Health care reform update
- Health care reform updates on anthem.com

Administrative and policy update
- Introducing Anthem Togetherworks
- Update to claims processing edits and reimbursement policies
- Changes to sleep disorder management diagnostic and treatment guidelines
- Update provider demographic information via Availity Web Portal
- Coverage for digital breast tomosynthesis or 3-D mammography
- Place of Service and Evaluation and Management Facility Reimbursement Policy effective January 1, 2016
- Breast cancer patient protection act

Medicare Advantage update
- Imaging site scores for outpatient diagnostic imaging could impact reimbursement
- Routine physical exams are covered in 2016
- Administrative denials may be appealed
- Radiation therapy: select brachytherapy, IMRT CPT codes to require prior authorization
- HRM program designed to reduce risk
- Precertification requirements updated for 2016

Behavioral health update
- New fax number for OTRs and TMS request forms
- Behavioral health outpatient coding
- Central nervous system (CNS) assessments
- 2015 updated Outpatient Treatment Report

Quality programs update
- Clinical practice and preventive health guidelines on anthem.com
- National Consumer Cost Tool (NCCT) provider cost data available for review

Pharmacy update
- Pharmacy information available on anthem.com
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

Introducing Anthem Togetherworks

At Anthem, we look for ways to get results and achieve goals together. Every day we bring our tools, information, and expertise to the table in ways that benefit our members and providers. With this effort, we introduce Anthem Togetherworks – a new name for our provider collaboration strategy. Anthem Togetherworks refers to a broad spectrum of our collaborative options already in place, and includes programs like Enhanced Personal Health Care (EPHC) and the Quality-In-Sights® Hospital Incentive Program (Q-HIP®). Anthem Togetherworks also includes tools we offer, such as our web-based Provider Care Management Solutions and Care Delivery Transformation support. Through Anthem Togetherworks, we’ll continue to offer a wide range of provider collaboration programs and offerings based on your needs, to help us work together to meet the challenges of a new era in health care.

Update to claims processing edits and reimbursement policies

On October 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 identify if the article pertains to professional or facility provider billing.

Review of reimbursement policies -professional

The following professional reimbursement policies received an annual review and include minor language revisions but do not have changes to the policy position or criteria:

- Health and Behavior Assessment/Intervention Services
- “Incident To” Services
- Injection and Infusion Administration and Related Services & Supplies
- Moderate Sedation
- Modifier 22
- Overhead Expense for Surgical Procedures and Diagnostic Testing
- Routine Obstetrical Services
Bundled Services -professional
Based on coding changes effective January 1, 2014, providers should no longer separately report CT guidance, represented by CPT® code 77014 (Computed tomography guidance for placement of radiation therapy fields), when reporting simulation services represented by codes 77280-77290. The use of CT guidance is considered integral to the simulation; therefore, for claims processed on or after November 16, 2015, CPT code 77014 will no longer be eligible for separate reimbursement when reported with CPT codes 77280-77290. This information is included in our Modifiers 59, XE, XP, XS, and XU policy since modifiers will not override this edit.

Frequency Editing -professional
For claims processed on or after November 16, 2015, when the same provider reports an unmodified procedure and the same procedure with modifier 62 on the same date of service, the claim will be subject to our frequency editing logic.

Based on CPT Appendix A - Modifiers, when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the applicable procedure code.

Modifiers 59 and XE, XP, XS, and XU - professional
Our current bundling edit logic denies CPT code 76098 (radiological examination, surgical specimen) as mutually exclusive when reported with CPT codes 19081 – 19086 (breast biopsy with placement of breast localization device(s)). Based on CPT instructions which state “Do not report 76098 in conjunction with 19081 – 19086,” beginning with claims processed on or after November 16, 2015, modifiers will no longer override the mutually exclusive edit.

Unit Frequency Maximums for Drugs and Biologic Substances -professional
In the August 2015 issue of Network Update, we advised that for dates of service on or after November 16, 2015, we would be implementing a maximum units limit for specific drugs and biologic substances. Please note we will be delaying the implementation of these edits and will post updated information in a future Network Update.

Coding tip for reporting modifiers 54, 55, and 56: split surgical care -professional
According to CPT surgical package definition, the global surgical package includes pre-operative care, the surgical care, and typical postoperative care. When a provider renders care that does not include all the components of the global surgical package, the following modifiers should be used with the reported surgical procedure code to indicate which portion of the care was rendered:

- Modifier 54 - surgical care only
- Modifier 55 - postoperative management only; postoperative care begins on the next day following the surgical procedure
- Modifier 56 - preoperative management only; preoperative care begins on the day before and/or the day of the surgical procedure

For example, when an emergency room (ER) provider reports the surgical service for the closed treatment of a radial shaft fracture; without manipulation (CPT code 25500), and postoperative care is transferred to another provider, the ER provider should report the surgical procedure code 25500 with modifiers 54 and 56 on one line to indicate surgical care only and preoperative management only. The provider who accepts the patient for postoperative management only should report the surgical procedure code 25500 with modifier 55 to indicate the postoperative care only.
Coding tip for reporting imaging guidance with intensity modulated radiation treatment (IMRT) - professional

Effective January 1, 2015, the American Medical Association (AMA), with input from the American Society for Therapeutic Radiology and Oncology (ASTRO), released the following new CPT codes for intensity modulated radiation treatment delivery (IMRT) services.

- 77385 – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- 77386 – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
- 77387 – Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

With the release of the new CPT codes, ASTRO also released the following coding guidance:

- The nomenclature for the new IMRT delivery CPT codes (77385 and 77386) includes the following language: “includes guidance and tracking, when performed”.
- The technical component of the image guidance and tracking (IGRT) part of the procedure is now packaged into the IMRT delivery CPT codes 77385 and 77386, and is not reported or allowed separately. Consequently, the total component for CPT code 77387 is not separately reimbursed with CPT codes 77385 and/or 77386.
- When the professional component of IGRT (77387 -26) is a separately identifiable service, the most appropriate modifier that designates the service as a distinct procedural service should be used.

Coding tip for reporting a separate procedure with a related procedure - professional

According to CPT, some procedures or services that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term “separate procedure." The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedures/services provided at the same time, the "separate procedure" may be reported by itself, or in addition to other procedures/services by appending the most appropriate modifier to the code to indicate that the procedure is a distinct, independent procedure. This may represent a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury.

For example, when 99195 (phlebotomy, therapeutic (separate procedure)) is reported with 36415 (collection of venous blood by venipuncture), 99195 must include the most appropriate modifier that designates the service as a distinct procedural service.

CPT® is a registered trademark of the American Medical Association.

Changes to sleep disorder management diagnostic and treatment guidelines

An important component of AIM Specialty Health’s (AIM) Sleep Disorder Management program focuses on the management of obstructive sleep apnea (OSA) through the use of custom made oral appliances. These appliances include mandibular repositioning appliances that are billed using HCPCS code E0486.*
Effective January 1, 2016, AIM will be revising this guideline to help ensure that oral appliances used in the treatment of OSA meet the criteria established by CMS for mandibular repositioning appliances. The CMS specifies that to be coded as E0486, custom fabricated mandibular advancement devices must:

- Have a fixed mechanical hinge at the sides, front or palate, and,
- Have a mechanism that allows the mandible to be advanced in increments of one millimeter or less, and,
- Be able to protrude the mandible beyond the front teeth at maximum protrusion, and,
- Be adjustable by the beneficiary in increments of one millimeter or less, and,
- Retain the adjustment setting when removed, and
- Maintain mouth position during SLEEP so as to prevent dislodging the device.

Also, along with this addition to the preamble section of the Guideline, a question will be added to the pre-authorization request. The question will read: ‘Does the mandibular repositioning device requested comply with CMS criteria?’ Cases in which the provider responds “No” or “I don’t know” will be routed for review.

*Prefabricated oral appliances (HCPCS code E0485) are not considered appropriate therapy for OSA in any clinical situation.

Now available! Easily update your provider demographic information via the Availity Web Portal

Submit demographic and/or practice changes, i.e. address changes, tax ID changes, provider leaving a group etc. using the online Provider Maintenance Form available on the Availity Web Portal. Your organization’s Primary Access Administrator (PAA) and Assistant PAAs can find the form under the Payer Resources Page > Anthem > Physician Change Requests > online Provider Maintenance Form and Provider Maintenance Instructions. Note: The use of this form is limited to CMS-1500 claim format billers only.

Important information about coverage for digital breast tomosynthesis (DBT) or 3-D mammography

In 2015, the USPSTF reviewed screening recommendations for breast cancer and concluded in a draft recommendation statement that digital breast tomosynthesis (DBT) or 3-D mammography does not meet evidence level A or B and should not be recommended in place of digital mammography for routine breast cancer screening. The draft statement also notes that DBT may expose women to approximately twice the radiation of 2-D digital mammography.

Based on the USPSTF conclusion and Anthem's independent review of the available evidence, we consider digital breast tomosynthesis investigational and not medically necessary for all indications.

Please note that two imaging vendors currently have FDA approval for DBT and actively promote their services to academic centers and private hospitals or imaging centers. As marketing and adoption of DBT increases, we expect an increase in interest and use of this service, which is why it is important for providers to be aware that DBT is a non-covered service.

We have extensively reviewed the available evidence addressing the use of digital breast tomosynthesis and presented this data to our Medical Policy and Technology Assessment Committee (MPTAC) for discussion and evaluation. The MPTAC agrees with the USPSTF concerns and recommendations.

To read more about the USPSTF’s conclusion, please see the USPSTF Breast Cancer Screening Draft Recommendation Statement. Providers can also review our medical policy for Digital Breast Tomosynthesis.
Place of Service and Evaluation and Management Facility Reimbursement Policy effective January 1, 2016

As part of our ongoing commitment to share current administrative, billing, and reimbursement policies with you, we’ve posted a Place of Service and Evaluation and Management Facility Reimbursement Policy that will become effective for dates of service on or after January 1, 2016. To view this and other facility reimbursement policies, visit anthem.com > Providers > Maine > Provider Reference Materials > Administrative, Billing and Reimbursement Policies.

Breast cancer patient protection act

Background: In accordance with 2015 amendments to the Maine Breast Cancer Patient Protection Act of 1997, found in Public Law, Chapter 227, LD 359, insurers offering health plans in Maine are now required to provide to participating network physicians copies of member notices regarding coverage provided by the Maine Breast Cancer Patient Protection Act, and participating network physicians are required to provide notice to breast cancer treatment patients regarding the coverage provided by the Breast Cancer Patient Protection Act.

Patient Notice: “Under your health plan, as required by the Maine Breast Cancer Patient Protection Act of 1997, coverage will be provided for inpatient care subsequent to a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer for a period of time determined to be medically appropriate by the attending physician in consultation with the patient.

This coverage will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.”

For additional information regarding P.L. 227, LD 359 please go to: H.P. 246 - L.D. 359

Medicare Advantage update

Imaging site scores for outpatient diagnostic imaging could impact reimbursement

We are dedicated to meeting the evolving needs of our members and helping to ensure that they receive the most appropriate care possible. We are pleased to introduce a new program for imaging services administered by AIM Specialty Health® (AIM).

What does this mean to you?

Effective November 1, 2015, our Medicare Advantage plans will begin collecting information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of the following outpatient diagnostic imaging services for our individual Medicare Advantage members:

- Computed tomography (CT)
- Magnetic resonance (MR)
- Positron emission tomography (PET)
- Nuclear medicine (NUC)
- Ultrasound
- X-ray
- Echocardiograph
Emergency room outpatient diagnostic imaging services are excluded.

AIM's online registration tool, OptiNet®, will continue to collect modality-specific data from providers who render imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment, and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

That data will continue to be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. Each modality or piece of equipment will receive its own score. Providers with an imaging site score of 76 or higher will see no change in reimbursement.

- **Effective March 1, 2016 for providers who have not completed the online registration:** Claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

- **Effective March 1, 2016 for providers with an imaging site score below 76 for the applicable modality for any of the outpatient diagnostic imaging services listed above:** Claims with dates of service on or after March 1, 2016 for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

Members cannot be balance billed if a line-item denial occurs.

Please note that any decision to deny reimbursement and/or approval of an imaging service is separate and apart from the determination of the medical necessity of the same service.

Please note that the line-item denial for a site score below 76 for the applicable modality applies only to individual Medicare Advantage claims at this time.

Please see [Important Medicare Advantage Updates](#) for additional information.

Routine physical exams are covered in 2016

Anthem Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2016 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 in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay as applicable by the member’s plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider.
Additional details can be found at Important Medicare Advantage Updates.

**Administrative denials may be appealed**

For a member to receive maximum benefits for inpatient admissions, we must authorize or precertify the covered services prior to being rendered. 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.

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 they 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 and provider appeals.

**Radiation therapy: select brachytherapy, IMRT CPT codes to require prior authorization**

Effective November 1, 2015, we will require prior authorization of the following outpatient radiation therapy CPT codes for our individual Medicare Advantage members:

- Brachytherapy 77316, 77317 and 77318
- Intensity modulated radiation therapy (IMRT) 77386, G6016

Prior authorization requests will be handled by AIM Specialty HealthSM (AIM), an affiliate of Anthem. Contact AIM at https://www.providerportal.com/ or 800-714-0400. Additional information, including required information for radiation therapy requests, can be found here.

**HRM program designed to reduce risk for Medicare Advantage members**

We are working to decrease the amount of high risk medications (HRM) prescribed by primary care providers. HRMs contain a heightened risk for causing significant harm when Medicare Advantage members use them in error. Examples of commonly prescribed HRMs include zolpidem (Ambien®) and zaleplon (Lunesta®). Falls and fractures may occur when these HRMs are used.

We identify providers who have prescribed HRMs and will contact the prescriber's office to validate the prescriber/patient relationship. We will then schedule an appointment for an Anthem pharmacist to speak with the provider about HRMs.

**Precertification requirements updated for 2016**

For information on existing precertification requirements and new precertification requirements for 2016, please refer to your provider agreement, Medicare Advantage HMO & PPO Provider Guidebook/provider manual 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. Non-contracted providers should contact us.
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.

New fax number for OTRs and TMS request forms

For accounts that require authorization for outpatient visits, we have updated our Outpatient Treatment Report (OTR) form with a new fax number. Additionally, our trans-cranial magnetic stimulation (TMS) authorization request form has also been updated to reflect the same number. All OTR and TMS request forms should be faxed to 866-834-7469. All other forms should continue to be faxed to the number indicated on the form.

Behavioral health outpatient coding

In 2013, the AMA updated behavioral health outpatient CPT codes and issued new coding guidelines for their use. The new guidelines included CPT code 90834, 45-53 minutes face to face with the patient, and CPT code 90837, 53-60 minutes with the patient.

Prior to 2013, the psychotherapy “hour” was billed using a code for 45-50 minutes of time with the patient. With the release of the new CPT codes, we have observed that over half of the billing for this type of psychotherapy is now claiming 53-60 minutes spent face to face with the patient at each session.

We would like to remind you of specific guidelines per the AMA CPT codebook for commonly billed codes:

If you use an E/M code:

- The type and level of an E/M service is selected based on key components of history, examination and medical decision-making, therefore, time may not be used as the basis of E/M code selection.
- Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy add-on service.

If you use a psychotherapy code which is defined by time:

- Documentation should include the time spent face to face with the patient and give specific details to what was done in the session
- The American Psychological Association 2013 guidelines state:
“When billing a private insurer that does not require authorization for 90837 and has not indicated that this code should be used infrequently, you should bill this code if your session time falls into the 53-minute or more time frame that pertains to 90837. We recommend, however, that you record your exact session start and stop times in your clinical note (for example, 1:02 to 1:57) when billing the new codes, as Medicare providers must do. At any point, a company can ask you for appropriate documentation or explanations. Also be mindful that if you have historically billed a company primarily the 45-50 minute code and switch to primarily using the new 60-minute code, that company may ask you to explain this change.”

As always, we retain the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the AMA’s CPT codebook for further code definitions and details.

Central nervous system (CNS) assessments

An education and audit program for central nervous system (CNS) assessments begins later this fall; the purpose of this program will ensure proper documentation for the services billed.

Central nervous system (CNS) assessments and/or tests involve the testing of cognitive processes, visual motor responses and abstractive abilities and are accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate useful information for treating and caring for the patient. This includes psychological and aphasia assessments; neuropsychological, and developmental testing; and a neurobehavioral status exam.

Neuropsychological testing uses standard techniques to objectively evaluate behavioral and cognitive abilities of patients by comparing the patient's results to established normal results. Neuropsychological testing generally involves the use of paper/pencil and mechanical procedures and carries little, if any, risk to the patient. A complete neuropsychological evaluation includes:

a. review of information from the referral
b. face-to-face evaluation with the patient and/or the family, at which time some screening tests may be done
c. administration of various neuropsychological tests tailored to the patient's condition
d. test scoring and interpretation, which is reviewed with the referring clinician and/or the patient, for example Halstead-Reitan, LURIA, and WAIS-R testing

We require that the medical record documentation for CNS assessments/tests be legible, signed, dated, and contain, at a minimum, the following elements:

a. relevant medical and personal history
b. results of initial evaluation determining the need for testing
c. suspected mental illness and/or neuropsychological abnormality/dysfunction
d. types of testing indicated
e. previous testing (if conducted) by same or different provider and efforts to obtain those results
f. tests administered, scoring, and interpretation
g. time involved for each test performed; when the testing is done over several days, the testing time should be reported all on the last date of service
h. treatment report and recommendations

The time spent in interpreting and preparing the report and any explanation of the report to the patient and family are to be billed with the applicable code used to perform the test.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96101</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96102</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
</tr>
<tr>
<td>96103</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report</td>
</tr>
<tr>
<td>96105</td>
<td>Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report</td>
</tr>
<tr>
<td>96111</td>
<td>Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation</td>
</tr>
<tr>
<td>96116 (See also our Frequency Editing Policy.)</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report</td>
</tr>
<tr>
<td>96118</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96119</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96120</td>
<td>Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
</tr>
<tr>
<td>96125</td>
<td>Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
</tbody>
</table>

As always, we appreciate the care you provide to our members.

We retain the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the AMA’s CPT codebook and Anthem documentation policies to ensure your practice is in compliance with these documentation requirements.
2015 updated Outpatient Treatment Report

We have updated our Outpatient Treatment Report (OTR) to reflect the ICD10 diagnosis code set. The revised form has been posted on anthem.com > Providers > Anthem Behavioral Health > Forms > Outpatient Treatment Report. In 2012, we removed the behavioral health outpatient management for fully-insured products and plans; however, Medicare Advantage and some self-funded groups continue to require outpatient management after the pass-through visits have been exhausted. In these instances, please submit the updated form to us with the requested number of units for ongoing treatment.

Quality programs update

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.

National Consumer Cost Tool (NCCT) provider cost data available for review

We continue to support cost transparency, which involves making provider cost information available to members. We do this via our consumer transparency tools, Anthem Care Comparison (ACC), Estimate Your Cost (EYC), and Castlight. We display costs for common procedures that are non-emergent, high-cost, or high-volume. For these procedures, we derive a cost range for the total episode of care, which includes all facility, professional, and ancillary services provided during an admission or outpatient visit. These costs are based on historical rates.

ACC cost and quality information is available nationally through the Blue Cross and Blue Shield Association and is known as the National Consumer Cost Tool (NCCT). In addition, the ACC/NCCT data are used as the basis for the EYC tool and other third party transparency initiatives, which can be found on the home page of our Consumer Portal website.

We have expanded the cost information that will be made available to members through the EYC tool. Members using EYC will be able to view provider-specific costs for additional professional and ancillary services, including provider-specific office visit cost data.

The current version of the NCCT cost comparison transparency data will be updated in January, 2016, and will be available for provider review prior to its release. If you have questions regarding Anthem Care Comparison, Estimate Your Cost, or our expanded transparency initiatives, contact David Spencer, Sr. Provider Network Manager at david.spencer@anthem.com.

Pharmacy update

Pharmacy information available on anthem.com

Visit http://www.anthem.com/pharmacyinformation for more information on the following:

- copayment/coinsurance requirements and their applicable drug classes
medical policy update

medical policy updates are available on anthem.com

The following new and revised policies were endorsed at the August 6, 2015 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 August 10, 2015
(The following policies were revised to expand medical necessity indications or criteria.)

DRUG.00046  Ipilimumab (Yervoy™)
GENE.00010  Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status
GENE.00026  Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy
SURG.00014  Cochlear Implants and Auditory Brainstem Implants
SURG.00055  Cervical Total Disc Arthroplasty
SURG.00098  Mechanical Embolectomy for Treatment of Acute Stroke

Revised medical policies effective August 10, 2015
(The following policies were updated and do not have significant changes to present clinical criteria coverage.)

ADMIN.00006  Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
DRUG.00015  Prevention of Respiratory Syncytial Virus Infections

New medical policy effective August 10, 2015
(The following policy was created and does not have significant change to present clinical criteria coverage.)
Revised medical policy effective October 1, 2015
(CPT/HCPCS procedure codes added and/or deleted on an existing policy effective on 07-01-2015.)

DRUG.00074  Alemtuzumab (Lemtrada™)

Revised medical policy effective October 6, 2015
(The following policy was revised to expand medical necessity indications or criteria.)

SURG.00037  Treatment of Varicose Veins (Lower Extremity)

Revised medical policies effective October 6, 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
ADMIN.00004  Medical Necessity Criteria
ADMIN.00005  Investigational Criteria
ANC.00006  Biomagnetic Therapy
ANC.00007  Cosmetic and Reconstructive Services; Skin Related
ANC.00009  Cosmetic and Reconstructive Services of the Trunk and Groin
BEH.00004  Behavioral Health Treatments for Autism Spectrum Disorders and Rett Syndrome
DME.00004  Electrical Bone Growth Stimulation
DME.00009  Vacuum Assisted Wound Therapy in the Outpatient Setting
DME.00024  Transtympanic Micropressure for Treatment of Ménière’s Disease
DME.00027  Ultrasound Bone Growth Stimulation
DME.00030  Altered Auditory Feedback (AAF) Devices for the Treatment of Stuttering
DME.00037  Cooling Devices and Combined Cooling/Heating Devices
DRUG.00002  Tumor Necrosis Factor Antagonists
DRUG.00006  Botulinum Toxin
DRUG.00017  Hyaluronan Injections in Joints Other than the Knee
DRUG.00031  Subcutaneous Hormone Replacement Implants
DRUG.00041  Rituximab (Rituxan®)
DRUG.00043  Tocilizumab (Actemra®)
DRUG.00057  Canakinumab (Ilaris®)
DRUG.00058  Pharmacotherapy for Hereditary Angioedema (HAE)
DRUG.00064  Enteral Carbidopa and Levodopa Intestinal Gel Suspension
GENE.00002  Preimplantation Genetic Diagnosis Testing
GENE.00021  Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
GENE.00040  Genetic Testing for CHARGE Syndrome
GENE.00041  Short Tandem Repeat Analysis for Specimen Provenance Testing
GENE.00042  Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome
LAB.00011  Analysis of Proteomic Patterns
LAB.00016  Fecal Analysis in the Diagnosis of Intestinal Disorders
LAB.00027  Selected Blood, Serum and Cellular Allergy and Toxicity Tests  
MED.00005  Hyperbaric Oxygen Therapy (Systemic/Topical)  
MED.00055  Wearable Cardioverter Defibrillators  
MED.00081  Cognitive Rehabilitation  
MED.00090  Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders  
MED.00098  Hyperoxic Reperfusion Therapy  
MED.00107  Medical and Other Non-Behavioral Health Related Treatments for Autism Spectrum Disorders and Rett Syndrome  
MED.00112  Autonomic Testing  
OR.PR.00005  Upper Extremity Myoelectric Orthoses  
RAD.00019  Magnetic Source Imaging and Magnetoencephalography  
RAD.00034  Dynamic Spinal Visualization (Including Digital Motion X-ray and Cineradiography/ Videofluoroscopy)  
RAD.00042  SPECT/CT Fusion Imaging  
RAD.00045  Cerebral Perfusion Imaging using Computed Tomography  
RAD.00046  Cerebral Perfusion Studies using Diffusion and Perfusion Magnetic Resonance Imaging  
RAD.00063  Magnetization-Prepared Rapid Acquisition Gradient Echo Magnetic Resonance Imaging (MPRAGE MRI)  
SURG.00005  Partial Left Ventriculectomy  
SURG.00020  Bone-Anchored and Bone Conduction Hearing Aids  
SURG.00023  Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedure  
SURG.00026  Deep Brain, Cortical, and Cerebellar Stimulation  
SURG.00028  Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions  
SURG.00032  Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention  
SURG.00033  Implantable Cardioverter-Defibrillator (ICD)  
SURG.00047  Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia  
SURG.00049  Mandibular/Maxillary (Orthognathic) Surgery  
SURG.00051  Hip Resurfacing  
SURG.00054  Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection  
SURG.00071  Percutaneous and Endoscopic Spinal Surgery  
SURG.00074  Nasal Surgery for the Treatment of Obstructive Sleep Apnea (OSA) and Snoring  
SURG.00076  Nerve Graft after Prostatectomy  
SURG.00077  Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques  
SURG.00084  Implantable Middle Ear Hearing Aids  
SURG.00085  Mastectomy for Gynecomastia  
SURG.00090  Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia (TGN)  
SURG.00093  Treatment of Osteochondral Defects  
SURG.00103  Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)  
SURG.00105  Bicompartmental Knee Arthroplasty  
SURG.00116  High Resolution Anoscopy Screening for Anal Intrathelial Neoplasia (AIN) and Squamous Cell Cancer of the Anus  
SURG.00118  Bronchial Thermoplasty  
SURG.00122  Venous Angioplasty with or without Stent Placement  
SURG.00125  Radiofrequency and Pulsed Radiofrequency Treatment of Trigger Point Pain  
SURG.00126  Irreversible Electroporation (IRE)  
SURG.00127  Sacroiliac Joint Fusion  
SURG.00132  Devices for Maintaining Sinus Ostial Patency Following Sinus Surgery
Revised medical policies effective January 1, 2016
(The policies listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

- **GENE.00021** Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- **GENE.00043** Genetic Testing of an Individual’s Genome for Inherited Diseases
- **MED.00064** Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
- **SURG.00048** Panniculectomy and Abdominoplasty
- **SURG.00066** Percutaneous Neurolysis for Chronic Neck and Back Pain
- **TRANS.00035** Mesenchymal Stem Cell Therapy for Orthopedic Indications

New medical policies effective January 1, 2016
(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.00077** Secukinumab (Cosentyx™)
- **SURG.00141** Doppler-Guided Transanal Hemorrhoidal Dearterialization

Clinical guidelines update

Clinical guideline updates are available on anthem.com

The following new and revised clinical guidelines were endorsed at the August 6, 2015 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 August 10, 2015
(The following adopted guideline was revised to expand medical necessity indications or criteria.)

- **CG-SURG-12** Penile Prosthesis Implantation

Revised clinical guidelines effective October 6, 2015
(The following adopted guidelines were revised to expand the medical necessity indications or criteria.)

- **CG-BEH-02** Adaptive Behavioral Treatment for Autism Spectrum Disorder
- **CG-SURG-27** Gender Reassignment Surgery
Revised clinical guidelines effective October 6, 2015
(The following guidelines were revised and had no significant changes to the position or criteria.)

CG-BEH-03 Psychiatric Disorder Treatment
CG-BEH-04 Substance-Related and Addictive Disorder Treatment
CG-BEH-07 Psychological Testing
CG-DME-07 Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
CG-DRUG-05 Recombinant Erythropoietin Products
CG-DRUG-11 Infertility Drugs
CG-DRUG-24 Repository Corticotropin Injection (H.P. Acthar® Gel)
CG-DRUG-28 Alglucosidase alfa (Lumizyme®, Myozyme®)
CG-MED-26 Neonatal Levels of Care
CG-MED-31 Skilled Nursing Facility Services
CG-REHAB-09 Acute Inpatient Rehabilitation
CG-SURG-05 Maze Procedure
CG-SURG-08 Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
CG-SURG-24 Functional Endoscopic Sinus Surgery (FESS)
CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy

Revised clinical guidelines effective January 1, 2016
(The guidelines listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

CG-MED-46 Ambulatory and Inpatient Video Electroencephalography
CG-SURG-27 Gender Reassignment Surgery