

Network Update

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

The information in this newsletter is for informational purposes only and should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for our members and enrollees is the responsibility of physicians and providers.

Unless otherwise noted, the information contained in this **Network Update** applies to all Anthem Blue Cross and Blue Shield's plans and programs in New Hampshire.

Please note: All policies are subject to the terms, conditions and limitations of the member's plan or program.

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[Important phone numbers](#)

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NH1215

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Health care reform update

Health care reform updates on anthem.com

Please be sure to check the [Health Care Reform Updates and Notifications](#) and [Information about Health Insurance Exchanges](#) sections of our website regularly for the latest updates on health care reform and Health Insurance Exchanges.

In December, we'll be updating the following online documents to reflect the changes for 2016. Be sure to check our website for updates.

Network Update

- 2016 Health Insurance Exchange Product Quick Reference Guide
- Member ID Card Update for ACA-compliant Health Plans

Administrative and policy update

Sign-up now for Network eUPDATE today – 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:

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ICD indicator required on paper claim forms

With the October 1, 2015, implementation of ICD-10, it may be appropriate to report either ICD-9 or ICD-10 codes depending upon the dates of service. Paper claim forms have an ICD Indicator that identifies the ICD code set being reported on the claim. Please note that the ICD Indicator field is a *required* field on UB-04 or CMS 1500 paper claim forms submitted to us, and any paper claims received without this field being populated will be rejected.

- UB-04 form (also known as the CMS-1450 form) – the ICD indicator is field 66. (also known as the diagnosis and procedure code qualifier)
- CMS 1500 form version 02/12 – the ICD indicator is box 21. (Reminder: We only accept the 02/12 form version)

Providers must enter the qualifier code that denotes the version of the ICD code set being reported on the claim.

Indicator Code Set

- 9 - ICD-9 diagnosis codes and/or procedure codes
- 0 - ICD-10 diagnosis codes and/or procedure codes

Update to claims processing edits and reimbursement policies

On December 1, 2015, we will be updating our Anthem Online Provider Services (AOPS) website with the following new and/or revised reimbursement policies. The updates below identify if the article pertains to professional or facility provider billing.

Review of reimbursement policies – professional

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

- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Documentation and Reporting Guidelines for Evaluation and Management
- Drug Screen Testing
- Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Physical and Manipulative Maintenance Services
- Place of Service
- "Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Sleep Studies and Related Bundled Services and Supplies
- Telemedicine/Telehealth
- Vaccine Procurement

Anesthesia Services – professional

CPT code 93355 (guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s)...), effective January 1, 2015, was added by the Centers for Medicare & Medicaid Services (CMS) to the National Correct Coding Initiative (NCCI) edit that denies 93355 when reported with an anesthesia service. 93355 is an NCCI column 2 (denied) code with a superscript of "0"; therefore, the denial will not be overridden by an override modifier. We are adding this code to the Services Included/Excluded in the Global Reimbursement for Anesthesia section of the policy to document the current NCCI edit. Additional word changes and clarifications were also made without changes to the policy position or criteria.

Bundled Services and Supplies – professional

Beginning with claims processed on or after November 16, 2015, we implemented an edit that Healthcare Common Procedure Coding System (HCPCS Level II) codes S0395 (casting), A4580 (cast supplies) and A4590 (special casting materials) are not eligible for separate reimbursement when reported with custom foot orthotics HCPCS codes L3000, L3010, L3020 and L3030. We consider casting and cast supplies and materials to be mutually exclusive to the manufacture and provision of custom foot orthotics. Modifiers will not override this edit.

For dates of service on or after January 1, 2016, new CPT codes 99415 and 99416 (prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision..... list separately in addition to code for outpatient evaluation and management service)) are being added to Section 1 of our policy as an always bundled service. We consider this service to be part of the overall care of the patient and not eligible for reimbursement.

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

Beginning with dates of service on or after March 1, 2016, Current Procedural Terminology (CPT®) code 95940 (continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes) will not be eligible for separate reimbursement when reported with CPT code 95941 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour). We consider 95940 to be an overlapping/mutually exclusive service when reported with 95941 during the same patient encounter on the same date of service. Modifiers will not override this edit; therefore this information is included in our Modifiers 59 and XE, XP, XS, and XU professional reimbursement policy.

Claim Editing Overview – professional

For claims processed on or after November 16, 2015, we implemented an edit to our “Procedure to Diagnosis Rule” that urinary system CPT code 50590 (lithotripsy, extracorporeal shock wave), which signifies a procedure to break up a stone or stone in the urinary system, will not be eligible for reimbursement when reported with any orthopedic diagnosis.

Documentation and Reporting Guidelines for Applied Behavior Assessments (ABA) and Treatments for Autism Spectrum Disorder – professional

We implemented the new ABA CPT codes effective January 1, 2015. We are publishing a new policy effective December 1, 2015, that outlines our documentation and reporting guidelines for ABA and treatments for autism spectrum disorder utilizing this code set. Please refer to the AMA's CPT codebook and our documentation policies to ensure your practice is in compliance with these documentation requirements. The documentation policies can be found at anthem.com. Please review the policy and ensure that all aspects are being addressed.

Duplicate Reporting of Diagnostic Services – professional

Our policy is being updated December 1, 2015 to document our current edit that when one provider reports a global procedure and a different provider reports the same procedure with a professional (26) or technical (TC) component modifier for the same patient on the same date of service, the first charge approved by Anthem will be eligible for reimbursement and subsequent charges processed will be considered duplicate services and will not be eligible for separate reimbursement. This information is also included in our Claim Editing Overview and Laboratory & Venipuncture reimbursement policies.

Frequency Editing – professional

By definition, HCPCS codes S9123 (nursing care, in the home; by registered nurse, per hour) and/or S9124 (Nursing care, in the home; by licensed practical nurse, per hour) are reported on a once per hour basis. Since a day consists of 24 hours, the maximum number of reported hours/units would be 24 per date of service for a code that includes “per hour” in the definition. Therefore, for claims processed on or after November 16, 2015 we implemented a frequency maximum of 24 hours/units per date of service for HCPCS codes S9123 and/or S9124.

In addition, we added J2505 (injection, pegfilgrastim, 6 mg (Neulasta)) to our code table to support our current frequency limit of 1 per date of service.

Beginning with dates of service on or after March 1, 2016, we will apply a frequency limit of one unit per 60 days for CPT codes 11720 (Debridement of nail(s) by any method(s); 1 to 5) and/or 11721 (Debridement of nail(s) by any method(s); 6 or more). This frequency limit is in agreement with CMS's 60-day limitation for these codes. This edit will use claim lines processed in history that have previous, current, and subsequent dates of service to accumulate and apply this frequency limit.

Example:

A claim for code 11721 for date of service March 2, 2016 is received on March 20, 2016. A claim for code 11720 for date of service February 1, 2016 is received on April 1, 2016. Processing for these codes will be based on the date that the claim is *received* and not the date of service. ClaimXten will allow the first claim received - date of service March 2 - to process, and will deny the second claim received - date of service February 1 - based on the established frequency limit.

Effective for dates of service on or after March 1, 2016, we are adding frequency limits to the drugs listed in the table below. These limits are based on FDA approval and/or manufacturers' dosage guidelines. Unless otherwise noted, these maximums are per date of service.

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HCPCS Drug Codes	Description	Frequency Limit
J0129	Orencia, 10 mg	100 per date of service
J0585	Botox / Botox cosmetic, 1 unit	400 per date of service
J0586	Dysport, 5 units	200 per date of service
J0717	Cimzia, 1 mg	400 per date of service
J0897	Prolia/Xgeva, 1 mg	120 per date of service
J1453	Fosaprepitant (Emend), 1 mg	150 per date of service
J1750	Iron dextran, 50 mg	20 per date of service
J2353	Octreotide, depot form for intramuscular injection, (Sandostatin, depot) 1 mg	40 per date of service
J2357	Injection, omalizumab, 5 mg (Xolair)	90 per 14 days
J2469	Injection, palonosetron HCl, 25 mcg (Aloxi)	10 per date of service
J2507	Pegloticase (Krystexxa), 1 mg	8 per date of service
J3489	Zoledronic acid, 1 mg	5 per date of service
J7312	Dexamethasone, intravitreal implant (Ozurdex), 0.1 mg	14 per 90 days
J7325	Hyaluronan or derivative (Synvisc or Synvisc-One), 1 mg	96 per date of service
J9031	BCG (intravesical) per instillation (Theracys/Tice Bcg)	1 per date of service
J9047	Carfilzomib (Kyprolis), 1 mg	60 per date of service
J9202	Goserelin acetate implant (Zoladex), per 3.6 mg	3 per date of service
J9217	Leuprolide acetate (for depot suspension), 7.5 mg (Lupron Depot, Eligard)	6 per date of service
J9395	Fulvestrant (Faslodex), 25 mg	20 per date of service

Modifier Rules – professional

For claims processed on or after November 16, 2015, we implemented an edit that when orthotic and prosthetic items (HCPCS codes L0112-L9900) are reported with rental modifiers KI, KR, LL, NR, and RR, the items will be denied for invalid use of modifier. Because orthotic and prosthetic items are used only by the patient they are prescribed for and are not reusable by any other patient, these items are considered always purchased items and are not eligible for reimbursement when reported as rental items.

Once per Lifetime – professional

We are posting a new policy effective for dates of service on or after December 1, 2015 that documents our once per lifetime procedures guidelines. Once per lifetime procedures are those procedures that may, clinically, anatomically, per code description, or based on coding instructions, be performed once per lifetime on an individual patient by a physician(s) or other qualified healthcare provider(s).

Place of Service Edit – professional

We consider the provision of radiopharmaceuticals to be included under the facility's reimbursement as part of the technical portion of diagnostic imaging or treatment services when provided in a facility setting; therefore, beginning with claims processed on or after November 16, 2015 when HCPCS code A9606 (radium RA-223 dichloride, therapeutic, per microcurie) is reported by a professional provider with a facility setting place of service, A9606 will not be eligible for reimbursement.

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Significant Edits – professional

We have updated our Significant Edits posting to reflect the 2015 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 2016 – professional

As a reminder, our ClaimsXten editing software package will be updated quarterly in February, May, August and November of 2016. These upgrades will:

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

Notice of reimbursement policy modifications due to these updates will continue to be published in *Network Update* and on Anthem Online Provider Services (AOPS).

Coding Tip: Radiation Treatment Delivery and IGRT – professional

Effective January 1, 2015, the American Medical Association (AMA) with input from the American Society for Therapeutic Radiology and Oncology (ASTRO) released CPT code 77387 for guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed (IGRT). According to the CPT Radiation Management and Treatment Table, the professional component (modifier -26) of 77387 is not bundled into treatment delivery codes 77371, 77372, 77373, 77385, and 77386; therefore, beginning with dates of service on or after January 1, 2016, the professional component of IGRT (77387) will be eligible for separate reimbursement when reported with treatment delivery codes 77371, 77372, 77373 (stereotactic radiation treatment delivery), 77385, and 77386 (intensity modulated radiation treatment delivery).

Correct Coding Reminder: Manifestation Diagnosis Codes –professional

Per ICD-10 guidelines, a manifestation diagnosis code is not eligible as the only diagnosis billed on a claim or claim line (example: E13.39 - Other specified diabetes mellitus with other diabetic ophthalmic complication, should be the first/primary diagnosis code with manifestation diagnosis code H42 - Glaucoma in diseases classified elsewhere, reported as the 2nd diagnosis). When the only diagnosis on the claim line is a manifestation code the claim line will not be reimbursed due to correct coding guidelines

Correct coding reminder: neonatal and/or pediatric critical or intensive care per day codes – professional

Per CPT guidelines, neonatal or pediatric critical care codes 99468-99476 and initial and continuing intensive care codes 99477-99480 "may be reported by a single individual and only once per day, per patient in a given facility".

Correct coding reminder: oral appliances E0485 and E0486 – professional

The code descriptions for HCPCS codes E0485 (oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, prefabricated, includes fitting and adjustment) and E0486 (Oral device/appliance used to reduce upper airway collapsibility, adjustable or nonadjustable, custom fabricated, includes fitting and adjustment) include fitting and adjustment, which would require face-to-face contact with the patient. When durable medical equipment, dental or medical laboratory, or pharmacy providers have not directly provided face-to-face fitting and adjustment services to the patient,

E0485 and E0486 are not to be reported. The provider should report their provision of an oral appliance with the appropriate code that reflects the actual oral appliance provided.

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Updates to the Cancer Care Quality Program

Attention professional oncologists, hematologists and urologists

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

Effective December 1, 2015, we added the following cancer treatment Pathways for the Program.

New Pathways added to the Program include:

- Pathways for kidney cancer
- Pathways for gastric and esophageal cancers
- Pathways for head and neck cancers

Effective January 1, 2016, the following Pathways are moving from "on" pathway to "off" pathway status:

- Fludarabine+cyclophosphamide+mitoxantrone+rituximab (FCMR) for follicular lymphoma, 2nd and subsequent lines of therapy
- Rituximab for chronic lymphocytic leukemia (CLL), 1st line therapy

This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members' benefit plans.

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

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

New prior authorization requirements for radiation therapy services begins March 1, 2016

On March 1, 2016, we are expanding our Radiation Therapy Program to require prior authorization of:

- Image guided radiation therapy (IGRT)
- Fractions (also referred to as units) for breast and bone metastases for covered individuals undergoing external beam radiation therapy (EBRT) or intensity modulated radiation therapy (IMRT)

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- Special treatment procedure and special physics consult (CPT® codes 77470 and 77370) (e.g., total body irradiation, hemibody radiation, or endocavitary irradiation and special medical radiation physics consultation)

The Radiation Therapy Program is managed by AIM Specialty Health® (AIM®), a separate company administering the program on our behalf.

A complete list of CPT codes requiring prior authorization under the Radiation Therapy Program will be available on our website in January 2016 at anthem.com > Providers > New Hampshire > [Diagnostic Imaging and Cardiac Imaging](#). The newly added CPT codes effective March 1, 2016, under the expanded Radiation Therapy Program include:

Type of Service	CPT Code
IGRT	G6001
	G6002
	G6017
	77387
	77014
IMRT	G6015 or 77385-6
	77427
EBRT	G6003-6 or 77402
	G6007-10 or 77407
	G6011-14 or 77412
	77427
Special Treatment (e.g., total body irradiation, hemibody radiation, per oral, or endocavitary irradiation)	77470
Special medical radiation physics consultation	77370

All Anthem local members who currently require prior authorization for non-emergency outpatient radiation therapy are included in this program. These prior authorization requirements do not apply to the following plans: Medicare Advantage, National accounts, Medicare Supplement, Federal Employee Program® (FEP®), Taft-Hartley, and members with Anthem as secondary.

To determine if prior authorization is needed for an Anthem member, click the [Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements](#) link on our anthem.com provider website or call the prior authorization phone number printed on the back of the member's ID card.

Starting February 22, 2016, ordering physicians may submit a prior authorization request for these additional requirements to AIM through the AIM [ProviderPortal](#)SM (available 24/7 to process orders in real-time), through the [Availity Web Portal](#) or by calling the AIM call center at 866-714-1107, Monday-Friday, 7:00 a.m.-4:00 p.m.

Note: Retrospective requests received more than 2 business days after the date of service will not be accepted by AIM for review. Any post-service clinical review will be handled by Anthem according to the terms of the applicable health benefit plan and/or provider agreement.

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through our inpatient prior authorization process. Members currently undergoing treatment on March 1, 2016 will not be impacted by the new

enhancements to this program; however, members starting treatment on or after March 1, 2016 must follow the enhanced Radiation Therapy Program prior authorization requirements noted above.

Thank you for your collaboration and ongoing support of the Radiation Therapy Program. If you have further questions, please call the [Provider Call Center](#).

New prior authorization requirements added to the cardiovascular program

We are expanding our cardiovascular program to require prior authorization for arterial ultrasound and percutaneous coronary intervention (PCI) beginning March 1, 2016. The program is managed by AIM Specialty Health® (AIM®), a separate company administering the program on behalf of Anthem.

The specific CPT codes requiring precertification under the expanded cardiovascular program are listed below and will also be updated on our website in January 2016 at [anthem.com > Providers > New Hampshire > Diagnostic Imaging and Cardiac Imaging](#). The clinical guidelines that will be adopted by Anthem to review arterial ultrasound, cardiac catheterization, and PCI for medical necessity are also available on [anthem.com](#).

Please note that all local Anthem members who currently require precertification for high-tech imaging and echocardiograms are included in the program. These prior authorization requirements do not apply to the following plans:

- Federal Employee Program® (FEP®)
- Medicare Supplemental plans
- BlueCard®
- National accounts
- Taft-Hartley
- Tonik, Blue Direct, Individual Blue and Lumenos individual plans

Medicare Advantage plans should continue to obtain precertification as they do today. Procedures performed in an inpatient setting or on an emergent basis are not included in the program.

To determine if prior authorization is required for an Anthem member, click the [Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements](#) link on our [anthem.com](#) website, or by calling the prior authorization phone number printed on the back of the member's ID card.

Beginning February 22, 2016, ordering physicians may submit a prior authorization request for the new codes in the expanded cardiovascular program by contacting AIM through the AIM ProviderPortalSM at [aimspecialtyhealth.com/goweb](#) (available 24/7 to process orders in real-time), through the Availity Web Portal at [availity.com](#) or by calling the AIM call center at 866-714-1107, Monday–Friday, 8:30 a.m.–7:00 p.m.

We recognize that the necessity for arterial duplex imaging of the extremities may not be identified by providers until their patients have undergone physiologic testing. Similarly, the need for percutaneous coronary intervention (PCI) is predicated upon the results of cardiac catheterization. In these cases, we ask that you contact AIM no later than 10 business days after you perform arterial duplex imaging or PCI, but before you submit the claim, to request clinical appropriateness review.

Thank you for your collaboration and ongoing support of the cardiology program. If you have further questions, please contact the [Provider Call Center](#).

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CPT	Description
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study
93930	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study
93931	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study
93880	Duplex scan of extracranial arteries; complete bilateral study
93882	Duplex scan of extracranial arteries; unilateral or limited study
93451	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed
93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
93454	Catheter placement in coronary artery(s) for coronary angiography
93455	Catheter placement in coronary artery(s) for coronary angiography, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography
93456	Catheter placement in coronary artery(s) for coronary angiography, with right heart catheterization
93457	Catheter placement in coronary artery(s) for coronary angiography, with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
93458	Catheter placement in coronary artery(s) for coronary angiography, with left heart catheterization including intraprocedural injection(s) for left ventriculography
93459	Catheter placement in coronary artery(s) for coronary angiography, with left heart catheterization including intraprocedural injection(s) for left ventriculography, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93460	Catheter placement in coronary artery(s) for coronary angiography, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography
93461	Catheter placement in coronary artery(s) for coronary angiography, with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
93530	Right heart catheterization, for congenital cardiac anomalies
93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch

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CPT	Description
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel

Enhancements to AIM clinical appropriateness guidelines for advanced imaging

On February 22, 2016, the following changes to the AIM Clinical Appropriateness Guidelines for radiology, oncologic PET, and cardiology will become effective.

A summary of these changes is provided below.

Radiology guidelines

- MRI and CT
 - Expanded list of “red flag” indications for headache evaluation and added a requirement for conservative therapy in low-risk patients
 - Developed comprehensive new criteria for venous sinus thrombosis based on risk factors
- MRI/MRA or CT/CTA
 - Developed new criteria for headache evaluation for appropriate simultaneous imaging
- CT Neck (soft tissue) and CT Chest
 - Added new requirement of short course conservative therapy for low-risk patients with hoarseness
- CT Chest
 - Developed new criteria for immunosuppressed patients with persistent pneumonia
 - Aligned pulmonary nodule criteria with the Fleischner Society guidelines
- MRI Pelvis
 - Developed new criteria for sports hernia after sufficient initial evaluation and failed conservative management
 - Revised criteria for advanced imaging in low risk prostate cancer and in the surveillance of gynecologic malignancy
- MRI Upper and Lower Extremity
 - Expanded criteria for suspected occult fractures at high-risk sites following non-diagnostic radiographs

Oncologic PET guidelines

- Clarified language for surveillance PET imaging
- Clarified PET requirement for breast cancer to include invasive disease
- Expanded thyroid cancer to include well-differentiated follicular subtype
- Replaced “not covered” with “not medically necessary”

Cardiology guidelines

- Revised cardiac imaging criteria for management of patients with Kawasaki disease to align with published literature
- Clarified appropriate frequency of echocardiography in children with established congenital heart disease. For younger children with complex congenital heart disease, evaluation based on symptoms is difficult; therefore, the guideline has been liberalized to allow more frequent echocardiography in this cohort.
- Clarified language to reduce variability of guideline interpretation based on user feedback

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click [here](#) to access and download a copy of the current guidelines.

Updates to Blue Physician Recognition Program

We are committed to providing members with the tools they need to effectively partner with their doctors and make more informed health care choices. As part of that effort, we are pleased to participate in the Blue Cross and Blue Shield Association's consumer engagement initiative.

The Blue Physician Recognition (BPR) Program is designed to reinforce Blue Plans' commitment to quality by providing more meaningful and consistent information on physician quality improvement and recognition on the [Blue National Doctor & Hospital Finder](#) site and on our online provider directories. A BPR indicator is used to identify physicians, groups and/or practices who have demonstrated their commitment to delivering quality and patient-centered care by participating in local, national, and/or regional quality improvement programs as determined by the local Blue Plan.

We recognize primary care physicians practicing in the specialties of family practice, internal medicine and general practice with a BPR designation if they have achieved recognition from either the National Committee for Quality Assurance (NCQA) or Bridges to Excellence (BTE) based on their successful completion of a care recognition program. Information regarding these recognition programs can be found at <http://www.ncqa.org> or <http://www.hci3.org>.

At a minimum, we will update these recognitions annually to reflect the current status as identified by the Blue Cross and Blue Shield Association's Quality Recognition Extract.

If you have questions regarding the update, please contact the [Provider Call Center](#).

Where to find the 2015 AQI PCP Survey

PCPs who are eligible for the 2015 AQI PCP program can access the 2015 PCP Survey on Anthem Online Interactive Tool (POIT). The required survey for the external physician recognition and care systems component questions is available at www.Availity.com > My Payer Portals > Anthem Provider Portal. Once you read the statement and click 'I Agree', select Anthem Provider Services > Provider Online Interactive Tool (POIT) > Rewards and Recognition (orange print).

Please note that your survey is not completed until you click the submit button. Please remember to attach required support documents to your completed survey.

All surveys must be completed no later than February 28, 2016, to be included in the 2015 yearend scoring.

Atlantic Health Partners Vaccine Purchasing Program

We recognize that physician practices are continually faced with increased vaccine costs. As a result, we are pleased to announce that participating physicians are now eligible to participate in the Atlantic Health Partners Vaccine Purchasing Program. Atlantic Health Partners offers favorable pricing and purchasing terms, along with delivery of online and phone orders submitted directly to vaccine manufacturers such as Sanofi Pasteur, Merck, Pfizer and MedImmune.

There are no minimum quantity requirements, and physicians have access to a full spectrum of pediatric, adolescent and adult vaccines. In addition, the program offers local customer service support backed by Atlantic's national strength and expertise. Atlantic Health Partners and Anthem are independent entities. We do not have a financial interest in the Atlantic Health Partners Vaccine Purchasing Program and are offering access to this program to assist participating network physicians in purchasing immunizations at a reasonable cost.

For additional information about this program, please contact 800-741-2044 or by e-mail at info@atlanticealthpartners.com.

Updated contact information for ERA and EFT registration

Please note that we have updated the contact information for providers registering for Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT). We continue to use [EnrollHub™](#), a CAQH Solution™ for the enrollment of EFT and ERA as noted below, but we have updated the amount of time a provider should wait before contacting Provider Services to resolve any EFT registration issues.

Electronic Remittance Advice (ERA), Electronic Funds Transfer (EFT) Registration and Contact Information			
Type of Transaction	How to Register, Update, or Cancel	For registration related questions, contact:	To resolve issues after registration, contact:
EFT only	Use EnrollHub	EnrollHub Help Desk at 844-815-9763	800-332-6558
EFT and ERA (both)	Use EnrollHub	EnrollHub Help Desk at 844-815-9763	<p>For EFT questions, contact: 800-332-6558</p> <p>NOTE – Providers should allow one week from the date Anthem receives the EFT enrollment from EnrollHub, as reflected on the EnrollHub EFT enrollment summary screen.</p> <p>For ERA questions, contact E-Solutions at 800-470-9630 or e-solutions.support@anthem.com</p> <p>NOTE – Providers should allow 4-6 weeks from successful ERA registration before contacting E-Solutions.</p>
ERA only	Use the anthem.com/edi website	E-Solutions at 800-470-9630	<p>E-Solutions at 800-470-9630 or e-solutions.support@anthem.com</p> <p>Note – Providers should allow 4-6 weeks from successful ERA registration before contacting E-Solutions.</p>

Primary care provider (PCP) terminations – member reassignment

Last year we began converting to a new claims platform. With that new system, we will no longer have the ability to accommodate requests by practices to reassign a member to a specific PCP within that practice. Moving forward, members will be reassigned as follows:

- to same PCP if they have another active location within 45 miles of the members home address
- to another PCP within the same tax ID based on specialty and accepting patient status (this is an enhancement coming soon) or
- to a random PCP based on accepting patient status and within 45 miles of members home address

To assist members in remaining with a PCP in your practice, we encourage you to send out a member communication with the specific PCP that will be taking over the terming PCPs panel of patients, and advise members to contact their customer service department as soon as possible to update their PCPs.

Incentive opportunity for physicians treating members with Anthem plans purchased on or off the exchange

In 2014, we announced that we would engage Inovalon – an independent company that provides secure, clinical documentation services – to conduct outreach efforts for our health care exchange business. We are working with Inovalon to help ensure that our members, who have purchased health care plans on and off the exchange, get their diagnoses confirmed, corrected, and updated every year, as well as have potential preventive care gaps addressed. To accomplish this goal, network providers – usually primary care physicians - may receive letters from Inovalon asking you to perform member outreach and assessments, followed by submission of a SOAP Note (also called Encounter Facilitation Form). SOAP Note stands for subjective, objective, assessment, and plan which is the standardized document format of a medical record.

If you receive a request from Inovalon, we understand that completing these SOAP Note requests may take time, and we're offering contracted exchange providers the opportunity to increase your reimbursement. As a reminder, you are eligible to receive \$100 in addition to your office visit fee for each properly submitted electronic SOAP Note submitted through Inovalon's ePASS tool.

You may also elect to submit your patient assessment data for the members we request using the paper SOAP Note option via Inovalon's secure fax line at 866-682-6680. For each paper SOAP Note properly submitted for patient assessments performed, you are eligible to receive \$50 in addition to your office visit fee.

Submitting a SOAP Note

Paper: You have the option to fax in a completed paper SOAP Note to Inovalon at 866-682-6680. To ensure that the paper SOAP Note is fully processed, all required fields must be completed and signed by the member's physician.

Electronically: You may use ePASS (Electronic Patient Assessment Solution Suite), an electronic tool that retrieves information about your Anthem members, including potential preventive care gaps, and drops this data into the SOAP Note to document the members' conditions. The ePASS® tool may be used for members Inovalon identifies, and the members have purchased individual and small group health plans on and off the exchange. To utilize ePASS®, please sign up online at the following web address: <https://ePASS.inovalon.com>

Overview of the ePASS® tool

If you're interested in an overview of the ePASS® tool, please see below for various webinar dates. We encourage you to register in advance by sending an email to ePASSProviderRelations@Inovalon.com with your name, organization, contact information and date of the webinar you'd like.

This webinar provides a practical overview of how ePASS can be used to access a supplemental clinical profile and complete a compliant electronic encounter SOAP Note for members identified by Inovalon on our behalf. The webinar typically lasts 30 minutes with time for questions.

Webinar Date	Time
December 9, 2015	3:00 - 3:30 p.m.
December 16, 2015	3:00 - 3:30 p.m.
January 6, 2016	3:00 - 3:30 p.m.
January 13, 2016	3:00 - 3:30 p.m.
January 20, 2016	3:00 - 3:30 p.m.
January 27, 2016	3:00 - 3:30 p.m.

The following dial-in information and WebEx link/entry code are the same for all webinar dates. To join one of the ePASS® tool overview webinars:

- Call 888-850-4523 and enter access code 10860
- Click on [WebEx Link](#) and enter meeting code 745 497 369

For more information on the outreach process or the ePASS tool, please go to anthem.com > Providers > select state > Information about Health Insurance Exchanges > [Anthem engages Inovalon to conduct outreach efforts](#). You may also contact Inovalon toll free at 877-448-8125.

Enhanced personal health care: referral providers benefit by improving quality and controlling costs

A key goal of the Enhanced Personal Health Care Program is to improve quality while controlling health care costs. One of the ways this is done is by giving primary care physicians (PCPs) in the Program quality and cost information about the health care providers to which the PCPs refer their attributed members (the referral providers). If a referral provider is higher quality and/or lower cost, this component of the Program should result in their getting more referrals from PCPs. The converse should be true if referral providers are lower quality and/or higher cost. We will share data on which we relied in making these evaluations upon request, and will discuss it with referral providers including any opportunities for improvement. Any such requests should be directed to NHprimarycareprogram@anthem.com.

Misrouted protected health information (PHI)

As a reminder, providers and facilities are required to review all member information received from us 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.

Case Management Program

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

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

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

How do you contact us?

CM Telephone Number	CM Email Address	CM Business Hours
800-231-8254	CMReferralSpecialistNE@anthem.com	Monday – Friday, 8:00 a.m. to 9:00 p.m. Saturday, 9:00 a.m. to 5:30 p.m.
Federal Employee Program® 800-711-2225	No email	Monday – Friday, 8:00 a.m. to 7:00 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 and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. We urge all practitioners to obtain the appropriate permission from these members to coordinate care between behavioral health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.

6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
 - Diagnosis
 - Treatment plan
 - Referrals
 - Psychopharmacological medication (as applicable)

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

*Access to the forms and cover letters are available at anthem.com > Providers > New Hampshire > Answers@Anthem.

**Access to the Toolkit is available at anthem.com > Providers > New Hampshire > [Health and Wellness](#).

Important information about utilization management

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

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

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

- Call us toll free from 8:30 a.m. – 5:00 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 a.m. – 7:00 p.m.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID cards.

To discuss UM process and authorizations	Discuss peer-to-peer UM denials with physicians	To request UM criteria	TTY/TDD
800-531-4450	800-437-7162	800-437-7162	711 or 800-735-2964 (TTY/Voice)
Federal Employee Program Phone - 800-860-2156 Fax - 800-732-8318 (UM) Fax - 877-606-3807 (ABD)	FEP Phone - 800-860-2156	FEP Phone - 800-860-2156 Fax - 800-732-8318 (UM) Fax - 877-606-3807(ABD)	

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

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

Members' Rights and Responsibilities

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

It can be found on our website at anthem.com > Providers > **New Hampshire** > Health & Wellness > Quality > [Member Rights & Responsibilities](#).

Medicare Advantage update

Avoid denials of Medicare Advantage diagnostic claims by completing item 20 (CMS 1500) correctly – individual membership only

The Centers for Medicare & Medicaid Services requires that providers billing for diagnostic tests subject to the anti-markup payment limitation complete item 20 on the CMS-1500 form. A "YES" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "NO" check indicates "no anti-markup tests are included on the claim." When "YES" is annotated, item 32 is required to be completed.

Claims for Anthem individual Medicare Advantage members received with Item 20 checked as "YES" and incomplete or missing information in item 32 will be denied with denial Z01 "Claim must be billed with Provider's NPI". To help prevent unnecessary denial of claims, only complete Item 20 when you are billing diagnostic tests subject to the anti-markup payment limitation.

For more information on diagnostic tests subject to the anti-markup payment limitation refer to [Medicare Claims Processing Manual, Chapter 35, Section 30](#).

Please include modifiers to help ensure accurate payment

Codes not recognized by original Medicare are considered by Anthem Medicare Advantage as not reimbursable unless otherwise noted for both individual and group-sponsored claims.

During the past year, some providers have found that certain individual and group-sponsored claims are denied for missing or inconsistent modifiers as the claims are not consistent with CMS payment guidelines. Please ensure you use the most current and appropriate CMS codes and modifiers when submitting your claims.

Check [Important Medicare Advantage Updates](#) at <http://www.anthem.com/medicareprovider> for [additional information](#).

Network Update

Oxygen DME prior authorizations will be reduced in 2016

Providers who prescribe durable medical equipment for oxygen delivery for our individual and group-sponsored Medicare Advantage members will find that fewer items will require prior authorization in 2016. Detailed prior authorization requirements for individual MA members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. Go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the Precertification look-up tool.

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

Precertification guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at anthem.com for further information on existing precertification requirements.

ER Level 5 professional claims to be reviewed

We are initiating a review of ER professional claims billed with a level 5 ER Evaluation and Management (E/M) code (99285 or G0384) to ensure the documentation meets or exceeds the components necessary to support its billing. The review for the necessary components will be based on the coding guidelines outlined in the AMA CPT coding reference. Documentation will be requested and the review will be performed on a pre-pay basis. The review for selected ER professional claims with level 5 E/M codes is scheduled to begin January 1, 2016.

All radiology providers -- register for imaging site scores by March 1, 2016 to help avoid unnecessary line-item denials

The following information does not apply to delegated providers with delegated risk agreements.

On November 1, 2015, Anthem Medicare Advantage plans began collecting information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of a number of outpatient diagnostic imaging services for our individual Medicare Advantage members, including:

- Computed tomography (CT)
- Magnetic resonance (MR)
- Positron emission tomography (PET)
- Nuclear medicine (NUC)
- Ultrasound
- X-ray
- Echocardiograph

Emergency room outpatient diagnostic imaging services are excluded.

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

This data will continue to be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. Each modality or piece of equipment will receive its own score. Providers with an imaging site score of 76 or higher for the applicable modality will see no change in reimbursement. Providers who score less than 76 or who do not complete the survey by March 1, 2016, will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Globally billed claims will deny in total if the provider scores less than 76 or if the provider does not complete the survey. If billing globally and the claim is denied, the provider has the option to resubmit a corrected claim for the professional component (interpretation) with modifier 26 for payment consideration. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

We strongly encourage any provider who scores below 76 to improve their site score for the applicable modality before the line item denial of claims begins on claims submitted for dates of service on or after March 1, 2016. Providers who have not registered and therefore have no score also will be subject to line-item denials for claims submitted for dates of service on or after March 1, 2016.

AIM will send the site score to the provider within one business day of the provider's completion of the online registration. Providers may use the online registration at any time to update their score.

Providers who score below 76 will receive individualized information they can use to improve their score.

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

AIM will conduct random audits to ensure that the provider's survey information is supported by documentation. Recovery of technical component payments will occur for those providers found to have had a score less than 76 at the time of the outpatient diagnostic imaging service.

Contracted providers will be asked to update their online information periodically.

The provider registration is available online at www.aimspecialtyhealth.com/goweb. Simply select Anthem from the drop down menu. Only those providers who have completed the provider registration will be able to view their information online. Site information will be available for review online starting November 1, 2015. If you have questions or need help completing the registration, please call AIM Customer Service at 800-252-2021.

Please note that if you have already completed the registration in connection with another health plan, you do not need to re-enter your information. Please review what has been prepopulated, make any updates and submit your information to register for Anthem. To copy your registration, select "Copy" from the "Actions" column on the site list after you log in and follow the steps when prompted.

The online registration tool was designed with convenience in mind. You can save your data as you go which means you will not need to complete it in one sitting. These resources are accessible on AIM's ProviderPortalSM website at www.aimspecialtyhealth.com/goweb. Once you complete the registration, the tool will remain available so you can update your information at any time. We recognize your office is busy and we appreciate the time spent completing the registration.

Check [Important Medicare Advantage Updates](#) at www.anthem.com/medicareprovider for [additional information](#).

Network Update

More \$0 copay medications available to Medicare Advantage members with chronic conditions

Individual MAPD plans in 2016 will continue to offer select drugs at a \$0 member co-pay for the following conditions: high blood pressure, high cholesterol and diabetes. The 2015 medication list (glipizide, lisinopril, losartan, metformin, and simvastatin) will continue to be included. New medications on this list in 2016 include benazepril, enalapril, enalapril-hctz, lisinopril-hctz, glimepiride, glipizide ER, losartan-hctz, metformin ER, atorvastatin, lovastatin and pravastatin.

Group-sponsored plans will continue to offer the Select Generics benefit, which offers \$0 copay for select generic drugs.

Avastin for ophthalmic use – C9257 can be billed in office setting for network providers

Beginning January 1, 2016, C9257, Avastin 0.25mg (for ophthalmic use), will be payable for facilities and professional providers when other criteria are met for individual Medicare Advantage claims. In addition, Anthem will no longer require a prior authorization for Avastin for ophthalmic injection. Check [Important Medicare Advantage Updates](#) at www.anthem.com/medicareprovider for more information.

Enhanced reimbursement available for certain Part B injectable drugs

Beginning first quarter 2016, Anthem Individual Medicare Advantage plans will reimburse providers with enhanced payments for using less expensive but therapeutically equivalent select Part B injectable drugs. The reimbursement change is specific to only the following drugs.

- Therapeutic Class – Antiemetics. HCPCS (drug) – J1626 (Kytrel), J2405 (Zofran)
- Therapeutic Class – Folinic Acid. HCPCS (drug) – J0640 (Leucovorin)
- Therapeutic Class – Osteoporosis. HCPCS (drug) – J3489 (Reclast)

Check [Important Medicare Advantage Updates](#) at www.anthem.com/medicareprovider for additional information.

Place of service claims processing mirrors CMS guidelines

[CMS recently revised](#) place of service code sets by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to “On Campus-Outpatient Hospital.” Please ensure your claims include these new and revised POS codes where applicable. We mirror CMS place of service guidelines when processing claims.

Individual Medicare Advantage plan names changing for 2016

We have introduced a standard nomenclature to our affiliated MA plans. In most instances, plan names start with the local brand name, followed by the word “MediBlue,” then a plan descriptor, such as “Access,” and finally the plan type. For instance, a standard HMO would be referred to as “Anthem MediBlue Essential (HMO),” while a standard PPO would be called “Anthem MediBlue Access (PPO).” Group-sponsored Medicare Advantage plans are not impacted by these changes. No member ID prefixes are changing for 2016. Check [Important Medicare Advantage Updates](#) at www.anthem.com/medicareprovider for [additional information](#).

Keep up with Medicare Advantage news at Important Medicare Advantage Updates

Please continue to check [Important Medicare Advantage Updates](#) at www.anthem.com/medicareprovider for the latest Medicare Advantage information including:

- [ICD-10-CM Educational Material Now Available on Provider Website](#)
- [Providers Must Enroll with Medicare to be Able to Prescribe Part D Beginning June 1, 2016](#)
- [Anthem Encourages High-Risk Members to get a Flu Shot](#)
- [2016 New Hampshire Medicare Advantage Plan Changes](#)
- [Medicare Advantage reimbursement policies](#)
- [Important 2016 coverage changes for diabetic supplies](#)
- [New 2016 Prior Authorization Requirements Effective January 1, 2016](#)

6815WPPENMUB 10/16/2015

Brachytherapy and IMRT CPT codes prior authorization information updated

Prior authorization procedures for the following outpatient radiation therapy CPT codes for our individual Medicare Advantage members have been updated:

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

Prior authorization requirements for individual Medicare Advantage members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity. Go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well via the precertification look-up tool. Providers also may contact Provider Services at the number on the back of the member's ID card.

Additional information, including required information for radiation therapy requests, can be found [here](#).

57215WPPENMUB 11/02/2015

Programs and benefits update

New Hampshire Premium Assistance Program (PAP) effective January 1, 2016

The New Hampshire Department of Health and Human Services (NH DHHS) began enrolling members in the New Hampshire (NH) Premium Assistance Program (PAP) on November 1 for a coverage effective date of January 1, 2016. NH DHHS will purchase coverage for NH PAP members into one of two on-exchange products similar to the current silver plan.

Eligible individuals enrolled through the state's Medicaid program will then transition to qualified health plan (QHP) products offered by Anthem and other insurers. Policies are for individual members between the ages of 19-64.

PAP members may be responsible for \$0 or up to \$147 quarterly maximum in co-pays, depending on the contract in which they are enrolled.

HMO 2908 premium assistance program

Member cost shares are limited to \$147 per quarter. The deductible applies to all covered services except for:

- Network preventive care services required by law

Network Update

- Covered prescription drugs
- Pediatric vision services
- Services that specifically indicate that the deductible does not apply

HMO 1X07 premium assistance program

This plan is 100% subsidized by the New Hampshire DHHS. The member will never have any cost shares on this contract unless they receive care from an out of network provider other than urgent/emergent care. Note that the NH DHHS requires that these are individual policies only. A dependent can never be added and family cost shares cannot be used on child contracts.

Please see frequently asked questions below for more information about the NH PAP:

Is there anything on the ID card that identifies these members?

The ID card prefix is YGQ, and the product/plan name will include 'Premium Assistance Program (PAP)'.

What is the network?

Pathway X Enhanced

What is the Product/Plan name?

Silver Pathway X Enhanced

What is the medical product type?

HMO

What are the plan benefits?

This is an exchange plan with subsidy and mirrors the current Anthem Silver subsidy plan. This plan covers medical and prescription only.

Are members required to select a PCP?

No. Members can see anyone in the Pathway X Enhanced network.

2016 FEP Benefit information available online

To view the 2016 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org > Benefit Plans > [Brochure & Forms](#). Here you'll find the Service Benefit Plan Brochure and Benefit Plan Summary information for 2016. For questions please contact FEP Customer Service at 800-852-3316.

GeoBlue - BlueCard® Provider Outreach

GeoBlue, in partnership with Blue Cross Blue Shield of Michigan, began serving over 3,000 internationally-based General Motors employees effective January 1, 2015. Many of these members will be seeking care in the U.S. and presenting the GeoBlue identification card. These members are enrolled in a Blue Cross Blue Shield product and have full access to the BlueCard provider network. Their identification card follows all BlueCard specifications and all BlueCard processes apply. If you have any questions please contact our Customer Service team at 855-282-3517.

Network Update

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.

Documentation and reporting guidelines for applied behavior analysis (ABA) and treatments for autism spectrum disorder

Please click [here](#) to read this article in the Administrative updates section of this newsletter.

2016 outpatient visits

Please note that we no longer manage traditional behavioral health outpatient therapy for all fully insured products, including our health insurance exchange products. Many of our self-funded groups have also removed review of the traditional outpatient therapy visits; however, some groups continue to require a review after a certain number of pass-through visits. With the new calendar year please be certain to verify benefits for new patients to help ensure you are aware of any requirements.

Partial hospitalization, intensive outpatient, applied behavior analysis, trans-cranial magnetic stimulation (TMS) services continue to require prior authorization from the first visit.

Quality programs update

Clinical practice and preventive health guidelines available on anthem.com

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, that 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 > New Hampshire > Health & Wellness > Practice Guidelines](#).

We believe in continuous improvement

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

Improving your patients' health care experience

We are committed to working with our network physicians to make our members' health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

Simply log onto our website at www.anthem.com and follow this path: Providers > New Hampshire > Communications > General Information > Guide to Improving the Patient Experience.

"This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California."

HEDIS® 2015 commercial results are in

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) data collection for 2015. 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.

Further information regarding documentation guidelines can be found on the HEDIS page of our Provider Portal. Visit anthem.com > Provider > Health and Wellness > [Quality](#). You'll find reference documents entitled "HEDIS 101 for Providers" and "HEDIS Documentation Guidelines".

Click [here](#) to find a comparison of some of our key measure rates for our Connecticut, Maine and New Hampshire Commercial HMO and Commercial PPO plans across the Northeast.

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

Sharing results of member satisfaction survey regarding physician care

Every year, we send out the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to our HMO/POS members. The survey provides our 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).

Click [here](#) to view tables that compare our results from 2014 with those in 2015. 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 the 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.

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

Respiratory antibiotic use performance

Improving antibiotic use improves patient outcomes and saves money. The National Committee for Quality Assurance (NCQA) has identified three Health Effectiveness Data and Information Set (HEDIS) measures around antibiotic use:

- Children (2 to 18 years) who present with pharyngitis who are first given a group A streptococcus (strep) test and then appropriately receive an antibiotic. A higher score is better.
- Children (3 months to 18 years) with a diagnosis of upper respiratory infection who are not given an antibiotic prescription. The rates are reported as an inverse rate, so a higher rate is better.
- Adults with a diagnosis of acute bronchitis who are not given an antibiotic prescription. The rates are reported as an inverse rate, so a higher rate is better.

The ratings for each of these metrics are determined by claims data only. Furthermore, it only takes one time of an antibiotic being inappropriately prescribed (and filled) in the one year measurement period to lower the scores.

Local performance for appropriate testing and antibiotic prescribing was based on the Northeast Region commercial health plan claims data, and the reported HEDIS rates are provided below.

	Measurement Period	Connecticut		Maine		New Hampshire	
		HMO Rates	PPO Rates	HMO Rates	PPO Rates	HMO Rates	PPO Rates
Appropriate testing for pharyngitis in children	7/1/13-6/30/14	90.70%	87.05%	85.98%	85.95%	86.59%	83.64%
Appropriate treatment for children with upper respiratory infection	7/1/13-6/30/14	92.10%	91.33%	94.39%	93.25%	91.81%	90.67%
Appropriate treatment for adults with acute bronchitis	1/1/13-12/31/14	17.97%	21.71%	28.57%	25.59%	21.83%	31.89%

In an effort to help slow the emergence of antibiotic resistant bacteria and prevent the spread of antibiotic resistant infections, please commit to:

- Avoid prescribing antibiotics inappropriately: Recent studies have shown that displaying poster-sized commitment letters in exam rooms to avoid inappropriate antibiotic prescribing was a simple, low-cost, and effective method for improvement.¹ Write a prescription for symptom relief instead of an antibiotic and educate patients on comfort measures that may work without antibiotics.
- Communicate with patients: Parents indicate that they would be satisfied with their medical visit even if antibiotics are not prescribed, provided that the physician explains the reasons for the decision.² Discuss realistic expectations for recovery time, explain that antibiotics do not significantly reduce the duration of symptoms, and that unnecessary use of antibiotics may cause adverse effects that lead to antibiotic resistance.
- Test for bacterial infections: If a child presents with a sore throat, do a strep test and prescribe accordingly. Don't send a script home with the patient "just in case," but rather offer to call it in if the test comes back positive.
- Code claims correctly and accurately: If your patient has comorbidities, bacterial infections, or competing diagnoses, the standard codes for adults with acute bronchitis (AAB) and upper respiratory infection (URI) may not be applicable. Ensure proper documentation is in the medical record and use correct diagnosis and procedure codes on claim/encounter.

Here are some resources that might help you and your patients:

- Anthem one-minute video: www.anthem.com/cold
- Choosing Wisely—www.choosingwisely.org: [5 Patient Questions to ask Before Taking Antibiotics](#) and [Antibiotics: When you Need them and When you Don't in English](#) and [Antibiotics: When you Need them and When you Don't in Spanish](#)
- AWARE program materials: [Physician-Patient Resources in English and Spanish](#)
- CDC "Get Smart about Antibiotics": [Patient and Provider Materials and References including Clinical Guidelines](#)

1. Meeker, Daniella, et al. "Nudging Guidelines—Concordant Antibiotic Prescribing: A Randomized Clinical Trial." *JAMA Internal Medicine*. 2014; 174 (3): p 425-431.
2. Barden, LS, et al. "Current Attitudes regarding use of Antimicrobial Agents: Results from Physicians' and Parents' Focus Group Discussions." *Clinical Pediatrics (Phila)*. Nov 1998; 37(11): p 665-671.

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 commercial drug list, go to anthem.com > Customer Support > New Hampshire > 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 > New Hampshire > Download forms > New Hampshire 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.

Network Update

In addition, FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > [Medical Policies](#).

Searchable formulary tool gives providers easier access to Anthem formulary/drug list information

We recently launched a new Searchable Formulary Tool, providing access to all relevant medication information about five of our drug lists, including clinical edits, like prior authorization or step therapy, dosage/strength options, and details about brands and generics.

Providers can quickly access the Searchable Formulary Tool through the [pharmacy microsite](#) where our drug lists are housed. The following five drug lists are set up with searchable capabilities:

- National
- Select
- Preferred
- Essential
- Generic Premium

Once you select the applicable drug list, you can search the drug list for a wealth of information including:

- Tier status
- Clinical programs/edits including quantity limits, dose optimizations, prior authorizations and step therapies
- Drug label name
- Generic drug name
- Generic drug indicator
- Therapeutic class and category
- Available dosage/strength options

If needed, you are also able to access printable versions of these drug list PDFs.

Additionally, members with our pharmacy benefit will have the added functionality of benefit-specific drug list search capabilities, which eliminates the need to identify and select the drug list that applies to their pharmacy benefit.

CVS/specialty exclusive in-network specialty pharmacy for Anthem members

As the exclusive Anthem provider for specialty injectable and infusion medication, CVS is able to ship to a physician's office or to the member's location of choice. Through Coram, a division of CVS they can also administer infusion drugs in one of their infusion suites or in the member's home. Whether it is an infusion or injection medication, CVS/specialty can support ongoing patient care.

Injectables

Members have 24/7 access to a pharmacist-led care team that includes specially-trained nurses, nutritionists, and support staff. This team supports, motivates, and educates members and caregivers throughout treatment.

Members can have their specialty medications delivered to the location of their choice which may be their home or physician's office. CVS/specialty is the only pharmacy that can ship medications to physician offices. If CVS is not utilized by

the treating provider for specialty drugs shipped to physician office, claims will process according to the member's out-of-network benefits as applicable.

Phone, fax, or e-scribe your prescription to any CVS/pharmacy or CVS/specialty pharmacy:

Phone - 800-237-2767

Fax - 800-323-2445

Infusions

As a division of CVS/specialty, Coram's infusion nurses are experienced in administering infusion medications to complex patients with rare or autoimmune disorders.

Members can choose to receive infusions from experienced staff nurses in the convenience of their home, or at a local Coram infusion suite. Both options may reduce the risk of infection and help patients save money by moving infusions to lower cost sites of care.

Coram offers convenient care nationwide in more than 65 infusion suites. To find a Coram infusion suite near you, go to coramhc.com/locations.

Phone or fax your infusion referral to Coram:

Phone - 866-899-1661

Fax - 866-843-3221

Medical policy update

[Medical policy updates are available on anthem.com](#)

The following new and revised policies were endorsed at the November 5, 2015, Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com > Providers > Select state > Enter > [Medical Policies and Clinical UM Guidelines](#).

If you do not have access to the Internet, you may request a hard copy of any updated policy by contacting the [Provider Call Center](#).

New medical policy effective March 1, 2016

(The policy below was created and might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

Ther-RAD.00011 Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT)

Clinical guideline update

[Clinical guideline updates are available on anthem.com](#)

The following new and revised clinical guidelines were endorsed at the August 6, 2015, Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com > Providers > Select state > Enter > [Medical Policies and Clinical UM Guidelines](#).

Network Update

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 guidelines adopted effective March 1, 2016

(The following guidelines will be applied and might result in services that were previously covered but may now be found to be not medically necessary.)

CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting
CG-SURG-48	Elective Percutaneous Coronary Interventions (PCI)
CG-THER-RAD-01	Fractionation and Radiation Therapy: Bone Metastases and Whole-Breast Irradiation Following Breast-Conserving Surgery
CG-THER-RAD-02	Special Radiation Physics Consult and Treatment Procedure