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

## Administrative and policy 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 an endorsement, preference, or recommended practice guidance. Diagnosis, treatment recommendations, and the provision of medical care services by our members and providers is the responsibility of the provider and patient.

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 refer to all updates are subject to the terms, conditions and limitations of the member’s plan or program.*

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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.

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:

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

......and much more

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

On February 1, 2016, we will be updating our Anthem Online Provider Services (AOPS) website with the following new and/or revised reimbursement policies. The updates below identify if the article pertains to professional or facility provider billing.

Bundled Services and Supplies – professional

Beginning with claims processed on or after February 22, 2016, HCPCS code C9257 for Avastin 0.25 mg will be eligible for reimbursement to professional providers who report their services on a CMS 1500 claim form as an exception to our always bundled edit for HCPCS “C” codes. Based on our policy, all other HCPCS “C” codes are not eligible for reimbursement when reported by professional providers.

For dates of service on or after January 1, 2016, services in the home or hospice setting identified by HCPCS codes G0151-G0164, G0299-G0300 and G9473-G9479 (effective January 1, 2016), Q5001-Q5002, and Q5009 will be added to our always bundled edit and will not be eligible for reimbursement when reported on a CMS 1500 claim form. This information will be reflected in Section 1 of our policy.

Please note that effective January 1, 2016, HCPCS has deleted codes G0431 (Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter) and G0434 (Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter); therefore, we are removing these two codes from Section 1 of our policy.

As a reminder, in our recent Network eUPDATE dated December 15, 2015, we advised that we will be adding CPT® codes for presumptive (80300-80304) and definitive (80320-80377 and 83992) drug testing to our always bundled services edit beginning with dates of service on or after March 15, 2016. Providers are reminded to use the new HCPCS “G” codes (G0477-G0483) when reporting presumptive and definitive drug testing services for dates of service on or after March 15, 2016.

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

Beginning with dates of service on or after May 1, 2016, we are adding to Section 2 of our Bundled Services and Supply policy that CPT codes 82570 (assay of urine creatinine) and 83986 (assay PH body fluid NOS) are considered incidental to and not eligible for separate reimbursement when reported with presumptive and definitive drug testing CPT codes 80300-80377 and 83992 or HCPCS codes G0477-G0483. Bypass modifiers will not override the edit therefore the information is also included in our Modifiers 59 and XE, XP, XS & XU reimbursement policy.

Durable Medical Equipment – professional

When durable medical equipment (DME) is rented by a member, we allow rental up to the purchase price or a maximum 10 month rental period, whichever comes first. When a member was previously covered by another health insurance policy and such other policy covered a portion of the DME purchase price or rental period, we will apply the previous policy’s allowed amount or rental months to our current purchase allowance or 10 month rental period, whichever comes first, when the DME item is procured from the same DME provider. This information may be found under the “Purchase/Rent to Purchase” section of our policy dated February 1, 2016.

Frequency Editing – professional

Beginning with claims processed on or after February 22, 2016 with dates of service on or after January 1, 2016 we will apply a frequency limit of one per date of service for new CPT code 0403T (Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day).
In addition, for claims processed on February 22, 2016 we will apply a frequency limit of 24 per 365 days to new CPT code 0403T. Please note that 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.

For claims processed on or after February 22, 2016, we will be adding procedure codes to our one per date of service frequency limit edit. These are procedure codes that include in their description an indication that the code may be bilateral, or a particular code is designated by CMS as a bilateral service, or service is considered inherently bilateral. These codes should be reported with only one unit per date of service whether performed unilaterally or bilaterally. We consider this edit to be correct coding.

In December, we advised that effective with dates of service on or after March 1, 2016 we would apply a limit of 400 units for J0585 (Botox, 1 unit) per date of service. Please note that we are updating the limit to allow 600 units per date of service.

Beginning with dates of service on or after May 1, 2016, we will apply a frequency limit of 90 units every 28 days to HCPCS code J3357 (injection ustekinumab 1 mg (Stelara)). Stelara is a human monoclonal antibody that is a human interleuken-12 and 23 antagonist and is indicated as a treatment for adult patients diagnosed with moderate to severe plaque psoriasis.

In our recent Network eUPDATE dated December 15, 2015, we advised that effective January 1, 2016, CMS will use new HCPCS “G” codes for “per day” presumptive (G0477-G0479) and definitive (G0480-G0483) drug testing. Beginning with dates of service on or after January 1, 2016, we accept these “G” code and will apply a frequency limit of 1 unit per date of service on HCPCS codes HCPCS codes G0477 – G0483. We will also apply a frequency limit of 18 units per 365 days on HCPCS definitive drug testing codes G0480 –G0483. This edit will use claim lines processed in history with prior, current, and subsequent dates of service to accumulate and apply this frequency limit.

HCPCS drug testing codes effective January 1, 2016:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0477</td>
<td>Presumptive, per day, dip sticks, cups, cards, cartridges</td>
</tr>
<tr>
<td>G0478</td>
<td>Presumptive, per day, dip sticks, cups, cards, cartridges</td>
</tr>
<tr>
<td>G0479</td>
<td>Presumptive, per day, instrumented chemistry analyzers</td>
</tr>
<tr>
<td>G0480</td>
<td>Definitive, per day, 1 - 7 drug classes</td>
</tr>
<tr>
<td>G0481</td>
<td>Definitive, per day, 8 - 14 drug classes</td>
</tr>
<tr>
<td>G0482</td>
<td>Definitive, per day, 15 - 21 drug classes</td>
</tr>
<tr>
<td>G0483</td>
<td>Definitive, per day, 22 or more drug classes</td>
</tr>
</tbody>
</table>

Modifer Rules – professional
When modifiers LT, RT, or 50 are reported with a procedure code that is inherently a bilateral procedure or includes “unilateral or bilateral” in the code description, we do not consider this correct use of modifiers. Therefore, beginning with claims processed on or after February 22, 2016, codes considered bilateral or described as “unilateral or bilateral” will not be eligible for reimbursement when reported with modifiers LT, RT, or 50. This will eliminate incorrect reimbursement and retractions. This information is also included in our Multiple and Bilateral Surgery Processing reimbursement policy.
Modifiers 59 and XE, XP, XS, & XU – professional

Beginning with dates of service on or after May 1, 2016 a bypass modifier will not override the denial of CPT code 29875 to be overridden when reported with 29880-29883. Our current code to code bundling edit denies CPT code 29875 (arthroscopy, knee, surgical; synovectomy, limited... separate procedure) as incidental when reported with other arthroscopic knee procedure codes 29880, 29881, 29882 and 29883 when performed on the same knee. According to the American Academy of Orthopaedic Surgeons (AAOS), the work associated with 29875 is inclusive to more extensive procedures performed in the same anatomic site (the knee) and is not separately reportable and should only be reported if it is the only procedure performed. We will, however, allow CPT code 29875 when performed on the opposite knee of the arthroscopic surgery and each knee is identified with the appropriate site specific modifiers LT and RT.

Multiple and Bilateral Surgery Processing – professional

In our policy dated January 1, 2016, we have updated the arthroscopic and endoscopic surgical procedures coding table to include new CPT code 43210 (esophagogastroduodenoscopy (EGD)). Claims processed on or after February 22, 2016 that includes 43210 and another EGD code identified in the table will be subject to the endoscopic reimbursement reduction for any subsequent procedures.

Place of Service – professional

We consider the provision of any vaccine and the administration of such vaccines to be included under the facility's reimbursement when the vaccines are provided in a facility setting. Therefore, beginning with claims processed on or after February 22, 2016 when a vaccine and the vaccine administration are reported by a professional provider with a facility setting place of service code, the vaccine and vaccine administration charges will not be eligible for separate reimbursement.

Beginning with claims processed on or after May 23, 2016 when materials, supplies, or elements for enteral and parenteral therapy services represented by HCPCS “B” codes and durable medical equipment (DME) “E” codes are reported by a professional provider with a facility setting place of service (19, 21, 22, 23, 24, and 31) the charges will not be eligible for reimbursement. We consider enteral and parenteral therapy and DME to be included under the facility’s reimbursement when provided in a facility setting.

Review of reimbursement policies – professional

The following professional reimbursement policies have been reviewed and include minor language revisions but do not have changes to the policy position or criteria:

- Documentation Guidelines for Psychotherapy Services
- Surgical Pathology for Prostate Needle Biopsy

Revised coding tip: radiation treatment delivery and IGRT professional component – professional

In our December 2015 Network Update we advised in our coding tip for radiation treatment delivery and IGRT that the professional component of CPT code 77387 (IGRT) would be eligible for separate reimbursement beginning with dates of service January 1, 2016 when reported with the treatment delivery codes based on the “Radiation Management and Treatment” table published in the CPT codebook. We have made a decision to move this edit back to when 77387 became effective January 1, 2015. HCPCS code G6015 is also included in this edit.

CPT® is a registered trademark of the American Medical Association.
AIM Specialty Health® online pre-authorization requests (for ordering and servicing providers) available via Availity’s Web Portal

In 2015, AIM Specialty Health® (AIM) enhanced their web portal experience to enable servicing providers (those free-standing or hospital facilities that perform imaging procedures) to initiate and complete diagnostic imaging requests through AIM. Previously, servicing providers could only initiate requests for review of diagnostic imaging exams by phone. As a reminder, servicing providers should continue to coordinate care with the member’s ordering provider.

Please note that prior authorization is not required for Federal Employee Program® (FEP®) members. Participation, although not required, is encouraged to help promote the FEP quality program. You may also contact FEP directly for assistance. The additional functionality for servicing providers to submit an order request for FEP members is available.

AIM pre-authorization requests for both ordering and servicing providers can be accessed online 24 hours a day, seven days a week. Your office can save time, save money, and eliminate hassles by requesting and obtaining pre-authorizations online for radiology, cardiology, sleep, oncology, and specialty drugs. Information is available for both ordering and servicing providers.

Ordering and servicing providers may submit online pre-certification requests to AIM by either of the following options:
- Directly via AIM’s ProviderPortalSM at www.providerportal.com, or
- To AIM via the Availity Web Portal at www.availity.com

To submit a pre-authorization request through Availity

If you have an Availity User ID and Password, use the following steps:

- Log in to the Availity Web Portal at www.availity.com
- Enter your Availity User ID and password
- Click the Auths & Referrals link from the left side navigation menu
- Select AIM Specialty Health
- Click Continue to accept the AIM Specialty Health Internet Hyperlink Disclaimer, that you are leaving the Availity site and being routed to AIM
- Once routed to AIM, from the My Homepage screen, click Start Your Order Request Here
- Complete requested information. If submitted information meets criteria, an authorization number will be issued.

Note: The user must have an active user ID on Anthem Online Provider Services to access the AIM system through Availity. The Availity PAA must complete the Anthem Services Registration for each User to access AIM.

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

As a reminder, 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 getting external beam radiation therapy (EBRT) or intensity modulated radiation therapy (IMRT)
- 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)
Starting February 22, 2016, ordering physicians may submit a prior authorization request for these additional requirements to 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, 8:00 a.m.–5:00 p.m. Note: Prior authorization for these services is not required for FEP members.

For more information, please review the article titled ‘New prior authorization requirements for radiation therapy services begins March 1, 2016’ that was published in the December 2015 edition of Network Update.

In addition, AIM will be hosting two webinars in February to provide additional information and clarification about the radiation therapy program enhancements. Attend one of the following webinars by phone or by clicking on the WebEx meeting link.

- **Friday, February 19, 2016, 12:00 p.m.**  
  Join WebEx meeting  
  Meeting number: 621 880 300  
  Meeting password: Anthem  
  Join by phone: 877-668-4490 or 408-792-6300  
  Access code: 621 880 300

- **Friday, February 26, 2016, 2:00 p.m.**  
  Join WebEx meeting  
  Meeting number: 629 387 251  
  Meeting password: Anthem  
  Join by phone: 877-668-4490 or 408-792-6300  
  Access code: 629 387 251

**New prior authorization requirements for cardiovascular services begins March 1, 2016**

As a reminder, we are expanding our cardiovascular program to require prior authorization for arterial ultrasound, cardiac catheterization, 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.

Starting February 22, 2016, ordering physicians may submit a prior authorization request for the additional program requirements to 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, 8:00 a.m.–5:00 p.m. Note: Prior authorization for these services is not required for FEP members.

The clinical guidelines for arterial ultrasound, cardiac catheterization, and PCI outlining the clinical criteria for medical necessity are located on anthem.com.

For more information, please review the article titled “New prior authorization requirements added to the cardiovascular program beginning March 1, 2016” that was published in the December 2015 edition of Network Update.

**Precision Medicine: Cancer Care Quality Program expansion supports NCI-MATCH**

The Cancer Care Quality Program is expanding to include enhanced reimbursement for treatment planning and care coordination services provided by network providers for those eligible members who enroll in NCI-Molecular Analysis for...
Therapy Choice (NCI-MATCH), a National Cancer Institute clinical trial. NCI-MATCH seeks to determine whether treating cancers according to their molecular abnormalities will show evidence of effectiveness.

The Cancer Care Quality Program Precision Medicine expansion provides a unique opportunity to support the White House’s Precision Medicine Initiative through the National Cancer Institute to accelerate knowledge and learn as rapidly as possible which genes and therapies are clinically effective. It also supports your practice with enhanced reimbursement for treatment planning and care coordination services provided to those eligible members who enroll in NCI-MATCH.

Learn more
Visit our special website, www.CancerCareQualityProgram.com/PrecisionMedicine, to learn more about the program:

- How to participate
- Member eligibility
- Enhanced reimbursement
- Frequently asked questions

Facility audit vendor name change
Connolly Healthcare, an Anthem facility audit vendor, has recently changed their name to Cotiviti Healthcare and is in the process of rebranding all of their communications. If you receive correspondence from Cotiviti Healthcare on behalf of Anthem, please accept this as a valid request. The rebranding is expected to be completed during the first quarter of 2016. You may still receive documentation from Connolly Healthcare until the process is complete.

Important information about providing services to out-of-state Medicaid members
Beginning April 18, 2016, we will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims. Additional information may require the provider to enroll in the member’s out-of-state Medicaid program, or provide missing Medicaid encounter data.

Enrolling in an out-of-state Medicaid program
At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Some state Medicaid programs require providers to enroll in a member’s state Medicaid program when services are performed for their members (Section 1902(kk)(7) of the Social Security Act, 42 CFR 455.410, and 42 CFR 455.440). If a provider submits a claim for a Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. We will also send the provider a letter with information about how to enroll in the member’s state Medicaid program online.

Producers are encouraged to always verify member eligibility and benefits prior to performing services. This step will help determine if a member is enrolled in an out-of-state Medicaid program, and if provider enrollment is required. Whenever possible, the enrollment process should take place prior to submitting the claim to prevent delays in processing the claim. If the claim has been denied prior to enrollment, providers are advised to resubmit the claim for processing once enrollment is complete.

Medicaid encounter data
Encounter data includes records of health care services for which managed care organizations pay. In order to process a claim and apply appropriate benefits, providers are asked to submit all encounter data when billing for Medicaid services.
The list below reflects fields that are needed and if not included can result in claim denial. The provider should submit the claim following the directions on the back of the member’s identification card.

If an out-of-state Medicaid claim is denied, we will send a letter to indicate the encounter data needed. Upon return of this information, the claim will be reprocessed.

**Professional Encounter Data Fields Required when Billing for Medicaid Services**

<table>
<thead>
<tr>
<th>Actual ambulance mileage</th>
<th>Performing provider taxonomy code</th>
<th>Service facility location state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing provider address</td>
<td>Referring provider number and</td>
<td>Service facility location ZIP</td>
</tr>
<tr>
<td></td>
<td>referring provider number qualifier</td>
<td></td>
</tr>
<tr>
<td>Billing provider middle initial</td>
<td>Performing provider NPI</td>
<td>National drug code</td>
</tr>
<tr>
<td>Provider NPI</td>
<td>Service facility name</td>
<td>Condition code</td>
</tr>
</tbody>
</table>

**Institutional Encounter Data Fields Required when Billing for Medical Services**

<table>
<thead>
<tr>
<th>Actual ambulance mileage</th>
<th>Occurrence span code</th>
<th>Operating physician number and operating physician number qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attending physician number and attending physician number qualifier</td>
<td>Occurrence date</td>
<td>Performing provider taxonomy code</td>
</tr>
<tr>
<td>Condition code</td>
<td>Occurrence from date</td>
<td>Provider NPI</td>
</tr>
<tr>
<td>National drug code</td>
<td>Occurrence to date</td>
<td>Value amount</td>
</tr>
<tr>
<td>Occurrence code</td>
<td>Referring provider number</td>
<td>Value code</td>
</tr>
</tbody>
</table>

**837 Field Name**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Claim Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim or line note text</td>
<td>Institutional and professional</td>
</tr>
<tr>
<td>Certification condition applies indicator and condition indicator - early and periodic screening diagnosis and treatment (EPSDT)</td>
<td>Institutional and professional</td>
</tr>
<tr>
<td>Service facility name and location information</td>
<td>Institutional</td>
</tr>
<tr>
<td>Ambulance transport information</td>
<td>Professional</td>
</tr>
</tbody>
</table>

**PCP guidelines for access to care**

We must verify that participating primary care physicians (PCPs) provide our members adequate access to medical care. Here is a quick reminder of our accessibility of primary care services rules as outlined in our Provider Manual:

- Network/participating providers who are designated as PCPs agree HMO or POS covered individuals will be able to receive:
  - routine physical examination appointment within forty-five (45) days of request;
  - elective appointment for symptomatic care within three (3) days;
  - office visits for urgent care within twenty-four (24) hours;
  - care for emergencies (through coverage arrangements as necessary) seven (7) days a week and twenty-four (24) hours a day, including twenty-four (24) hour per day phone accessibility
Network/participating provider will arrange for off-hour physician coverage by other Anthem network/participating providers. In the event that this is not possible, network/participating provider will obtain a letter of agreement with a non-participating provider in which the covering physician agrees to follow the same procedures as does network/participating provider to the greatest extent possible.

Improving documentation of high blood pressure

Hypertension (HTN) is the most common condition seen in primary care practices and if managed well, can reduce the burden of cardiovascular disease for members. The Eighth Joint National Committee (JNC 8) guideline on the management of adult HTN was released in 2014. The new changes recommend physicians treat to 150/90 mm Hg in members over age 60 and 140/90 for everybody else, including those members who have diabetes.

Each year, health plans collect data from provider records to look at members with HTN to see if their blood pressure (BP) is under control. The National Committee for Quality Assurance (NCQA) made changes to the 2015 Healthcare Effectiveness Data and Information Set (HEDIS) Controlling High Blood Pressure (CBP) measure to align with the new JNC8 guidelines. Improvements in documentation of the diagnosis and BP can make a difference in whether CBP is considered compliant or not. The 2015 medical record review findings from provider offices that contributed to decreased scores included:

- No diagnosis confirmed
  - Diagnosis must be noted in the chart on or before 6/30 of the measurement year being reviewed.
- Diagnosis confirmed, but either no BP was taken since diagnosis or no BP was taken at all during the measurement year
- Diagnosis was listed as pre-hypertension
  - Pre-hypertension is not acceptable for confirming a diagnosis of HTN. Also, “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm diagnosis.
- BP documented as exactly 140/90
  - BP must be less than 140/90 mm Hg unless the member is 60-85 years of age and not a diabetic, in which case the BP needs to be less than 150/90 mm Hg.
- BP out of control
  - Many times, there are no follow-up visits in the chart or additional BPs are not taken the same day as an elevated BP reading.

The Journal of American Medical Association (JAMA) offers a CME course to earn a maximum of 1 AMA PRA Category 1 Credit™ for the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults. (JAMA. 2014;311(5):507-520).

Register and access the JAMA course here.
The JNC8 guidelines can be found here.

1. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, JAMA. 2014;311(5):507-520
Medicare Advantage update

Medicare Advantage webinar for all imaging providers: Learn how to complete the AIM OptiNet imaging services registration

We are 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.

AIM’s online registration tool, OptiNet®, will collect modality-specific data from providers who render X-ray, ultrasound, magnetic resonance (MR), computed tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

This data will be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, should complete the registration. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements. Previous communications incorrectly indicated that the OptiNet imaging services registration was not applicable to providers with delegated risk agreements.

Providers who score less than 76 or who do not complete the survey by second quarter 2016 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

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 for dates of service on or after second quarter 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 second quarter 2016.

Attend one of the webinars below to learn how to:

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

Choose one of the sessions below to register for the webinar.

Thursday, Feb. 4, 2:00 p.m. – 3:00 p.m.
Thursday, Feb. 18, 12:00 p.m. – 1:00 p.m.

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.

Care coordination encouraged for Medicare Advantage members with depression

We encourage care coordination and continuity of care for members with a diagnosis of depression who have been admitted to a hospital. To enhance care coordination efforts, our behavioral health case coordinators will help ensure that care plans
are sent to the hospital, the member, the members' primary care physician and/or the members' behavioral health provider upon notice of an inpatient admission.

**Additional support available for individual Medicare Advantage members with rare conditions**

*Please note: This article does not apply to providers with certain delegated risk agreements.*

We will be working with Accordant Health Services (AccordantCare) to provide targeted disease management services for our individual Medicare Advantage members with rare medical conditions, including:

- Amyotrophic lateral sclerosis (ALS)
- Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
- Crohn’s disease
- Cystic fibrosis
- Dermatomyositis
- Epilepsy
- Gaucher disease
- Hemophilia
- Multiple sclerosis (MS)
- Myasthenia gravis
- Parkinson’s disease
- Polymyositis
- Rheumatoid arthritis
- Scleroderma
- Sickle cell disease
- Systemic lupus erythematosus
- Ulcerative colitis

Members in your care who may benefit from additional outreach and information may receive letters, emails or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention.

If you feel that an individual Medicare Advantage member would benefit from this program, please have the member contact AccordantCare at 866-247-1150.

**Radiation therapy brachytherapy, 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:

- 3D Conformal Therapy (EBRT)
- Brachytherapy, including CPT codes 77316, 77317 and 77318
- Intensity modulated radiation therapy (IMRT) including CPT codes 77386 and G6016
- Proton Beam Radiation Therapy
- Stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS)

Prior authorization can be obtained by contacting AIM at [https://www.providerportal.com/](https://www.providerportal.com/) or 800-714-0400.
HIPPS codes required for SNF and HHA claims

All claims from skilled nursing facilities (SNFs) and home health agencies (HHAs) received July 1, 2014 and after must contain a valid HIPPS code. This pertains to contracted and non-contracted providers. CMS requires us to include this information on all processed claims data that we submit, regardless of the payment methodology. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including Medicare-Medicaid plans. This does not apply to dual special needs plans (D-SNPs) or Medicare Supplement plans.

SNFs
- SNFs should bill the HIPPS code derived from the “Admission Assessment”
- Only the HIPPS code from the initial assessment is required, but any updates to the HIPPS codes are welcomed by CMS.
- Bill the first line with the applicable revenue code (0022), the HIPPS code, 1 or more units, billed charges of 0.00 or one cent.

HHAs
- HHAs should bill the HIPPS code derived from the date of assessment
- Bill the first line with the applicable revenue code (0023), the HIPPS code, date of the first covered visit, one or more units, billed charges of 0.00 or one cent.
- HHAs are not required to bill treatment authorization codes.

If you currently have a contract with Anthem, the CMS mandated addition of the HIPPS code on your claim will not affect your contracted rate but is required to process your claim for payment.

Provider requirements and Medicare notices

The Centers for Medicare & Medicaid Services (CMS) requires providers to deliver the Notice of Medicare Non-Coverage (NOMNC) to every Medicare beneficiary at least two (2) days prior to the end of their skilled nursing, home health or comprehensive outpatient rehabilitation facility services, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice.

Additionally, CMS requires that providers deliver the Important Message from Medicare about Your Rights (IM) notice to every Medicare beneficiary within two (2) calendar days of the date of an inpatient hospital admission, and obtain the signature of the beneficiary or his or her representative to indicate that he or she received and understood the notice. The IM, or a copy of the IM, must also be provided to each beneficiary again, no sooner than two (2) calendar days before discharge.

CMS requires 100 percent compliance. To help our providers meet these CMS requirements, we periodically conduct IM and NOMNC Audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve their process and increase compliance with CMS requirements.

For more information about compliance with the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Federal Clinical Compliance Department -- phone: 317-287-0196, fax: 877-261-2134, email: carol.bossingham@anthem.com.

Check Important Medicare Advantage Updates at anthem.com/medicareprovider for additional information.
SNF, home health and LTC: Please contact OrthoNet for outpatient OT and PT precertifications

We are collaborating with OrthoNet, LLC to conduct medical necessity reviews for outpatient physical therapy, occupational therapy for our individual Medicare Advantage members.

Effective April 1, 2016, OrthoNet will accept precertification requests for outpatient and home-based occupational therapy and physical therapy from skilled nursing facilities, home health providers and long-term care facilities. SNF and LTC providers please note: inpatient PT/OT services rendered as part of a skilled nursing level of care are excluded from this authorization process.

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.

Help ensure members have accurate information about your practice

Please keep us apprised of any changes to street address, phone number, office hours or any other change that affects your availability to see existing Anthem Medicare Advantage members. In addition, we also need to know if you are accepting new patients or if you stop accepting new patients. This helps ensure that our Medicare Advantage members have accurate information about your practice.

Please review formulary changes to help members find best medication values

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes for 2016 include: tier changes, drug removals and new prior authorization and quantity limit requirements.

Our members will need your help to ensure they get their medications at the most affordable cost. Please encourage members to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications that will meet their needs at a lower cost.

Current and previous year Medicare Advantage formularies are published at www.anthem.com/medicareprovider. An overview of plan changes for 2016, including notable formulary changes, can be found at www.anthem.com/medicareprovider under Important Medicare Advantage Updates. See the 2016 Medicare Advantage Plan Changes for your state dated 10/1/2015.

Keep up with Medicare Advantage news

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

- Medicare Advantage reimbursement policies
- Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning June 1, 2016

57786WPPENMUB 12/11/2015
EDI update

Delivery of multiple F checks in the HIPAA 835 payment cycle discontinued

In December 2015, we eliminated the use of the ‘F’ check number in the HIPAA 835 and now combine ALL claims, paid and zero pay’ into a single 835 file for each payment cycle. This single 835 file now contains one check number. The 835 will report all finalized claim activity for that weekly payment cycle.

Change: The HIPAA 835 transaction file can contain both paid and rejected claims under the assigned check number. This is consistent with what is reported on the provider voucher/EOP.

In the event that there is no monetary payment, the 835 associated with the non-paid claims reported under that 835 is now grouped in a single file.

When the HIPAA 835 transaction file has all zero pay claims, there will not be a check/EFT number. The number mapped in TRN02 (check number field of the HIPAA 835 transaction) will be the vouchers FDSN (Financial Document Serial Number).

The FDSN will start with ‘V’ and be followed by up to 9 numbers (Example: V123456789). This number, minus the ‘V’ is located at the bottom right of the Provider voucher/EOP, under the page number. There is no change to the provider voucher/EOP, or where the FDSN is located.

Note: Blue Exchange 835s will not be impacted by this change and will continue to produce single 835s for non-paid claims.

To view provider voucher examples, go to anthem.com/edi, select state, click on Communications then EDI Latest News link.

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.

Member satisfaction with behavioral health outpatient services

We conduct an annual satisfaction survey of our member’s behavioral health outpatient service experience. The random survey is conducted based on receipt of claims. We have recently reviewed the 2015 survey experience results and wanted to share highlights with our network of behavioral health providers. The survey inquires about the member’s satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member’s various providers), prescriptions/medication management process (if applicable), financial and billing process, and their perceived clinical improvement. Our members were also asked to give their overall ratings of the experience. The 2015 overall practitioner rating was 92% in New Hampshire based on the survey results.

We are pleased with our member’s experience with our participating provider network and thank you for your network participation and the services you provide. Many of the responses were equal to or showed a slight improvement over last
year’s high baseline. There are a few areas that reflected a decrease or the responses were not as high other metrics. These areas for improvement include:

- Member’s access to behavioral health care
  As a participating provider, please be reminded of our expectation, based on NCQA definitions of access to behavioral healthcare to help ensure our members have prompt access to behavioral health care:
    - Non-life threatening emergency needs - must be seen, or have appropriate coverage directing the member, within 6 hours. When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.
    - Urgent needs - must be seen, or have appropriate coverage directing the member, within 48 hours. Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.
    - Routine office visit - must be within 10 business days. Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

We use several methods to monitor adherence to these standards. Monitoring is accomplished by a) assessing the availability of appointments via phone calls and surveys by our staff or designated vendor to the provider’s office; b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members.

- Members held harmless
  As a participating provider in Anthem’s behavioral health provider network, a participating provider shall look solely to us for compensation for covered services and under no circumstances shall render a bill or charge to any member except for applicable co-payments, deductibles and coinsurance and for services that are not medically necessary or are otherwise not covered, provided that the provider obtains the consent of the member before providing such service. We recommend that consent be in writing and dated, in order to protect our members and providers from disputes.

In addition, we also remind our participating providers that our members must be advised of missed or cancelled appointment policies at the onset of treatment. We also recommend that the advisement be acknowledged by the member in writing, and that acknowledgement is dated.

- Drug prescriptions
  The survey indicated that behavioral health providers did a very good job in explaining the potential side effects and the benefits of the prescriptive medication to assist with members’ conditions. However, there appeared to be a disconnect with members when discussing alternatives to medication or supplemental activities such as therapy, connections to community supports and other similar activities. We recommend that all three areas – side effects, pharmaceutical benefits and additional supports to medication be part of the conversation.

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

**Quality programs update**

**Commercial HEDIS® 2016 starts early February**

We will begin requesting medical records for HEDIS 2016 in February via a phone call to your office followed by a fax. The fax will contain:

1) cover letter with contact information if you have any questions
2) member list which includes the member and HEDIS measure(s) they were selected for
3) instruction sheet listing the details for each HEDIS measure

As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within five business days. All offices meeting this timeframe will be entered into a drawing to win a small prize, and the winners will be announced in Network Update during the third quarter.

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

1. Upload to our secure portal; it’s quick and easy. Logon to www.submitrecords.com, enter the password: wphedis57 and select the files to be uploaded. Once uploaded you’ll receive a confirmation number to retain for your records.
2. Send a secure fax to 888-251-2985
3. Mail to us via the US Postal Service to:
   Anthem, Inc.
   10897 S. River Front Parkway, Suite 110H
   South Jordan, UT 84095-9984

Thank you in advance for your support of HEDIS.

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

Clinical practice and preventive health guidelines available on anthem.com

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

Pharmacy update

Pharmacy information available on anthem.com

Visit the applicable websites noted below for more information on the following:

- copayment/coinsurance requirements and their applicable drug classes
- drug lists and changes
- prior authorization criteria
- procedures for generic substitution
- therapeutic interchange
- step therapy or other management methods subject to prescribing decisions
- other requirements, restrictions or limitations that apply to certain drugs

Network Update

February 2016 New Hampshire
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.

**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.


**Revised medical policies effective November 9, 2015**

(The following policies were revised to expand medical necessity indications or criteria.)

- **DRUG.00046** Ipilimumab (Yervoy®)
- **DRUG.00053** Carfilzomib (Kyprolis®)
- **DRUG.00066** Antihemophilic Factor and Clotting Factors
- **DRUG.00071** Pembrolizumab (Keytruda®)
- **DRUG.00075** Nivolumab (Opdivo®)
- **GENE.00029** Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- **SURG.00033** Cardioverter Defibrillators
- **SURG.00121** Transcatheter Heart Valve Procedures
- **THER-RAD.00007** Intensity Modulated Radiation Therapy (Note: use to be RAD. 00041.)

**New medical policy effective November 9, 2015**

(The following policy was created and does not have significant change to present clinical criteria coverage.)
Revised medical policies effective November 23, 2015
(The following policies were revised to expand medical necessity indications or criteria.)

DRUG.00002 Tumor Necrosis Factor Antagonists
DRUG.00043 Tocilizumab (Actemra®)
DRUG.00047 Brentuximab Vedotin (Adcetris®)
DRUG.00050 Eculizumab (Soliris®)
DRUG.00051 Ziv-aflibercept (Zaltrap®)
GENE.00002 Preimplantation Genetic Diagnosis Testing
GENE.00011 Gene Expression Profiling for Managing Breast Cancer Treatment
GENE.00019 BRAF Mutation Analysis
TRANS.00029 Hematopoietic Stem Cell Transplantation for Genetic Diseases and Aplastic Anemias

Revised medical policies effective December 18, 2015
(The following policies were revised effective November 9, 2015 to expand medical necessity indications or criteria; they also had another revision effective December 18, 2015.)

SURG.00033 Cardioverter Defibrillators
THER-RAD.00007 Intensity Modulated Radiation Therapy (Note: formerly RAD.00041.)

Revised medical policies effective January 1, 2016
(The following policies were revised to expand medical necessity indications or criteria; and had CPT/HCPCS procedure codes added and/or deleted.)

DRUG.00070 Siltuximab (Sylvant®)
GENE.00028 Genetic Testing for Colorectal Cancer Susceptibility

Revised medical policies effective January 1, 2016
(CPT/HCPCS procedure codes added and/or deleted on an existing policies.)

DRUG.00017 Hyaluronan Injections in Joints Other than the Knee
DRUG.00032 Intravitreal Corticosteroid Implants
DRUG.00058 Pharmacotherapy for Hereditary Angioedema (HAE)
DRUG.00064 Enteral Carbopoda and Levodopa Intestinal Gel Suspension
DRUG.00066 Antihemophilic Factor and Clotting Factors
DRUG.0006 Ramucirumab (Cyramza®)
DRUG.00068 Vedolizumab (Entyvio™)
DRUG.0007 Pembrolizumab (Keytruda®)
DRUG.00074 Alemtuzumab (Lemtrada™)
DRUG.00075 Nivolumab (Opdivo®)
DRUG.00076 Blinatumomab (Blinacyto™)
GENE.00001 Genetic Testing for Cancer Susceptibility
GENE.00005 BCR-ABL Mutation Analysis
GENE.00008 Analysis of Fecal DNA for Colorectal Cancer Screening
GENE.00009 Gene-Based Tests for Screening, Detection and Management of Prostate Cancer
GENE.00010 Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status
GENE.00012 Preconceptional or Prenatal Genetic Testing of a Parent or Prospective Parent
GENE.00014 Analysis of KRAS Status
GENE.00016 Gene Expression Profiling for Colorectal Cancer
GENE.00018 Gene Expression Profiling for Cancers of Unknown Primary Site
GENE.00019 BRAF Mutation Analysis
GENE.00025 Molecular Profiling for the Evaluation of Malignant Tumors
GENE.00029 Genetic Testing for Breast and/or Ovarian Cancer Syndrome
GENE.00030 Genetic Testing for Endocrine Gland Cancer Susceptibility
GENE.00032 Molecular Marker Evaluation of Thyroid Nodules
GENE.00035 Genetic Testing for TP53 Mutations (Li-Fraumeni Syndrome)
GENE.00043 Genetic Testing of an Individual’s Genome for Inherited Diseases
LAB.00003 In Vitro Chemosensitivity Assays and In Vitro Chemoresistance Assays
LAB.00011 Analysis of Proteomic Patterns
LAB.00031 Advanced Lipoprotein Testing
MED.00077 In-Vivo Analysis of Gastrointestinal Lesions
MED.00104 Non-invasive Measurement of Advanced Glycation Endproducts (AGEs) in the Skin
MED.00109 Corneal Collagen Cross-Linking
MED.00117 Autologous Cell Therapy for the Treatment of Damaged Myocardium
RAD.00002 Positron Emission Tomography (PET) and PET/CT Fusion
RAD.00043 Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening
SURG.00009 Refractive Surgery
SURG.00011 Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
SURG.00026 Deep Brain, Cortical, and Cerebellar Stimulation
SURG.00047 Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
SURG.00060 Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
SURG.00098 Mechanical Embolectomy for Treatment of Acute Stroke
SURG.00116 High Resolution Anoscopy Screening for Anal Intraepithelial Neoplasia (AIN) and Squamous Cell Cancer of the Anus
SURG.00121 Transcatheter Heart Valve Procedures
SURG.00132 Devices for Maintaining Sinus Ostial Patency Following Sinus Surgery
SURG.00136 Intraocular Telescope
THER-RAD.0001 Brachytherapy for Oncologic Indications (Note: use to be RAD.00014.)
THER-RAD.0003 Intravascular Brachytherapy (Coronary and Noncoronary) (Note: use to be RAD.00016.)
TRANS.00008 Liver Transplantation
TRANS.00025 Laboratory Testing as an Aid in the Diagnosis of Heart Transplant Rejection

Revised medical policies effective January 5, 2016
(The following policies were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.)

ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
DME.00011  Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices
DME.00034  Standing Frames
DME.00035  Electric Tumor Treatment Field (TTF)
DME.00036  Ultraviolet Light Therapy Delivery Devices for Home Use
DME.00038  Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices
DRUG.00006  Botulinum Toxin
DRUG.00034  Insulin Potentiation Therapy
DRUG.00035  Panitumumab (Vectibix®)
DRUG.00038  Bevacizumab (Avastin®) for Non-Ophthalmologic Indications
DRUG.00039  Trastuzumab (Herceptin®)
DRUG.00042  Ustekinumab (Stelara®)
DRUG.00052  Pertuzumab (Perjeta®)
DRUG.00060  Plerixafor (Mozobil®)
DRUG.00061  Radium Ra 223 Dichloride (Xofigo®)
GENE.00004  Janus Kinase 2 (JAK2) V617F Gene Mutation Assay
GENE.00017  Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)
GENE.00020  Gene Expression Profile Tests for Multiple Myeloma
GENE.00022  In Vitro Companion Diagnostic Devices
GENE.00027  The Panexia™ Test for Oncologic Indications
GENE.00033  Genetic Testing for Inherited Peripheral Neuropathies
GENE.00044  Analysis of PIK3CA Status in Tumor Cell
LAB.00019  Serum Markers for Liver Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease
LAB.00026  Systems Pathology Testing for Predicting Risk of Prostate Cancer Progression and Recurrence
MED.00032  Treatment of Hyperhidrosis
MED.00080  Cryopreservation of Oocytes or Ovarian Tissue
MED.00082  Quantitative Sensory Testing
MED.00083  Melanoma Vaccines
MED.00085  Antineoplaston Therapy
MED.00089  Quantitative Muscle Testing Devices
MED.00095  Anterior Segment Optical Coherence Tomography
MED.00096  Low-Frequency Ultrasound Therapy for Wound Management
MED.00099  Electromagnetic Navigational Bronchoscopy
MED.00106  Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
OR.PR.00003  Microprocessor Controlled Lower Limb Prosthesis
OR.PR.00006  Powered Robotic Lower Body Exoskeleton Devices
RAD.00004  Peripheral Bone Mineral Density Measurement
RAD.00023  Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
RAD.00029  CT Colonography (Virtual Colonoscopy) as a Screening or Diagnostic Test for Colorectal Cancer
RAD.00036  MRI of the Breast
RAD.00037  Whole Body Computed Tomography Scanning
RAD.00049  Low-Field and Conventional Magnetic Resonance Imaging (MRI) for Screening, Diagnosing and Monitoring
RAD.00057  Neovascular Hidden Coronary Imaging and Neovascular Intravascular Ultrasound Coronary Imaging
RAD.00061  PET/MRI
RAD.00062  Intravascular Optical Coherence Tomography (OCT)
RAD.00064  Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)
SURG.00008  Mechanized Spinal Distraction Therapy for Low Back Pain
SURG.00025  Cryosurgical Ablation of Solid Tumors Outside the Liver
SURG.00032  Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
SURG.00044  Breast Ductal Examination and Fluid Cytology Analysis
SURG.00050  Radiofrequency Ablation to Treat Tumors Outside the Liver
SURG.00064  Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
SURG.00082  Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
SURG.00092  Implanted Devices for Spinal Stenosis
SURG.00095  Viscocanalostomy and Canaloplasty
SURG.00101  Suprachoroidal Injection of a Pharmacologic Agent
SURG.00104  Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
SURG.00114  Facet Joint Allograft Implants for Facet Disease
SURG.00120  Open Treatment of Rib Fracture(s) Requiring Internal Fixation
SURG.00128  Implantable Left Atrial Hemodynamic (LAH) Monitor
SURG.00129  Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
SURG.00135  Radiofrequency Ablation of the Renal Sympathetic Nerves
SURG.00140  Peripheral Nerve Blocks for Treatment of Neuropathic Pain
THER-RAD.00004  External Beam Intraoperative Radiation Therapy (Note: use to be RAD.00017.)
THER-RAD.00005  Radioimmuno-therapy and Somatostatin Receptor Targeted Radiotherapy Radiotherapy (Note: use to be RAD.00031.)
THER-RAD.00006  Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors (Note: use to be RAD.00033.)
THER-RAD.00010  Stereotactic Radiosurgery and Stereotactic Body Radiotherapy (Note: formerly SURG.00017.)
TRANS.00013  Small Bowel, Small Bowel/Liver and Multivisceral Transplantation
TRANS.00014  Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
TRANS.00018  Donor Lymphocyte Infusion for Hematologic Malignancies after Allogeneic Hematopoietic Progenitor Cell Transplantation
TRANS.00023  Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias
TRANS.00027  Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors
TRANS.00028  Hematopoietic Stem Cell Transplant for Hodgkin Disease and non-Hodgkin Lymphoma
TRANS.00033  Heart Transplantation
TRANS.00034  Hematopoietic Stem Cell Transplantation for Diabetes Mellitus
TRANS.00036  Stem Cell Therapy for Peripheral Vascular Disease

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

DRUG.00053  Carfilzomib (Kyprolis®)
GENE.00029  Genetic Testing for Breast and/or Ovarian Cancer Syndrome
LAB.00028  Serum Biomarker Tests for Multiple Sclerosis
MED.00103  Automated Evacuation of Meibomian Gland
New medical policy effective May 1, 2016
(The policy listed below was created and might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

DRUG.00079   Bendamustine Hydrochloride (Trenda®)

Clinical guidelines update

Clinical guideline updates are available on anthem.com
The following new and revised clinical guidelines 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.

Revised clinical guideline effective November 9, 2015
(The following guideline was revised to expand the medical necessity indications or criteria.)

CG-DRUG-38   Pemetrexed Disodium (Alimta®)

Revised clinical guideline effective December 18, 2015
(The following guideline was revised with clarifications.)

CG-BEH-02   Adaptive Behavioral Treatment for Autism Spectrum Disorder

Revised clinical guidelines effective January 1, 2016
(CPT/HCPCS procedure codes added and/or deleted on an existing guidelines.)

CG-DRUG-05   Recombinant Erythropoietin Products
CG-DRUG-09   Immune Globulin (Ig) Therapy

Revised clinical guidelines effective January 5, 2016
(The following guidelines were revised and had no significant changes to the position or criteria.)

CG-DME-06   Pneumatic Compression Devices for Lymphedema
CG-DRUG-03   Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
CG-DRUG-08   Enzyme Replacement Therapy for Gaucher Disease
CG-DRUG-42   Asparagine Specific Enzymes (Asparaginase)
CG-MED-3  Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry
CG-SURG-09  Temporomandibular Disorders
CG-SURG-28  Transcatheter Uterine Artery Embolization
CG-SURG-30  Tonsillectomy for Children with or without Adenoidectomy
CG-SURG-47  Surgical Interventions for Scoliosis and Spinal Deformity
CG-TRANS-02  Kidney Transplantation

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

CG-DRUG-45  Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)