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

A new look is coming to provider communications

We are committed to continuously improving the way we do business with our contracted provider community. In that respect, we have listened to your feedback and are pleased to announce that in early 2017, a new look and feel is coming to Network Update and the Communications page on our anthem.com provider website. The new design of Network Update will allow you to easily read and print individual articles that pertain to your practice.

While the Communications page may look a little different the next time you visit, we hope that the new design will allow you to more easily find the specific communications that are important to you and your practice.
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.

Recent updates include the 2017 Affordable Care Act (ACA)-compliant Health Plans Quick Reference Guide.

Administrative and policy update

Sign-up today for Network eUPDATE – it's free!

Connecting with Anthem and staying informed is easy, faster and convenient with our Network eUPDATEs. Network eUPDATE is our web tool for sharing vital information with you. It features short topic summaries on late breaking news that impacts providers:

- Important website updates
- System changes
- Medical policy updates
- Claims and billing updates

......and much more

Registration is fast and easy. There is no limit to the number of subscribers who can register for Network eUPDATEs, so you can submit as many e-mail addresses as you like.

Update to claims processing edits and reimbursement policies

On December 1, we will be updating our Anthem Online Provider Services (AOPS) website with the following new and/or revised reimbursement policies. Please note that AOPS will be retired soon. See related article in this newsletter to learn where these policies will be available once AOPS is retired.

The updates below identify if the article pertains to professional or facility provider billing.

Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU – professional

Beginning with dates of service on or after March 1, 2017, we will be implementing the following code pair edits and have documented these edits in our future Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU reimbursement policies:

- Current Procedural Terminology (CPT®) code 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar) will not be eligible for separate reimbursement when reported with CPT code 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare...
interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.

- CPT code 22614 (arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (list separately in addition to code for primary procedure)) will not be eligible for separate reimbursement when reported with CPT codes 22600 (arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment), 22610 (arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)), 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)), 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar), and 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.

- CPT codes 63081, 63082, 63085, 63086, 68087, and 63088 (vertebral corpectomies) will not be eligible for separate reimbursement when reported with CPT code 22558 (arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar). Modifiers will not override this edit.

- CPT code 82542 (column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen) will not be eligible for separate reimbursement when reported with CPT code 91065 (breath hydrogen or methane test). Modifiers will not override this edit.

- We consider cervical and vaginal cytopathology to be incidental to evaluation and management (E/M) services. We currently deny CPT codes 88141-88155, 88165-88167, and 88174-88175 as incidental to preventive and problem oriented E/M services identified by such CPT codes as 99381-99397 and 99201-99215 when reported by the same provider for the same patient on the same date of service. Based on our current edit, we are adding HCPCS codes G0101, G0402, G0438, G0439, S0610 and S0612 (screening exams, preventive exams, and wellness exams) as additional support codes that cervical and vaginal cytopathology will not be eligible for separate reimbursement. Modifiers will not override the edit.

- Taking guidance from the February 2016 CPT Assistant which states that train-of-four monitoring is bundled with the intraoperative neuro monitoring and should not be separately reported, we are adding an edit that CPT code 95937 (neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method) will not be eligible for separate reimbursement when reported with CPT codes 95940 (continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes), 95941 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour), and G0453 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes). Modifiers will not override these edits.

- Our current edit denies 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental when reported with 76882 (ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific).

Based on our interpretation of CPT guidelines that state "Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized. Use of ultrasound, without
thorough evaluation of organ(s), or anatomic region, image documentation, and final, written report, is not separately reportable. We are updating our edit and will deny 76882 when reported with 76942; modifiers will not override the edit.

Also, please note that we are moving our Section 1 code table from our Bundled Services and Supplies policy to a separate document.

Claims Requiring Additional Documentation – professional
There may be times when we conduct claim reviews or audits either on a prepayment or post payment basis and we, or our designee, may request documentation, most commonly in the form of patient medical records. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the patient’s plan of treatment or to confirm that charges were accurately reported in compliance with our policies and procedures as well as general industry standard guidelines and regulations.

Effective for claims with dates of service on or after March 1, 2017, we will have a new professional reimbursement policy titled Claims Requiring Additional Documentation. This policy documents our guidelines for claims requiring additional documentation and the professional provider’s compliance for the provision of requested documentation. Please refer to the policy for further details.

Durable Medical Equipment – professional
For claims processed on or after November 21, 2016, we updated our policy to reflect that we will allow rental of two units per month for durable medical equipment (DME) that requires a back-up unit. These include items such as E0465 (home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)) and E0466 (home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)).

Frequency Editing – professional
Based on changes in vial size available for J9047 (injection, Carfilzomib, 1 mg (Kypolis)), we have updated our maximum dosage amount to 150 units. This update will apply to claims with dates of service on or after July 15, 2016.

We currently apply a frequency limit of one unit per date of service to CPT code 91065 (hydrogen or methane breath test). We consider this one test per challenge regardless of the number of samples collected; therefore, beginning with claims processed on or after November 21, 2016, modifiers will not override the frequency limit for CPT code 91065.

We consider that only one unit is applicable to HCPCS codes S9140 (diabetic management program follow-up visit non-MD provider) and S9141 (diabetic management program follow-up visit MD provider); therefore, beginning with dates of service on or after January 1, 2017, we will be applying a frequency limit of one per date of service; modifiers will not override this frequency limit.

Beginning with dates of service on or after March 1, 2017, we will be implementing the following frequency limits:

- We consider HCPCS code(s) H0020 (alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)) and H0022 (alcohol and/or drug intervention service (planned facilitation)) to be “per day” services. Therefore, we will apply a frequency limit of one per date of service to HCPCS codes H0020 and H0022; modifiers will not override the frequency limit.

- We will apply a frequency limit of one per date of service to CPT code 49185 (sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study,
imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed). This limit is based on our interpretation of CPT parenthetical instruction and the March 2016 CPT® Assistant Q&A which state “49185 may only be reported once per day for the treatment of multiple interconnected lesions via single access.” Modifiers will not override the frequency limit.

- Based on the Centers for Disease Control and Prevention (CDC) recommendation, we will apply a frequency limit of three per date of service to CPT codes 87491 (Chlamydia trachomatis, amplified probe technique) and 87591 (Neisseria gonorrhoeae, amplified probe technique).

**Global Surgery and Modifier Rules – professional**

Taking guidance from the Centers for Medicare & Medicaid Services, beginning with claims processed on or after November 21, 2016, for dates of service on or after October 1, 2016, when modifier 55 (postoperative management only) is appended to a surgical procedure with zero post-operative days, the procedure will not be eligible for reimbursement.

**Moderate (Conscious) Sedation, Bundled Services and Supplies, and Modifiers 59, XE, XP, XS, and XU – professional**

For dates of service on or after January 1, 2017, we will continue with the concept that moderate (conscious) sedation, identified by new CPT codes 99151-99153 and 99155-99157 is included with the reimbursement for certain health plan designated surgical, diagnostic, or therapeutic procedures, and such sedation is not eligible for separate reimbursement when reported by the physician or other qualified health care professional performing one of the designated procedures. These designated procedures were previously listed in the deleted CPT Appendix G and are now identified in our “Codes that Include Moderate (Conscious) Sedation” list. Modifiers will not override the edits.

**Modifiers 59, XE, XP, XS, and XU – professional**

Beginning with dates of service on or after March 1, 2017, modifiers will no longer override the following edits:

Our current edit denies 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)) when reported with 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Based on CPT instruction that states to not report 22633 with 22612, modifiers will no longer override the edit.

Our current edit denies 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure) when reported with 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar). We consider this correct coding; therefore, modifiers will not override the denial.

Our current edit denies CPT code 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental to 76881 (ultrasound, extremity, nonvascular, real-time with image documentation; complete). We consider this to be correct coding; therefore, modifiers will not override the denial.

We have a current edit that denies CPT code 42950 (pharyngoplasty (plastic or reconstructive operation on pharynx) as mutually exclusive to CPT code 15757 (free skin flap with microvascular Anastomosis), when a free flap is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy). We consider this to be correct coding; therefore, modifiers will not override the edit.
Our edit denies CPT code 27275 (manipulation, hip joint, requiring general anesthesia) as incidental to procedures 27093 (injection procedure for hip arthrography; without anesthesia) and 27095 (injection procedure for hip arthrography; with anesthesia). We consider this correct coding; therefore, modifiers will not override the edits.

**Multiple Diagnostic Cardiovascular Procedures – professional**

We are adding information to section B of our policy that our multiple diagnostic cardiovascular reimbursement rules are not applicable to procedures for which there are no RVUs assigned to the technical component of a code.

**Prolonged Services – professional**

We have updated our Prolonged Services Diagnosis Coding list dated October 1, 2016, to include additional ICD-10-CM diagnosis codes that were effective October 1, 2016, and for which prolonged services are allowed-- E083211-E083213, E083219, E083311-E083313, E083319, E083411-E083413, E083419, I16, I160, I161, I169, O115, O165. In addition, we have removed the ICD-9-CM diagnosis codes which are no longer valid for dates of service on or after October 1, 2015.

**Sleep Studies and Related Services & Supplies and Frequency Editing – professional**

In our June 2016 issue of Network Update, we advised we would be implementing a one (1) per 60 days frequency limit to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783 for dates of service on or after September 1, 2016. Upon further review, we have reconsidered our position and have removed this edit for dates of service on or after September 1, 2016.

**Unit Frequency Maximums for Drugs and Biologic Substances – professional**

We are adding information to our policy to document that modifiers do not override our unit frequency maximums for drugs and biologic substances.

**Review of reimbursement policies – professional**

The following professional reimbursement policies received an annual review and may have word changes or clarifications however they do not have significant changes to the policy position or criteria:

- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Duplicate Reporting of Diagnostic Services Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Once per Lifetime Procedures
- Physical and Manipulative Maintenance Services
- “Rule of Eight” Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Three Dimensional Rendering of Imaging Studies

**Significant Edits – professional**

We have updated our Significant Edits posting to reflect the 2016 analysis of claims data for significant edits. We define a significant edit as: A code pair edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial of payment for a particular CPT code or HCPCS code submitted more than two-hundred and fifty (250) times per year in the Plan’s service area.
**Coding tip: 2017 Presumptive Drug Tests – professional**

Effective January 1, 2017, CPT has deleted presumptive drug class screening codes 80300 – 80304 and has added replacement codes 80305 – 80307. The new codes 80305 – 80307 have the same description as G0477 – G0479 and HCPCS Coding Standards: Levels of Use state “... When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used.” Providers are encouraged to follow HCPCS coding guidance and report the 80305 – 80307 CPT codes for presumptive drug screening services. Do not report both 80305 – 80307 and G0477 – G0479 for same date(s) of service as this would represent a duplication of services.

**Coding tip: 2017 Modifier 95 for Telehealth Services – professional**

Effective January 1, 2017, CPT is adding modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). Based on CPT instruction, modifier 95 is to be used only with the services listed in Appendix P of the CPT codebook when those services are rendered via real-time (synchronous) interactive telecommunication.

**System Updates for 2017 – professional**

As a reminder, our ClaimsXten (or other proprietary) editing software package will be updated quarterly in February, May, August and November of 2017. These updates will:

- reflect the addition of new and revised CPT/HCPCS codes and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

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

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

**Tips for billing CPT modifier 33**

Modifier 33 was created to aid compliance with the Affordable Care Act (ACA) which prohibits member cost sharing for defined preventive services for non-grandfathered health plans. The appropriate use of modifier 33 reduces claim adjustments related to preventive services and your corresponding refunds to members.

Modifier 33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier 33 will process under the member’s medical or preventive benefits, based on the diagnosis and CPT codes submitted.

Modifier 33 should be appended to codes represented for services described in the US Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) Guidelines.

The CPT 2016 Professional Edition manual shares the following information regarding the billing of modifier 33, “When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive mandates (legislative or regulatory),
the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used."

Report HCPCS code C9257 for Avastin intravitreal injection

We will now accept HCPCS code C9257 for physician reporting of Avastin for intravitreal injection. Physicians should no longer report codes J3490, J3590, J9035, or J9999 for Avastin used in intravitreal injections.

We have established a reimbursement allowance for code C9257, and will allow a maximum of 5 units per injection. Use of code C9257 will ensure that the appropriate reimbursement for this specific treatment is made.

This reporting and reimbursement change impacts commercial Anthem members only.

Pre-service clinical review changes for specialty pharmacy drugs effective March 1, 2017

We will be expanding the list of specialty pharmacy drugs that are a part of the pre-service clinical review process. Listed below are specialty pharmacy codes from new or current medical policies and/or clinical UM guidelines that will be added to our existing pre-service review process effective March 1, 2017.

Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM®), a separate company.

<table>
<thead>
<tr>
<th>Clinical UM Guideline or Medical Policy</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>J3590</td>
<td>Erelzi</td>
</tr>
<tr>
<td>DRUG.00081</td>
<td>J3490, J3590</td>
<td>Exondys 51</td>
</tr>
</tbody>
</table>

Ordering physicians can submit a pre-service clinical review request to AIM for these drugs starting March 1, 2017, through one of the following options:

- AIM ProviderPortalSM available 24/7 to process orders in real-time
- Access AIM’s portal via the Availity Web Portal
- AIM’s call center - 866-714-1107, 8:00 a.m. – 5:00 p.m.

Requests received by AIM more than two business days after the date of service will not be accepted by AIM. Post service clinical review will be handled by Anthem.

These medical policies and/or clinical UM guidelines can be accessed at anthem.com > Providers > Maine > Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements > Medical Policies and Clinical UM Guidelines (for Local Plan Members). Recent changes to Medical Policies can be found under “Recent Updates”.

Specialty pharmacy level of care review drug list expanding effective April 24, 2017

In July 2016, we implemented an expansion of the specialty pharmacy program to include a review of the requested level of care for certain drugs. We will be expanding the list of specialty pharmacy drugs that are part of the level of care review
process. Listed below are the specialty pharmacy codes from our new or current Medical Policies and Clinical UM Guidelines that will be added to our existing Level of Care review process using clinical guideline, CG-DRUG-47, effective April 24, 2017.

Level of care pre-service clinical review of these specialty pharmacy drugs will continue to be managed by AIM Specialty Health, (AIM), a separate company. Please visit AIM’s Provider Portal for a complete level of care drug list and FAQ.

<table>
<thead>
<tr>
<th>Clinical UM Guideline or Medical Policy</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>Inflectra</td>
<td>Q5102</td>
</tr>
<tr>
<td>DRUG.00084</td>
<td>Actimmune</td>
<td>J9216</td>
</tr>
<tr>
<td>DRUG.00086</td>
<td>IncreLex</td>
<td>J2170</td>
</tr>
<tr>
<td>CG-DRUG-43</td>
<td>Tysabri</td>
<td>J2323</td>
</tr>
</tbody>
</table>

Ordering physicians can submit a level of care pre-service clinical review request to AIM for these drugs starting March 1, 2017 through one of the following options:

- AIM Provider PortalSM available 24/7 to process orders in real-time
- Access AIM’s portal via the Availiity Web Portal
- AIM’s call center - 866-714-1107, 8:00 a.m. – 5:00 p.m.

Requests received by AIM more than two business days after the date of service will not be accepted by AIM. Post service clinical review will be handled by Anthem.

These medical policies and/or clinical UM guidelines can be accessed at anthem.com > Providers > Maine > Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements > Medical Policies and Clinical UM Guidelines (for Local Plan Members). Recent changes to Medical Policies can be found under “Recent Updates”.

**Hyaluronic acid preferred products**

We have reviewed the hyaluronic acid agents through the Pharmacy & Therapeutics (P&T) Committee process and have selected four preferred drugs: Synvisc-One®, Synvisc®, Monovisc® and Orthovisc®. When prescribing these products, please consider the preferred agents for initial therapy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Weekly Injections</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synvisc-One®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Synvisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Monovisc®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Orthovisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Euflexxa®</td>
<td>3</td>
<td>Non-preferred</td>
</tr>
</tbody>
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Network Update

December 2016  Maine
<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Weekly Injections</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gel-One®</td>
<td>1</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Hyalgan®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Supartz®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

**Botulinum toxin agents preferred products**

We have reviewed the botulinum toxin agents and have selected Xeomin® as the preferred agent. When prescribing these products, please consider Xeomin® for initial therapy.

<table>
<thead>
<tr>
<th>Product</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xeomin*</td>
<td>Preferred</td>
</tr>
<tr>
<td>Botox®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Myobloc®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Dysport®</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

*Preferred product for the following medical indications: upper limb spasticity, cervical dystonia and blepharospasm.

**Immunoglobulin preferred products**

We have reviewed the immunoglobulin products through the Pharmacy & Therapeutics (P&T) Committee process and have selected two preferred drugs: Gamunex-C® and Octagam®. When prescribing these products, please consider the preferred agents for initial therapy.

<table>
<thead>
<tr>
<th>Product</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamunex C®</td>
<td>Preferred</td>
</tr>
<tr>
<td>Octagam®</td>
<td>Preferred</td>
</tr>
<tr>
<td>Gammagard®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Privigen®</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

**A better way to manage specialty drugs**

As specialty drugs become more widely used, we’re looking for new ways to control costs while helping to keep members healthy. That’s why we created our Right Drug Right Channel (RDRC) program.

Our Right Drug Right Channel programs help ensure:
Better medication management - members are reminded about refills and have access to support programs through the specialty pharmacy provider.

Better cost management - by placing drugs under the appropriate benefit.

Simplify access to medications - RDRC simplifies which benefit the drug falls under based on how the medication is administered.

Providers need to know certain self-administered medications will now be covered under the member’s pharmacy benefit and certain clinician administered medications will be covered under the member’s medical benefit. Providers can view the RDRC drug lists on anthem.com/pharmacyinformation.

If a member believes this change poses a hardship for them, he or she and/or the member’s doctor can ask us to keep covering the drug(s) under the member’s pharmacy benefit by submitting a request for an exception by calling us at the number on the member’s ID card.

**Important update: Delay of the transition of NOC oncology and biologic drugs to pre-service clinical review**

In collaboration with AIM Specialty Health (AIM), we had planned an expansion of pre-service review to the medical necessity of coverage requests for all not otherwise classified “NOC” oncology and biologic drugs starting November 1, 2016. We are delaying this transition to pre-service review by AIM until further notice. Any medical necessity review of NOC oncologic and biologic drugs will continue to be reviewed by Anthem as they are today.

**ePASS® weekly webinars**

These webinars provide a practical overview of how eligible providers can use the Electronic Patient Assessment Solution Suite (ePASS®) to access a supplemental clinical profile and complete a compliant medical SOAP Note for patients identified by us. A SOAP Note – or Subjective, Objective, Assessment, and Plan – is the standardized document format of a medical record. These webinars typically take 30 minutes followed by time for questions.

**Registration**

We encourage you to register in advance by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

**Webinar Dates (choose the date that best fits your schedule)**

- **Wednesday, December 7, 2016:** 3:00 p.m. – 4:00 p.m.
- **Wednesday, December 14, 2016:** 3:00 p.m. – 4:00 p.m.
- **Wednesday, December 21, 2016:** 3:00 p.m. – 4:00 p.m.
- **Wednesday, December 28, 2016:** 3:00 p.m. – 4:00 p.m.

**How to Join**

Use the following information to join all webinars listed above:

- Teleconference: Dial 1-888-850-4523 and enter access code: 108 607
- WebEx: Visit https://inovalon.webex.com and enter meeting number: 746 707 227

Once you join the call, live support is available at any time by dialing *0.
Referrals to network/participating providers

As a network/participating provider, you have a contractual obligation to refer our members to other network/participating providers when non-emergent services are available in network. The use of network/participating providers helps to ensure that our members receive quality and efficient care at the most affordable costs. Network/participating providers agree to accept a negotiated, discounted, rate as payment in full which results in lower out of pocket costs for our members. Services provided by non-network/non-participating providers often results in higher out of pocket costs for our members since not all benefit plans offer out of network benefits and those that do will usually have higher cost sharing provisions (deductible, coinsurance and/or copayments). Additionally, non-network/non-participating providers are not obligated to accept the Anthem rate as payment in full and may bill members for the difference between their charge and Anthem’s rate.

Our online provider directory allows you and our members to search our list of network/participating physicians, hospitals, pharmacies, medical equipment providers, laboratories and many other providers. You may wish to refer to the online provider directory at anthem.com or contact Provider Service if you have any questions regarding a provider’s participation status.

AOPS retirement coming: Transition to Availity Web Portal now

Don’t let these upcoming changes catch you out in the cold!

We are targeting February 2017 to retire Anthem Online Provider Services (AOPS) and we continue to improve your web portal experience by transitioning all functionality to a single website, the Availity Web Portal. After this date, electronic access to Eligibility, Benefits, Claim Status Inquiry, Remittance Inquiry, Professional Fee Schedule and important proprietary information will be available exclusively through Availity, our multi-payer portal solution. Note: This change does not affect the anthem.com public website or electronic transactions submitted via our Enterprise EDI Gateway; you may continue to submit all X12 transactions through your current EDI transmission channels.

See something you can’t access, but you need it?

Contact your organization’s administrator to request the role you need. To determine who your organization’s administrator is, select “Who controls my access” from your account drop down box located in the upper right corner of the Availity Web Portal’s top menu bar.

Want quick and easy access to the tools you use most?

On the Availity Web Portal, you can now save your frequently used tools by selecting the heart icon next to the tool. This action will save it to your personal favorites. To access your favorites quickly and easily going forward, select My Favorites from the top menu bar.

Do you have all of your tax IDs registered on the Availity Web Portal?

If not, now is the time to register. Your organization’s administrator can add additional tax ids by selecting Maintain Organization from the Admin Dashboard.

If your organization is not registered for Availity:

- Have your organization’s designated administrator go to www.availity.com and select Register.
- Complete the online registration wizard.
- The administrator will receive an e-mail from Availity with a temporary password and next steps.
Free Training

Once you log into the secure portal, you'll have access to many resources to help jumpstart your learning, including free live training, on-demand training, frequently asked questions, and comprehensive help topics. To view the current training resources, access the Help menu on the Availity Web Portal.

Reminder: Important information about billing habilitative and rehabilitative services

In compliance with requirements of the Notice of Benefit and Payment Parameters for 2016 issued pursuant to the Affordable Care Act, we will apply separate and distinct benefit limits for habilitative and rehabilitative services for all Anthem individual and small group On-Exchange and Off-Exchange health plans beginning with dates of service on and after January 1, 2017. This means these plans will no longer have a combined visit limit for habilitative and rehabilitative services. Habilitative services help a person keep, learn, or improve skills and functioning for daily living which have not (but normally would have) developed. Rehabilitative services help a person keep, restore, or improve skills and functioning for daily living which have been lost or impaired after an illness or injury, such as a car accident or stroke. Please note that this regulation does not apply to early intervention services.

Beginning with dates of service on and after January 1, 2017, the appropriate use of the modifier SZ is necessary when billing habilitative services to us for members seeking care in an outpatient facility or professional office setting. The SZ modifier was effective in 2014 and distinguishes between habilitative and rehabilitative services. Appropriate use of the modifier will help reduce claims issues and adjustments related to habilitative services.

Please review your current coding practices as it relates to the use of modifier SZ and the billing of habilitative and rehabilitative services.

Misrouted protected health information (PHI)

As a reminder, providers and facilities are required to review all member information received from Anthem to help ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Anthem provider services area to report receipt of misrouted PHI.

Home health agency Medicaid RAP and final claims

We will begin accepting Medicaid RAP (Request for Anticipated Payment) claims to process through BlueCard®. Claims should be submitted to your local Blue Plan for processing as of October 17, 2016.

The Medicaid RAP claims are in addition to Medicare Advantage claims which are processing through BlueCard today. Providers are reminded when billing on a RAP claim to submit services with zero charges for Medicare Advantage and/or Medicaid. There is no longer the need to submit services as $0.01.

For assistance on how to bill RAP claims, refer to our website to view the Home Health Billing Instructions that pertain to providers contracted to Medicare pricing and non-contracted providers. For more information on types of bills, revenue codes, etc. to be submitted for home health RAP services, click here.
Ambulance claim point of pick-up ZIP codes

Providers are reminded of the need to pass the point of pickup (POP) ZIP code for all ambulance (including air ambulance) claims, both institutional outpatient and professional. These claims should be filed with the local Blue Plan in whose service area the point of pickup (POP) ZIP code is located.

The POP ZIP code should be submitted as follows:

- Professional claims – Report POP ZIP code in field 23 on a CMS-1500 claim form
- Institutional outpatient claims – To report the ambulance POP ZIP code, the value code ‘A0’ (zero) and the related ZIP code of the geographic location from which the beneficiary was placed on board the ambulance should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes
- Claims received after October 16, 2016, without the POP ZIP code may be returned for this information and will delay claims processing.

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

We are available to offer assistance in these difficult moments with our Case Management Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-231-8254</td>
<td><a href="mailto:CMReferralSpecialistNE@anthem.com">CMReferralSpecialistNE@anthem.com</a></td>
<td>Monday – Friday, 8:00 a.m. to 9:00 p.m.</td>
</tr>
<tr>
<td>Federal Employee Program®</td>
<td>800-711-2225</td>
<td>Monday – Friday, 8:00 a.m. to 7:00 p.m.</td>
</tr>
</tbody>
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Coordination of care

Coordination of care among providers is a vital aspect of good treatment planning to help ensure appropriate diagnosis, treatment and referral. We would like to take this opportunity to stress the importance of communicating with your patients' other health care practitioners. This includes primary care physicians and medical specialists, as well as behavioral health practitioners.
Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. We urge all practitioners to obtain the appropriate permission from these members to coordinate care between behavioral health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, we have several tools available on our provider website including a Coordination of Care template and cover letters for both behavioral health and other healthcare practitioners.* In addition, there is a Provider Toolkit on the website with information about alcohol and other drugs which contains brochures, guidelines and patient information.**

*Access to the forms and cover letters is available at anthem.com > Providers Maine > Answers@Anthem.
**Access to the Toolkit is available at anthem.com > Providers > Maine > Health and Wellness.

Important information about utilization management

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

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. UM criteria are also available on our website at anthem.com > Providers > Maine > Medical Policies and Clinical UM Guidelines.

We work with providers to answer questions about the utilization management process and the authorization of care. Here’s how the process works:

- Call us toll free from 8:00 a.m. – 5:00 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 a.m. – 7:00 p.m.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.
The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID cards.

<table>
<thead>
<tr>
<th>Discuss UM Process and Authorizations</th>
<th>Discuss Peer-to-Peer UM Denials w/Physicians</th>
<th>Request UM Criteria</th>
<th>TTY/TDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-392-1016</td>
<td>800-437-7162</td>
<td>800-437-7162</td>
<td>711 or 800-437-1220 (T) or 800-457-1220 (V)</td>
</tr>
<tr>
<td>Federal Employee Program (FEP)</td>
<td>FEP</td>
<td>FEP</td>
<td></td>
</tr>
<tr>
<td>Phone - 800-860-2156</td>
<td>Phone - 800-860-2156</td>
<td>Phone - 800-860-2156</td>
<td></td>
</tr>
<tr>
<td>Fax - 800-732-8318 (UM)</td>
<td>Fax - 800-732-8318 (UM)</td>
<td>Fax - 877-606-3807(ABD)</td>
<td></td>
</tr>
</tbody>
</table>

For language assistance, members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

**Members’ Rights and Responsibilities**

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, we have adopted a Members’ Rights and Responsibilities statement.

It can be found on our website at anthem.com > Providers > Maine > Health & Wellness > Quality > Member Rights & Responsibilities. Practitioners may access the Federal Employee Program (FEP) member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

**Medicare update**

**Attend December webinar to learn how to complete OptiNet® assessments**

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM’s online registration tool, OptiNet. OptiNet will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), magnetic resonance (MR), computed tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services. Areas of assessment include facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

These data will be used to calculate site scores for providers who render imaging services for our individual Medicare Advantage members.
All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey by January 1, 2017, will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements. Participating providers who have already completed the survey but scored less than 76 can use the online registration at any time to update their information and improve their score. **All providers**, including those who score less than 76, will receive individualized information they can use to improve their score.

**Act now to avoid line-item claims denials**

Providers are strongly encouraged to register and improve their scores as needed before the line-item denials for claims submitted for dates of service on or after January 1, 2017 begins. Facilities billing on a UB-04 claim form will be excluded from line item denials at this time.

The provider registration is available online at www.aimspecialtyhealth.com/goweb.

- Select Anthem MA from the drop down menu.
- Only those providers who have completed the provider registration will be able to view their information online.
- If you have questions or need help completing the registration, call AIM Customer Service at 800-252-2021.

To learn how to complete your survey, attend a webinar and find out how to:

- Access the **OptiNet** Assessment
- Copy previously completed **OptiNet** Assessments to your Anthem Medicare Advantage account
- Complete a new AIM **OptiNet** registration
- Interpret and improve your site score

**Webinar details**

**Dec. 7, 2016, 4:00-5:00 p.m.**

Dial 866-308-0254
Pass code 804 205 7402#
Smart Phone 1-Click Dial 866-308-0254,,8042057402#

If you would like an invite for this webinar sent to your calendar please contact ronald.younger@anthem.com.

Additional information is available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

**Cardioverter defibrillators -- confirm if authorization required for implants**

When obtaining an authorization for a surgery that involves an implant, you must check the associated implant codes to determine if an authorization is also needed for the implant.

**2017 Medicare Advantage individual benefits and formularies available**

Summary of benefits, evidence of coverage and formularies for 2017 Individual Medicare Advantage plans can be found at anthem.com/medicareprovider. A few notable benefit changes for 2017 are listed below. An overview of additional 2017 benefit changes is available at www.anthem.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information.
Application of Copayments
When member cost share is a copayment amount, members will be responsible for a copayment for each type of service rendered. If a member receives more than one type of service, the applicable copayment for each service will apply. Only one copayment will apply for each type of service rendered.

As an example, if a member receives three X-rays in a specialist office on the same date of service, the member would be responsible for the one X-ray copayment and one specialist office copayment.

Please note: Certain places of service; including but not limited to, inpatient hospital, outpatient hospital, emergency room and urgent care will only assess one member copayment for each visit.

No copay for diabetes retinal exam and HbA1c testing effective January 1, 2017
Effective January 1, 2017, no copay will be required for HbA1c testing for individual and group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual retinal exam at no out-of-pocket cost.

Routine physical exams are covered in 2017
The majority of Anthem Medicare Advantage (MA) plans will continue to supplement Medicare covered preventive services and offer coverage for routine physicals in 2017 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 or coinsurance 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. Please call the number on the back of the member’s ID card for specific coverage information.

Additional information is available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

Dual Eligible Special Needs Plans – provider training required
In 2017, we are offering Dual Eligible Special Needs Plans (D-SNPs) to individuals who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors’ appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items. Centers for Medicare & Medicaid Services regulations protect D-SNP members from balance billing.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans will receive notices in Q4 2016 that contain information for online training through self-paced training. Every provider contracted for our D-SNP plans is required to complete this annual training and click the attestation within the training site stating that they have completed the training. These attestations can be completed by individual providers or at the group level with one signature.
Additional information will be available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

Dual Eligible Special Needs Plans may not be balance billed

Centers for Medicare & Medicaid Services regulations and Anthem’s provider contracts protect Dual Eligible Special Needs Plan (D-SNP) members and members of plans similar to D-SNPs from balance billing. Our D-SNPs are “zero cost share” plans, meaning we only enroll dual-eligible beneficiaries (people eligible for both Medicare and Medicaid) who have Medicare cost sharing protection under their Medicaid benefits. The provider may not seek payments for cost sharing from dual-eligible members for health care service rendered to dual-eligible members. For any questions regarding how claims are paid, please contact Customer Service (MediBlue Dual Advantage) at 855-310-2472.

Claim adjustments may change member cost share

We remind providers to please check the explanation of payments on claims. There are situations in which a claim may be adjusted and this may change a member’s cost-share. If you receive a claim adjustment from us, please ensure the member cost-share is still accurate. Basic member cost-share information is located on the front right-side of the member ID card but please note that not all cost shares are listed. If you have any questions about a member’s cost share, please call the number on the back of the member ID card.

Verify injectable, infusion billable units approved via AIM

Providers must submit claims for medical injectable and infusion drugs in billable units for the Healthcare Common Procedure Coding System (HCPCS) code authorized. Providers can verify the amount of billable units approved for a case by using the member ID and authorization number provided. All claims submitted for more units than approved are subject to denial. To adjust the dose of an approved AIM authorization, please contact AIM for a new drug authorization request. Claims are submitted in billable units per the HCPCS code. The billable units are calculated based on the HCPCS code administered and the dose associated with the code.

For example:
One (1) HCPCS unit of Rituxan represents 100mg of drug per HCPCS code J9310
Rituxan is administered at 1000mg for two doses
1000mg = 10 units (HCPCS code is 100mg)
Each dose of 1000mg is 10 billable units
Two doses = 20 billable units

AIM authorization details can be obtained via phone or the provider portal.

- AIM phone number: 800-714-0040
- AIM provider portal: www.providerportal.com

For AIM ProviderPortalSM support please contact AIM at 800-252-2021 option 2.

Note: An email address and the tax ID number for the facility/provider are needed to register for the site. Once registered, providers can view all AIM oncology drug approvals/denials by using the member information (name, ID#, Date of Birth).
For all other Part B injectable and infusion approvals/denials, inquiries will be answered via email at www.MASpecialtyPharm@Anthem.com or via phone at 866-797-9884 option 5.

**HCPCS codes required for rural health clinic claims**

All claims from rural health clinics (RHC) with dates of service April 1, 2016, and after must contain an appropriate HCPCS code for each service line along with a revenue code on their Medicare Advantage claims. This pertains to contracted and non-contracted providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans, including Dual Special Needs Plans, and Medicare-Medicaid Plans.

**Transitional care management services eligibility**

A beneficiary is not eligible to receive TCM services until 30 days have passed since the beneficiary was discharged from an inpatient hospital setting. We determine the date of discharge based on the date the beneficiary received their discharge evaluation and management (E&M) visit. TCM services will be denied if the discharge E&M visit is not received before the TCM service.

These billing instructions apply to all individual Medicare Advantage plans, including Dual Special Needs Plans, and Medicare-Medicaid Plans.

For more information on TCM services, click [here](#).

**Avoid needless claim denials**

Tips for avoiding unnecessary claim denials are available at anthem.com/medicareprovider under Important Medicare Advantage Updates. They include:

- Services disallowed by utilization management
- Valid Clinical Laboratory Improvement Amendments number must be submitted
- Procedure not covered by diagnosis
- Inappropriate or missing modifier
- Duplicate claim

**Clarification – Requesting authorization for certain arterial duplex imaging procedures**

As communicated in the April 2016 Network Update and Important Medicare Advantage Updates, we are collaborating with AIM Specialty Health to conduct medical necessity reviews for vascular ultrasound management for our individual Medicare Advantage members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days from the day the procedure is performed, and before you submit a claim.

Please note failure to contact AIM within the 10 day post service window for review will result in a denial of payment. Impacted codes are as follows:
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93925</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS COMPL BI STUDY</td>
</tr>
<tr>
<td>93926</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
<tr>
<td>93930</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS COMPL BI STUDY</td>
</tr>
<tr>
<td>93931</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
</tbody>
</table>

To submit your request, go to AIM’s ProviderPortalSM at www.aimspecialtyhealth.com. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 8:00 a.m. to 8:00 p.m.

**AIM clinical appropriateness guidelines for advanced imaging**

Effective February 18, 2017, the following changes to AIM Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

**Oncologic imaging (CT, MRI and PET)**

- Enhanced criteria around surveillance following completion of therapy for colorectal cancer
- Updated criteria for appropriate use of imaging studies in the management of prostate cancer and breast cancer
- New guidelines for appropriate use of multiparametric MRI in the diagnosis of prostate cancer

**Breast MRI**

- Enhanced criteria for appropriateness of MRI in DCIS, atypical ductal hyperplasia, and follow up imaging of BIRADs 3 studies

**Abdominal and pelvic imaging (CT and MRI)**

- Updated criteria for appropriateness of imaging in inflammatory bowel disease
- Guidelines for follow up of incidental liver lesions utilizing advanced imaging
- Enhanced criteria for imaging in chronic abdominal pain and nephrolithiasis

**Keep up with Medicare news – Beth Laws**

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

- September reimbursement policy provider bulletin
- Medicare Advantage reimbursement policies
- Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning February 1, 2017
- Medicare Notices and provider requirements
- Clinical Cumulative Morphine Equivalent Dosing Point of Sale Edit effective January 1, 2017
- Diabetic supply coverage for individual Medicare Advantage members
- Prior authorization requirements for Erelzi, Amjevita, Voretigene neparvovec, Nanacog and Lartruvo
- Prior authorization requirements for Cuvitru, Ocrevus and Lutathera
- Prior authorization requirements for continuous interstitial glucose monitoring
Programs and benefits update

2017 FEP benefit information available online

To view the 2017 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org > select Benefit Plans > Brochure & Forms. You’ll find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2017. For questions please contact FEP Customer Service at 800-722-0203.

OB/GYN Providers: Prenatal/postpartum related HEDIS measure information

Recently, Anthem Federal Employee Program mailed out a Quick Reference Guide to OB/GYNs in an effort to help provide important information about prenatal and postpartum claim submission. The mailer included guidance for providers to submit the Category II CPT codes for prenatal services: 0050F (Initial prenatal care visit), 0501F (Prenatal flow sheet documented in medical record by first prenatal visit) and postpartum services: 0503F (indicating a postpartum visit) and ICD-10 code Z39.2 (routine postpartum follow-up). Submitting these codes helps alleviate the need for medical record submission and less time and disruption to your office by the health plan to review patient charts. We value the relationship we have with you, and appreciate your effort on this request. If your office did not receive a Quick Reference Guide to post in your office billing department, please contact FEP Customer Service at 800-722-0203.

Quality programs update

Antidepressant medication management provider toolkit

Depression, which presents in various forms, is the most prevalent behavioral health issue in the United States. Accordingly, it is the most common clinical behavioral health problem that primary care physicians have to diagnose and treat. Once diagnosed, the type of physician-patient relationship determines outcomes for the patient. When a physician is limited in his understanding of the patient, communication becomes ineffective and patient satisfaction suffers.

This Provider Toolkit is an educational resource facilitated as a collaborative effort between the Clinical Quality Management Team for Maine and Anthem’s Behavioral Health Provider Collaboration departments. The toolkit information is presented utilizing the research and material delivered through a collaboration of Minnesota’s six health plans Blue Cross, HealthPartners, Medica, Metropolitan Health Plan, Hennepin Health, and UCare, with project support provided by Stratis Health. The Toolkit includes resources on:

- Best practices for depression care
- Behavioral health resources for providers and patients
- Shared decision making
- Behavioral health resources for seniors

The goal of this project is to improve antidepressant medication adherence and increase scores on HEDIS® measures for better patient outcomes. Outcomes will be measured by the HEDIS (Healthcare Effectiveness Data and Information Set) Antidepressant Medication Management (AMM) measure. HEDIS is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service, including medication adherence. Medication is often a key component of depression treatment. The HEDIS AMM measure consists of two sub-measures:
Antidepressant Medication Management – Acute Phase: Percent of health plan members 18 years and older with a diagnosis of depression who were treated with an antidepressant medication and remained on the medication for at least 12 weeks

Antidepressant Medication Management – Continuation Phase: Percent of members 18 years and older with a diagnosis of depression who were treated with an antidepressant medication and remained on the medication for at least 6 months

The toolkit is available now at anthem.com > scroll to bottom of page and select Providers > Maine > Health & Wellness > Provider Toolkits > Antidepressant Medication Management.

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

HEDIS spotlight: Respiratory conditions

Asthma and chronic obstructive pulmonary disease (COPD) are major causes of morbidity, mortality, lower quality of life, and lost productivity including missed days from school or work. According to the Centers for Disease Control and Prevention, 1 in 14 people have asthma or about 24 million Americans (roughly 7.4% of adults and 8.6% of children). Asthma causes almost 2 million emergency room visits each year; more than 14 million doctor visits; and 439,000 hospital stays. More than half of children and one-third of adults missed school or work due to their asthma. Each day, ten Americans die from asthma.¹ Many of these deaths are avoidable with proper treatment and care.

Since medication is vital to controlling asthma exacerbations, the National Commission for Quality Assurance (NCQA) requires health plans to review claims for medication management among members with persistent asthma, and contributes to health plan Accreditation levels and the Quality Rating System (QRS) measurement weight for Marketplace plans. The three measures are:

- **Use of Appropriate Medications for People with Asthma (ASM):** The percentage of members 5-85 years of age who were identified as having persistent asthma and who were appropriately prescribed medication.
- **Medication Management for People with Asthma (MMA):** The percentage of members 5-85 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported:
  - The percentage of members who remained on asthma controller medication for at least 50% of their treatment period.
  - The percentage of members who remained on asthma controller medication for at least 75% of their treatment period.
- **Asthma Medication Ratio (AMR):** The percentage of members 5-85 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of .50 or greater.

COPD can also be managed by medication; however, it is important to distinguish diagnosis between asthma and COPD because of the differences in treatment, disease progression, and outcomes. According to the American Lung Association, COPD cost the U.S. $49.9 billion in 2010. Of that, $29.5 billion was spent on direct healthcare costs, $8 billion from indirect morbidity costs, and $12.4 were indirect mortality costs.² COPD is often misdiagnosed or undiagnosed until later in the disease. Almost 15.7 million Americans (6.4%) reported that they have been diagnosed with COPD. More than 50% of adults with low pulmonary function were not aware that they had COPD.³ In 2014, COPD was the third leading cause of death in the U.S. Establishing a diagnosis of COPD requires spirometry testing, interpreted in the context of the patient’s symptoms, smoking status, age, and comorbidities.⁴
The HEDIS measures related to COPD are:

- **Use of spirometry testing in the Assessment and diagnosis of COPD (SPR):** The percentage of members 40 years of age and older with a new diagnosis of COPD, or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.

- **Pharmacotherapy Management of COPD Exacerbation (PCE):** The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit and who were dispensed appropriate medications. Two rates are reported:
  - Dispensed a systemic corticosteroid (or evidence of an active prescription) within 14 days of the event.
  - Dispensed a bronchodilator (or evidence of an active prescription) within 30 days of the event.

**How we are helping**
A consolidated medication review note may be sent to members and their providers when the following criteria are met:

- Member is less than 80% compliant on their asthma controller medication
- Member shows high utilization of short-acting beta agonist medication and not on an asthma controller (inhaled corticosteroid)
- Member has claim(s) for COPD medications including Atrovent, instead of more effective therapy (Spiriva)

**What can you do?**

- Use spirometry to diagnose and monitor treatment efficacy.
- Adopt a patient centered planned visit model. Provide ongoing follow-up and care plans for patients throughout the year. Use every patient engagement/acute appointment to discuss concerns, compliance, and closing gaps in care.
- Educate your patients about their disease, possible consequences to their health and quality of life.
- Remind patients to take and refill controller medications. Discuss patient concerns that might interfere with adherence. Provide simple written instructions that are appropriate both culturally and in literacy level.
- Review proper inhaler use at each visit, encouraging patients to demonstrate. Work with your patients who have asthma to have a current written action plan and to use a peak flow meter to monitor control. Discuss patient’s triggers and ways to avoid exposure to triggers.
- Code and document visits accurately.


**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 2017, and will be available for provider review prior to its release via the Anthem POIT web tool through Availity. If you have questions regarding Anthem Care Comparison, Estimate Your Cost, or our expanded transparency initiatives, please contact David Spencer, Sr. Provider Network Manager at david.spencer@anthem.com.

**HEDIS® 2016 commercial results are in**

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) commercial data collection project for 2016. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate commercial HEDIS process improvement by:

- Responding to our requests for medical records within five days if at all possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient’s medical record

Further information regarding documentation guidelines can be found in the HEDIS section of our provider website. The website can be accessed by visiting anthem.com > scroll down to bottom of page > Providers > Health and Wellness > Quality Improvement and Standards. You’ll find reference documents entitled “HEDIS 101 for Providers” and “HEDIS Documentation Guidelines”.

Please [click here](#) to view the 2016 HEDIS commercial results.

**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](#).
We believe in continuous improvement

Commitment to our members' health and their satisfaction with the care and services they receive is the basis for our Quality Improvement Program. Annually, we prepare a quality program description that outlines our clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of Anthem's quality program and most current outcomes, visit us at anthem.com.

Pharmacy update

Pharmacy information available on anthem.com

Visit the applicable websites noted below 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

To locate the commercial drug list, go to anthem.com > Customer Support > Maine > Download forms > Anthem Blue Cross and Blue Shield Drug Lists.

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 > Download forms > Maine Select Drug List.

Website links for the Federal Employee Program formulary Basic and Standard Options are:

- Basic Option: https://www.caremark.com/portal/asset/z6500_drug_list807.pdf
- Standard Option: https://www.caremark.com/portal/asset/z6500_drug_list.pdf

This drug list is also reviewed and updated regularly as needed.

Prescription refill timing tightened

In an effort to reduce medication waste and encourage medication dosage compliance, we are updating the system logic that determines the date on which a member can refill a prescription. This change will require members to refill their prescriptions closer to when their current supply ends; however, members should still have enough medication supply on hand to last until their next refill is allowed.
As always, it is important to prescribe medications with the appropriate quantity and directions so that the member has enough medication to last for the duration of each prescription fill. To provide clarity for the patient and the pharmacy, prescribers can take the following steps:

- If the dosage of a medication has changed since the initial prescription was written, a new prescription should be written for the patient, with the new directions clearly indicated.
- For as directed or as needed (PRN) prescriptions, try to be as clear as possible on your intentions for how long a prescription should last. For example, consider providing explicit directions such as: use as directed for 15 days, or take as needed for 30 days.\(^2\)
- Prescriptions for oral contraceptives should clearly indicate when a member is not taking the inactive tablets. The table below includes examples\(^2\) of how prescriptions for oral contraceptives should be written:

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 (1 pack)</td>
<td>If patient only taking active tabs, directions should be:</td>
</tr>
<tr>
<td></td>
<td>1 tab daily x 21 days, skip the last week and start new packet on day 22.</td>
</tr>
<tr>
<td>84 (3 packs)</td>
<td>If patient only taking active tabs, directions should be:</td>
</tr>
<tr>
<td></td>
<td>1 tab daily x 21 days, skip the last week and start new packet on day 22.</td>
</tr>
<tr>
<td>21 (1 pack)</td>
<td>1 tab daily</td>
</tr>
<tr>
<td>63 (3 packs)</td>
<td>1 tab daily</td>
</tr>
<tr>
<td>28 (1 pack)</td>
<td>If patient taking all tabs, directions should be:</td>
</tr>
<tr>
<td></td>
<td>1 tab daily x 28 days.</td>
</tr>
<tr>
<td>84 (3 packs)</td>
<td>If patient taking all tabs, directions should be:</td>
</tr>
<tr>
<td></td>
<td>1 tab daily x 28 days.</td>
</tr>
</tbody>
</table>

\(^1\) The new system logic requires that members use at least 75% of a prescription dispensed by Home Delivery (mail order) and 85% of a prescription dispensed by a retail pharmacy before a refill of the same medication is allowed.

\(^2\) Examples are for illustrative purposes only. The prescriber must determine which directions are most appropriate for the medication prescribed.