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Anthem news

Prepare NOW - only one week to go!

This is a reminder that, effective December 8, 2017, Anthem Online Provider Services (AOPS) our secure provider portal will be retired and all information formerly on AOPS will be available exclusively via the Availity Portal at www.availity.com.

Your preparations for this transition are vital and should include:

If you are your organization's Availity Administrator:
Continue to use My Account Dashboard from the Availity home page to register new users and update or unlock accounts for existing users. Make sure all of your users have the roles they need to ensure a smooth transition.

If you are a user today who regularly uses tools on both AOPS and Availity:
In these final days before the retirement of AOPS, make sure you are able to access everything you require to perform your job duties directly off of the Availity Portal and work with your administrator to update your access if needed.
Finally, users now have two places to obtain valuable training tools and information. If you would like more information on navigating in Availity, select Help & Training > My Learning Plan from the top navigation menu on the Availity home page to plot your learning journey. Availity also offers onboarding modules for new administrators and users. To locate these modules in the Availity Learning Center type “onboarding” in the search field.

For more information on Anthem features and navigation, select Payer Spaces > Applications > Education and Reference Center to find presentations and reference guides that can be used to educate you and your staff on our proprietary tools.

Health care reform update

Preventive care expands to include generic low-to-moderate dose statins

Based on the recommendation from the United States Preventive Service Task Force (USPSTF) regarding Statin Use for the Primary Prevention of Cardiovascular Disease in Adults, we are updating our Affordable Care Act (ACA) preventive care coverage to include generic low-to-moderate dose statins. This coverage is effective December 1, 2017 for all non-grandfathered health plans, and for grandfathered plans that utilize our ACA preventive care coverage. Providers should continue to verify coverage and benefits for all members. For members with this coverage, low-to-moderate dose statins are covered at 100% with no member cost share.

In general, this coverage applies to members between the ages of 40-75 years old who have one of the following cardiovascular disease (CVD) risk factors: diabetes, hypertension, dyslipidemia and/or smoking. Members with these risk factors will be proactively identified. In some scenarios, it is possible that a member may not be proactively identified. If a provider feels the member meets the preventive care coverage criteria outlined in the USPSTF statin recommendation, they can call the Express Scripts Prior Authorization Center at 866-310-3666 and provide qualifying information.

Health care reform updates on anthem.com

Please be sure to visit the Health Care Reform Updates and Notifications and Information about Health Insurance Exchanges section of our website for this and other updates on health care reform and Health Insurance Exchanges, including an updated 2018 Health Insurance Exchange Quick Reference Guide, expected to be available on our website in early December.

Integrated Care Model for plans purchased on the Health Insurance Marketplace benefits members and physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the exchange) the ability to have continuity of care with each care management case. A single primary care nurse provides case and disease assessment and management. This continuity provides an opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals who are there to support members, families, primary care physicians and caregivers.
Nurse care managers encourage participants to follow their physician’s plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician’s instructions, we collaborate with the treating physician to understand the member’s plan of care and educate the member on options for their treatment plan.

Members or caregivers can refer themselves or family members by calling the number located in the grid below.

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: 800-231-8254</td>
<td><a href="mailto:CMReferralSpecialistNE@anthem.com">CMReferralSpecialistNE@anthem.com</a></td>
<td>Monday – Friday, 8:00 a.m. – 7:00 p.m.</td>
</tr>
<tr>
<td>Fax: 800-947-4074</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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, 2017, unless otherwise noted, we will be posting the following new and/or revised reimbursement policies for our commercial products. Professional reimbursement policies may be reviewed through Availity at www.availity.com. Once signed on to the Availity site, select Payer Spaces > Anthem > Resources > Provider Portal (Anthem). Once on the Anthem Provider Services page, choose the link for Reimbursement Policies located under Claim Processing Edits.

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

Durable Medical Equipment – professional

On October 1, 2017, we advised we were updating the Continuous Rental section of our policy to indicate that pressure/automatic positive airway pressure (CPAP/APAP) devices, bi-level positive airway pressure (BPAP) devices, and corresponding humidifiers would be designated as continuous rental items. Please note, we are correcting our policy dated October 1, 2017 to reflect, as previously noted in the “Purchase and Rent to Purchase (P/RTP)” section of the policy, that we consider these CPAP/APAP/BPAP and corresponding humidifier items to be “rent to purchase” (RTP) items and RTP items must be reported with durable medical equipment (DME) rental modifiers. As a reminder, when RTP items are reported with
DME purchase modifiers, the RTP items will not be eligible for reimbursement. Please review our Durable Medical Equipment policy for further information.

**Frequency Editing – professional**
Based on the code description for HCPCS codes A4221 (supplies for maintenance of non-insulin drug infusion catheter, per week (list drugs separately)) and A4224 (supplies for maintenance of insulin infusion catheter, per week), for claims processed on or after November 18, 2017, we implemented a frequency limit of 1 unit per 7 days for HCPCS codes A4221 and A4224, which we consider to be correct coding. Modifiers will not override the frequency limit edit.

**Modifier Rules and Laboratory and Venipuncture – professional**
We have updated our policies dated November 18, 2017 to reflect that, based on CPT instructions, only laboratory services 86701, 86702, 86703 and 87389 reported with modifier 92 will be eligible for reimbursement. Any other laboratory services reported with modifier 92 will not be eligible for reimbursement.

**Scope of License - professional**
Beginning March 1, 2018, we will implement a new policy regarding reimbursement for services or procedures performed outside the scope of a provider's license. If a provider performs a service or procedure that is outside of the provider’s scope of license, reimbursement may be denied. Please review the policy in its entirety for more detailed information.

**Significant Edits – professional**
We have updated our Significant Edits posting to reflect the 2017 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.

**System updates for 2018 – professional**
As a reminder, our claim editing software package will be updated quarterly in February, May, August and November of 2018. 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 our Network Update and online.

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

**New musculoskeletal program effective March 1, 2018**
Effective March 1, 2018, AIM Specialty Health® (AIM), a separate company, will perform medical necessity review of certain elective surgeries of the spine and joints, as well as interventional pain treatment for our fully insured members. AIM works with leading insurers to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable.
Our new musculoskeletal program reviews certain spine and joint surgeries, and interventional pain services against clinical appropriateness criteria to help ensure that care aligns with established evidence-based medicine. Many of these spine and joint procedures are currently reviewed by us today. Medical necessity review of interventional pain treatments may be new for some states and health plans. AIM will utilize AIM guidelines to apply the review. In addition, AIM will also utilize related Anthem medical policies. To determine if pre-service clinical review is needed for an Anthem member, please check online at anthem.com > Menu > Support > Providers > Maine > Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements or call the pre-service clinical review number located on the back of the member’s ID card.

Additionally, the program includes a member engagement initiative, designed to educate your patients about the surgeries and treatments your practice recommends for them, prior to the scheduled procedure. Our member engagement initiative supports your efforts to reinforce important information about the surgeries and treatments you recommend. This initiative is designed to reduce anxiety, drive adherence to care plans, motivate preventive action, and improve appropriate use of care for our members. Members are contacted by email or telephone and are provided a link to review educational multimedia programs, based on the order requests are submitted to AIM. As they view these multimedia programs, members will have an opportunity to note and submit any questions and concerns. Member input will be sent to your practice, giving you the opportunity to follow up and provide any additional education and information required.

For surgeries and pain treatment that are scheduled to begin on or after March 1, 2018, all providers must contact AIM to obtain a pre-service clinical review for the following non-emergency modalities:

**Spinal surgeries – cervical, thoracic, lumbar, and sacral (including all concurrent spinal procedures and all associated revision surgeries):**

- Fusion surgery
- Decompression
- Disc replacement
- Surgical treatment of scoliosis
- Sacroiliac joint fusion
- Total disc arthroplasty
- Vertebroplasty/kyphoplasty

**Joint replacement (including all associated revision surgeries)**

- Total knee arthroplasty
- Partial knee replacement
- Total hip arthroplasty
- Hip resurfacing
- Total shoulder arthroplasty
- Total elbow arthroplasty
- Total ankle arthroplasty

**Interventional pain management**

- Spinal cord stimulators
- Facet injections
- Epidural steroid injections
- Percutaneous neurolysis
- Peripheral nerve blocks for treatment of neuropathic pain
Pain management devices
- Implantable pain pumps
- Radio ablations
- Sacroiliac joint

Surgeries and pain treatments performed as part of an inpatient admission are included.

The program will be offered to self-funded accounts (ASO) to add to their members' benefit package as of July 1, 2018 and to National Accounts as of January 1, 2019.

**Members included in the new program**
All members in your area are included except for the following: Medicare Advantage, Medicare, Medicare supplement, MA Employer Group Retirees, National Accounts, Federal Employee Program® (FEP®), Taft Harley and Anthem as secondary.

**Pre-service review requirements**
For self-funded accounts (ASO), current pre-service clinical review requirements will continue using AIM guidelines and Anthem medical policies until this program is offered at the time of their renewal, beginning July 1, 2018. For National Accounts, current pre-service clinical review requirements will continue using AIM guidelines and Anthem medical policies until this program is offered to them at the time of their renewal beginning January 1, 2019.

Physicians will continue to request pre-service clinical review for these services in one of several ways:

- Access AIM’s ProviderPortalSM directly at www.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’s portal via the Availity Web Portal
- Access AIM’s call center at 866-714-1107, 8:00 a.m. – 5:00 p.m.

Go to www.aimspecialtyhealth.com/goweb to register. Registration opens February 19, 2018

For more information go to www.aimprovider.com/msk for resources to help your practice get started with the musculoskeletal and pain management program. Our website contains helpful information and tools such as order entry checklists, clinical guidelines, and FAQs.

For questions, please contact the provider service number on the back of the member’s ID card.

**Update to AIM Diagnostic Imaging Clinical Appropriateness Guidelines**
Beginning with dates of service on and after March 9, 2018, the following updates will apply to the AIM Diagnostic Imaging Clinical Appropriateness Guidelines:

**Criteria for imaging of suspicion for pulmonary embolism**
- The evaluation for pulmonary embolism requires the use of well validated clinical prediction rules.
- The addition of the use of D-Dimer to identify patients where imagining for pulmonary embolism is appropriate.

For questions related to guideline updates, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.
Ambulance response and treatment with no transport HCPCS code A0998

Beginning with dates of service on and after January 1, 2018, we will reimburse appropriate and medically necessary care billed under HCPCS code A0998 (Ambulance response and treatment, no transport) by emergency medical service (EMS) providers. The HCPCS code is billed when care is provided in response to an emergency call to a member’s home or on a scene, whether or not transportation to the hospital was necessary and occurred. In the past, we reimbursed EMS providers for treatment rendered only when the patient was transported to the hospital emergency room. We will apply medical necessity review to A0998 using coverage guideline CG-ANC-06.

This reimbursement policy change will apply to commercial health plans, and reimbursement will be made in accordance with the member’s benefits. As we receive state by state approvals from regulators, we will begin reimbursing for A0998 for Medicare plans.

In order to be eligible for this payment, you must provide treatment to your patient per your EMS protocols which are approved by your medical director at the local or state level. Billing of A0998 when treatment is not rendered is not appropriate.

Provider payments will be made weekly

Starting in 2018, we will begin issuing more claim payments and remittance advices on a weekly basis. Additionally, non-FEP payments under $5 will be held for a maximum of 14 days to allow for additional claims to combine to increase the payment amount.

This change is being made for greater efficiency and to help ensure consistency between professional and facility claim payments for commercial, Federal Employee Program (FEP) and Medicare Advantage members. Please note that this change will not affect payments made from our National Account system.

If you receive paper reimbursement checks or electronic fund transfer (EFT) payments from us on a daily basis, you will be able to schedule posting on a weekly cycle after this change.

If you have questions, please contact the Provider Call Center.

Opioid medications

We are committed to leading the movement to address the national opioid epidemic. In collaboration with our participating providers, we are also focused on prevention, treatment and recovery and deterrence of substance use disorders.

In March of 2016, the Centers for Disease Control released guidelines for prescribing of opioid medications. In the fall of 2016, we created clinical edits to put the CDC guidelines into practice:

- For short-acting opioids, members not currently using opioid analgesics on a regular basis will be limited to a 7 days' supply per fill and 14 days' supply per 30 days before requiring a prior authorization.
- For long-acting opioids, members who are new starts and are not currently using a long-acting opioid analgesic will require prior authorization.
- Members who are newly prescribed a long-acting opioid and are in active treatment for cancer or those who are terminal and undergoing palliative care will be automatically approved.
We are approaching opioid misuse from multiple avenues. We identify members with opioid use patterns of concern and alert their prescriber(s) through our Controlled Substance Utilization Monitoring program. Our Pharmacy Home Program identifies members who meet criteria for possible misuse and requires them to designate one pharmacy for filling their prescriptions. We also expanded access to medications used to treat substance use disorder. Suboxone and similar medications have been made readily available on all Anthem formularies. Prior authorization has been removed on Suboxone, buprenorphine/naloxone sublingual tablets, Bunavail, and Zubsolv.

The below recommendations should be considered by all clinicians who prescribe opioids:

- Register with and use the prescription drug monitoring program (PDMP).
- Discuss members’ responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.
- Consider nonsteroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.
- Consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.
- Closely evaluate and monitor members who have a history of alcoholism or other substance use disorder.

**Psychiatric care collaboration codes effective December 1**

Please be reminded that effective December 1, we will begin to separately reimburse the new psychiatric care collaborative codes G0502, G0503 and G0504 through the end of December. Effective for dates of service on and after January 1, 2018, please bill for those services using the new CPT codes 99492, 99493 and 99494. These codes are reportable by primary care providers for their collaboration with a qualified behavioral health provider, such as a psychiatrist, licensed clinical social worker, etc. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations. These codes are intended to represent the care and management for members with behavioral health conditions that often require extensive discussion, information sharing, and planning between a primary care physician and a specialist.

**Specialty pharmacy updates**

**Pre-service clinical review drug list**

Listed below are specialty pharmacy codes from new or current medical policies that will be added to our existing pre-service review process effective March 1, 2018.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Name</th>
<th>Drug Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00110</td>
<td>Besponsa</td>
<td>J3490, J3590</td>
</tr>
<tr>
<td>CG-DRUG-64</td>
<td>Cyltezo, Mvasi</td>
<td>J3590</td>
</tr>
</tbody>
</table>

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

**Level of care drug list**

Effective for dates of service on and after March 1, 2018, the following specialty pharmacy code from clinical guideline CG-DRUG-64 will be included in our existing level of care pre-service clinical review process.
The level of care pre-service clinical review of specialty pharmacy drugs will be managed by AIM.

View the [Level of Care (Clinical Site of Care) drug list](#) for the entire list of drugs for level of care pre-service clinical review. View the [level of care pre-service clinical review FAQs](#) for more information.

**Expanded specialty pharmacy precertification requirements**

Effective for dates of service on and after March 1, 2018, the following clinical UM guideline will be updated to include additional requirements as part of the existing pre-service clinical review process.

The following clinical guidelines or medical policies will be effective March 1, 2018.

<table>
<thead>
<tr>
<th>Clinical Guideline</th>
<th>Treatment</th>
<th>Drug Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DRUG-09</td>
<td>Immune Globulin (IG) Therapy</td>
<td>J1459, J1460, J1556, J1557, J1559, J1560, J1561, J1566, J1568, J1569, J1572, J1575, J1599, J3490, S9338</td>
</tr>
</tbody>
</table>

**Contact AIM**

Ordering physicians can submit a pre-service clinical review request to AIM for any of the above drugs starting March 1, 2018 through one of the following options:

- Access AIM’s [ProviderPortal](#) directly at [www.providerportal.com](http://www.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’s portal via the [Availity Web Portal](#)
- Access AIM’s call center at 866-714-1107, 8:00 a.m. – 5:00 p.m.
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”.

**Vitals® SmartShopper® program reminder and update**

The October 2017 edition of Network Update shared information about the Vitals® SmartShopper® program that will be offered to our small group members in Maine effective January 1, 2018. Below is a list of services included in the SmartShopper® program. Please note that CT Scans and MRIs will be added to the program effective February 2, 2018.

<table>
<thead>
<tr>
<th>Incentive Reward Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Back surgery (outpatient laminectomy, discectomy, foraminotomy)</td>
<td>Back surgery (inpatient laminectomy)</td>
</tr>
<tr>
<td>Bariatric surgery (inpatient laparoscopic gastric bypass)</td>
<td>Bladder repair for incontinence (sling)</td>
</tr>
<tr>
<td>Bone and joint imaging of the whole body</td>
<td>Bone density study of the spine or pelvis</td>
</tr>
<tr>
<td>Bunionectomy</td>
<td>Colonoscopy</td>
</tr>
<tr>
<td><strong>CT scan – effective 2/1/2018</strong></td>
<td>Eye surgery - cataract removal</td>
</tr>
<tr>
<td>Gall bladder removal (laparoscopic)</td>
<td>Groin – hernia repair</td>
</tr>
<tr>
<td>Hand surgery – carpal tunnel</td>
<td>Joint replacement (knee and hip)</td>
</tr>
<tr>
<td>Knee surgery (arthroscopic)</td>
<td>Laparoscopic tubal block and tubal ligation</td>
</tr>
<tr>
<td>Lithotripsy – fragmenting of kidney stones</td>
<td>Mammogram</td>
</tr>
<tr>
<td><strong>MRI – effective 2/1/2018</strong></td>
<td>Nasal/sinus – corrective surgery - septoplasty</td>
</tr>
<tr>
<td>Nasal/sinus – endoscopy – sinus surgery</td>
<td>PET scan</td>
</tr>
<tr>
<td>Shoulder surgery (arthroscopic)</td>
<td>Spinal fusion of neck – front</td>
</tr>
<tr>
<td>Stomach – upper GI examination (endoscopy)</td>
<td>Tonsillectomy &amp; adenoidectomy</td>
</tr>
<tr>
<td>Ultrasound (non-maternity)</td>
<td></td>
</tr>
</tbody>
</table>

As a reminder, the SmartShopper® program does not take the place of any precertification/prior authorization requirements you may have as a participating provider. All referral and precertification/prior authorization requirements remain in place.

Vitals® utilizes data from the National Consumer Cost Transparency (NCCT) database, developed by the Blue Cross Blue Shield Association, to identify cost-effective providers for services in the SmartShopper® program. The NCCT data is refreshed bi-annually in May and November. Providers may view their data by accessing the current version of the NCCT data via the Anthem POIT web tool through Availity. If you have any questions regarding the NCCT data, please contact David Spencer, Sr. Network Manager, at 207-822-8453 or david.spencer@anthem.com.

**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.
Electronic data interchange (EDI) update

New edit for 837 professional independent lab claims

Effective December 8, 2017, we will be implementing a new EDI edit related to independent laboratory claims. This update will help reduce the processing time and manual intervention for lab claims.

The update requires a referring provider to be indicated when the place of service is billed as an independent laboratory. If the referring provider is not indicated, the claim will reject.

By implementing this edit, we will help ensure the appropriate data is submitted per the HIPAA Implementation Guide which is in agreement with the Blue Cross Blue Shield Association ancillary filing guidelines.

Below is the edit will be implemented on December 8, 2017 on the providers EDI level II report:

- 60117- Referring Provider, qualifier DN loop 2310A, must be present when place of service, CLM05-1, is 81, Independent Laboratory.

If you have any questions, please contact your local EDI Help Desk at 800-470-9630.

Sign up for electronic funds transfer

If you still receive reimbursement from us by paper check, it’s time to go green! Take advantage of our electronic solutions by signing up today for payments by electronic funds transfer (EFT). EFT helps you streamline your operations and reduce your administrative costs. Consider these benefits:

- Reimbursements are deposited to your account faster.
- EFT payments don’t get delayed or lost in the mail.
- EFT payments are more protected from fraud.
- Bank fees are lower.
- You save time by making fewer trips to the bank.

Setting up EFT is a fast and reliable method to receive payment. You can sign up using the CAQH EFT EnrollHub tool – or you can sign up via the Availity Web Portal. Also on Availity, you can access a detailed explanation of payment for each transaction and register to receive email notification for electronic payments. If you wish, you can elect to receive an email notification each time a payment is made to you.

Anthem E-Solutions support reminder Q & A

- Who do I contact for assistance with electronic data interchange (EDI) transactions?
  - If you use a clearinghouse to submit and receive, please make them your first point of contact.
  - If you submit directly or are referred to Anthem, our knowledgeable and experienced E-Solutions Service Desk associates are available to assist you.

- What self-service tools and resources are available?
  - The Availity Portal or other electronic options to check eligibility and claims status.
- Check your Level II report for EDI submissions daily to review and resolve any rejections.

○ Where can I get further assistance if I have tried the self-service options?

<table>
<thead>
<tr>
<th>E-Solutions contact information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Solutions EDI Website</td>
<td><a href="http://www.anthem.com/edi">www.anthem.com/edi</a></td>
</tr>
<tr>
<td>E-Solutions EDI Online Support Mailbox</td>
<td><a href="mailto:E-solutions.support@anthem.com">E-solutions.support@anthem.com</a></td>
</tr>
<tr>
<td>E-Solutions Helpdesk</td>
<td>800-470-9630</td>
</tr>
</tbody>
</table>

Medicare update

2018 Medicare Advantage individual benefits and formularies

Summary of benefits, evidence of coverage and formularies for 2018 individual Medicare Advantage plans will be available at anthem.com/medicareprovider. An overview of notable 2018 benefit changes also will be available at Important Medicare Advantage Updates at anthem.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information.

2018 annual visit guidelines

Our Medicare Advantage plans will continue to offer coverage for routine physicals in 2018 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately diagnosing, monitoring, assessing, evaluating and/or treating conditions that may not otherwise be captured, closing gaps in care and creating a comprehensive care plan to manage possible chronic conditions. Please see Important Medicare Advantage Updates at anthem.com/medicareprovider for claims submission and other information.

SNF network tiered

It is important to know when a member is discharged to a skilled nursing facility setting to coordinate patient care. To help ensure optimal quality with reduced readmissions to acute care facilities, we are implementing tiering for our skilled nursing facility provider network based on a preferred designation for qualified providers within Anthem’s Medicare Advantage network.

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

Dual Eligible Special Needs Plans – provider training required

In 2018, we are offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). 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.

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 2017 that contain information for online self-paced training through our training site, hosted by
SkillSoft. 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.

The Centers for Medicare & Medicaid Services regulations protect D-SNP members from balance billing.

**Change to the 835 / electronic remittance advice (ERA) for all MA members enrolled in D-SNPs**

In late July, we updated the 835 ERA for individual Medicare Advantage members who are enrolled in our Dual Eligible Special Needs Plans. These members have both Medicare and Medicaid coverage.

This change was to be in alignment to the CMS Change Request CR9911 [https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3802CP.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3802CP.pdf). The purpose is to have an indicator on the 835 file to prevent the member from being balanced billed for this cost share and help ensure the state Medicaid agency is billed for this balance.

The following has been implemented:

There will be a claims adjustment reason code (CARC) 209 and remittance advice remark code (RARC) assigned for the cost share that should be filed with the state Medicaid agency.

- **Claim adjustment reason code (CARC) 209** – group code other adjustment (OA) will be assigned.
  
  CARC 209 - *Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with group code OA)*

- **Remittance advice remark codes (RARC)** will be used with the CARC 209
  - N781 – *No deductible may be collected as patient is a Medicaid/Qualified Medicare Beneficiary*. Review your records for any wrongfully collected deductible.
  - N782 – *No coinsurance may be collected as patient is a Medicaid/Qualified Medicare Beneficiary*. Review your records for any wrongfully collected coinsurance.
  - N783 – *No co-payment may be collected as patient is a Medicaid/Qualified Medicare Beneficiary*. Review your records for any wrongfully collected copayments.

Please be sure to ask Medicare Advantage members for their state Medicaid Identification Number to assist with billing for the cost share. This will be different from their Medicare Advantage plan member Identification Number.

**Post-service reviews of certain modifiers and services to be conducted**

Beginning in the fourth quarter of 2017, we will conduct post-service reviews of professional individual and group-sponsored Medicare Advantage claims billed with following modifiers: 25, 62, 80, 81, 81, AS, and 91. Additionally, we will conduct post-service reviews of evaluation and management (E&M) services billed during a global surgery period.

As part of the review, we may contact providers to request additional documentation related to the services. If billing discrepancies are identified, we will provide a written report of our findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.
Provider payments will be made weekly
Please see article content in the Administrative update section of this newsletter issue.

Coordination of benefits update
On September 11, 2017, we began sending trauma and accident claims through the standard coordination of benefits where third party payers are identified.

This is not a change to how we coordinate benefits; Medicare Advantage coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare Advantage members.

When we are aware of third-party resources prior to paying for a medical service, we will follow appropriate coordination of benefits standards by either rejecting a provider’s claim and redirecting the provider to bill the appropriate insurance carrier or, if we do not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

For additional information please see the Medicare Advantage Provider Guidebook.

MA ID cards redesigned
Anthem Medicare Advantage ID cards have been redesigned. Changes include:

- Focus on key information with use of blue bars
- Replaced Identification Number with Member ID
- Cost share information is highlighted for improved readability
- Primary customer service number is highlighted for improved readability

This change does not affect benefits, phone numbers or any other aspect of a member’s plan. Sample ID cards will be available at anthem.com/medicareprovider.

New original Medicare ID cards on the way
The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 requires the Centers for Medicare & Medicaid Services to remove social security numbers (SSN) from all Medicare ID cards by April 2019. For an overview of the SSNRI, including the goal, impact, timeline, implementation and helpful resources, please see Important Medicare Advantage Updates at anthem.com/medicareprovider.

Additional hypertension drugs available at $0 copay
Beginning January 1, 2018, seven more drugs have been added to MAPD at $0 copay. These drugs are used to treat hypertension and include: Benazepril HCTZ, Fosinopril, Irbesartan, Quinapril, Ramipril, Trandolapril and Valsartan HCTZ. These drugs are $0 copay for members utilizing MAPD benefits.
Keep up with Medicare Advantage news

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

- Medicare risk adjustment training
- Prior authorization requirements for Part B: Aliqopa, Cinvanti and Opsiria
- Information for transplant facilities in MA HMO networks
- Medication Reconciliation Post-Discharge (MRP): billing codes for reimbursement
- Prior authorization change for orthotics
- August reimbursement update
- Medicare Advantage provider reimbursement bulletin

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Programs and benefits update

Federal Employee Program Standard Option skilled nursing facility benefit changes for 2018

Effective January 1, 2018, the skilled nursing facility (SNF) benefit for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program (FEP), coverage is changing. This change affects Standard Option PPO members.

Standard Option members will have a limit of thirty (30) days of coverage per year. The benefit is payable when the member signs a case management letter with Anthem FEP case management and the treatment plan for admission to the SNF has been developed and documented prior to the member’s admission to the SNF. Members admitted without both the signed case management letter and the documented treatment plan will not have coverage under the Standard Option, and will be responsible for all charges incurred.

Please contact FEP Customer Service at 800-722-0203 with any questions about this benefit update.

2018 FEP benefit information available online

To view the 2018 benefits and changes for FEP, go to www.fepblue.org > select Benefit Plans > Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2018. For questions please contact FEP Customer Service at 800-722-0203.

Behavioral health update

Behavioral health providers – please review the entire newsletter

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

Effective December 2017, we have contracted with Alliant Health Solutions to assist us in validating provider compliance with applicable reimbursement policies and identifying instances of incorrect billing for behavioral health services. Alliant is a behavioral health audit and review company, and will examine our outpatient behavioral health claims data. Utilizing systematic sampling methodology and a broad range of algorithms, the audits and findings will be customized to support Anthem expectations as outlined in our Provider Manuals and related policies and procedures. Alliant findings may result in provider audits and record reviews, education and other direct outreach.

Transcranial magnetic stimulation (TMS) form updated

We have updated our Outpatient Treatment Report - TMS Form for more concise submission. The revised form has been posted on anthem.com > Menu > Support > Providers > Maine > Anthem Behavioral Health > Forms > TMS Request Form. TMS continues to require prior authorization. Please submit the updated form to us when requesting treatment authorization.

Psychological testing form updated with new fax number

For accounts that require authorization for outpatient psychological testing and neuropsychological testing visits, we have updated our Psychological Testing Report form with a new fax number. These request forms should be faxed to 866-613-4246. All other forms should continue to be faxed to the number indicated on the form. The revised form has been posted on anthem.com > Menu > Support > Providers > Maine > Anthem Behavioral Health > Forms > Neuropsychological/Psychological Testing Form.

Quality programs update

New provider website “Asthma & Me” app

Are you looking for innovative ways to engage your patients with asthma? Now you can show them the pathophysiology of asthma. The new Asthma & Me app is a valuable, free, support tool in the care of this pervasive chronic condition. The app uses face detection technology along with augmented reality to simulate a diseased airway.

- When the camera on a mobile device is aimed at the patient’s face, an animation of the lungs is overlaid and a short video illustrating the physiology of an asthma attack is produced and recorded.
- The video can be used to facilitate discussion with the patient about what occurs during an asthma attack – airway inflammation, bronchiole constriction, and mucus production.
- The video can be saved and shared via social media or email.

The app is currently available in three languages: English, Spanish, and Tagalog. The language is selected based on the patient’s smartphone or tablet settings.

A new website to support your diverse patient panel: MyDiversePatients.com

The Asthma & Me app can be accessed at MyDiversePatients.com using your smartphone, tablet, or computer. The app supplements the “Moving Toward Equity in Asthma Care” online provider CME experience, which is available on the site.

MyDiversePatients.com features robust resources for providers to help support addressing racial and ethnic disparities in health and health care:
CME learning experiences about disparities, potential contributing factors, and opportunities for providers to enhance care
- Real-life stories about diverse patients and the unique challenges they face
- Tips and techniques for working with diverse patients to promote improvement in health outcomes

The enduring material activity, Moving Toward Equity in Asthma Care, has been reviewed and is acceptable for up to 1 prescribed credit by the American Academy of Family Physicians. Term of approval begins September 28, 2017. 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.

**HEDIS® 2017 Commercial results are in**

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) commercial data collection project for 2017. 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. To view the results for 2017, please click [here](#).

**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 > Menu > Support > Providers > Maine > Health & Wellness > Practice Guidelines.

**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 (CM) 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.
**ConditionCare Program benefits members and physicians**

Our members have resources available to help them better manage chronic conditions. The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of registered nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor’s orders and how to become a better self-manager of their condition.

Engagement methods vary by the individual’s risk level but can include:

- Education about their condition through mailings, email newsletters, telephonic outreach, and/or online tools and resources.
- Round-the-clock phone access to registered nurses.
- Guidance and support from nurse care managers and other health professionals.

Physician benefits:

- Save time by answering members’ general health questions and responding to concerns, freeing up valuable time for the physician and their staff.
- Support the doctor-patient relationship by encouraging participants to follow their doctor's treatment plan and recommendations.
- Inform the physician with updates and reports on the member’s progress in the program.

Please visit our website to find more information about the program such as program guidelines, educational materials and other resources. Go to anthem.com > Menu > Support > Providers > Maine > ConditionCare Program. Also on our website is the Patient Referral Form, which you can use to refer other members you feel may benefit from our program.

If you have any questions or comments about the program, call 877-681-6694. Our nurses are available Monday-Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 5:30 p.m.

For Federal Employee Program members, call 844-730-0088. Nurses are available Monday – Friday, 9:00 a.m. to 8:00 p.m.

**Coordination of care**

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. We would like to take this opportunity to stress the importance of communicating with your patient’s other health care practitioners. This includes primary care physicians (PCPs) 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:

- Discuss with the patient the importance of communicating with other treating practitioners.
- Obtain a signed release from the patient and file a copy in the medical record.
- Document in the medical record if the patient refuses to sign a release.
- Document in the medical record if you request a consultation.
- If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
- 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 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 are available at anthem.com > Menu > Support > Providers > Maine > Answers@Anthem > Coordination of Care.

**Access to the Toolkit is available at anthem.com > Menu > Support > Providers > Maine > Health and Wellness > Provider Toolkits.

**Important Information about Utilization Management**

Our utilization management (UM) decisions are based on written criteria, 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 at the toll-free numbers listed below. UM criteria are also available on the web. Just select “Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider home page at anthem.com.

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 8:30 a.m. – 5:00 p.m. Monday - Friday (except 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 staff. Members should call the customer service number on their health plan ID card.

<table>
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<tr>
<th>To Discuss UM Process and Authorizations</th>
<th>To Discuss Peer-to-Peer UM Denials</th>
<th>To Request UM Criteria</th>
<th>TDD/TTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>800-392-1016</td>
<td>800-437-7162</td>
<td>800-437-7162</td>
<td>711, Or</td>
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<tr>
<td>Behavioral Health:</td>
<td>FEP</td>
<td></td>
<td>TTY: 800-437-1220</td>
</tr>
<tr>
<td>800-755-0851</td>
<td>FEP Phone: 800-860-2156</td>
<td></td>
<td>Voice: 800-457-1220</td>
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<tr>
<td>FEP Phone: 800-860-2156</td>
<td>FEP</td>
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<tr>
<td>Fax: 800-732-8318 (UM)</td>
<td>Phone: 800-860-2156</td>
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<tr>
<td>Fax: 877-606-3807 (ABD)</td>
<td>Fax: 800-732-8318 (UM)</td>
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<td></td>
<td>Fax: 877-606-3807 (ABD)</td>
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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 members, their providers and their health care benefit plans. One of the first steps is for members 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 > Menu > Support > Providers > Maine > Health & Wellness > Quality > Member Rights & Responsibilities. Practitioners may access the FEP member portal at [www.fepblue.org/memberrights](http://www.fepblue.org/memberrights) to view the FEPDO Member Rights Statement.

**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

**Network Update**

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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.