – Subsequent Annual Wellness Visit (AWV): One year after the member’s annual wellness visit. Once every 12 months. Includes a personalized prevention plan of services; face-to-face visit. This exam is a preventive physical exam and not a comprehensive physical checkup.</td>
<td>99381-99397 - Preventive Medicine Services: The examination for this visit is multi-system, and the exact content and extent of the exam is based on the member’s age, gender, and identified risk factors; face-to-face visit. “The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.” Includes clinical laboratory tests.</td>
</tr>
</tbody>
</table>

OB/GYN providers please note: A Pap test and pelvic exam for our Medicare Advantage members is covered annually only if at high risk for developing cervical or vaginal cancer, or childbirthing age with abnormal Pap test within past three years. Otherwise a Pap test and pelvic exam is covered every two years for women at normal risk. These services should be filed as separate codes from the routine physical, if they are rendered.

Medicare Advantage member benefits are subject to change from year to year – please review 2015 benefits on the Medicare Advantage Providers page of the Anthem provider portal. Annual summaries of Medicare Advantage plan changes also can be found under Important Medicare Advantage Updates.

For further information or to verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member’s identification card.

**Individual MA claims have moved to a new claims system**

Effective January 1, 2015, we moved Individual (non-group) MA member claims to a new processing system. This new system has some new and updated MA reimbursement policies. These policies will be in effect unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Please continue to check Important Medicare Advantage Updates on your provider portal for additional information.
Home health claims – split dates of service for 2014 and 2015

To expedite the processing of your home health claims, please split the date of services for your 2014 and 2015 services. Please review the following information to help ensure your claims are processed accurately and efficiently.

When billing for your home health services please bill the dates of services using calendar year format.
Example:
   Actual dates of service 12/18/2014 through 1/20/2015
   Submit a claim for:
       Dates of service 12/18/2014 through 12/31/2014
       Dates of service 1/01/2015 through 1/20/2015

Submit only one place of service per claim

Medicare Advantage providers should not submit claims with more than one place of service. Please submit separate claims for each place of service.

Law excludes some Part D drugs; Customer Service ready to help with members’ questions

There are some drugs that are excluded from the majority of Medicare Part D coverage by law. These include:

- Drugs for:
  - Anorexia, weight loss or weight gain (except to treat physical wasting caused by AIDS, cancer or other diseases)
  - Fertility
  - Cosmetic purposes or hair growth
  - Relief of the symptoms of colds, like a cough and stuffy nose
  - Erectile dysfunction
  - Durable medical equipment
- Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs (over-the-counter drugs)

A few plans may cover the above as an enhanced benefit. If there is a question of coverage, please have the member call their customer service line on the back of their benefit card.

$0 copay medications available to Medicare Advantage members with chronic conditions

New to Individual MAPD plans in 2015, select drugs will be available at a $0 member co-pay for the following conditions: high blood pressure, high cholesterol and diabetes. Medications include Glipizide, Lisinopril, Losartan, Metformin Hcl and Simvastatin.

Group-sponsored plans will continue to offer the Select Generics benefit, which offers $0 copay for select generic drugs.

Avoid second fills of high-risk medications

We are required to monitor prescription activity for high-risk medications as defined by The Centers for Medicare & Medicaid Services (CMS) to improve patient safety.
To help ensure providers are aware of any high-risk medications prescribed for our Medicare Advantage members, we fax a list of high-risk medication claims to providers each week. We also distribute a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication fax or report from us, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed at www.anthem.com/maprovidertoolkit.

Provider requirements and Medicare notices

The Centers for Medicare & Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two (2) days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires providers to deliver the Important Message from Medicare about Your Rights (IM) notice to every Medicare beneficiary within 2 calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than 2 calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, we periodically conduct IM and NOMNC Audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

Our audit findings show providers would benefit from focusing in on the following elements required by CMS:

- NOMNC Notices:
  - Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
  - Include the beneficiaries Health Care Identification Number or Medical Record Number on page one
  - Include the specific type of services ending on page one
  - Include the Health Plans contact information on page two
  - Have the beneficiary or authorized representative sign and date page two at least two (2) days prior to the end of services
  - Retain a copy of the signed notice, both page one and page two.

- IM Notices:
  - Deliver notice to Managed Medicare beneficiaries the way you do to Traditional Medicare beneficiaries
  - Include the physician's name on page one
  - Have the beneficiary or authorized representative sign and date page one within 2 calendar days of the date of an inpatient hospital admission
  - Call the authorized representative to deliver the IM when the beneficiary is unable to sign
  - Deliver the IM, or copy of the IM again, no sooner than 2 calendar days before discharge
  - Retain a copy of the signed notice, both page one and page two.

To download the standardized IM/NOMNC Notices required by CMS, along with accompanying instructions, go to CMS website at www.cms.hhs.gov/bni or refer to the specific links below:
ICD-10-CM: ICD-9 vs. ICD-10 for atrial fibrillation and flutter

In previous articles, we shared some basic information and recommendations to help identify how specific ICD-9 codes will be impacted by the implementation of ICD-10.

The diagnosis data we receive from providers is critical to help meet the health care needs of our members and remain compliant with Centers for Medicare & Medicaid (CMS) regulatory requirements. The information below supports accurate and complete diagnoses reports and ensures the medical chart documentation for each encounter supports and validates the reported diagnoses codes. This helps avoid unnecessary and costly administrative revisions as a result of an audit.

This article focuses on atrial fibrillation and flutter. According to the ICD-10 codebook, atrial fibrillation and flutter are the most common abnormal heart rhythms (arrhythmia) presenting as irregular/regular, rapid beating (tachycardia) of the heart’s upper chamber. The ICD-10 code set provides multiple codes that represent a progressive path (severity of illness) for atrial fibrillation, requiring more specificity for accurate code assignment. The table below demonstrates what terms need to be documented in ICD-10 to appropriately capture the type of atrial fibrillation and flutter.

<table>
<thead>
<tr>
<th>ICD-9 (Single code)</th>
<th>ICD-10 (Multiple specific codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>Atrial Fibrillation</td>
</tr>
<tr>
<td>427.31 (Established or Paroxysmal)</td>
<td>148.0 Paroxysmal</td>
</tr>
<tr>
<td></td>
<td>– Irregular, rapid atrial contractions</td>
</tr>
<tr>
<td>Atrial Flutter</td>
<td>148.1 Persistent</td>
</tr>
<tr>
<td>427.32</td>
<td>– Rapid contractions of the upper heart chamber</td>
</tr>
<tr>
<td></td>
<td>148.2 Chronic</td>
</tr>
<tr>
<td></td>
<td>– Permanent atrial fibrillation</td>
</tr>
<tr>
<td></td>
<td>148.3 Typical</td>
</tr>
<tr>
<td></td>
<td>– Type I atrial flutter</td>
</tr>
<tr>
<td></td>
<td>148.4 Atypical</td>
</tr>
<tr>
<td></td>
<td>– Type II atrial flutter</td>
</tr>
<tr>
<td></td>
<td>Unspecified atrial fibrillation and flutter</td>
</tr>
<tr>
<td></td>
<td>148.91 Unspecified atrial fibrillation</td>
</tr>
<tr>
<td></td>
<td>– Type not specified</td>
</tr>
<tr>
<td></td>
<td>148.92 Unspecified atrial flutter</td>
</tr>
<tr>
<td></td>
<td>– Type not specified</td>
</tr>
</tbody>
</table>
In future articles, we will continue to bring you helpful coding tips to assist you and your coding staff with the transition from ICD-9 to ICD-10.

CMS will not accept ICD-9 codes for dates of service beginning on October 1, 2015. It will be critical to keep this in mind as all encounters/claims submitted with ICD-9 codes will reject beginning October 1, 2015 resulting in delay or denial of payment. We all must be prepared to meet CMS guidelines.

To further assist you in your preparation we are providing the following references, helpful links and additional resources:

- The one-page reference sheet produced by AAPC shows how the code sets are organized, with easy color coding to help you find what you’re looking for. It also has mnemonic tips (such as “C is for cancer” and “T is for toxicity”) to help you remember where the new codes are located.
- American Medical Association physician resource page
- Centers for Medicare & Medicaid Services (CMS) Provider Resources
- AAPC ICD-10 Implementation and Training Opportunities

Compounded drugs no longer covered for individual MAPD and PDP plans

Effective January 1, 2015, compounds are no longer a covered benefit for individual MAPD and PDP plans. Members who had a compound prescription filled in the last six months of 2014 were notified of this coverage change via mail and/or phone.

Please note that members of group sponsored MAPD and PDP plans will have coverage for only the Part D eligible drugs that are part of a compound.

If you believe the compounded medication you have prescribed is medically necessary, the member may request an exception. The prescriber must provide a statement along with the exception request that explains the medical reasons for supporting the exception.

New D-SNP plans offered in 2015; D-SNP training available

We now offer dual eligible special needs plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs) in ME and CT. D-SNPs coordinate Medicare and Medicaid programs and provide enhanced member benefits.

We are offering an introduction to D-SNP plans, including claims submission, coding procedures and model of care information. Providers can access the training as it becomes available at the Medicare Advantage Public Provider Portal and under Important Medicare Advantage Updates.

Prior authorization required for members

We want to remind providers that they are required to request a prior authorization for Medicare Advantage members for services that require prior authorization. Failure to obtain a prior authorization will result in an administrative denial. The 2015 prior authorization requirements were posted to the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal on October 4, 2014. Members cannot be balance billed for an administrative denial.
To obtain prior authorization or to verify member eligibility, benefits or account information, please call the telephone number listed on the member's plan membership card.

Please visit the Provider Forms section of the Anthem Medicare Advantage Public Provider Portal at www.anthem.com/medicareprovider to see the prior authorization list that is effective for 2015 as well as prior authorization requirements for 2014.

New 2015 precertification fax number for skilled nursing, long term acute care and inpatient rehab

Effective January 1, 2015, we will have a separate fax number for providers and facilities to use for Medicare Advantage members. The new fax numbers should only be used when submitting precertification requests or additional clinical information for the following services:

- Skilled nursing facility (SNF)
- Long term acute care (LTAC)
- Inpatient rehabilitation

The precertification fax number for skilled nursing, long term acute care and inpatient rehab is 877-744-2319.

Please note, submitting requests for services not listed above may cause a delay in processing requests.

Behavioral health update

Behavioral health providers – please review the entire newsletter

While the articles in this section are of specific interest to participating behavioral health providers, there are other articles in this publication that apply to or could be of interest to behavioral health providers as well. Please review the entire issue. In addition, please note that the information and articles in this newsletter related to behavioral health services are for plans and products managed by Anthem Behavioral Health.

Member outpatient satisfaction survey

As part of our accrediting process by the National Committee on Quality Accreditation (NCQA), we are now measured on our member's satisfaction with their outpatient provider and the treatment and experience, in general. We are responsible for evaluating our member's experience and implementing action items to improve the experience by identifying trends with our outpatient provider network. In order to measure the experience, we have instituted an annual survey sent to our member’s based on receipt of an outpatient behavioral health claim from a participating professional behavioral health provider. The survey consists of questions around the ease of scheduling an appointment, access and availability, wait time at the office, the office environment, receiving appropriate education and general outcome – including whether the patient feels that therapy has or is helping the issue that brought them into the office as well as other aspects of the overall outpatient experience. The survey will be mailed to members in the spring, based on claims processed through winter 2015.
Quality programs update

HEDIS® 2015 measure: controlling high blood pressure

One of the HEDIS measures we are collecting this year is Controlling High Blood Pressure. This measure is collected on members ages 18 to 85 with a diagnosis of hypertension. The following items are needed from the member’s medical record:

- This measure requires the earliest documented date of hypertension (prior to 7/1/14) found in your medical record. For example, the earliest documented date might not be in 2014, but instead, several months or years earlier. If the member’s earliest documented date of hypertension actually is 7/1/14 or after, please be sure to include a note verifying the validity of that date when you submit the records for that member. The diagnosis can be found on a dated history form, a problem list, or a progress note.

- Blood pressure (BP) reading(s) from the last two visits in 2014. This does not have to be from a hypertension diagnosis; the last two blood pressure readings can be from any diagnosis in 2014. Please note – the blood pressure readings cannot be from the same date as the earliest documented hypertension date listed above, or from the same day as a major diagnostic or surgical procedure. Please include all BP readings for the last two visits documented in progress notes and/or vital signs flow sheets.

If the following applies to the member, please submit additional documentation:

- If the member has end stage renal disease, is receiving renal dialysis or a history of renal transplant, provide documentation with date of occurrence.
- If the member was pregnant in 2014, provide documentation of pregnancy.
- If the member had a non-acute inpatient admission during 2014, provide documentation of admission.

Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures.

We look forward to working with you this HEDIS season and thank you in advance for your continued cooperation and support of HEDIS.

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

Easy submission of HEDIS medical records

We want to make returning HEDIS medical records as easy as possible for your office. To return the time sensitive medical record documentation back to us in the recommended 5 day turnaround time, simply choose one of these options:

- Upload to our secure portal. This is quick and easy. Logon to www.submitrecords.com, enter the password: wphedis57 and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.

- Send a secure fax to 1-888-251-2985.

- Mail to us via the US Postal Service to: Anthem Blue Cross and Blue Shield, 10897 S. River Front Parkway, Suite 110H, South Jordan, UT 84095-9984
We began requesting medical records in January via phone followed by a fax. Contact information will be included with the fax should you have any questions. We thank you in advance for your support of HEDIS.

**Clinical practice and preventive health guidelines available on anthem.com**

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website at anthem.com > Providers > Select state > Health & Wellness > Practice Guidelines.

**Pharmacy update**

**Pharmacy information available on anthem.com**

Visit [http://www.anthem.com/pharmacyinformation](http://www.anthem.com/pharmacyinformation) for more information on the following:

- 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
- other requirements, restrictions or limitations that apply to certain drugs

The commercial drug list is reviewed and updates are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate the 'Marketplace Select Formulary' and pharmacy information for health plans offered on the Exchange Marketplace, go to Customer Support, select Maine, Download Forms and choose ‘Select Drug List’.

**Medical policy update**

**Medical policy updates are available on anthem.com**

The following new and revised policies were endorsed at the August 14, 2014 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com > Providers > Select state > Enter > Medical Policies and Clinical UM Guidelines.

If you do not have access to the Internet, you may request a hard copy of any updated policy by calling Provider Service at 800-832-6011.

**Revised medical policies effective November 17, 2014**

(The following policies were revised to expand medical necessity indications or criteria.)
DRUG.00002  Tumor Necrosis Factor Antagonists
DRUG.00015  Prevention of Respiratory Syncytial Virus Infections
DRUG.00028  Intravitreal and Periocular Injection Treatment for Retinal Vascular Conditions
DRUG.00032  Intravitreal Corticosteroid Implants
DRUG.00041  Rituximab (Rituxan®)
SURG.00064  Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure

Revised medical policies effective January 1, 2015
(The following policies were revised to expand medical necessity indications or criteria.)

DRUG.00065  Recombinant Coagulation Factor IX, Fc Fusion Protein (Alprolix™)
GENE.00028  Genetic Testing for Colorectal Cancer Susceptibility
GENE.00029  Genetic Testing for Breast and/or Ovarian Cancer Syndrome
SURG.00121  Transcatheter Heart Valve Procedures

Revised medical policies effective January 1, 2015
(CPT/HCPCS procedure codes added and/or deleted on existing policies effective on 01-01-2015.)

DME.00009  Vacuum-Assisted Wound Therapy in the Outpatient Setting
DRUG.00061  Radium Ra 223 Dichloride (Xofigo®)
GENE.00001  Genetic Testing for Cancer Susceptibility
GENE.00009  Gene-Based Tests for Screening, Detection and Management of Prostate Cancer
GENE.00011  Gene Expression Profiling for Managing Breast Cancer Treatment
GENE.00013  Diagnostic Genetic Testing of a Potentially Affected Individual (Adult or Child)
GENE.00025  Molecular Profiling for the Evaluation of Malignant Tumors
GENE.00026  Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy
GENE.00029  Genetic Testing for Breast and/or Ovarian Cancer Syndrome
GENE.00030  Genetic Testing for Endocrine Gland Cancer Susceptibility
GENE.00033  Genetic Testing for Inherited Peripheral Neuropathies
MED.00005  Hyperbaric Oxygen Therapy (Systemic/Topical)
MED.00032  Treatment of Hyperhidrosis
MED.00077  In Vivo Analysis of Gastrointestinal Lesions
MED.00080  Cryopreservation of Oocytes or Ovarian Tissue
MED.0101  Physiologic Recording of Tremor using Accelerometer(s) and Gyroscope(s)
MED.0105  Bioimpedance Spectroscopy Devices for the Detection and Management of Lymphedema
RAD.00014  Brachytherapy for Oncologic Indications
RAD.00041  Intensity Modulated Radiation Therapy (IMRT)
RAD.00060  Digital Breast Tomosynthesis
SURG.00001  Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
SURG.00011  Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
SURG.00017  Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
SURG.00025  Cryosurgical Ablation of Solid Tumors Outside the Liver
SURG.00028  Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
SURG.00033  Implantable Cardioverter-Defibrillator (ICD)
SURG.00054  Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
SURG.00055  Cervical Artificial Intervertebral Discs
SURG.00065  Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
SURG.00067  Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
SURG.00103  Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
SURG.00106  Ablative Techniques as a Treatment for Barrett’s Esophagus
SURG.00116  High Resolution Anoscopy Screening for Anal Intrathelial Neoplasia (AIN) and Squamous Cell Cancer of the Anus
SURG.00120  Open Treatment of Rib Fracture(s) Requiring Internal Fixation
SURG.00127  Sacroiliac Joint Fusion

Revised medical policies effective January 13, 2015
(The following policies were revised to expand medical necessity indications or criteria.)

DRUG.00039  Trastuzumab (Herceptin®)
DRUG.00059  Romiplostim (Nplate®)
MED.00113  Therapeutic Apheresis
RAD.00015  Proton Beam Radiation Therapy

Revised medical policies effective January 13, 2015
(The following policies were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.)

ADMIN.00002  Preventive Health Guidelines
DME.00034  Standing Frames
DME.00035  Electric Tumor Treatment Field (TTF)
DME.00036  Ultraviolet Light Therapy Delivery Devices for Home Use
DRUG.00034  Insulin Potentiation Therapy
DRUG.00042  Ustekinumab (Stelara®)
DRUG.00046  Ipilimumab (Yervoy™)
DRUG.00048  Eribulin mesylate (Halaven®)
DRUG.00051  Ziv-aflibercept (Zaltrap®)
DRUG.00053  Carfilzomib (Kyprolis™)
DRUG.00055  Denosumab (Prolia®, Xgeva™)
DRUG.00060  Plerixafor Injection (Mozobil™)
DRUG.00063  Ofatumumab (Arzerra™)
GENE.00004  Janus Kinase 2 (JAK2) V617F Gene Mutation Assay
GENE.00017  Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)
GENE.00018  Gene Expression Profiling for Cancers of Unknown Primary Site
GENE.00019  BRAF Mutation Analysis
GENE.00020  Gene Expression Profile Tests for Multiple Myeloma
GENE.00022  In Vitro Companion Diagnostic Devices
GENE.00023  Gene Expression Profiling for Uveal Melanoma
GENE.00027  The Panexia™ Test for Oncologic Indications
LAB.00026  Systems Pathology Testing for Predicting Risk of Prostate Cancer Progression and Recurrence
LAB.00028  gMS® Dx and the gMS® Pro EDSS Serum Biomarker
MED.00082  Quantitative Sensory Testing
MED.00083  Melanoma Vaccines
MED.00085  Antineoplaston Therapy
MED.00089  Quantitative Muscle Testing Devices
MED.00095  Anterior Segment Optical Coherence Tomography
MED.00096  Low-Frequency Ultrasound Therapy for Wound Management
MED.00099  Electromagnetic Navigational Bronchoscopy
MED.0103  Automated Evacuation of Meibomian Gland
OR.PR.00003  Microprocessor Controlled Lower Limb Prostheses
RAD.00004  Peripheral Bone Mineral Density Measurement
RAD.00017  External Beam Intraoperative Radiation Therapy
RAD.00023  Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
RAD.00029  CT Colonography (Virtual Colonoscopy) as a Screening or Diagnostic Test for Colorectal Cancer
RAD.00031  Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy
RAD.00036  MRI of the Breast
RAD.00037  Whole Body Computed Tomography Scanning
RAD.00047  Neutron Beam Radiotherapy
RAD.00049  Low-Field and Conventional Magnetic Resonance Imaging (MRI) for Screening, Diagnosing and Monitoring
RAD.00057  Near-Infrared Coronary Imaging and Near-Infrared Intravascular Ultrasound Coronary Imaging
RAD.00058  Real-Time Intra-Fraction Target Tracking During Radiation Therapy
RAD.00061  PET/MRI
RAD.00062  Intravascular Optical Coherence Tomography (OCT)
RAD.00064  Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)
SURG.00008  Mechanized Spinal Distraction Therapy for Low Back Pain
SURG.00044  Breast Ductal Examination and Fluid Cytology Analysis
SURG.00059  Recombinant Human Bone Morphogenetic Protein
SURG.00082  Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
SURG.00092  Implanted Devices for Spinal Stenosis
SURG.00095  Viscocanalostomy and Canaloplasty
SURG.00098  Mechanical Embolectomy for Treatment of Acute Stroke
SURG.00101  Suprachoroidal Injection of Pharmacologic Agent
SURG.00104  Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
SURG.00114  Facet Joint Allograft Implants for Facet Disease
SURG.00128  Implantable Left Atrial Hemodynamic (LAH) Monitor
SURG.00129  Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
SURG.00135  Radiofrequency Ablation of the Renal Sympathetic Nerves
TRANS.00013  Small Bowel, Small Bowel/Liver and Multivisceral Transplantation
TRANS.00018  Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation
TRANS.00023  Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias
TRANS.00027  Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors
TRANS.00028  Hematopoietic Stem Cell Transplant for Hodgkin Disease and non-Hodgkin Lymphoma
TRANS.00029  Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias
TRANS.00033  Heart Transplantation
TRANS.00034  Hematopoietic Stem Cell Transplantation for Diabetes Mellitus
New medical policy effective January 13, 2015
(The following policy was created and does not have a significant change on how we presently cover the service.)

OR.PR.00006  Powered Robotic Lower Body Exoskeleton Devices

Revised medical policies effective May 1, 2015
(The policies listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DME.00011  Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices
DRUG.00015  Prevention of Respiratory Syncytial Virus Infections
DRUG.00024  Omalizumab (Xolair®)
DRUG.00032  Intravitreal Corticosteroid Implants
DRUG.00035  Panitumumab (Vectibix®)
GENE.00028  Genetic Testing for Colorectal Cancer Susceptibility
SURG.00024  Surgery for Clinically Severe Obesity
SURG.00037  Treatment of Varicose Veins (Lower Extremity)
SURG.00060  Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
SURG.00066  Percutaneous Neurolysis for Chronic Neck and Back Pain

New medical policies effective May 1, 2015
(The policies listed below were created and might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DME.00038  Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices for the Treatment of Joint Stiffness and Contracture
DRUG.00066  Antihemophilic Factor and Clotting Factors
DRUG.00067  Ramucirumab (Cyramza™)
DRUG.00068  Vedolizumab (Entyvio™)
DRUG.00069  Recombinant Antihemophilic Factor, Fc Fusion Protein (Eloctate™)
DRUG.00070  Siltuximab (Sylvant™)
DRUG.00071  Pembrolizumab (Keytruda®)
GENE.00044  Analysis of PIK3CA Status

Clinical guidelines update

Clinical guideline updates are available on anthem.com

The following new and revised clinical guidelines were endorsed at the August 14, 2014 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com > Providers > Select state > Enter > Medical Policies and Clinical UM Guidelines.

If you do not have access to the Internet, you may request a hard copy of any updated policy by calling Provider Service at 800-832-6011.
Revised clinical guideline effective November 17, 2014
(The following adopted guideline was revised and had no significant changes to the position or criteria.)

CG-REHAB-05 - Occupational Therapy

Revised clinical guidelines effective January 1, 2015
(CPT/HCPCS procedure codes added and/or deleted on existing guidelines effective on 01-01-2015.)

CG-MED-39 Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry
CG-SURG-09 Temporomandibular Disorders

Revised clinical guidelines effective January 13, 2015
(The following adopted guidelines  were revised to expand medical necessity indications or criteria.)

CG-DRUG-08 Enzyme Replacement Therapy for Gaucher Disease
CG-DRUG-09 Immune Globulin (Ig) Therapy
CG-DRUG-15 Gonadotropin Releasing Hormone (GnRH) Analogs

Revised clinical guidelines effective January 13, 2015
(The following adopted guidelines were revised and had no significant changes to the position or criteria.)

CG-DME-06 Pneumatic Compression Devices for Lymphedema
CG-SURG-12 Penile Prosthesis Implantation
CG-SURG-28 Transcatheter Uterine Artery Embolization
CG-SURG-30 Tonsillectomy with or without Adenoidectomy for Children
CG-TRANS-02 Kidney Transplantation

Revised clinical guidelines effective May 1, 2015
(The guidelines listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

CG-DRUG-03 Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
CG-DRUG-15 Gonadotropin Releasing Hormone (GnRH) Analogs
CG-SURG-09 Temporomandibular Disorders
CG-SURG-33 Lumbar Fusion or Lumbar Artificial Intervertebral Disc (LAID)

New clinical guidelines adopted effective May 1, 2015
(The new guideline listed below is being adopted and might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

CG-DRUG-38 Pemetrexed Disodium (Alimta®)