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**ME 15009**

**MENL0815**

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August 2015

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 recommended by identified practices, guidelines. Diagnosis, treatment recommendation, and the provision of services are practiced by our members and providers. The responsibility of physicians and providers.

Unless otherwise noted, the information contained in this Network Update applies to Anthem Blue Cross and Blue Shield’s plans and programs in Maine.

Unless otherwise noted, the information contained in the Behavioral Health updates reflect the Network Update database and services managed by Anthem Behavioral Health.

Please note that updates are subject to the terms, conditions and limitations of the member’s plan or program.

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**Important phone numbers**

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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: No delay yet…..this might really happen
It’s August 2015, and though there is some proposed legislation suggesting another ICD-10 delay, to date none of them have been successful in moving the October 1, 2015 compliance date. So, contrary to prior years, it’s really looking like ICD-10 will happen in about two months.

Are you ready?
Prior delays may have slowed, or even stopped, your implementation plans. If you fall in this category, the truth is you have a lot of work to do in a short period of time. However, if you move quickly, a successful ICD-10 implementation can still happen for your practice before the October 1, 2015 deadline.
Here are some suggestions:

Need a plan to get started? **CMS’s Road to 10** provides a complete roadmap for small and medium practices to follow to get you to your ICD-10 destination by October 1, 2015.

Need to practice using ICD-10-CM codes? Coders with some training can take advantage of the free scenario-based Coding Practice Tool we are offering through our [Anthem’s ICD-10 webpage](#). It’s designed to give physicians and their coders the opportunity to test their knowledge of the ICD-10 code set by applying it to medical scenarios.

Want to work on improving your clinical documentation? CMS is offering [Interactive Case Studies](#) designed can help you understand key ICD-10 documentation concepts. The case studies include sample clinical scenarios, short quizzes on related coding concepts, and documentation tips. New scenarios are added weekly.

Check our [ICD-10 Updates - Resources](#) webpage for more suggested resources that can help you prepare for ICD-10.

**National Uniform Billing Committee UB-04 code change**

The National Uniform Billing Committee (NUBC) implemented a change to require an admission date be submitted on specific inpatient and outpatient institutional claim types of bill (TOB). We will begin to enforce this requirement beginning October 1, 2015.

Admission date required effective October 1, 2015 - TOB: 12X, 22X, 32X, 34X, 81X and 82X

<table>
<thead>
<tr>
<th>Type of bill</th>
<th>Type of bill description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12x</td>
<td>Hospital inpatient Part B</td>
</tr>
<tr>
<td>22x</td>
<td>SNF inpatient Part B</td>
</tr>
<tr>
<td>32x</td>
<td>Home health</td>
</tr>
<tr>
<td>34x</td>
<td>Home health (Part B only)</td>
</tr>
<tr>
<td>81x</td>
<td>Non hospital-based hospice</td>
</tr>
<tr>
<td>82x</td>
<td>Hospital-based hospice</td>
</tr>
</tbody>
</table>

Please ensure all billing staff is aware of this change. The changes affect commercial, Federal Employee Program (FEP®) and Medicare Advantage products.

**CMS 1500 claim form version 08/05 for paper claims no longer accepted effective October 1, 2015**

Effective October 1, 2015, we will no longer accept the old CMS 1500 Claim Form version 08/05 for paper claims. Paper claims will only be accepted on the CMS 1500 Claim Form version 02/12.

Any paper claims received on or after October 1, 2015 using the old CMS 1500 claim form version 08/05 will be rejected. This will include any claims submitted prior to the October 1 effective date that we receive on or after October 1.

We began accepting the CMS 1500 claim form version 02/12 in January 2014. We suggest that you transition to the updated CMS 1500 claim form version 02/12 now, if you have not already done so.
For information on how to complete the updated 1500 claim form version 02/12, follow the guidelines set forth by the National Uniform Claim Committee (NUCC). Please visit the NUCC website at www.nucc.org which provides helpful resources such as a list of changes between the 08/05 and 02/12 claim form versions and the 1500 Instruction Manual.

Mailed paper remittances to be discontinued for all ERA registered providers - have you taken the steps to prepare?

Attention Primary Access Administrators:
In support of HIPPA Administrative Simplification requirements, we will discontinue mailing paper remittances to all providers currently registered for electronic remittance advice (ERA) effective October 1, 2015. You will not be impacted by this change if you have already taken action to manage your paper remittances.

It's easy to access your online remittances through the Availity Web Portal. As an ERA-registered provider, please complete the steps outlined below to access your online remittances through Availity immediately.

Access your Paper Remittances Online
Registered users can now follow the steps below to access your organization’s paper remittances online:

- On Availity, click My Payer Portals from the left navigation bar > then select Anthem Provider Portal.
- Click on “I Agree” to link out to AOPS. You are now logged directly into the AOPS Home page.
- From the AOPS Home page select Remittances – Institutional / Professional; enter the search criteria for the remittance.

Note: Only network providers who participate with us can access AOPS.

Is Training Available?
Availity offers a variety of ongoing training options, including live and on-demand webinars, online demonstrations, local workshops, comprehensive help topics, tip sheets and more. For a full list of learning options, login to the Availity portal and click Free Training at the top of any page.

Please share this important information with your staff and/or billing company.

Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.

AIM online pre-authorization requests accessible via Availity
Your office can save time, save money, and eliminate hassles by requesting and obtaining pre-authorizations online for radiology, cardiology, sleep, oncology, and specialty drugs. Information is available for both ordering and servicing providers. Ordering providers can request and obtain a pre-authorization online. Servicing providers can inquire about an authorization, as well as obtain pre-authorization, prior to rendering services to a member.

To submit a pre-authorization request
If you have an Availity user ID and password, use the following steps:

- Log in to the Availity Web Portal at www.availity.com
- Enter your Availity user ID and password
Click the Auths & Referrals link, from the left side navigation menu
Then select AIM Specialty Health
Click continue to accept the Anthem Internet Hyperlink Disclaimer
Once logged into AIM, from the My Homepage screen, click Start Your Order Request Here
Complete requested information. If submitted information meets criteria, an authorization number will be issued.

Note: The user must have an active User ID on AOPS to access the AIM system through Availity. The Availity PAA must complete the Anthem Services Registration for each user to access AIM.

Availity launched new E&B functionality
The Availity Web Portal launched new eligibility and benefits (E&B) functionality and features on June 27, 2015. These changes will make finding eligibility and benefits easier and faster for you. Following is a list of the new features:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New request page</td>
<td>A new design makes it easier for users to find and focus on tasks at hand. Now users can submit multiple member inquiries without having to wait for individual results before starting another request.</td>
</tr>
<tr>
<td>Patient history list</td>
<td>The results list automatically summarizes user’s most recent member inquiries and stays visible for 24 hours. Just click the member name and see the results. Plus only information relevant to that member is displayed. Users can also see transactions by other users within their organization (shared history).</td>
</tr>
<tr>
<td>Menu by benefit type</td>
<td>Located under the ‘Coverage and Benefits’ tab, this interactive list displays all service types and benefits returned from the health plan.</td>
</tr>
<tr>
<td>Patient snapshot</td>
<td>The summary of patient information is easily found at the top of the page.</td>
</tr>
<tr>
<td>Clearer display of details</td>
<td>Users have a clearer and more complete view of specific benefit and financial information.</td>
</tr>
<tr>
<td>Advanced printing</td>
<td>By selecting which sections to print, users save paper and can customize prints to target necessary information.</td>
</tr>
<tr>
<td>Real-time feedback</td>
<td>Feedback buttons on every returned eligibility query allows users to provide instant feedback of missing or inaccurate information.</td>
</tr>
</tbody>
</table>

To learn more about these time-saving features, take a quick tour, view a recorded webinar, or join Availity for a live webinar.

Provider secure messaging enhancements
If you are a current user of secure messaging, a feature available from the Claim Status Detail page on the Availity Web Portal, please take note of recent upgrades.

We can now send you follow-up messages on your claim inquiry. These may share pertinent detail or request additional specific information. You will know if we have sent you a new message because a new column, titled ‘Messages Needing Attention’, has been added to your inbox. In this column, if you have a new message, you will see Attention Needed. If you use Secure Messaging, check your inbox periodically for this indicator. For your convenience, we’ve included a sample screenshot below.
Also, when you view your message, look for a new option, Download Secure Message, which is located to the right of the message. Use Download Secure Message to save or print the content of the entire message. This eliminates the need for multiple print screens in order to capture the message detail.

Pathway updates for Cancer Care Quality Program - professional

Attention oncologists, hematologists and urologists

As a reminder, our Cancer Care Quality Program (Program), a quality initiative launched on July 1, 2015, provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways (Pathways). Participating physicians who are in-network for the member’s benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.

Effective September 1, 2015, we are making the following changes to some cancer treatment Pathways for the Cancer Care Quality Program.

New Pathways added to the Program include:

- Pathways for bladder cancer
- Carfilzomib+lenalidomide+dexamethasone (CRD) treatment pathway for multiple myeloma, 2nd and subsequent lines of therapy
- Nivolumab treatment pathway for non-small cell lung cancer, 2nd line, squamous histology
- Nivolumab treatment pathway for metastatic melanoma, 1st line
- Dabrafenib+trametinib treatment pathway for metastatic melanoma, BRAF mutations, 2nd line

Pathways removed from the Program include the following regimens that will be moving from “on” pathway to “off” pathway status:

- Lenalidomide+dexamethasone (RD) for multiple myeloma, 2nd and subsequent lines of therapy
- Dabrafenib for metastatic melanoma, BRAF mutations, 1st and subsequent lines of therapy
- Pembrolizumab for metastatic melanoma, 2nd and subsequent lines of therapy
This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members’ benefit plans.

The following regimens remain “on” pathway but the following changes apply:

- FOLFIRI+panitumumab, FOLFOX+panitumumab, and irinotecan+panitumumab for metastatic colorectal cancer have been removed from 1st line and added to 2nd line therapy, RAS wild-type
- Ipilimumab for metastatic melanoma has been removed from 1st line and added to 2nd line therapy

The Pathways developed for this Program are intended to support quality cancer care. To access the full Pathways document, go online to CancerCareQualityProgram.com our dedicated provider website.

Note: Participating physicians who are in-network for the member’s benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway.

For more information on the Program:
- Register for access to the AIM Provider Portal.
- View the Cancer Care Quality Program website.
- Get more information on Cancer Treatment Pathways.
- Access program FAQs.

For questions or if you need support, call the AIM Call Center at 866-714-1107, Monday through Friday, 8:00 a.m.–5:00 p.m.

Include reference number when faxing to UM

As part of our continuing efforts to improve efficiencies in the utilization management (UM) process, we have identified an opportunity to expedite information received by fax. When faxing our UM area, please be sure to include the reference number on the fax cover sheet. The reference number is provided on our fax communications to you or when a case is set up via phone. This will make it easier to match new information with previously received material, and will benefit the provider and member by providing timelier, cost-efficient and more streamlined communications.

As a reminder, please do NOT include personal health information (PHI) on fax cover sheets.

Thank you for your assistance.

Neonatal Facility Reimbursement Policy effective October 1, 2015

As part of our ongoing commitment to share current administrative, billing, and reimbursement policies with you, we’ve posted a Neonatal Facility Reimbursement Policy that will become effective for dates of service on or after October 1, 2015. To view this and other facility reimbursement policies, visit anthem.com > Providers > Maine > Provider Reference Materials, Administrative Billing and Reimbursement Policies.

Update to claims processing edits and reimbursement policies

On August 1, 2015, we will be updating our Anthem Online Provider Services (AOPS) website with the following new and/or revised reimbursement policies. The updates below indicate if the article pertains to professional or facility provider billing.
Bundled Services and Supplies – professional
Healthcare Common Procedure Coding System (HCPCS II) code Q9977 (compounded drugs, not otherwise classified) is a new code effective July 1, 2015 that we consider to be an always bundled service; therefore, Q9977 will not be eligible for reimbursement for claims with dates of service on and after July 1, 2015 that are processed on or after August 17, 2015. This information will be added to Section 1 of the policy.

For claims processed on or after August 17, 2015, HCPCS code S8262 (mandibular orthopedic repositioning device, each) will be added to our always bundled service edit and will not be eligible for reimbursement. This edit is based on correct coding and will be documented in Section 1 of the policy. This information will be documented in Section 2 of our policy.

Beginning with dates of service on or after April 1, 2015, ClaimsXten removed their incidental edit on Current Procedural Terminology (CPT®) code 43235 (esophagogastroduodenoscopy (EGD), flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)) when reported with CPT codes 43770-43775 (laparoscopy, surgical, gastric restrictive procedures). However, when an EGD is performed following a gastric restrictive procedure to confirm there is no leakage, we consider the EGD to be an integral part of the primary procedure and not eligible for separate reimbursement. Therefore, beginning with claims processed on or after August 17, 2015, we will again apply the bundled services incidental edit on CPT code 43235 (EGD) when reported with CPT codes 43770-43775 (gastric restrictive procedures). This information will be documented in Section 2 of our policy.

For dates of service on or after August 17, 2015, codes for digital breast tomosynthesis (DBT) will be removed from our bundled services edit; therefore, CPT codes 77061, 77062, 77063, and G0279 associated with DBT are being removed from our Bundled Services and Supplies reimbursement policy. In addition, we will also remove DBT information from our Three-Dimensional (3D) Radiology and Modifiers 59 and XE, XP, XS, & XU reimbursement policies.

For claims processed on or after August 17, 2015, CPT code 36000 (introduction of needle or intracatheter, vein) will not be eligible for separate reimbursement when reported with CPT codes 96360, 96365, 96374-96376, 96405, 96406, 96409, 96413, 96416, 96440, 96446, 96450 or 96542 (injection and infusion services). Modifiers will not override this edit; therefore, this information is included in our Modifiers 59 and XE, XP, XS, & XU reimbursement policy.

Beginning with dates of service on or after November 1, 2015, HCPCS codes S5000 and S5001 (prescription drugs) will be added to our always bundled services edit for HCPCS ‘S’ codes; therefore, S5000 and S5001 will be added to Section 1 of our Bundled Services and Supplies policy.

For dates of service on or after November 1, 2015, we are updating Section 1 of the policy to include Current Procedural Terminology (CPT®) code 98960 (education and training for patient self-management by a qualified, non-physician health care professional) as an always bundled service. We consider this service to be part of the overall care management of the member.

For dates of service on or after November 16, 2015, HCPCS code A4648 (tissue marker, implantable, any type, each) will not be eligible for separate reimbursement when reported with breast biopsy CPT codes 19081 – 19101 and/or placement of breast localization devices CPT codes 19281 – 19288. Modifiers will not override this edit therefore this information is included in our Modifiers 59 and XE, XP, XS, & XU reimbursement policy.

Durable Medical Equipment – professional
We have made some minor word changes to the policy language however these updates do not change the policy position or criteria.
**Frequency Editing – professional**

Effective January 1, 2015, CPT published new codes for definitive drug testing. Beginning with claims processed on or after May 18, 2015, we implemented a frequency limit of 1 per date of service for the following codes: 80321-80322, 80324-80337, 80339-80344, 80346-80347, 80350-80352, 80361-80364, 80369-80370, and 80375-80377. This limit is supported by CPT nomenclatures that these codes are multiple unit codes therefore they should only be reported once per date of service.

For claims processed on or after August 17, 2015, we will also implement a frequency limit of 1 per date of service for the following definitive drug testing codes based on CPT nomenclature: 80320, 80323, 80338, 80345, 80348, 80349, 80353-80360, 80365, 83992, 80366-80368 and 80371-80374.

For dates of service on or after November 16, 2015, we will apply a frequency limit of 18 units within a rolling 365 day period to definitive drug testing codes 80320-80377 and 83992. Note that this edit will use claim lines processed in history that have previous, current, and subsequent dates of service to accumulate and apply this frequency limit.

In addition, we have implemented frequency limits on the following prescription drugs:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency Limit</th>
<th>Rationale</th>
<th>Effective for claims processed on or after:</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7307</td>
<td>Etonogestrel (contraceptive implant system (Nexplanon or Implanon)</td>
<td>1 unit per date of service</td>
<td>Based on prescribing information</td>
<td>August 17, 2015</td>
</tr>
<tr>
<td>J2800</td>
<td>Injection, methocarbamol, up to 10 ml (Robaxin)</td>
<td>3 units per date of service</td>
<td>Based on manufacturer's guidelines FDA approval</td>
<td>May 18, 2015</td>
</tr>
<tr>
<td>J0696</td>
<td>Injection, ceftriaxone sodium, per 250 mg (Rocephin)</td>
<td>16 units per date of service</td>
<td>Based on manufacturer's guidelines FDA approval</td>
<td>May 18, 2015</td>
</tr>
</tbody>
</table>

**Global Surgery – professional**

As documented in our Global Surgery policy, we consider local infiltration, anesthetic blocks, or topical anesthesia to be part of the global surgical package; therefore, for claims processed on or after August 17, 2015 HCPCS codes J2001 (injection, lidocaine HC1 for intravenous infusion, 10 mg) and S0020 (injection, bupivacaine, HC1, 30 ml) will not be eligible for separate reimbursement when reported with a surgical procedure.

**Laboratory and Venipuncture Services – professional**

Effective April 1, 2014, the Centers for Medicare & Medicaid Services (CMS) released HCPCS code G0471 (collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency). We consider G0471 eligible for separate reimbursement when reported on the same date of service as a laboratory service therefore this information is being included in our policy dated August 1, 2015. In addition, we are adding 80076 (hepatic function panel) to the list of laboratory panels identified in the “Description” section of the policy.

We have added language to document our current edit that when two providers submit the same test code, only the first claim processed and approved will be eligible for reimbursement and subsequent claims processed will be denied even when one provider reports a global procedure code and a different provider reports the same procedure code with a professional component (26) or a technical component (TC) modifier appended to the code.
Modifiers 59 and XE, XP, XS, & XU – professional
Per CPT introductory guidelines for definitive drug testing, “Drug classes may contain one or more codes based on the number of analytes. For example, an analysis in which five or more amphetamines and/or amphetamine metabolites would be reported with 80326. The code is based on the number of reported analytes and not the capacity of the analysis.” Based on these guidelines, definitive drug testing codes within the same drug classes reported more than once per date of service are considered mutually exclusive and not eligible for separate reimbursement; therefore, beginning with claims processed on or after August 17, 2015, modifiers will not override the mutually exclusive edits. Please refer to our policy for code information.

Prolonged Services – professional
Beginning with claims processed on or after August 17, 2015, we are adding the diagnosis of post-traumatic stress disorder (ICD-9 309.81; ICD-10 (effective for dates of service on or after October 1, 2015) F43.10- F43.12) to our list of diagnoses that will allow separate reimbursement for prolonged services CPT codes 99354 and 99355.

Unit Frequency Maximums for Drugs and Biologic Substances – professional
We are posting a new policy titled Unit Frequency Maximums for Drugs and Biologic Substances. The policy outlines our maximum units allowed and our rationale for the maximum units allowed for the drugs and biologic substances listed below. The noted maximum units will be applied to the listed codes for dates of service on or after November 16, 2015. Please refer to our policy for additional information.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>HCPCS maximum units</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0180</td>
<td>Injection, agalsidase beta, 1 mg (Fabrazyme)</td>
<td>115 units</td>
</tr>
<tr>
<td>J0490</td>
<td>Injection, belimumab, 10 mg (Benlysta)</td>
<td>120 units</td>
</tr>
<tr>
<td>J1745</td>
<td>Injection infliximab, 10 mg (Remicade)</td>
<td>120 units</td>
</tr>
<tr>
<td>J2357</td>
<td>Injection, omalizumab, 5 mg (Xolair)</td>
<td>90 within a 14 day period</td>
</tr>
<tr>
<td>J2469</td>
<td>Injection, palonosetron HCl, 25 mcg (Aloxi)</td>
<td>10 units</td>
</tr>
<tr>
<td>J2505</td>
<td>Injection, pegfilgrastim, 6 mg (Neulasta)</td>
<td>1 unit</td>
</tr>
<tr>
<td>J2796</td>
<td>Injection, romiplostim, 10 mcg (Nplate)</td>
<td>125 units</td>
</tr>
<tr>
<td>J9035</td>
<td>Injection, bevacizumab, 10 mg (Avastin)</td>
<td>180 units</td>
</tr>
<tr>
<td>J9041</td>
<td>Injection, bortezomib, 0.1 mg (Velcade)</td>
<td>35 units</td>
</tr>
<tr>
<td>J9055</td>
<td>Injection, cetuximab, 10 mg (Erbitux)</td>
<td>100 units</td>
</tr>
<tr>
<td>J9217</td>
<td>Leuprolide acetate (for depot suspension), 7.5 mg (Lupron Depot, Eligard)</td>
<td>6 units</td>
</tr>
<tr>
<td>J9228</td>
<td>Injection, ipilimumab, 1 mg (Yervoy)</td>
<td>350 units</td>
</tr>
<tr>
<td>J9310</td>
<td>Injection, rituximab, 100 mg (Rituxan)</td>
<td>12 units</td>
</tr>
</tbody>
</table>

Coding Tip for Modifiers 25 and 57 – professional
According to Coding with Modifiers, Grider, Deborah, 4th edition ©2011, “Modifier 57 should not be used with E/M services during the global period for minor procedures (0-10 global days) unless the purpose of the visit was a decision for major surgery”. Therefore, we require modifier 57 to be used when the evaluation and management service is for the initial decision for surgery made on the day before or the same day as the major surgical procedure (90-day global).
Coding with Modifiers also states: “For most payers, modifier 25 is to be used when the decision is made on the same day to perform a minor surgical procedure with a global period of 0 to 10 days”. Therefore, modifier 25 is to be used when the E/M service is for a separately identifiable E/M by the same provider on the same day as a minor procedure (0 or 10 global days). Please see our Evaluation and Management Services and Related Modifiers -25 & -57 reimbursement policy for further information.

**Coding tip for site specific modifiers – professional**

When procedures allow for a site specific modifier, including but not limited to LT, RT, E1-4, FA, F1-F9, TA and T1-T9, site specific modifiers are to be used when appropriate on all associated codes submitted for the same date of service.

Currently our claim editing system assumes different sites when one code has a site specific modifier and other codes do not; therefore, if an edit exists between two codes and one code has a site specific modifier and the other code does not, we will no longer assume different sites and may deny services based on same site assumption.

**Coding tip for 76818 and 76819 (fetal biophysical profile) – professional**

Based on CPT instruction for codes 76818 and 76819, assessments for a second and any additional fetuses should be reported on separate lines with modifier 59 appended; therefore, for claims processed on or after November 16, 2015, when subsequent fetal biophysical profiles for additional fetuses are reported without modifier 59, our editing system will deny the subsequent service.

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**Updates to Find a Doctor tool**

The Find a Doctor tool at anthem.com is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans.

Beginning this fall, you’ll notice some updates to our Find a Doctor tool that will make it even easier to search for providers. These changes include:

- An updated screen layout with cues to encourage members to login for the most accurate results, or search as a guest by selecting a plan to find in-network doctors and hospitals.
- Guided assistance asking a short set of questions to personalize and narrow the plan selection list.
- Quick search links for users familiar with the state and plan they are searching.
- More prominent placement of the provider name search option, to help users determine if a doctor is in-network after selecting a plan.

We believe these updates will improve the consumer, member, broker, and provider experience when using the Find a Doctor tool.

**Colonoscopy billing reminder - preventive vs. diagnostic**

The Affordable Care Act (ACA) requires non-grandfathered health plans to cover outlined preventive care and screenings without member cost sharing, when the services are rendered by an in-network provider and/or facility. Colorectal cancer screenings are included as a covered preventive care service under these guidelines.
Since colonoscopies are rendered for both screening and diagnostic purposes, it is very important for providers to use appropriate ICD-9 diagnosis coding guidelines when reporting colonoscopies. When inappropriate ICD-9 diagnosis codes are submitted on claims, it can result in incorrect provider payment and/or incorrect member cost sharing.

To reduce claim adjustments and your corresponding refunds to members, we recommend the following approach when coding a colonoscopy claim.

- In a situation where an individual presents for treatment solely for the purpose of a screening exam, without any signs or symptoms of a disease, then such a procedure should be considered a screening. The appropriate use of screening diagnosis codes and procedure codes is valuable in promoting appropriate adjudication of the claim.
- In a circumstance where an individual presents for a screening exam (without signs or symptoms), and an issue is encountered during that preventive exam, then such a circumstance would warrant the use of the PT modifier. The procedure and diagnosis codes that would typically be used in such an instance may not clearly demonstrate that the service began as a screening procedure but had to be converted to a diagnostic procedure due to a pathologic finding (e.g. polyp, tumor, bleeding) encountered during that preventive exam.
- In the instance that an individual presents for treatment due to signs or symptoms to rule out or confirm a suspected diagnosis, such an encounter should be considered a diagnostic exam, not a screening exam. In such a situation, the modifier PT should not be used and the sign or symptom should be used to explain the reason for the test.

Access surveys for PCP and BHP services to be conducted this fall

As a participating provider, please be reminded of your contractual obligation to help ensure our members have prompt access to services. Please visit anthem.com to access our Provider Manual for our guidelines for access to care for primary care practitioners (PCPs) and behavioral health practitioners (BHPs).

We use several methods to monitor adherence to these standards. Monitoring is accomplished by a) assessing the availability of appointments via phone calls by our staff or designated vendor to the provider’s office b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members.

Here's a quick reminder of our guidelines for PCPs:

- After-hours access - members must have access to care 24 hours a day, 7 days a week. PCPs must arrange after hours care to provide 24 hour coverage for our members by a network provider during non-business office hours. Members have the ability to reach a recorded message or a live voice response providing instructions on how to access care for emergencies and conditions requiring urgent attention.
- Preventive care - members scheduling periodic routine exams (well care/preventive visits), appointments should be available within 45 days of a member’s call. Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears.
- Urgent care appointment with acute symptoms - appointments should be available within 24 hours of the member’s call. Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.
- Elective appointment for symptomatic care - appointments should be available within three (3) days of the member’s call.
Though it is important for members to have the continuity of receiving care from their PCPs, there are occasions when you may not be available at a time that meets their scheduling needs. As a reminder, we now contract with walk-in centers and urgent care facilities which are listed in our directory.

- For walk-in centers, go to anthem.com > Find a Doctor > Maine > select plan > select and continue then “urgent care” > Specializes in > Walk-in Center > then enter a zip code in or near the city where care is needed.
- For urgent care facilities, go to anthem.com > Find a Doctor > Maine > select plan > select and continue then “urgent care” > Specializes in > Urgent Care Centers > then enter a zip code in or near the city where care is needed.

Here’s a quick reminder of our guidelines for BHPs:

- Non-life threatening emergency needs - must be seen, or have appropriate coverage directing the member, within six (6) hours. Emergent behavioral health care provided when a member is in crisis, experiencing acute distress and/or other symptoms and needs immediate attention; no risk of loss of life.
- Urgent needs - must be seen, or have appropriate coverage directing the member, within 48 hours. Non-emergent behavioral health illness that requires immediate care; member is experiencing significant psychological distress with symptoms that impairs daily functioning; no risk of loss of life.
- Routine office visit - must be within 10 business days. Routine calls are non-urgent behavioral health care; member has been referred or scheduled for a non-urgent consultation or requires services including, but not limited to, follow-up and existing medication management.

**BRCA gene testing alternatives**

Public awareness of genetic testing continues to grow. In response, more labs are providing this type of testing. For example, did you know that the number of labs offering the BRCA gene test has increased significantly and we now contract with multiple labs for this service? This gives you and most of your patients* greater choice in BRCA gene testing and an opportunity to compare costs and potentially save money. The following are some additional network options now available:

- Ambry Genetics
- BioReference
- Counsyl
- LabCorp
- Quest

* Some Plans may restrict BRCA gene testing to specific labs in network. Please refer to Provider Finder for a list of in network independent labs by Plan. Check member benefit plan information for coverage terms and conditions.

**Expanded list of predetermination recommendations for outpatient procedures**

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 November 1, 2015. These recommendations apply only to our local plans and do not apply to National accounts, Medicare supplemental, Medicare Advantage, the Federal Employee Program (FEP), BlueCard®, Taft-Hartley, or when Anthem is secondary.
Surgical Interventions for Scoliosis and Spinal Deformity. Codes added for clinical review: 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22842-22847, 22849, 77.99, 81.00, 81.04-81.08 and 81.62-81.64.

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 > Maine enter > Medical Policies and Clinical UM Guidelines.

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

We will be offering predetermination for clinical review for the following specialty pharmacy drugs beginning November 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 clinical guidelines effective November 1, 2015

- **DRUG.00075** Nivolumab (Opdivo®). Code added for clinical review: J9999
- **DRUG.00076** Blinatumomab (Blincyto™). Codes added for clinical review: C9449 and J9999
- **CG-DRUG-09** Immune Globulin Therapy- HyQvia. Codes added for clinical review: J3490 and J7799
- **CG-DRUG-45** Octreotide Acetate (Sandostatin, Sandostatin LAR). Codes added for clinical review: J2353 and J2354

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:**
Fax predetermination forms are available on provider website: anthem.com > Providers > Maine > Answers@Anthem > Forms > [Predetermination forms](#).

**Phone:** 800-392-1016

**Specialty pharmacy update**

Currently, the pre-service clinical review of specialty pharmacy infusion/injectable drugs is handled by AIM Specialty Health® (AIM), on behalf of Anthem. Beginning on September 1, 2015, providers will see a new message on the AIM ProviderPortalSM when requesting prior authorization for specialty pharmacy drugs. This message encourages providers to select from a list of providers who offer specialty infusion/injectable medications in an in-office, home health care, or infusion setting that may cost less and be more convenient for the member. The message will read: “Please select a provider from the list below that may be more cost effective and convenient for the member if you believe it is clinically appropriate to do so.” We hope this reference will help members save on potential out-of-pocket costs or have access to convenient locations for their treatment.
Fraud, waste and abuse detection

We recognize the importance of preventing, detecting, and investigating fraud, waste and abuse and are committed to protecting and preserving the integrity and availability of health care resources for our members, clients, and business partners. We accordingly maintain a program, led by our Special Investigations Unit (SIU), to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans.

Pre-payment review

One method we use to detect fraud, waste and abuse is through pre-payment review. Through a variety of means, certain providers or certain claims submitted by providers may come to our attention for some reason or behavior that might be identified as unusual, or which indicates the provider is an outlier with respect to his/her/its peers. One such method is through computer algorithms that are designed to identify a provider whose billing practices or other factors indicate conduct that is unusual or outside the norm of his/her/its peers.

Once such an unusual claim is identified or a provider is identified as an outlier, further investigation is conducted by SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual claim. If the investigation results in a determination that the Provider’s actions may involve fraud, waste or abuse, the provider is notified and given an opportunity to respond.

If, despite the provider’s response, we continue to believe the provider’s actions involve fraud, waste or abuse or some other inappropriate activity, the Provider is notified he/she/it is being placed on pre-payment review. This means that the provider will be required to provide medical records with each claim submitted so that we will be able to review them compared to the services being billed. Failure to submit medical records to us in accordance with this provision may result in a denial of a claim under review. The provider will be given the opportunity to request a discussion of his/her/its pre-payment review status. Under this program, we may review coding and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of claims submitted by the Provider, even if those guidelines are not used for all providers delivering services to Plan members.

The provider will remain subject to the pre-payment review process until we are satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the provider could face corrective measures, up to and including termination from our provider network.

Finally, providers are prohibited from billing covered individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other billing issue or for failure to submit medical records as set forth above. Providers whose claims are determined to be not payable may make appropriate corrections and resubmit such claims in accordance with the terms of the applicable provider agreement and state law. Providers also may appeal such determination in accordance with applicable grievance procedures.

Medicare Advantage update

Facilities: failure to pre-certify an admission or provide notice of emergent inpatient admission results in administrative denial

Facilities and network physicians are required to obtain precertification for specified services for individual and group-sponsored MA members, including an admission to any inpatient facility. For the member to receive maximum benefits, we must authorize or pre-certify the covered services prior to being rendered.
To obtain precertification or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member’s identification card. As previously communicated, please notify us as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

Effective May 1, 2015, if a facility does not obtain the required precertification within the specified timeframe, the claim will be administratively denied due to failure to notify us of the admission. The facility will not receive payment for the service. Facilities cannot bill the member for these denied admissions.

If you do not notify us within the required timeframe, you may file an appeal. As part of the appeal, providers must demonstrate that they did notify us or attempted to notify us AND that the service is medically necessary. We also remind all providers – network physicians and facilities – that you cannot bill the member if the services are denied for the failure to obtain a required precertification.

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on our provider home page at anthem.com for further information on existing precertification requirements.

Precertifications for Anthem individual MA members also can be initiated via the Availity web portal at www.Availity.com. To access this new functionality, go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. You will find precertification requirements there as well via the Precertification look-up tool.

Please visit www.anthem.com/medicareprovider to learn more about this online provider self-service tool.

Additional fax numbers available to pre-certify skilled nursing, long term acute care and inpatient rehab

To help ensure timely responses to precertification requests, we’ve added additional fax lines for facilities to precertify admission requests or submit additional clinical information for individual and group-sponsored Medicare Advantage members for the following services:

- Acute initial hospital admissions and continued stay reviews: 877-744-2319
- Patient review instrument/skilled nursing facility/rehab requests: 844-211-7140 (new number)
- Skilled nursing facility continued stay reviews: 844-211-7141 (new number)

Requests for services not listed above that are faxed to one of these numbers may cause a delay in processing those requests.

All clinical information relevant to the request for acute inpatient hospital admissions should continue to be sent to the 877-744-2319 fax line.
Appeals information for participating Medicare Advantage providers

Anthem Medicare Advantage plans have a separate and distinct Contracted Provider Appeal Process. Contracted providers who appeal any determination that does not involve Medicare Advantage member liability under Federal regulations [CFR §422.568(c) and (d)], have separate Medicare Advantage processing and timeframe guidelines. There are no second level appeals for Anthem Medicare Advantage products.

As previously required, the provider appeal should be accompanied by a letter that explains why the provider believes the decision should be overturned. Any information necessary to review the appeal must be included with the letter, such as the complete medical records needed to justify the services for which the provider is seeking payment. Since we will only review one level of appeal, providers must include all information needed to justify the requested services with the request for appeal. All appeals must be submitted within 180 days of the initial decision. Appeals received outside of the 180 day timeframe may not be processed.

Please note that Anthem Medicare Advantage plans administer Medicare coverage for our Medicare Advantage members and follow Medicare guidelines with regard to coverage of certain items and services. 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 initial request for coverage to allow for an appropriate decision to be made; we may not request additional information to support payment for the services you are requesting.

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 only be made when the documentation supports the service/item.

A Medicare Advantage appeal is initiated by writing or sending a fax to the Anthem Medicare Advantage Appeals Department within one hundred eighty (180) calendar days of our initial decision at:

Medicare Advantage Grievance and Appeals
Mail location OH0205-A537
4361 Irwin Simpson Road
Mason, OH 45040
Fax: 888-458-1406

Physician orders required for home health services; precertification and face-to-face evaluations not required

We require a physician’s order for home health services for our individual and group-sponsored Medicare Advantage members. Precertification for home health services is not required. At this time, contracted home health providers are not required to present evidence of a face-to-face evaluation for home health services claims.
HIPPS codes required for skilled nursing and home health providers

All claims from skilled nursing facilities (SNFs) and home health agencies (HHAs) received July 1, 2014 and after must contain a valid HIPPS code. This pertains to contracted and non-contracted providers. The Centers for Medicare & Medicaid Services requires that we include this information on all processed claims data we submit to CMS.

- SNFs should bill the HIPPS code derived from the “Admission Assessment”
- HHAs should bill the HIPPS code derived from the “Start of Care Assessment”
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable PPS Revenue Code (022 or 023), the HIPPS code, 1 unit, and billed charges of 0.00.
- This billing instruction applies to all Medicare Advantage Plans including Dual Eligible Special Needs Plans.
- This does not apply to Medicare Supplemental Plans.
- HHAs are not required to bill treatment authorization codes.
- If you currently have a contract with us, the CMS mandated addition of the HIPPS code on your claim will not affect your payment.

Medicare Advantage precertification requirements available on provider portal, Availity

Network physicians are required to obtain precertification for specified services for Medicare Advantage members. For the member to receive maximum benefits, we must authorize or precertify the covered services prior to being rendered. Detailed prior authorization requirements for individual Medicare Advantage members are available to the contracted provider by accessing the provider self-service tool within Availity. Go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the Precertification look-up tool.

Please visit www.anthem.com/medicareprovider to learn more about this online provider self-service tool.

Non-contracted providers should contact the Health Plan. General information on 2015 Medicare Advantage precertification requirements can be found here.

Cancer Care Quality Program launched

As a reminder, we launched the Cancer Care Quality Program (Program), a quality initiative, on July 1, 2015 for individual and group-sponsored Medicare Advantage members.

For more information on the Program:

- Register for access to the AIM Provider Portal.
- View the Cancer Care Quality Program website.
- Get more information on Cancer Treatment Pathways.
- Access program FAQs.

For questions or if you need support, call the AIM Call Center at 866-714-1107, Monday through Friday, 8:00 a.m.-5:00 p.m.
Submit claims for shingles or tetanus vaccinations to Medicare Part D

Providers who have administered a shingles (90736; regardless of any diagnosis) or tetanus vaccine (90714, 90715, 90718 & 90723; regardless of any diagnosis) to our individual and group-sponsored Medicare Advantage plan members with pharmacy benefits should bill the Medicare Part D Benefit. Providers will encounter a denial if these claims are billed to the Medical benefit because the claim is covered under Medicare Part D only. This applies to the vaccine and the administration charges. Please note you can refer your patients to their local pharmacy for administration as well.

For Medicare Part B benefit of tetanus vaccine (90703; diagnosis range 800.00 to 897.99), this may be submitted as a medical claim for processing.

More information can be found here.

Labs: Medicare Advantage plans accept G codes for definitive drug testing

To help ensure alignment with the Centers for Medicare & Medicaid services billing guidelines, our Medicare Advantage plans accept G codes for definitive drug testing. Therefore, labs should use codes G6030-G6058 for definitive drug testing for Anthem individual and group-sponsored Medicare Advantage members.

Medicare Advantage reimbursement policies available on our provider portal

For Anthem Medicare Advantage reimbursement policy updates, please see Important Medicare Advantage Updates. To review our complete set of reimbursement policies, select Medicare Advantage Reimbursement Policies. Our reimbursement policies apply to participating providers who serve Individual Anthem Medicare Advantage business unless provider, federal, or CMS contracts and/or requirements indicate otherwise.

Proton pump inhibitors – consider less costly alternatives to the purple pill

To help manage rising healthcare costs, we removed Nexium and the generic from the majority of individual 2015 Medicare Advantage formularies and group-sponsored closed formularies. Lower-cost alternatives (omeprazole and pantoprazole) and over-the-counter proton pump inhibitor (Prilosec, Nexium) are available in this class and on the non-preferred generic tier in majority of Anthem Medicare Advantage formularies. (The group-sponsored MAPD open formulary does cover Nexium at this time.) Nexium brand and generic pricing is significantly higher than the generic proton pump inhibitors, pantoprazole and omeprazole, which are less than $20 per prescription.

Please consider prescribing omeprazole and pantoprazole, the lower-cost alternatives for members with excess stomach acid.

Adult BMI and medical records – please record exact number, not range

Please document body mass index (BMI) as an exact number and not a range. BMI can be documented by billing CPT code 3008F and the appropriate V code. Adding the BMI to the claim helps to decrease the number of chart reviews needed throughout the year and during the HEDIS collection season. Greater precision in charting the member’s BMI will help members achieve or remain at a healthy weight.
Important screenings for Medicare Advantage members

We appreciate your help in ensuring that our Medicare Advantage members receive key services recommended by the Centers for Medicare & Medicaid Services, including:

- Diabetes
  - Members with diabetes ages 18-75 require a yearly dilated retinal exam (DRE), kidney function test
  - Members with diabetes ages 18-75 require a HbA1C every three to six months
- Colorectal screening -- members ages 50 to 75 require a colorectal cancer screening
  - Screenings include fecal occult blood test (FOBT) during the measurement year, flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year and/or colonoscopy during the measurement year or the nine years prior to the measurement year.

Medicare Supplement Plan N ID cards have a new look

Medicare Supplement Plan N includes an office visit benefit. The member is responsible for 20% coinsurance of the Medicare approved amount up to a maximum $20 copay for each office visit.

The identification card previously indicated “Office Visit $20 copay” or “Office Visit $20.” Going forward the wording on the new identification cards is “Office Visit up to $20.” The office visit benefit is not changing; the new wording on the ID cards is a clarification of the benefit. The new wording will be on ID cards issued to new members and members requesting a duplicate card.

Reminder: Individual MA membership moved to new claims system

Effective Jan. 1, 2015, we moved individual (non-group) MA members to a new claims processing system. Please continue to check Important Medicare Advantage Updates on your provider portal for additional information.

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.

Access surveys for PCP and BHP services to be conducted this fall

This article appears in the Administrative update section of this issue because it also applies to PCPs. Click here to access the article.
Quality programs update

HEDIS® 2015: Provider incentive winners announced

We have completed the commercial HEDIS data collection for 2015 and want to thank all of our provider offices and their staff who assisted us. Your partnership in this process allows us to achieve the best HEDIS results possible.

This is the 4th year for our incentive program to acknowledge some of our providers who either responded in a timely manner or went “above & beyond” to help make our HEDIS data collection successful. Any practices that responded within 5 business days of our initial request, or who went out of their way by taking additional steps to help us with data collection, were entered in a drawing to receive a gift. In the event an office was not able to accept a tangible gift, a special written recognition was given. We are pleased to announce our incentive winners as follows:

- Back Cove Midwives
- Central Maine Pediatrics
- David Frasz, MD
- InterMed
- Maine Medical Partners Pediatric Specialty Care
- Martin’s Point
- Gerrard Rudmin, OD
- Sebasticook Family Doctors -Newport
- Southern Maine Medical Center

Thanks again to all of our provider offices and their staff for assisting us in collecting HEDIS data. Our HEDIS results reflect the excellent care you provide to our members. An overview of our HEDIS rates will be published in the December issue of *Network Update*. In addition more information on HEDIS can be found by visiting the provider portal at anthem.com > Provider > Maine > Health & Wellness > Quality Improvement and Standards > HEDIS Information.

We look forward to working with you next HEDIS season!

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

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 > Maine > 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 anthem.com > Customer Support > Maine > Forms Library > Maine Select Drug List.

Medical policy update

Medical policy updates are available on anthem.com

The following new and revised policies were endorsed at the May 7, 2015 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com > Providers > Maine > 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 May 11, 2015
(The following policies were revised to expand medical necessity indications or criteria.)

DRUG.00006 Botulinum Toxin
DRUG.00028 Intravitreal and Periocular Injection Treatment for Retinal Vascular Conditions
DRUG.00038 Bevacizumab (Avastin®) for Non-Ophthalmologic Indications
DRUG.00047 Brentuximab Vedotin (Adcetris®)
DRUG.00048 Eribulin mesylate (Halaven®)
DRUG.00055 Denosumab (Prolia®, Xgeva™)
DRUG.00059 Romiplostim (Nplate®)
DRUG.00066 Antithemophilic Factors and Clotting Factors
DRUG.00067 Ramucirumab (Cyramza®)
DRUG.00071 Pembozilumab (Keytruda®)
SURG.00011 Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
SURG.00033 Implantable Cardioverter-Defibrillator (ICD)
SURG.00098 Mechanical Embolectomy for Treatment of Acute Stroke
TRANS.00024 Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome

Archived medical policy effective May 15, 2015
(The following policy was archived.)

RAD.00058 Real-Time Intra-Fraction Target Tracking During Radiation Therapy

Revised medical policy effective July 1, 2015
(CPT/HCPCS procedure codes added and/or deleted on an existing policy effective on 07-01-2015.)

SURG.00131  Lower Esophageal Sphincter Augmentation Devices for the Treatment of GERD

Revised medical policies effective July 7, 2015
(The following policies were revised to expand medical necessity indications or criteria.)

DRUG.00052  Pertuzumab (Perjeta®)
GENE.00043  Genetic Testing of an Individual's Genome for Inherited Diseases
RAD.00011  Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary of Metastatic Liver Tumors
RAD.00033  Selected Internal Radiation Therapy of Primary Metastatic Liver Tumors
SURG.00050  Radiofrequency Ablation to Treat Tumors outside the Liver
SURG.00065  Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies

Revised medical policies effective July 7, 2015
(The following policies were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.)

ANC.00008  Cosmetic and Reconstructive Services of the Head and Neck
DME.00009  Vacuum-Assisted Wound Therapy in the Outpatient Setting
DME.00022  Functional Electrical Stimulation FES; Threshold Electrical Stimulation TES
DME.00032  Automated External Defibrillators for Home Use
DRUG.00003  Chelation Therapy
DRUG.00032  Intravitreal Corticosteroid Implants
DRUG.00036  Cetuximab (Erbitux®)
DRUG.00040  Abatacept (Orencia®)
DRUG.00049  Belatacept (Nulojix®)
DRUG.00050  Eculizumab (Soliris®)
DRUG.00056  Ado-trastuzumab emtansine (Kadcyla®)
DRUG.00063  Ofatumumab (Arzerra™)
DRUG.00073  Rilonacept (Arcalyst®)
GENE.00003  Genetic Testing and Biochemical Markers for the Diagnosis of Alzheimer's Disease
GENE.00005  BCR-ABL Mutation Analysis
GENE.00006  Epidermal Growth Factor Receptor (EGFR) Testing
GENE.00009  Gene-Based Tests for Screening, Detection and Management of Prostate Cancer
GENE.00011  Gene Expression Profiling for Managing Breast Cancer Treatment
GENE.00014  Analysis of KRAS Status
GENE.00024  DNA-Based Testing for Adolescent Idiopathic Scoliosis
GENE.00031  Genetic Testing for PTEN Hamartoma Tumor Syndrome
GENE.00032  Molecular Marker Evaluation of Thyroid Nodules
GENE.00037  Genetic Testing for Macular Degeneration
GENE.00038  Genetic Testing for Statin-Induced Myopathy
GENE.00044  Analysis of PIK3CA Status in Tumor Cells
LAB.00003  In Vitro Chemosensitivity Assays and In Vitro Chemoresistance Assays
LAB.00015  Detection of Circulating Tumor Cells in the Blood as a Prognostic Factor for Cancer
LAB.00020  Skin Nerve Fiber Density Testing
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<thead>
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<th>Description</th>
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<tr>
<td>LAB.00024</td>
<td>Immune Cell Function Assay</td>
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<tr>
<td>LAB.00025</td>
<td>Topographic Genotyping (PathFinderTG® Test)</td>
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<tr>
<td>MED.00004</td>
<td>Technologies for Evaluation of Skin Lesions (includes Dermatoscopy, Epiluminescence Microscopy, Videomicroscopy, Ultrasonography)</td>
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<tr>
<td>MED.00007</td>
<td>Proltherapy for Joint and Ligamentous Conditions</td>
</tr>
<tr>
<td>MED.00011</td>
<td>Sensory Stimulation for Brain-Injured Individuals in Coma or Vegetative State</td>
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<tr>
<td>MED.00024</td>
<td>Adoptive Immunotherapy and Cellular Therapy</td>
</tr>
<tr>
<td>MED.00026</td>
<td>Hyperthermia for Cancer Therapy</td>
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<tr>
<td>MED.00053</td>
<td>Noninvasive Measurement of Left Ventricular End Diastolic Pressure (LVEDP) in the Outpatient Setting</td>
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<tr>
<td>MED.00057</td>
<td>MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids</td>
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<tr>
<td>MED.00059</td>
<td>Idiopathic Environment Illness (IEI)</td>
</tr>
<tr>
<td>MED.00076</td>
<td>Inhaled Nitric Oxide</td>
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<tr>
<td>MED.00079</td>
<td>Manipulation under Anesthesia of the Spine and Joints other than the Knee</td>
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<tr>
<td>MED.00087</td>
<td>Imaging Techniques for Screening and Identification of Cervical Cancer</td>
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<tr>
<td>MED.00101</td>
<td>Physiologic Recording of Tremor using Accelerometer(s) and Gyroscope(s)</td>
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<tr>
<td>MED.00102</td>
<td>Ultrafiltration in Decompensated Heart Failure</td>
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<tr>
<td>MED.00104</td>
<td>Non-invasive Measurement of Advanced Glycation Endproducts (AGES) in the Skin</td>
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<tr>
<td>MED.00105</td>
<td>Bioimpedance Spectroscopy Devices for the Detection and Management of Lymphedema</td>
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<tr>
<td>MED.00106</td>
<td>Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer</td>
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<tr>
<td>MED.00111</td>
<td>Intracardiac Ischemia Monitoring</td>
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<tr>
<td>MED.00115</td>
<td>Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management</td>
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<tr>
<td>OR.PR.00004</td>
<td>Partial-Hand Myoelectric Prosthesis</td>
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<tr>
<td>RAD.00001</td>
<td>Computed Tomography to Detect Coronary Artery Calcification</td>
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<tr>
<td>RAD.00012</td>
<td>Ultrasound for the Evaluation of Paranasal Sinuses</td>
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<td>RAD.00016</td>
<td>Intravascular Brachytherapy (Coronary and Non-Coronary)</td>
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<td>RAD.00022</td>
<td>Magnetic Resonance Spectroscopy (MRS)</td>
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<tr>
<td>RAD.00030</td>
<td>Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule</td>
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<tr>
<td>RAD.00038</td>
<td>Use of 3-D and 4-D Ultrasound in Maternity Care</td>
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<td>RAD.00040</td>
<td>PET Scanning Using Gamma Cameras</td>
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<td>RAD.00041</td>
<td>Intensity Modulated Radiation Therapy (IMRT)</td>
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<td>RAD.00043</td>
<td>Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening</td>
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<td>RAD.00044</td>
<td>Magnetic Resonance Neurography</td>
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<td>RAD.00052</td>
<td>Positional MRI</td>
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<td>RAD.00054</td>
<td>MRI of the Bone Marrow</td>
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<td>RAD.00056</td>
<td>Intraocular Epiretinal Brachytherapy</td>
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<tr>
<td>RAD.00059</td>
<td>Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions outside the Liver except Central Nervous System (CNS) and Spinal Cord</td>
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<tr>
<td>RAD.00060</td>
<td>Digital Breast Tomosynthesis</td>
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<td>REHAB.00003</td>
<td>Hippotherapy</td>
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<td>SURG.00009</td>
<td>Refractive Surgery</td>
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<td>SURG.00016</td>
<td>Stereotactic Radiofrequency Pallidotomy</td>
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<tr>
<td>SURG.00022</td>
<td>Lung Volume Reduction Surgery</td>
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<td>SURG.00025</td>
<td>Cryosurgical Ablation of Solid Tumors outside the Liver</td>
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<td>SURG.00037</td>
<td>Treatment of Varicose Veins (Lower Extremity)</td>
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<tr>
<td>SURG.00043</td>
<td>Electrothermal Shrinkage of Joint Capsules, Ligaments and Tendons</td>
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<tr>
<td>SURG.00045</td>
<td>Extracorporeal Shock Wave Therapy for Orthopedic Conditions</td>
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</tbody>
</table>
New medical policy effective July 7, 2015
(The following policy was created and does not have significant change to present clinical criteria coverage.)

MED.00118  Continuous Monitoring of Intraocular Pressure

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

DRUG.00055  Denosumab (Prolia®, Xgeva™)
DRUG.00062  Obinutuzumab (Gazyva®)
DRUG.00066  Antihemophilic Factors and Clotting Factors
GENE.00016  Gene Expression Profiling for Colorectal Cancer
GENE.00023  Gene Expression Profiling of Melanomas
RAD.00002  Positron Emission Tomography (PET) and PET/CT Fusion
RAD.00014  Brachytherapy for Oncologic Indications
New medical policy October 9, 2015
(The policy listed below was created and might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

LAB.00031  Advanced Lipoprotein Testing in Cardiac Disease Risk Assessment and Management

New medical policies effective November 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.)

DRUG.00075  Nivolumab (Opdivo®)
DRUG.00076  Blinatumomab (Blincyto™)
SURG.00140  Peripheral Nerve Blocks for Treatment of Neuropathic Pain

Archived medical policies effective November 1, 2015
(The following policies were archived and merged into DRUG.00066.)

DRUG.00065  Recombinant Coagulation Factor IX, Fc Fusion Protein (Alprolix™)
DRUG.00069  Recombinant Antihemophilic Factor, Fc Fusion Protein (Eloctate™)

Clinical guidelines update

Clinical guideline updates are available on anthem.com

The following new and revised clinical guidelines were endorsed at the May 7, 2015 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com > Providers > Maine > 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 calling Provider Service at 800-832-6011.

Revised clinical guidelines effective May 11, 2015
(The following adopted guidelines were revised to expand medical necessity indications or criteria.)

CG-BEH-04  Substance-Related and Addictive Disorder Treatment
CG-BEH-05  Eating and Feeding Disorder Treatment

Revised clinical guidelines effective July 7, 2015
(The following adopted guidelines were revised to expand the medical necessity indications or criteria.)

CG-DRUG-42  Asparagine Specific Enzymes (Asparaginase)
Revised clinical guidelines effective July 7, 2015
(The following guidelines were revised and had no significant changes to the position or criteria.)

CG-DME-01 External (Portable) Continuous Insulin Infusion Pumps
CG-DRUG-25 Intravenous versus Oral Drug Administration in the Outpatient and Home Setting
CG-DRUG-27 Clostridial Collagenase Histolyticum Injection
CG-MED-29 Inpatient Subacute Care
CG-MED-37 Intensive Programs for Pediatric Feeding Disorders
CG-SURG-18 Septoplasty

Revised clinical guidelines effective November 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-09 Immune Globulin (Ig) Therapy
CG-DRUG-15 Gonadotropin Releasing Hormone (GnRH) Analogs
CG-DRUG-16 White Blood Cell Growth Factors
CG-REHAB-04 Physical Therapy
CG-REHAB-05 Occupational Therapy
CG-REHAB-08 Private Duty Nursing in the Home Setting
CG-SURG-33 Lumbar Fusion and Lumbar Total Disc Arthroplasty (TDA)

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

CG-DRUG-45 Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)
CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity