# Network Update Maine

**February 2017**

## In this issue

<table>
<thead>
<tr>
<th>Health care reform update</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care reform updates on anthem.com</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative and policy update</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign-up today for Network eUPDATE – it’s free!</td>
<td>2</td>
</tr>
<tr>
<td>Update to claims processing edits and reimbursement policies</td>
<td>3</td>
</tr>
<tr>
<td>Anthem Online Provider Services web portal retirement delayed</td>
<td>5</td>
</tr>
<tr>
<td>Pre-service clinical review changes for specialty pharmacy 5/1/17</td>
<td>5</td>
</tr>
<tr>
<td>Specialty pharmacy level of care review drug list changes 5/1/17</td>
<td>6</td>
</tr>
<tr>
<td>Specialty pharmacy level of care review to include hemophilia drug indications 5/1/17</td>
<td>7</td>
</tr>
<tr>
<td>Eligible providers can register as a specialty drug infusion/injection provider using OptiNet</td>
<td>7</td>
</tr>
<tr>
<td>Specialty pharmacy program to include review of drug dosage and frequency 5/5/17</td>
<td>7</td>
</tr>
<tr>
<td>Clinically equivalent treatment requirements effective 5/1/17</td>
<td>8</td>
</tr>
<tr>
<td>Update to AIM Sleep Disorder Management Diagnostic and Treatment Guidelines</td>
<td>8</td>
</tr>
<tr>
<td>Myriad Genetic Laboratory, Inc. becomes non-participating 4/1/17</td>
<td>9</td>
</tr>
<tr>
<td>Re-admission Facility Reimbursement Policy effective 4/1/17</td>
<td>10</td>
</tr>
<tr>
<td>Please be sure to notify us of changes to your practice</td>
<td>10</td>
</tr>
<tr>
<td>Medical chart reviews for members with plans on or off the exchange</td>
<td>10</td>
</tr>
<tr>
<td>Inovalon outreach efforts to help identify members needing care</td>
<td>12</td>
</tr>
<tr>
<td>Webinars by Inovalon help you complete SOAP Notes</td>
<td>13</td>
</tr>
<tr>
<td>Practitioners’ rights during the credentialing process</td>
<td>13</td>
</tr>
<tr>
<td>Free training and CME credit – moving toward equity in asthma care</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare update</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM OptiNet imaging services initiative postponed</td>
<td>14</td>
</tr>
<tr>
<td>Claim adjustments may change member cost share</td>
<td>15</td>
</tr>
<tr>
<td>Payment reduction for X-rays taken using film</td>
<td>15</td>
</tr>
<tr>
<td>Tetanus vaccination claim filing</td>
<td>15</td>
</tr>
<tr>
<td>Individual MA members should use Hearing Care Solutions</td>
<td>16</td>
</tr>
<tr>
<td>Include NPI in surgical procedure bills</td>
<td>16</td>
</tr>
<tr>
<td>Transitional care management (TCM) services</td>
<td>16</td>
</tr>
<tr>
<td>Retrospective medical record review program launches</td>
<td>16</td>
</tr>
</tbody>
</table>
In this issue (continued)

Medicare update
- Radiation therapy services – contact AIM for delivery, Anthem for planning
- Keep up with Medicare news
- New CMS requirement – hospitals must use Medicare Outpatient Observation Notice (MOON) form

Programs and benefits update
- Blood pressure monitor benefits for Federal Employee Program® members

Behavioral health update
- Member satisfaction with behavioral health outpatient services
- Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5®)

Quality programs update
- Commercial HEDIS® 2017 starts early February
- Physician Quality Management and Blue Physician Recognition programs to sunset
- Sharing results of Member Satisfaction Survey regarding physician care
- Clinical practice and preventive health guidelines available on anthem.com

Pharmacy update
- Pharmacy information available on anthem.com

Medical policy update
- Medical policy updates available on anthem.com

Clinical guidelines update
- Clinical guideline updates 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.

The latest update is titled Preventive Care Services Covered with No Member Cost-share (updated December 2016).

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 February 1, 2017, 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.

Bundled Services and Supplies – professional

The following Healthcare Common Procedure Coding System (HCPCS Level II) codes were effective January 1, 2017. We consider these codes to be inclusive in the overall care of the patient and not eligible for separate reimbursement; therefore, we are adding these new codes to our always bundled edit and they will be added to the Section 1 code list effective for claims processed on or after February 20, 2017. Modifiers will not override the edit.

- G0500 (moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports... patient age 5 years or older...)
- G0501 (resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)
- G0502 (Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
- G0503 (Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
- G0504 (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional)
- G0505 (Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home)
- G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service))
- G0507 (psychiatric collaborative care management)

The following HCPCS codes were effective January 1, 2017 for Medicaid services and will be added to our always bundled edit for claims processed on or after February 20, 2017 and will be added to the Section 1 code list. Modifiers will not override the edit.
- T1040 - Medicaid certified community behavioral health clinic services, per diem
- T1041 - Medicaid certified community behavioral health clinic services, per month

**Drug Screen Testing – professional**
We updated our policy dated January 1, 2017, to include new Current Procedural Terminology (CPT®) codes 80305, 80306, and 80307 (presumptive drug testing) that became effective January 1, 2017. We'll accept these codes because HCPCS codes G0477, G0478, and G0479 (drug test(s), presumptive) have been deleted. In addition, we have added a new code HCPCS code G0659 for definitive drug testing, any number of drug classes. When G0480, G0481, G0482, or G0483 are reported with G0659, we consider this to be duplicate services and G0480, G0481, G0482, or G0483 will not be eligible for separate reimbursement; modifiers will not override the edit. Please review the policy in its entirety.

**Frequency Editing – professional**
We are updating our frequency limit for J1750 (injection, iron dextran (Infed), 50 mg) from 20 units per date of service to 40 units per date of service. This edit will be effective for claims processed on or after February 20, 2017 for dates of service on or after March 1, 2016.

For claims with dates of service on or after May 1, 2017, we are adding a limit of one per date of service for breast pumps E0602, E0603, and E0604.

For claims processed on or after February 20, 2017, we are adding frequency limits for the following HCPCS codes that were effective January 1, 2017:
- J7320 (hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 mg) will have a limit of 50 units per date of service
- J7322 (hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg) will have a limit of 48 units per date of service

As stated in our December 2016 Network Update article titled “Avastin for intravitreal injections,” we will allow a maximum of 5 units per injection of C9257 (injection, bevacizumab, 0.25 mg); therefore, for dates of service on or after March 1, 2017, we are adding a frequency limit of 10 units per date of service for HCPCS code C9257.

**Telehealth Services – professional**
We have updated our Telehealth Services policy to include new coding that is effective January 1, 2017. Updates include:
- Addition of modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) which is to be used only with the services listed in the new Appendix P of the CPT® 2017 Professional Edition codebook when those services are rendered via real-time (synchronous) interactive telecommunication (this information is also included in our Modifier Rules Reimbursement Policy)
- Addition of new place of service code “02” that identifies the place of service for the distant site telehealth provider
- Addition of new HCPCS telehealth codes G0508 and G0509 (telehealth critical care consults)

Please refer to our policy dated January 1, 2017 to view these updates.

CPT® is a registered trademark of the American Medical Association.
**Anthem Online Provider Services web portal retirement delayed**

We previously announced that we were targeting February 2017 to retire Anthem Online Provider Services (AOPS) and transition all functionality to a single website, the Availity Web Portal. Please be advised that the AOPS web portal retirement has been delayed.

Soon, we’ll be introducing our new, secure, self-service tool on the Availity Web Portal where you can access all the important proprietary information and educational materials found on AOPS today. After that tool is in place and you’ve had some time to become familiar with locating what you need, we will move forward with retiring AOPS. More communication will follow as soon as we have determined the dates for these exciting changes.

Many tools on AOPS have already been moved. If you’re still going to AOPS for Remittance Inquiry or the Professional Fee Schedule Inquiry tool, please start using these tools through Availity today. Currently, these tools are available in both systems, but after the retirement date, they will only be available through Availity.

**Pre-service clinical review changes for specialty pharmacy drugs effective May 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 May 1, 2017.

Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM®), a separate company administering the program on behalf of Anthem, as applicable.

<table>
<thead>
<tr>
<th>Clinical UM Guideline or Medical Policy</th>
<th>Drug Name</th>
<th>Drug Codes(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DRUG-09</td>
<td>Cuvitru</td>
<td>J3490</td>
</tr>
<tr>
<td>CG-DRUG-54</td>
<td>Agalsidase beta (Fabrazyme)</td>
<td>J0180</td>
</tr>
<tr>
<td>CG-DRUG-55</td>
<td>Elosulfase alfa (Vimizim)</td>
<td>J1322</td>
</tr>
<tr>
<td>CG-DRUG-56</td>
<td>Galsulfase (Naglazyme)</td>
<td>J1458</td>
</tr>
<tr>
<td>CG-DRUG-57</td>
<td>Idursulfase (Elaprase)</td>
<td>J1743</td>
</tr>
<tr>
<td>CG-DRUG-58</td>
<td>Laronidase (Aldurazyme)</td>
<td>J1931</td>
</tr>
<tr>
<td>CG-DRUG-62</td>
<td>Fulvestrant (Faslodex)</td>
<td>J9395</td>
</tr>
<tr>
<td>CG-DRUG-63</td>
<td>Levoleucovorin calcium (Fusilev)</td>
<td>J0641</td>
</tr>
<tr>
<td>DRUG.00002</td>
<td>Adalimumab-atto (Amjevita)</td>
<td>J3590</td>
</tr>
<tr>
<td>DRUG.00090</td>
<td>Bezlotoxumab (Zinplava)</td>
<td>J3490, J3590</td>
</tr>
<tr>
<td>DRUG.00097</td>
<td>Olaratumab (Lartruvo)</td>
<td>J9999</td>
</tr>
<tr>
<td>DRUG.00102</td>
<td>Cabazitaxel (Jevtana)</td>
<td>J9043</td>
</tr>
<tr>
<td>DRUG-66</td>
<td>Afstyla</td>
<td>J7192</td>
</tr>
</tbody>
</table>
Ordering physicians can submit a pre-service clinical review request to AIM for these drugs starting May 1, 2017 through one of the following options:

- **AIM ProviderPortal** 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 May 1, 2017**

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 May 1, 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 **ProviderPortal** 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>CG-DRUG-55</td>
<td>Vimizim</td>
<td>J1322</td>
</tr>
<tr>
<td>CG-DRUG-57</td>
<td>Elaprase</td>
<td>J1743</td>
</tr>
</tbody>
</table>

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

- **AIM ProviderPortal** 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”.

**Network Update**

February 2017  
Maine  
6 of 31
Specialty pharmacy level of care review to include hemophilia drug indications effective May 1, 2017

We will expand the specialty pharmacy program to include level of care review for hemophilia drug indications beginning with dates of service on or after May 1, 2017. Coverage guideline, Specialty Pharmaceuticals CG-DRUG-47, will apply to the level of care review for these specialty drugs.

Level of care pre-service clinical review for hemophilia drug indications will be managed by AIM Specialty Health, (AIM), a separate company. Ordering physicians can submit a level of care pre-service clinical review request to AIM for these drugs starting May 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”.

Eligible providers can register as a specialty drug infusion/injection provider using OptiNet

As communicated in the April 2016 issue of Network Update, we expanded the Specialty Pharmacy program to include level of care clinical review for specialty pharmacy infusions and injections for dates of service on and after July 18, 2016.

Ambulatory infusion suites, home infusion providers, and physician offices can register to be included as an alternative location for the administration of specialty drugs using the OptiNet registration tool. Providers that complete the registration process are available as an alternative provider the subsequent business day. Please note: Providers must be contracted as an ambulatory infusion suite, home infusion provider, or physician office to be eligible as an alternative specialty drug infusion/injection provider. Claim payment issues (e.g. delay in payment or denial of reimbursement) can result if hospital/facility providers incorrectly register as alternative providers.

Providers already registered as an alternative location can review or edit the list of drugs provided at their site by logging in here.

If providers have questions about their network contract status, please call the Provider Call Center prior to registration.

Specialty pharmacy program expands to include utilization review of drug dosage and frequency effective May 1, 2017

Beginning with dates of service on and after May 1, 2017, we will implement a new clinical guideline, CG-DRUG-53 Drug Dosage, Frequency, and Route of Administration. CG-DRUG-53 contains clinical criteria for review of the medical necessity of dosage and frequency and will apply to the review process for specialty pharmacy. The expanded program will continue to be administered by AIM Specialty Health® (AIM), a separate company. Based on the information you provide, AIM will review the drug for clinical appropriateness, and drug dosage and frequency against health plan clinical criteria.
As part of pre-service clinical review process for CG-DRUG-53, the following will be required:

- Weight, height, age and gender
- Dose per treatment and directions per treatment (frequency), and duration (length of therapy)

To help ensure accurate and timely payment, it is important that you provide the above requested information beginning May 1, 2017.

Providers may continue to request authorization for specialty drugs in one of several ways:

- Access AIM ProviderPortalSM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 866-714-1107, 8:00 a.m. – 5:00 p.m.

For more information on our medical policy and dosing guidelines, refer to the complete list of medical policies and clinical UM guidelines that are available on our provider website at anthem.com.

**Reminder – drug wastage should be reported with modifier “JW”**

Providers may be reimbursed for single dose vial drug wastage beyond the approved dosage that is authorized per the utilization review process outlined above. Providers are expected to utilize the most economical combination of vial sizes for the drug administered and must report the drug wastage as a separate line item on the claim form with modifier “JW” appended. Our reimbursement limits will apply and will take into consideration applicable wastage based on the most economical combination of vial sizes.

**Clinically equivalent treatment requirements effective May 1, 2017**

Below are Clinical Guidelines and Medical Policies that have been updated to include the requirement of a clinically equivalent treatment effective May 1, 2017.

For more information on our medical policy and clinical UM guidelines and dosing guidelines, refer to the complete list of medical policies and clinical UM guidelines that are available on our provider website at anthem.com.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Non-Preferred Product</th>
<th>Preferred Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-Approved Biosimilar Products; CG-DRUG-64</td>
<td>Inflectra®, Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®</td>
<td>Remicade®, Monovisc®, Orthovisc®, Synvisc®, Synvisc One®</td>
</tr>
<tr>
<td>CG-Drug-29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Update to AIM Sleep Disorder Management Diagnostic and Treatment Guidelines**

On May 12, 2017, the following enhancement to AIM Sleep Disorder Management Diagnostic and Treatment Guidelines will become effective: An exclusion of members with LV ejection fraction of <45% is being added to the appropriateness criteria for use of bi-level positive airway pressure (BPAP) (with back-up rate feature) in established central sleep apnea. This
change is based on safety concerns brought to light by the adaptive servo-ventilation for central sleep apnea in systolic heart failure (SERVE-HF) study, and is aligned with recommendations from the American Academy of Sleep Medicine (AASM).

This change will be effective for dates of service on or after May 12, 2017.

Ordering and servicing providers may submit pre-certification requests to AIM in one of several ways:

- Access AIM’s ProviderPortal℠ directly at www.providerportal.com, available 24/7 to process orders in real-time
- Call the AIM Contact Center toll-free number: 866-714-1107, 8:00 a.m. – 5:00 p.m.

**Myriad Genetic Laboratory, Inc. to become non-participating effective April 1, 2017**

Effective April 1, 2017, Myriad Genetic Laboratories, Inc. will no longer be an in-network laboratory provider for our Anthem Plans in Connecticut, Maine and New Hampshire.

The following laboratories will continue to be in-network for BRCA testing and other genetic testing services:

- Ambry Genetics
- Counsyl, Inc.
- Invitae Corp.
- LabCorp
- Quest Diagnostics

Please begin to use one of these labs for Anthem members requiring this testing. As a reminder, your Anthem agreement requires referrals to in-network providers and using an in-network laboratory helps your patients maximize their laboratory benefits and minimize their out-of-pocket expenses.

If you have specific questions regarding BRCA testing or other genetic testing performed by the following in-network labs, please contact them directly:

- Ambry Genetics: 866-262-7943 or http://www.ambrygen.com/contact-us
- Counsyl, Inc.: 888-268-6795 or https://www.counsyl.com/contact/
- Invitae Corp: 800-436-3037 or https://www.invitae.com/en/contact
- LabCorp: 888-LABCORP (888-522-2677) or www.LabCorp.com.

A complete up-to-date list of in-network participating laboratories may be obtained on our website at anthem.com > Providers > Find a Doctor.

It is important to check benefit plan details for coverage terms and conditions, including preauthorization requirements and coverage limits. If you or an Anthem member you are treating have questions regarding coverage for genetic testing under the member’s benefit plan, please contact the Member Services telephone number on the back of the member ID card.
Re-admission Facility Reimbursement Policy effective April 1, 2017

As part of our ongoing commitment to share current administrative, billing, and reimbursement policies with you, we’ve posted a Re-admission Facility Reimbursement Policy that will become effective for dates of service on and after April 1, 2017. To view this and other facility reimbursement policies, visit anthem.com > Providers > Maine > Provider Reference Materials, Administrative Billing and Reimbursement Policies.

Please be sure to notify us of changes to your practice

It is very important that all provider demographic information is accurate and up to date in our systems. We receive a significant number of claims with a name or address that does not match our provider files, which can result in a claim payment to an incorrect provider or a claim denial. In addition, our members frequently utilize the online provider directories to obtain information regarding our network of participating providers, and having accurate information is essential.

Please be sure to notify us of all changes such as:

- Telephone number for members to schedule appointments at your practice location
- Practice location address
- Provider name
- Practice name
- Providers terminating or leaving your practice
- Providers joining your practice
- PCP’s accepting new patients or not accepting patients
- Billing address
- Tax ID number
- Specialty
- Hospital privileges

How to access the new online Provider Maintenance Form:

- Go to anthem.com
- Select Menu, then under Support, choose Providers
- Select Maine and click enter
- On the Answers@Anthem tab (located in blue banner at the top of screen), select Forms
- On the Forms page, select Provider Maintenance Form
- Provider Maintenance Form Instructions are located to the right of the Provider Maintenance Form

Advance notice of provider demographic and/or practice changes is required; retroactive changes are not allowed. Requests must be received 30 days prior to the change/update. Any request received with less than 30 days advance notice may be assigned a future effective date. Please provide 90 days advance notice of termination from our network; however, your specific contract provisions may supersede the effective date of your request.

Medical chart reviews for members with plans on or off the exchange

Each year, we request your assistance in our retrospective medical chart review programs. We continue to request members’ medical records to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS).
We will continue our chart review program for those members who have purchased our individual and small group health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the exchange). This particular effort is part of our compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual or small group health plans on or off the exchange. The members’ medical record documentation helps support this data requirement.

**Inovalon to conduct medical chart reviews for our exchange members**

To assist with our ongoing medical chart review program for members enrolled in our individual and small group exchange plans, we are again collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon’s Web-based workflows help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. We are working with Inovalon in retrieving and reviewing our members’ medical records.

Inovalon is using the following methods of collecting medical record information:

- Scanned or faxed medical records that providers’ offices send to Inovalon
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider’s EHR system

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the provider fax or mail the medical chart information. We ask that providers fax or mail the medical record information to Inovalon within 30 days.

In cases where Inovalon is requesting more than six medical records to review, an Inovalon reviewer calls the provider to arrange a time convenient to visit the office onsite to collect the appropriate information. Before the onsite visit, Inovalon mails or faxes a letter to confirm the upcoming visit. The Inovalon medical record review personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, an automated, medical record data retrieval occurs through the provider’s EHR system. Upon receiving the provider group’s one-time authorization, Inovalon’s systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this collaboration is to improve the medical record data extraction experience for our network-participating hospitals, clinics and physician offices. We are working together with Inovalon to identify facilities and providers for engagement.

**Appropriate coding helps provide comprehensive picture of patients’ health and services provided**

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. *When members visit your practice or office, we encourage you to document ALL of their health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.*

By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping us meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.
Reminder about ICD-10 CM coding
As you are aware, the ICD-10 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, we use ICD-10 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:

Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.

Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider’s overall management or treatment of that patient in the remaining positions.

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

Inovalon continues outreach efforts on our behalf to help identify members needing care
We are working to update health documentation for our members in the individual and small group markets who have purchased our health insurance plans on and off the exchange. Working with our providers, we engaged Inovalon to contact our members and encourage in-office visits with their physicians. Therefore, as a physician, you may receive letters throughout the year from Inovalon on our behalf. In 2017, we are continuing these efforts and want to help ensure you and your office staff are aware of these ongoing outreach efforts Inovalon is conducting on our behalf. The goal is to identify or help close gaps in care. We appreciate your cooperation should Inovalon contact your office or facility.

In the event our members do not visit their physicians, Inovalon also offers the option of a personal health visit that a medical professional from Inovalon conducts in members' homes. The member may also opt to visit a retail clinic or other Inovalon location. We'll continue to provide updates about the Inovalon engagement in upcoming editions of the Network Update.

If you have questions about the Inovalon effort and this ongoing outreach effort, we've compiled a list of questions and responses for your reference on our website.

Reminder about completing SOAP Notes
The SOAP Note – the standardized documentation format of a medical record – stands for Subjective, Objective, Assessment, and Plan. SOAP Notes are used with the Inovalon outreach efforts and are meant to be a supplement to providers' usual documentation process. When submitting information to Inovalon, providers have the option of completing SOAP Notes electronically using Inovalon’s ePASS® Web-based tool or using a paper format. Here are some tips for completing SOAP Notes that we hope you find helpful.

- The exam date for the patient must match the exam date on the completed SOAP Note
- A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note
- The provider signature date should be the actual date the SOAP Note is signed
- All “mandatory” fields on the paper SOAP Note must be completed
- All “mandatory” fields on the paper SOAP Note must be completed to be eligible for incentive payment
Incentives are only paid once for each patient for whom a health assessment was requested. The exam date must always be in the current benefit year of when the member was targeted. For example: A member targeted in 2016 must have an exam date in 2016. Also, all SOAP notes for 2016 must be submitted no later than February 15, 2017.

For additional information about SOAP notes, incentives, the medical record review process or the outreach effort, please refer to the frequently asked questions document available on our website.

**Webinars by Inovalon help you complete SOAP Notes**

Webinars offered by Inovalon assist eligible providers in completing a SOAP Note and utilizing the ePASS® electronic tool. If you have not already done so, we encourage you to attend an upcoming session. All webinars take place on Wednesdays at 3:00 p.m.:

- February 8, February 15, February 22
- March 1, March 8, March 15, March 22, March 29

**How to join**

Teleconference: Dial 1-888-757-2790 and enter access code: 351117

WebEx: Visit [https://inovalon.webex.com](https://inovalon.webex.com) and enter Meeting Number 740117402

Once you join the call, live support is available at any time by dialing *0.

For more information on incentives for completing SOAP Notes, visit our website at anthem.com > Providers > Maine > Health Care Reform Updates and Notifications > [Anthem engages Inovalon to conduct outreach efforts for our ACA individual and small group on and off exchange business – FAQs](#).

**Practitioners’ rights during the credentialing process**

The credentialing process must be completed before a practitioner begins seeing enrollees and enters into a contractual relationship with a health care insurer or HMO. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application
- Correct erroneous information regarding a credentialing application
- Be notified of the status of credentialing or re-credentialing applications

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members’ claims.

**Free provider training and CME credit – moving toward equity in asthma care**

Did you know?

- Hispanics and African Americans with asthma are less likely to take daily controllers and are more likely to visit the emergency room and be hospitalized for asthma-related conditions than non-Hispanic Whites1
Asian Americans are more likely to die from asthma than non-Hispanic Whites.\(^2\)

We are committed to achieving health equity in asthma outcomes with diverse populations and now offer the free online experience, [Moving toward Equity in Asthma Care](#), to support providers in delivering culturally appropriate asthma care to diverse populations.

*Providers will receive 1.0 continuing Medical Education (CME) credit upon successful completion of the course and easy access to additional resources about asthma disparities.*

Key features of the course:

- Can be accessed from any mobile device, laptop, or desktop computer
- Interactive learning
- Bookmarking feature allows users to pause the course and resume it later
- Content is relevant for multiple diverse populations
- Focus on current disparities and what may contribute to them

To learn more about how providers and members can work together to reduce asthma disparities, access this important training [here](#).

**Sources:**

2. Office of Minority Health

This Enduring Material activity, Moving Toward Equity in Asthma, has been reviewed and is acceptable for up to 1.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 09/28/2016. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Hardware/Software Requirements** – To access activities, users will need:

- A computer, tablet, or smartphone with an Internet connection.
- Microsoft Internet Explorer (9 or later); Google Chrome (38 or later); Safari (5 or later); Mozilla Firefox (32 or later).

## Medicare update

**AIM OptiNet imaging services initiative postponed**

Recent issues of [Network Update](#) and previous Important Medicare Advantage Updates have included information about an initiative administered by AIM Specialty Health to collect information about imaging capabilities of our Medicare Advantage providers. This initiative has been postponed from January 1, 2017 to April 1, 2017. Medicare Advantage providers will not be subject to the requirement to have a specific OptiNet score to be reimbursed for outpatient diagnostic imaging services at this time. Although there is no reimbursement impact at this time, we continue to encourage network providers to submit imaging services data for the AIM Specialty Health initiative.

If you have not yet registered, registration is available online via the AIM [ProviderPortal].

To access:

- Go to [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb) (registration required).
Select Anthem Medicare Advantage from the drop down menu
Log in to ProviderPortal
Select “Access My OptiNet Registration” from the ProviderPortal home page to begin your registration

For additional assistance with registration or your score, you may also call AIM toll free at 800-714-0040, Monday-Friday, 8:00 a.m.-8:00 pm.

Learn more: Attend a webinar
Empire continues to offer webinars to help providers complete their OptiNet assessments. Attend one of the webinars below to learn 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

Webinars will be conducted February 2 and 23 from 4:30 to 5 p.m.

Please email ronald.younger@anthem.com to have an invitation for the webinar delivered directly to your calendar.

Additional information will be available at www.anthem.com/medicareprovider under Important Medicare Advantage Updates.

Claim adjustments may change member cost share
Please be sure to 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 has not changed due to the adjustment. 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.

Payment reduction for X-rays taken using film
Effective for services provided beginning January 1, 2017, we will follow the Centers for Medicare & Medicaid Services’ requirement for providers to bill modifier FX when billing for X-rays using film. A payment reduction of 20 percent will apply to the technical component (and the technical component of the global fee) for X-ray services furnished using film for which payment is made under the Medicare Physician Fee Schedule.

Tetanus vaccination claim filing
Since CPT code 90703 (tetanus vaccine) was deleted effective for dates of service January 1, 2016 and after, providers who have administered a tetanus vaccine for an open wound or laceration should bill 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to the administration 90471 and/or 90472, with the appropriate diagnosis to indicate open wound or laceration. Please submit the claim to the member’s Medicare Advantage or Medicare Medicaid Plan.

If a tetanus vaccine is administered for a reason other than puncture wound or laceration and the member has pharmacy benefits, please bill their Medicare Part D plan. This applies to the vaccine and the administration charges.
To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse at the website (http://www.transactrx.com) or call Customer Service at 866-522-3386.

Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

The Centers for Medicare & Medicaid Services provides more information on Part D vaccines here.

**Individual MA members should use Hearing Care Solutions**

As a reminder, members enrolled in individual Medicare Advantage plans that provide routine hearing exam and/or hearing aid benefits must use Hearing Care Solutions for their hearing benefits. When the members contact Hearing Care Solutions to use hearing benefits, Hearing Care Solutions staff will help members find a provider in their area that will best meet their needs. Providers interested in joining the Hearing Care Solutions network should call 855-312-2545.

If a member sees a provider who is not contracted with Hearing Care Solutions, those hearing claims will deny.

If you have questions, please call provider services on the number on the back of the member’s ID card.

**Include NPI in surgical procedure bills**

When billing a surgical procedure for a Medicare Advantage member, bill the surgical operator’s NPI in box 77 on the facility UB claim form, also known as the CMS 1450 claim form.

**Transitional care management (TCM) services**

This is a correction to the December 2016 newsletter.

A beneficiary is eligible to receive TCM services beginning on the date they are discharged from the inpatient hospital setting and continues for the next 29 days. 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.


**Retrospective medical record review program launches**

Our retrospective medical record review initiative is a risk adjustment program intended to identify and capture previously undocumented or new diagnosis data that might have been missed due to coding and/or technical limitations.

We contract with Verscend Health, formerly Verisk, to conduct provider outreach requesting medical records with dates of service for the target year (2016) thru present day, then review and code the record.
What you need to know
Jaime Marcotte, Retrospective Risk Program Lead, is managing this initiative. Should you have any questions regarding this program please do not hesitate to contact Jaime at Jaime.Marcotte@anthem.com or 314-925-6094.

Additional information, including FAQs, is available at Important Medicare Advantage Updates found at anthem.com/medicareprovider.

Radiation therapy services – contact AIM for delivery, Anthem for planning
Prior authorization of outpatient radiation therapy services for Anthem Individual Medicare Advantage and Medicare-Medicaid Plan members is required.

Providers should continue to request prior authorization for the radiation therapy modalities and services listed below:

- Intensity modulated radiation therapy (IMRT)
- 3D conformal/external beam radiation therapy (EBRT)
- Brachytherapy
- Proton beam therapy
- Stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS)

The type of review needed will determine the prior authorization steps to be taken:

- Planning – Prior authorization is administered by contacting Anthem through Availity.
- Planning and Delivery – Prior authorization is administered by AIM Specialty Health® (AIM).
- Delivery – Prior authorization is administered by AIM Specialty Health® (AIM).

If you are ready to deliver any of the services listed above, please contact AIM. AIM reviews authorizations for delivery and planning services under the umbrella of radiation therapy modalities. To submit your request, go to the AIM ProviderPortalSM at www.aimspecialtyhealth.com/goweb. From the dropdown menu, select Anthem MA. 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.

If you are ONLY requesting authorization for the planning codes, and not yet ready to request the delivery codes or radiation therapy is being performed as part of an inpatient admission, you may request approval by contacting us through Availity.

Examples and additional information will be available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

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

- Maine 2017 Medicare Advantage Plan Changes
- Update to ClaimCheck Upgrade to ClaimsXten December Reimbursement Policy Provider Bulletin
- Medicare risk adjustment and documentation guidance training offered
- Prior authorization requirements for intracardiac electrophysiological studies and catheter ablation
Providers must enroll with Medicare to be able to prescribe Part D beginning January 1, 2019.

New CMS requirement – hospitals must use Medicare Outpatient Observation Notice (MOON) form

CMS requires that all hospitals and critical access hospitals (CAHs) provide written notification and an oral explanation to individuals receiving observation services as outpatients for more than 24 hours.

Hospitals should use the OMB-approved standardized MOON form CMS-10611. All hospitals and CAHs are required to provide this statutorily required notification no later than March 8, 2017. The notice and accompanying instructions are available at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html

The MOON was developed to inform all Medicare beneficiaries, including Anthem Medicare Advantage members, when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.

Programs and benefits update

Blood pressure monitor benefits for Federal Employee Program members

The Blue Cross and Blue Shield Federal Employee Program® (FEP) and the American Medical Association (AMA) have come together in a collaborative effort to provide physicians with resources designed to improve health outcomes for patients with hypertension and suspected hypertension. This effort supports the goals of the Million Hearts® initiative.

Information can be found on the Availity provider portal covering self-measured blood pressure monitoring, a component of the Improving Health Outcomes: Blood Pressure Program developed by the AMA. The program is designed to help you and your office staff engage your patients in the self-measurement of their own blood pressure. The Community Preventive Services Task Force found “there is strong evidence of effectiveness for these interventions when combined with additional support (i.e., patient counseling, education, or web-based support). The economic evidence indicates that self-measured blood pressure monitoring interventions are cost-effective when they are used with additional support or within team-based care.” (http://www.thecommunityguide.org/cvd/RRSMBP.html)

In support of this effort, FEP initiated a program to provide free blood pressure monitors* to FEP enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If your patient indicates that they have high blood pressure on the Blue Health Assessment (BHA) and you discuss home monitoring with the patient, he/she is eligible to receive a free blood pressure monitor. The BHA is a health-risk assessment and the first step in the FEP Wellness Incentive Program. In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle (www.fepblue.org/bha).

Information is available on anthem.com > Providers > Maine > Health & Wellness > Blood Pressure Information. You can also call FEP Customer Service at 800-722-0203 for additional information.
The blood pressure monitors were selected by Anthem. The AMA does not endorse any particular brand or model of blood pressure monitor.

**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.

<ME only>In addition, please note that the information and articles in this newsletter related to behavioral health services are for plans and products managed by Anthem Behavioral Health.

**Member satisfaction with behavioral health outpatient services**

We conduct an annual satisfaction survey of our member’s behavioral health outpatient service experience. The random survey is conducted based on receipt of claims. We have recently reviewed the 2016 survey experience results and wanted to share highlights with our network of behavioral health providers. The survey inquires about the member’s satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member’s various providers), prescriptions/medication management process (if applicable), financial and billing process, and their perceived clinical improvement. Our member is also asked to give an overall rating of the experience. The 2016 overall practitioner rating was 90% in Maine based on the survey results.

We were pleased to see improvement in two areas of focus over the last year, prescriptions and coordination of care. Members responding to the survey indicated that conversations with their BH prescribers were in depth and covered aspects, positive and negative, about taking the medication, along with alternative and supplemental treatments to address behavioral health issues. In addition, many respondents indicated that care was being coordinated among their providers, including medical. Care coordination and collaboration, particularly medical-behavioral integration, is a key area of our 2017 initiatives.

While we are pleased with our members’ experience with our participating provider network and thank you for your network participation and the services you provide, there are areas of opportunity for improvement. These areas for improvement include:

**Member’s access to behavioral health care**

As a participating provider please be reminded of our expectation, based on NCQA definitions, of access to behavioral healthcare to help ensure our members have prompt access to behavioral health care:

- **Non-Life Threatening Emergency Needs** - must be seen, or have appropriate coverage directing the Member, within 6 hours. When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.
- **Urgent Needs** - must be seen, or have appropriate coverage directing the Member, within 48 hours. Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.
- **Routine office visit** - must be within 10 business days. Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

We use several methods to monitor adherence to these standards. Monitoring is accomplished by:
a. assessing the availability of appointments via phone calls and surveys by our staff or designated vendor to the provider’s office;
b. analysis of member complaint data, and
c. analysis of member satisfaction data.

Providers are expected to make best efforts to meet these access standards for all members. We continue to look at gaps, barriers and alternative options to improve access to behavioral healthcare including telehealth services among network providers.

Provider Attitude and Service
The score related to the service and attitude of the BH provider decreased year over year. We are in the process of reviewing and fine-tuning the member grievance and follow-up process to identify any specific trends and ensure timely inquiry with providers. We encourage our providers to be mindful of the discussions and perceived listening of their patients.

Members held harmless
As a participating provider in Anthem’s behavioral health provider network, a participating provider shall look solely to Anthem for compensation for covered services and under no circumstances shall render a bill or charge to any member except for applicable co-payments, deductibles and coinsurance and for services that are not medically necessary or are otherwise not covered, provided that the Provider obtains the consent of the Member before providing such service. We recommend that consent be in writing and dated, in order to protect our members and providers from disputes.
In addition, Anthem also reminds our participating providers that Anthem members must be advised of missed or cancelled appointment policies at the onset of treatment. We also recommend that the advisement be acknowledged by the member in writing, and that acknowledgement is dated.

Thank you again for the services that you provide to our members.

Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5®)
In an effort to help keep our provider community abreast of changes occurring in the behavioral health community, we wanted to share a couple of new changes from the DSM 5.

The transition from the DSM IV-TR to the DSM-5 involved moving from a multiaxial system to a non-axial system upon diagnosis; however, the information included in the diagnosis remains much the same. In fact, the axes from the DSM IV are still included in our diagnosis in the DSM-5 as appropriate. See the following table below:

<table>
<thead>
<tr>
<th>DSM-IV Multiaxial System</th>
<th>DSM-5 Non-axial System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I: Clinical d/o and other conditions that are focus of treatment</td>
<td>Combined attention to clinical disorders, including personality disorders and intellectual disability; other conditions that are the focus of treatment; and medical conditions.</td>
</tr>
<tr>
<td>Axis II: Personality d/o and mental retardation</td>
<td>Reason for visit, psychosocial, and contextual factors via expanded list of V Codes and Z Codes.</td>
</tr>
<tr>
<td>Axis III: General medical conditions</td>
<td>Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.</td>
</tr>
<tr>
<td>Axis IV: Psychosocial and environmental stressors</td>
<td></td>
</tr>
<tr>
<td>Axis V: Global Assessment of Functioning</td>
<td></td>
</tr>
</tbody>
</table>
Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled “Other Conditions That May Be a Focus of Clinical Attention”. In addition, Axis V, Global Assessment of Functioning (GAF), was removed from DSM-5. Alternatively, the World Health Organization Disability Assessment Schedule (WHODAS 2.0) is included in Section III of DSM-5.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM 5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations that require clinical expertise to differentiate from normal life variation and transient responses to stress.

**Examples of changes to some commonly used codes:**

<table>
<thead>
<tr>
<th>296.20</th>
<th>Major depressive affective disorder, single episode, unspecified</th>
<th>F32.9 Major depressive disorder, single episode, unspecified</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.21</td>
<td>Major depressive affective disorder, mild</td>
<td>F32.0 Major depressive disorder, single episode, mild</td>
</tr>
<tr>
<td>296.23</td>
<td>Major depressive affective disorder, single episode severe, without mention of psychotic behavior</td>
<td>F32.2 Major depressive disorder, single episode, severe without psychotic features</td>
</tr>
<tr>
<td>296.24</td>
<td>Major depressive affective disorder, single episode severe, specified as with psychotic behavior</td>
<td>F32.3 Major depressive disorder, single episode, severe with psychotic features</td>
</tr>
<tr>
<td>296.25</td>
<td>Major depressive affective disorder, single episode, in partial or unspecified remission</td>
<td>F32.4 Major depressive disorder, single episode, in partial remission</td>
</tr>
<tr>
<td>296.26</td>
<td>Major depressive affective disorder, single episode, in full remission</td>
<td>F32.5 Major depressive disorder, single episode, in full remission</td>
</tr>
<tr>
<td>311</td>
<td>Depressive Disorder NEC</td>
<td>F32.9 Major depressive disorder, single episode, unspecified</td>
</tr>
<tr>
<td>309.81</td>
<td>Posttraumatic Stress Disorder</td>
<td>F43.10 Posttraumatic Stress Disorder, unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>F43.12 Posttraumatic Stress Disorder, chronic</td>
</tr>
</tbody>
</table>

Some resources that may help you include:
- American Medical Association, 2016 Professional Edition CPT (current procedural terminology)

**Quality programs update**

**Commercial HEDIS® 2017 starts early February**

We will begin requesting medical records in February for HEDIS 2017 via a phone call to your office followed by a fax. The fax will contain:

1. a cover letter with contact information your office can use to contact us if there are any questions,
2. a member list that includes the member and HEDIS measure(s) the member was selected for, and
3. an instruction sheet listing the details for each HEDIS measure.
As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within five business days. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in the 3rd quarter provider newsletter.

To return the medical record documentation back to us in the recommended 5-day turnaround time, simply choose one of these options:

1. Upload to our secure portal; it's quick and easy. Logon to www.submitrecords.com, enter the password: wphedis57 and select the files to be uploaded. Once uploaded you'll receive a confirmation number to retain for your records.
2. Send a secure fax to 888-251-2985
3. Mail to us via the US Postal Service to:
   Anthem, Inc.
   66 E. Wadsworth Park Drive, Suite 110H
   Draper, UT 84020

Thank you in advance for your support of HEDIS.

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

Physician Quality Management and Blue Physician Recognition programs to sunset

In collaboration with the Blue Cross Blue Shield Association (BCBSA), we implemented two physician quality transparency programs for primary care physicians – Physician Quality Measurement (PQM) and Blue Physician Recognition (BPR) in 2012.

Both programs have supported members in their health care decision-making through display of nationally-recognized physician performance measurements (PQM) and a logo (BPR) that identified physicians demonstrating a commitment to quality performance. Since their implementation, quality measurement and consumer transparency and engagement have evolved. Based on this and the analyses of these programs, BCBSA decided to sunset these programs and removed these displays from their National Doctor and Hospital Finder.

We will remove this content from our website by April 23, 2017.

Sharing results of Member Satisfaction Survey regarding physician care

Every year, we send the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to our HMO/POS members. The survey provides Anthem members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. The CAHPS survey is used by all HMO/POS plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

The following table compares our results from 2015 with those in 2016. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem.
These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

When you’re reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.

2016 Anthem Maine HMO/POS CAHPS® Adult Member Satisfaction Survey Results and NCQA Quality Compass Percentiles Achieved

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating of Physician¹</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor</td>
<td>84%</td>
<td>87%</td>
<td>↑</td>
</tr>
<tr>
<td>Rating of Specialist Seen Most Often</td>
<td>84%</td>
<td>90%</td>
<td>↑</td>
</tr>
<tr>
<td>Rating of All Health Care Provided in Past 12 Months</td>
<td>81%</td>
<td>79%</td>
<td>↓</td>
</tr>
<tr>
<td>Getting Care Quickly²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Got appointment for urgent care as soon as needed</td>
<td>93%</td>
<td>90%</td>
<td>↓</td>
</tr>
<tr>
<td>Got appointment for check-up or routine care as soon as needed</td>
<td>86%</td>
<td>90%</td>
<td>↑</td>
</tr>
<tr>
<td>When calling PCP office after regular office hours for urgent care able to access the medical help or advice you needed?</td>
<td>89%</td>
<td>93%</td>
<td>↑</td>
</tr>
<tr>
<td>Doctor’s Communication with Patients²</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often personal doctor explained things understandably to you</td>
<td>98%</td>
<td>97%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor listened carefully to you</td>
<td>97%</td>
<td>95%</td>
<td>↓</td>
</tr>
<tr>
<td>How often personal doctor showed respect for what you had to say</td>
<td>97%</td>
<td>98%</td>
<td>↑</td>
</tr>
<tr>
<td>How often personal doctor spent enough time with you</td>
<td>94%</td>
<td>95%</td>
<td>↑</td>
</tr>
<tr>
<td>Shared Decision Making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor discussed reasons to take a medicine?³</td>
<td>94%</td>
<td>95%</td>
<td>↑</td>
</tr>
<tr>
<td>Doctor discussed reasons you may not want to take a medicine?³</td>
<td>83%</td>
<td>83%</td>
<td>=</td>
</tr>
<tr>
<td>Doctor asked what you thought was best for you?³</td>
<td>89%</td>
<td>84%</td>
<td>↓</td>
</tr>
<tr>
<td>Continuity of Care &amp; Health Promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often did your personal doctor seem informed about care you received from other health providers?²</td>
<td>86%</td>
<td>88%</td>
<td>↑</td>
</tr>
<tr>
<td>Did you and your doctor discuss ways to prevent illness?³</td>
<td>83%</td>
<td>81%</td>
<td>↓</td>
</tr>
</tbody>
</table>

1 = Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2 = Percent responding “Usually” or “Always.”
3 = Percent responding “Yes”
4 = Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.

Network Update
February 2017 Maine 23 of 31
NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

*The source of data contained in this report is Quality Compass ® 2016 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.

Clinical practice and preventive health guidelines available on anthem.com

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

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 website quarterly (the first of the month for January, April, July and October).


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.

Network Update

February 2017 Maine
Medical policy update

Medical policy updates are available on anthem.com

The following new and revised policies were endorsed at the November 3, 2016 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 contacting the Provider Call Center.


Revised medical policies effective November 17, 2016
(The following policies were revised to expand medical necessity indications or criteria.)

DME.00036   Ultraviolet Light Therapy Delivery Devices for Home Use
DRUG.00002   Tumor Necrosis Factor Antagonists
DRUG.00038   Bevacizumab (Avastin®) for Non-Ophthalmologic Indications
DRUG.00041   Rituximab (Rituxan®) for Non-Oncologic Indications
DRUG.00042   Ustekinumab (Stelara®)
DRUG.00048   Eribulin mesylate (Halaven®)
DRUG.00057   Canakinumab (Ilaris®)
DRUG.00068   Vedolizumab (Entyvio®)
DRUG.00071   Pembrolizumab (Keytruda®)
DRUG.00075   Nivolumab (Opdivo®)
DRUG.00082   Daratumumab (Darzalex™)
DRUG.00085   Ixabepilone (Ixempra®)
GENE.00019   BRAF Mutation Analysis
GENE.00035   Genetic Testing for TP53 Mutations
MED.00064   Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
MED.00083   Melanoma Vaccines
SURG.00055   Cervical Total Disc Arthroplasty
SURG.00121   Transcatheter Heart Valve Procedures
TRANS.00035   Mesenchymal Stem Cell Therapy For Orthopedic Indications

Archived medical policy effective November 17, 2016
(The policy listed below has been archived.)

DRUG.00039   Trastuzumab (Herceptin®)
New medical policy effective November 17, 2016
(The policy listed below is new and determined to not have significant change.)

DRUG.00097 Olaratumab (Lartruvo™)

Revised medical policies effective December 28, 2016
(The policy listed below was revised to expand medical necessity indications or criteria.)

DRUG.00055 Denosumab (Prolia®, Xgeva®)

Archived medical policy effective December 21, 2016
(The policy listed below has been archived.)

LAB.00032 Zika Virus Testing

Revised medical policies effective December 28, 2016
(The following policies were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.)

ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
DME.00011 Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices
DME.00034 Standing Frames
DME.00038 Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices
DRUG.00006 Botulinum Toxin
DRUG.00034 Insulin Potentiation Therapy
DRUG.00035 Panitumumab (Vectibix®)
DRUG.00043 Tocilizumab (Actemra®)
DRUG.00046 Ipilimumab (Yervoy®)
DRUG.00050 Eculizumab (Soliris®)
DRUG.00051 Ziv-aflibercept (Zaltrap®)
DRUG.00060 Plerixafor (Mozobil®)
DRUG.00061 Radium Ra 223 Dichloride (Xofigo®)
DRUG.00063 Ofatumumab (Arzerra®)
GENE.00001 Genetic Testing for Cancer Susceptibility
GENE.00004 Janus Kinase 2 (JAK2) V617F Gene Mutation Assay
GENE.00009 Gene-Based Tests for Screening, Detection and Management of Prostate Cancer
GENE.00011 Gene Expression Profiling for Managing Breast Cancer Treatment
GENE.00014 Analysis of KRAS Status
GENE.00017 Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)
GENE.00018 Gene Expression Profiling for Cancers of Unknown Primary Site
GENE.00020 Gene Expression Profile Tests for Multiple Myeloma
GENE.00022 In Vitro Companion Diagnostic Devices
GENE.00027 Combined PALB2 and BRCA2 Mutation Testing for Oncologic Indications
GENE.00028 Genetic Testing for Colorectal Cancer Susceptibility
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENE.00029</td>
<td>Genetic Testing for Breast and/or Ovarian Cancer Syndrome</td>
</tr>
<tr>
<td>GENE.00030</td>
<td>Genetic Testing for Endocrine Gland Cancer Susceptibility</td>
</tr>
<tr>
<td>GENE.00033</td>
<td>Genetic Testing for Inherited Peripheral Neuropathies</td>
</tr>
<tr>
<td>GENE.00044</td>
<td>Analysis of PIK3CA Status in Tumor Cells</td>
</tr>
<tr>
<td>LAB.00019</td>
<td>Serum Markers for Liver Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease</td>
</tr>
<tr>
<td>LAB.00026</td>
<td>Systems Pathology Testing for Predicting Risk of Prostate Cancer Progression and Recurrence</td>
</tr>
<tr>
<td>LAB.00028</td>
<td>Serum Biomarker Tests for Multiple Sclerosis</td>
</tr>
<tr>
<td>MED.00032</td>
<td>Treatment of Hyperhidrosis</td>
</tr>
<tr>
<td>MED.00080</td>
<td>Cryopreservation of Oocytes or Ovarian Tissue</td>
</tr>
<tr>
<td>MED.00082</td>
<td>Quantitative Sensory Testing</td>
</tr>
<tr>
<td>MED.00085</td>
<td>Antineoplaston Therapy</td>
</tr>
<tr>
<td>MED.00089</td>
<td>Quantitative Muscle Testing Devices</td>
</tr>
<tr>
<td>MED.00095</td>
<td>Anterior Segment Optical Coherence Tomography</td>
</tr>
<tr>
<td>MED.00096</td>
<td>Low-Frequency Ultrasound Therapy for Wound Management</td>
</tr>
<tr>
<td>MED.00099</td>
<td>Electromagnetic Navigational Bronchoscopy</td>
</tr>
<tr>
<td>MED.0103</td>
<td>Automated Evacuation of Meibomian Gland</td>
</tr>
<tr>
<td>MED.0106</td>
<td>Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer</td>
</tr>
<tr>
<td>MED.0113</td>
<td>Therapeutic Apheresis</td>
</tr>
<tr>
<td>OR-PR.00003</td>
<td>Microprocessor Controlled Lower Limb Prosthesis</td>
</tr>
<tr>
<td>OR-PR.00006</td>
<td>Powered Robotic Lower Body Exoskeleton Devices</td>
</tr>
<tr>
<td>RAD.00002</td>
<td>Positron Emission Tomography (PET) and PET/CT Fusion</td>
</tr>
<tr>
<td>RAD.00004</td>
<td>Peripheral Bone Mineral Density Measurement</td>
</tr>
<tr>
<td>RAD.00023</td>
<td>Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications</td>
</tr>
<tr>
<td>RAD.00035</td>
<td>Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI)</td>
</tr>
<tr>
<td>RAD.00036</td>
<td>MRI of the Breast</td>
</tr>
<tr>
<td>RAD.00037</td>
<td>Whole Body Computed Tomography Scanning</td>
</tr>
<tr>
<td>RAD.00049</td>
<td>Low-Field and Conventional Magnetic Resonance Imaging (MRI) for Screening, Diagnosing and Monitoring</td>
</tr>
<tr>
<td>RAD.00057</td>
<td>Near-Infrared Coronary Imaging and Near-Infrared Intravascular Ultrasound Coronary Imaging</td>
</tr>
<tr>
<td>RAD.00060</td>
<td>Digital Breast Tomosynthesis</td>
</tr>
<tr>
<td>RAD.00061</td>
<td>PET/MRI</td>
</tr>
<tr>
<td>RAD.00062</td>
<td>Intravascular Optical Coherence Tomography (OCT)</td>
</tr>
<tr>
<td>RAD.00064</td>
<td>Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)</td>
</tr>
<tr>
<td>SURG.00008</td>
<td>Mechanized Spinal Distraction Therapy for Low Back Pain</td>
</tr>
<tr>
<td>SURG.00025</td>
<td>Cryosurgical Ablation of Solid Tumors Outside the Liver</td>
</tr>
<tr>
<td>SURG.00044</td>
<td>Breast Ductal Examination and Fluid Cytology Analysis</td>
</tr>
<tr>
<td>SURG.00050</td>
<td>Radiofrequency Ablation to Treat Tumors Outside the Liver</td>
</tr>
<tr>
<td>SURG.00060</td>
<td>Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)</td>
</tr>
<tr>
<td>SURG.00064</td>
<td>Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure</td>
</tr>
<tr>
<td>SURG.00082</td>
<td>Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System</td>
</tr>
<tr>
<td>SURG.00092</td>
<td>Implanted Devices for Spinal Stenosis</td>
</tr>
<tr>
<td>SURG.00095</td>
<td>Viscocanalostomy and Canaloplasty</td>
</tr>
</tbody>
</table>
SURG.00101  Suprachoroidal Injection of a Pharmacologic Agent
SURG.00104  Extrasosseous Subtalar Joint Implantation and Subtalar Arthroereisis
SURG.00114  Facet Joint Allograft Implants for Facet Disease
SURG.00120  Open Treatment of Rib Fracture(s) Requiring Internal Fixation
SURG.00128  Implantable Left Atrial Hemodynamic Monitor
SURG.00129  Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
SURG.00131  Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
SURG.00135  Radiofrequency Ablation of the Renal Sympathetic Nerves
SURG.00143  Perirectal Spacers for Use During Prostate Radiotherapy
SURG.00145  Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts) (Previously categorized as TRANS.00014)
THER-RAD.00002  Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
THER-RAD.00004  External Beam Intraoperative Radiation Therapy
THER-RAD.00005  Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy
THER-RAD.00006  Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors
THER-RAD.00008  Neutron Beam Radiotherapy
THER-RAD.00010  Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
THER-RAD.00011  IGRT (Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT)
TRANS.00013  Small Bowel, Small Bowel/Liver and Multivisceral Transplantation
TRANS.00018  Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation
TRANS.00023  Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias
TRANS.00027  Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors
TRANS.00028  Hematopoietic Stem Cell Transplant for Hodgkin Disease and Non-Hodgkin Lymphoma
TRANS.00029  Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias
TRANS.00033  Heart Transplantation
TRANS.00034  Hematopoietic Stem Cell Transplantation for Diabetes Mellitus
TRANS.00036  Stem Cell Therapy for Peripheral Vascular Disease

New medical policy effective December 28, 2016
(The policy listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DRUG.00090  Bezlotoxumab (ZINPLAVA™)

Revised medical policies effective January 1, 2017
(The following policies were update with the new CPT/HCPCS procedure codes effective on 01-01-2017.)

DRUG.00006  Botulinum Toxin
DRUG.00017  Hyaluronan Injections in Joints Other than the Knee
DRUG.00066  Antihemophilic Factor and Clotting Factors
DRUG.00079  Bendamustine Hydrochloride
DRUG.00080  Monoclonal Antibodies for the Treatment of Eosinophilic Asthma
DRUG.00082  Daratumumab (Darzalex™)
DRUG.00083  Elotuzumab (Empliciti™)
New medical policies effective April 1, 2017
(The following policies might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DRUG.00102 Cabazitaxel (Jevtana®)

Revised medical policy effective May 1, 2017
(The following policies might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DRUG.00041 Rituximab (Rituxan®) for Non-Oncologic Indications
DRUG.00051 Ziv-aflibercept (Zaltrap®)
DRUG.00057 Canakinumab (Ilaris®)
DRUG.00066 Antihemophilic Factor and Clotting Factors
DRUG.00070 Siltuximab (Sylvant®)
GENE.00002 Preimplantation Genetic Diagnosis Testing
GENE.00025 Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignant Tumors
LAB.00011 Analysis of Proteomic Patterns
MED.00057 MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions

New medical policies effective May 1, 2017
(The following policies might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DME.00040 Automated Insulin Delivery Devices
LAB.00033 Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer
Clinical guidelines update

Clinical guideline updates are available on anthem.com

The following new and revised clinical guidelines were endorsed at the November 3, 2016 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 contacting the Provider Call Center.

Clinical guideline adopted effective November 17, 2016
(The guideline listed below is being adopted and determined to not have significant change.)

CG-DRUG-64  FDA-Approved Biosimilar Products

Revised clinical guideline effective November 17, 2016
(The guideline listed below was revised to expand the medical necessity indications or criteria.)

CG-DRUG-38  Pemetrexed (Alimta®)

Revised clinical guidelines effective December 28, 2016
(The following guidelines were revised and had no significant changes to the position or criteria.)

CG-DME-06  Pneumatic Compression Devices for Lymphedema
CG-DRUG-03  Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
CG-DRUG-05  Recombinant Erythropoietin Products
CG-DRUG-09  Immune Globulin (Ig) Therapy
CG-DRUG-42  Asparagine Specific Enzymes (Asparaginase)
CG-DRUG-45  Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)
CG-MED-39  Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry
CG-SURG-09  Temporomandibular Disorders
CG-SURG-28  Transcatheter Uterine Artery Embolization
CG-SURG-43  Knee Arthroscopy
CG-SURG-48  Elective Percutaneous Coronary Interventions (PCI)
CG-SURG-53  Elective Total Hip Arthroplasty
CG-THER-RAD-0 2  Special Radiation Physics Consult and Treatment Procedure
CG-TRANS-02  Kidney Transplantation

Clinical guideline adopted effective December 28, 2016
(The guideline listed below is being adopted and determined to not have significant change.)

CG-DRUG-61  Gonadotropin Releasing Hormone Analogos for the Treatment of Non-Oncologic Indications
Revised clinical guideline effective January 1, 2017
(The following guidelines were updated with the new CPT/HCPCS procedure codes effective on 01-01-2017.)

CG-DRUG-16 White Blood Cell Growth Factors
CG-MED-23 Home Health
CG-REHAB-04 Physical Therapy
CG-REHAB-05 Occupational Therapy

Clinical guideline adopted effective April 1, 2017
(The following guidelines listed below are being adopted and might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

CG-DRUG-54 Agalsidase beta (Fabrazyme®)
CG-DRUG-55 Eloulfase alfa (Vimizim®)
CG-DRUG-56 Galsulfase (Naglazyme®)
CG-DRUG-57 Idursulfase (Elaprase®)
CG-DRUG-58 Laronidase (Aldurazyme®)
CG-DRUG-62 Fulvestrant (FASLODEX®)
CG-DRUG-63 Levoleucovorin calcium (Fusilev®)