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Network Update is produced bi-monthly by Anthem Blue Cross and Blue Shield’s Marketing Communications Department.
Health Care Reform (including Health Insurance Exchange)

Updates and Notifications

Update regarding self-injected drug coverage for ACA-compliant health plans

Note: The following information applies to Indiana, Kentucky, Missouri and Wisconsin. It was distributed to providers in those states via Network eUPDATE on August 21, 2014 and is posted online at anthem.com, under the Health Insurance Exchange section which can be accessed from the Provider Home page.

Beginning in October 2014, the self-injected drugs indicated below are no longer covered under medical benefits for Anthem Blue Cross and Blue Shield (Anthem) ACA-compliant individual and small group health plans purchased on or off the exchange. Coverage for certain self-injected drugs may be available under the member’s pharmacy benefit.

Please note that provider administration of these drugs also is non-covered under medical benefits for impacted members.

When prescribing self-injected drugs, providers should verify member benefits and may need to make arrangements for member training on self-injection.

In situations where provider administration may be medically necessary for self-injected drugs, please contact Provider Services at (855)854-1438.

<table>
<thead>
<tr>
<th>Self-Injected Drugs Not Covered Under Medical Benefit October 2014</th>
</tr>
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<tbody>
<tr>
<td><strong>Indication</strong></td>
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<tr>
<td>BONE CONDITIONS</td>
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<tr>
<td>ENDOCRINE DISORDERS</td>
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<td>MULTIPLE SCLEROSIS</td>
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<tr>
<td>MULTIPLE SCLEROSIS</td>
</tr>
</tbody>
</table>

Please note this list is subject to change and may affect member coverage.

**Health Care Reform Updates and Notification and Health Insurance Exchange sections of our website**
Please be sure to check the Health Care Reform Updates and Notifications and Health Insurance Exchange sections of our website regularly for new updates on health care reform and Health Insurance Exchanges, at www.anthem.com>Providers (select state)>Health Care Reform/Health Insurance Exchange.

**Sign up to receive immediate notification of new information.**
Note that in addition to this newsletter and our website, we also use our email service, Network eUPDATE to communicate new information. If you are not yet signed up to receive Network eUPDATEs, we encourage you to enroll now so you’ll be sure to receive all information that we send about Exchanges. To sign up, visit www.anthem.com > Providers (enter state)> Network eUPDATE.

Account Update

**MO: Boeing home colon cancer screening**

Anthem would like to make you aware of a home colon cancer screening program that Boeing is implementing beginning in October 2014. Boeing, a National Account of Blue Cross Blue Shield of Illinois (BCBSIL), has significant membership in Missouri.

The program will send an initial mail communication to eligible members asking them to opt into receiving a kit, which is a fecal immunochemical testing kit (FIT). It is a simple, at home kit which allows the member to take a sample and send back to the lab in a postage paid envelope. Members will be asked if they want to share their test results with their provider. If the member chooses, they can provide their provider name and address to ensure the test results are also sent to their provider. BCBSIL primary nurses will outreach to members with positive results to make sure they know they need to follow-up with their physician on their result. Members will also be able to call BCBSIL with general questions on the kit, or benefit coverage questions they may have.

Administrative Update

**Enhancements to Anthem’s Find a Doctor tool**

The Find a Doctor tool at www.anthem.com is used by consumers, members, and providers to identify in-network physicians and other health care providers supporting member health plans. Specifically, providers often use the Find a Doctor tool as an online resource when referring members to other in-network providers.

Beginning this fall, you’ll notice some enhancements to our Find a Doctor tool that will make it even easier to search for providers. These enhancements include:

- A new screen layout that guides users more effectively to a specific health plan, helping ensure provider searches are conducted within the plan’s corresponding provider network.
- A simplified “Select a Plan/Network” option to help narrow searches.
- A more organized display of the health plans a doctor or hospital accepts.

We believe these enhancements will improve the consumer, member, and provider experience when using the Find a Doctor tool.
October 2014  5 of 23

OH: 75 years strong

1939 was quite a year. America was still recovering from the Great Depression and on the eve of a second world war. Movie audiences were “off to see the wizard” in theatres. And you could buy a gallon of gas for 10 cents – assuming you could afford a car. It was also the year Community Mutual started offering prepaid health care plans to Ohioans.

What a difference three-quarters of a century makes!

Anthem is proud to celebrate 75 years of serving the people of Ohio. Since our humble beginning in 1939 as Community Mutual, we’ve seen a lot of change. Membership has multiplied, health care has become more innovative and complex, and technology has transformed the way we do business. But one thing remains constant: our commitment to our members and providers.

While it’s fun to look back, we’re even more excited to look ahead. We’ve piloted innovative technologies such as electronic medical records, e-prescribing, health care cost and quality transparency tools, and online doctor visits through LiveHealth Online, and we look forward to rolling out more innovations to improve health care in the years ahead.

WI: 2014 Provider Expo

More than 120 providers braved a “change in the weather” to attend our 2014 Provider Expo. They received timely and important information on a variety of subjects including data and technology tools presented by Wisconsin and Anthem business leaders. Based on feedback from providers attending in 2013, the day included an expanded agenda of three general and nine unique breakout sessions.

John Foley, vice president of Wisconsin Provider Engagement and Contracting, delivered opening remarks with information on opportunities to engage members in their personal health through clinicians and technology. Larry Schreiber, Anthem Blue Cross and Blue Shield of Wisconsin President and General Manager shared his thoughts on the challenges and opportunities change presents within our industry, health plan and world during the first general session of the day.

After lunch, Karen E. Timberlake, JD, Director, Population Health Institute, University of Wisconsin School of Medicine and Public Health, and Director, Partnership for Healthcare Payment Reform, shared updates from the Statewide Value Committee and the Partnership for Healthcare Payment Reform. This information gave insight into how we can become involved in reducing health care cost growth while improving health care in Wisconsin.

During the last general session of the day, Karen Geiger walked us through the purpose and impacts of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act law and Christine Baldas helped us understand the impact on member benefits and changes that providers will see.

Anthem experts were available throughout the event and spoke with providers visiting the BadgerCare Plus, BlueCard® Operations, Medicare Programs and Network Relations booths. Two new expert booths, Behavioral Health and Enhanced Personal Health Care, demonstrated that Anthem can help providers “roll with the changes” by providing new and helpful information to make working with Anthem easier.

Comments from providers included:
“Very informative day. Thoroughly enjoyed the sessions we attended.”
“Lots of good information to take back for our new business office manager.”
“The information shared was extremely helpful.”
"It was so useful to connect with people for individual issues."
"I enjoyed the Expo. I did think it was well organized. Seemed like the speakers were passionate about their work."
"Anthem recognizes the need to work with everyone in the healthcare community."

Attendees told us the topics offered were important to them. If you were not able to join us, you can still find out what was shared during the 2014 Expo by going online. (Visit anthem.com > Provider (enter Wisconsin) > Communications > Provider Education.) The presentations are available for downloading under the 2014 Provider Expo heading on the Provider Education page. Here’s a list:

- **BlueCard® - The Times They Are A Changing** – Diane Duffy, Anthem
- **Change for Change Sake, Updates from the Statewide Value Committee and the Partnership for Healthcare Payment Reform** – Karen Timberlake, JD, Director, Population Health Institute, University of Wisconsin School of Medicine and Public Health and Director, Partnership for Healthcare Payment Reform
- **Creating a Documentation Improvement Team in the Office** – Jen Cohrs, Wisconsin Medical Society
- **E-Solutions Updates** – David Tucker, WellPoint, Inc.
- **Interactive Care Reviewer** – Donna Jorandby, Anthem
- **LiveHealth Online: A Provider Focused Telehealth Solution** - Wallace Adamson & Erica Terry, WellPoint, Inc.
- **Mental health Parity, The Law and Behavioral health care Management in Wisconsin** – Karen Geiger and Christine Baldas, Anthem
- **Now that we’re Anthem - Medicaid Update** – Bruce Kruger, Kathy Imig, Annette Korotko, Teresa Ortiz, Anthem
- **The Changing Landscape of Medicare Advantage Plans** - Patrick Lima for Richard Golden, Anthem
- **Using WHIO Data to Analyze Quality and Efficiency** – Sara Jensen, Wisconsin Health Information Organization
- **Whenever, You’re Ready…..Cancer Care Quality Program** – Michael Jaeger M.D., Anthem

We thank our sponsors and exhibitors for their support. The Expo would not be possible without their assistance. Our sponsors and exhibitors are shown below. Descriptions of products and services were provided by the exhibitors.

**Promotions Sponsor**
**Overture Premiums and Promotions (www.overturepromotions.com)**
*Product/Service: Promotional products and marketing*
595 North Lakeview Parkway
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Phone: 847-680-2254 Fax: 847-380-1114
Company Representatives: Laura Healy and Laura Isaacs
Protect your brand with compliant promotional products from Overture. We are a WBE company located in Vernon Hills, IL specializing in product based marketing and offering a variety of in house services including embroidery, screen printing and fulfillment.

**Bronze Sponsor**
**Availity (www.availity.com)**
*Product/Service: Web Portal*
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Jacksonville, FL 32256
Phone: 800-282-4548
Company Representatives: Leslie Kennedy and Dave Pape
Availity delivers revenue cycle and related business solutions for health care professionals who want to build healthy, thriving organizations.
Exhibitors

**EasyMed Billing LLC (www.easymedbilling.com)**
*Product/Service: Medical Billing Services*
2312 N Grandview Blvd Suite 104
Waukesha, WI 53188
Phone: 262-522-8512 Fax: 262-244-0914
Company Representative: Lynn Gorman
Billing service for medical and mental health practices.

**Easy PC Solutions LLC (www.easy-pc-solutions.com)**
*Product/Service: Medical Billing and Electronic Health Records Software*
2312 N Grandview Blvd Suite 100
Waukesha, WI 53188
Phone: 262-542-1337 Fax: 262-542-0128
Company Representative: Daryl Wessel
Software and support for Lytec, Medisoft, Practice Choice billing solutions and Lytec MD, Medisoft Clinical, and Practice Choice Electronic Health Records Solutions.

**Financial Control Solutions (www.fcs2collect.com)**
*Product/Service: Patient Statements, Collections, Remote Deposit Checking*
N114 W19225 Clinton Drive
Germantown, WI 53022
Phone: 262-251-4320 Fax: 262-251-2374
Company Representatives: Suzanne Gizella and Barbara Piaskoski
Receivables cycle management supporting patient payments, patient statements, robust reporting of receivables status to regain control of A/R and cash.

**Schenck SC (www.schencksc.com/health)**
*Product/Service: Consulting, medical billing, accounting and tax services*
Address: 11414 W. Park Place, Suite 200
Milwaukee, WI 53224
Phone: 414-463-4411 Fax: 414-463-4949
Company Representatives: Jeanne Jenkin and Mark DeBroux
Schenck’s health service consulting team has served the business needs of healthcare providers for 50-plus years. Services include strategic planning, chart audits, coding assistance, valuations, medical billing, and accounting/tax planning.

**Wisconsin Health Information Organization (WHIO) (www.wisconsinhealthinfo.org)**
*Product/Service: Quality and Resource Use data repository*
Address: 330 E. Lakeside Street
Madison, WI 53715
Phone: 608-442-3883
Company Representative: Glenda Hodge
The Wisconsin Health Information Organization is a voluntary initiative supported by visionary leaders from insurance companies, health care providers, major employers and public agencies who share a commitment to the future of health care.
The Wisconsin Medical Society is the largest association of medical doctors in the state, representing more than 12,000 physicians. The Society - a recognized, trusted and neutral source - has a long history of providing top-notch educational programs to physicians and their healthcare teams. Our portfolio of other services range from advocacy, professional development, quality improvement and data analytics to insurance services and more.

Anthem Blue Cross and Blue Shield does not advocate the use of any specific product or activity identified or otherwise endorse the content of the material provided by any sponsor or exhibitor.

Please contact your local Network Relations consultant if you would like additional information.

Reminder: Non-participating lab referrals

This is a reminder to refer Anthem members only to participating labs. Help us ensure that members receive their full benefits by continuing to refer our members to in-network providers. We realize that some labs that are not in our network may offer to waive, or cap co-payments, coinsurance or deductibles. However, some member benefit plans explicitly exclude coverage for any out-of-network services for which the provider waives the additional out-of-pocket costs to members. We appreciate your constant support.

Click here for a listing of Anthem participating laboratories, or go to www.anthem.com>Find a Doctor. Select Lab/Radiology/Pathology.

Reminder: Quality and cost program has expanded in Indiana and Ohio

Anthem previously has implemented an integrated management program to help members compare facility costs on imaging and sleep services. The program is administered in partnership with AIM Specialty Health®.

On September 1, 2014, this program expanded for some of your patients to include surgical procedures. Please check the back of members’ health plan identification (ID) cards to determine if they are included in the program (new additions may occur every few months). Note: The program expansion applies to fully insured members covered by Anthem plans in Indiana and Ohio.

Surgical procedures included in the expansion are:

- Colonoscopy - screening, biopsy, and lesion removal
- Endoscopy – Upper GI with Biopsy
- Arthroscopic ACL Repair
- Knee Arthroscopy with Cartilage Repair
- Shoulder Arthroscopy
- Shoulder Arthroscopy with Rotator Cuff Repair

Program components:

Provider notification
You may contact AIM when your patient requires one of the surgical procedures listed above. Both ordering and servicing providers may contact AIM.

You may contact AIM in one of two ways:

- Online through ProviderPortalSM at www.aimspecialtyhealth.com/goweb
- Via telephone at (800) 554-0580 or by using the number displayed on the back of the member ID card

Provider/patient transparency

Once AIM is notified, surgical facility cost information is shared with you and your patient. Cost information is based on Anthem's historical paid claims data for the various services in scope. This data is updated twice per year.

Claims are not denied for failure to inform AIM. Members are not denied access to services if they do not choose a lower-cost option. Our goal is simply to provide members with information to make informed choices about their health care. Note: Federal Employee Plan® (FEP) members are not included in this program.

If you have any questions about this information, please contact your local Network Relations consultant.

Reminder: Misrouted protected health information (PHI)

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

Use the Provider Maintenance Form to update your information

We continually update our provider directories to help ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice – updating address and/or phone number, adding or deleting a physician from your practice, etc. -- please notify us by completing the Anthem Provider Maintenance Form at anthem.com. Thank you for your help and continued efforts to keep our records up to date.

Claims

Customized edits

The following new Anthem customized claim edits will be implemented around January 15, 2014. The claim edits will apply to the following products: Blue Access®, Blue Access Choice, Blue Preferred®, Blue Preferred Primary, Blue Preferred Primary Plus, Blue Preferred Plus, Blue PrioritySM, Blue Priority Plus, Blue Traditional®, Anthem Essential® and Hospital Surgical (PPO) Blue Traditional®.
**New Edit #803** 27603 bundles with 27601  
*Rationale:* Incision and drainage of an abscess, bursa, hematoma, seroma or fluid collection is a component of the successful completion of a decompression fasciotomy and does not warrant separate reimbursement. The National Correct Coding Policy Manual for Part B Medicare Carriers, Chapter I, states: “If a definitive surgical procedure requires access through diseased tissue (e.g., necrotic skin, abscess, hematoma, seroma), a separate service for this access (e.g., debridement, incision and drainage) is not separately reportable.” Therefore, if 27603 is reported in conjunction with 27601 – only 27601 will reimburse.

**New Edit #804** 76000 and 76001 bundles with various spinal surgeries 20937-63091  
*Rationale:* CPT codes 76000 and 76001 have been designated as “separate procedure” codes in the CPT Manual. The 2014 CPT Manual states: “The codes designated as {separate procedure} should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. However, when a procedure or service that is designated as a {separate procedure} is carried out independently or considered to be unrelated or distinct from other procedures/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific {specific procedure} code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).” Therefore, when 76000 or 76001 is reported in conjunction with 20937, 20938, 22216, 22522, 22534, 22585, 22614, 22632, 22840-22847, 63035, 63044, 63048, 63057 or 63091 – only 20937, 20938, 22216, 22522, 22534, 22585, 22614, 22632, 22840-22847, 63035, 63044, 63048, 63057 and 63091 reimburse.

**New Edit #805** 49585 bundles with 43880  
*Rationale:* The performance of an abdominal procedure includes the reimbursement for hernia repair. The CMS National Correct Coding Manual states: “If a hernia repair is performed at the site of an incision for an open or laparoscopic abdominal procedure, the hernia repair (e.g., CPT codes 49560-49566, 49652-49657) is not separately reportable. The hernia repair is separately reportable if it is performed at a site other than the incision and is medically reasonable and necessary. An incidental hernia repair is not medically reasonable and necessary and should not be reported separately.” Therefore, if 49585 is reported in conjunction with 43880 – only 43880 is reimbursed.

Find additional detail about specific Claim Edits online at anthem.com>Providers (enter state)>Anthem Customized Claim Edit.

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

**eBusiness**

**Attention: Electronic trading partners**

**Changes to the file naming convention for activity logs and response reports for electronic trading partners**

As of December 13, 2014, we will implement an expanded file naming convention for our activity logs and response reports you may receive electronically. The file name will be changing from 12 characters to 15 characters to enable more efficient and faster processing of inbound Electronic Data Interchange (EDI) transactions at our enterprise EDI gateway. There is not a change to how you submit electronic transactions to us; however, the activity logs and response reports picked up from our EDI gateway mailbox will have this new naming convention beginning in December. If you use a clearinghouse or software...
vendor to pull these files into your system, they have already been notified of this implementation. The notification to trading partners can be found on the Latest News section of our EDI website.

We highly recommend that you consult with any clearinghouse or software vendor you use to ensure that they have made any needed modifications to support your business processes. If you have questions, please contact E-Solutions by phone, Live Chat, or e-mail. Our contact information can be found on www.anthem.com/edi.

**Tips to help you access MyAnthem via Availity**

Anthem has streamlined the way users access MyAnthem. Our single sign-on process allows you to register and have access to both Availity and MyAnthem quickly and efficiently and eliminates the need to log into two separate portals. For illustrated step-by-step instructions on the entire MyAnthem single sign-on process, see "Logging into MyAnthem" at www.anthem.com>Providers (select state)>Answers@Anthem.

Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.

## Health Care Management

**Medical policy update**

The following Anthem Blue Cross and Blue Shield medical polices were reviewed on May 15, 2014 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on January 2, 2015.

**DRUG.00064  Levodopa/Carbidopa Intestinal Infusion**

This new medical policy document addresses a novel formulation of the levodopa/carbidopa intestinal (intraduodenal) gel infusion for the treatment of late-stage Parkinson’s disease.

**DRUG.00065  Recombinant Coagulation Factor IX, Fc Fusion Protein (rFIXFc)**

This new medical policy addresses recombinant coagulation Factor IX protein, fusion protein (rFIXFc) (Alprolix™) that temporarily replaces the missing coagulation Factor IX needed for effective hemostasis in individuals with hemophilia B.

**GENE.00039  Genetic Testing for Frontotemporal Dementia (FTD)**

This new medical policy addresses genetic testing for the screening, diagnosis and management of frontotemporal dementia (FTD). This document does not address genetic testing for Alzheimer’s disease.

**GENE.00042  Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome**

This new medical policy addresses genetic testing for CADASIL syndrome, a rare, autosomal dominant, cerebrovascular disease which is considered to be the most common cause of hereditary stroke and hereditary vascular dementia in adults.

**OR-PR.00005  Upper Extremity Myoelectric Orthoses**

This new medical policy addresses the use of upper extremity myoelectric orthoses, which are intended to augment the function of individuals with upper arm weakness or partial paralysis due to neurological conditions, trauma, or other
problems. Such devices use neurologic sensors, microprocessor units, and electric motors to provide self-initiated movement of the affected limb.

DME.00011  Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices
The medical policy was revised to address auricular electrostimulation for the treatment of pain and related conditions, including but not limited to, acute and chronic pain.

DME.00037  Cooling Devices and Combined Cooling/Heating Devices
The medical policy coding section was updated to include existing HCPCS codes E0676 and E1399 which may be used for cooling devices.

DRUG.00015  Prevention of Respiratory Syncytial Virus Infections
The medical policy position statement was revised to correspond with updated 2014 American Academy of Pediatrics (AAP) recommendations.

DRUG.00043  Tocilizumab (Actemra®)
The medical policy position was revised to address janus kinase inhibitors (for example, tofacitinib citrate [Xeljanz®]) for use in combination with tocilizumab.

DRUG.00057  Canakinumab (Ilaris®)
This medical policy position was revised to address janus kinase inhibitors (for example, tofacitinib citrate [Xeljanz®]) for use in combination with canakinumab and to include a statement regarding the use of canakinumab for the treatment of Behçet's disease.

GENE.00010  Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status
The medical policy position statement was revised to address the use of testing panels for genetic polymorphisms to determine drug-metabolizer status.

LAB.00011  Analysis of Proteomic Patterns
The medical policy coding was updated to add the existing CPT code 83520 for the Early CDT lung test.

MED.00112  Autonomic Testing
The medical policy position statement was revised to address Sudoscan testing.

SURG.00007  Vagus Nerve Stimulation
The medical policy was revised to address non-implantable vagus nerve stimulation devices.

SURG.00020  Bone-Anchored and Bone Conduction Hearing Aids
The medical policy scope was expanded to include the use of implantable bone-anchored hearing aids; transcutaneously worn, non-surgical application of a bone-anchored hearing aids using headband or Softband; partially implantable magnetic bone conduction hearing aids; and intraoral bone conduction hearing aids.

SURG.00055  Cervical Artificial Intervertebral Discs
The medical policy position was revised to address cervical spine malignancy in relation to disc implantation.
To view all medical policies online, go to www.anthem.com>Providers (select state)>Medical Policies and Clinical UM Guidelines.

**Medical Policy DRUG 00015 will require precert**

On August 14, 2014, the medical policy position statement for medical policy DRUG.00015 *Prevention of Respiratory Syncytial Virus* was revised to correspond with updated 2014 American Academy of Pediatrics (AAP) recommendations. Based on the AAP recommendations, there were some major changes to Anthem’s medical policy (DRUG.00015), including:

- Synagis is no longer indicated for children less than six months of age who were born between 32 and 36 weeks gestation.
- Children less than one year of age (at the start of RSV Season) without hemodynamically significant congenital heart disease or anatomic pulmonary abnormalities, who were born between 29 and 32 weeks gestation, must meet criteria for chronic lung disease to be approved for Synagis.

The revised medical policy was posted and is available for viewing at www.Anthem.com as of August 18, 2014 and will be implemented on January 2, 2015.

Note: The above information does not apply to FEP.

**Specialty pharmacy drugs will require precert**

The following specialty drugs will require precertification for members covered by these Anthem local plans: Blue Priority℠, Blue Preferred® Primary, Blue Priority Plus, Blue Preferred Primary Plus, Blue Access®, Blue Access Choice, Blue Preferred Plus and Lumenos®, Anthem (Bronze/Silver/Gold/Platinum) Direct Access, Anthem (Catastrophic/Core/Essential/Preferred) Direct Access plans. Note: In most cases, the changes do not apply to Blue Traditional®, National Accounts, Medicare Advantage (MA), or FEP.

Effective December 31, 2014, the following specialty drugs will require precertification on these existing medical policies:

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Medical Policy or Clinical Guideline Name</th>
<th>Drug Name</th>
<th>Added Drug Code</th>
<th>Removed Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00051</td>
<td>Ziv-aflibercept (Zaltrap®)</td>
<td>Zaltrap</td>
<td>J9400</td>
<td>C9296</td>
</tr>
<tr>
<td>DRUG.00052</td>
<td>Pertuzumab (Perjeta™)</td>
<td>Perjeta</td>
<td>J9306</td>
<td>C9292</td>
</tr>
<tr>
<td>DRUG.00053</td>
<td>Carfilzomib (Kyprolis™)</td>
<td>Kyprolis</td>
<td>J9047</td>
<td>C9295</td>
</tr>
<tr>
<td>DRUG.00054</td>
<td>Ocriplasmin (Jetrea®) Intravitreal Injection Treatment</td>
<td>Jetrea</td>
<td>J7316</td>
<td>C9298</td>
</tr>
<tr>
<td>DRUG.00056</td>
<td>Ado-trastuzumab emtansine (Kadcyla™)</td>
<td>Kadcyla</td>
<td>J9354</td>
<td>C9131</td>
</tr>
<tr>
<td>DRUG.00058</td>
<td>Pharmacotherapy for Hereditary Angioedema (HAE)</td>
<td>Ruconest</td>
<td>J3490</td>
<td></td>
</tr>
<tr>
<td>CG-DRUG-05</td>
<td>Recombinant Erythropoietin Products</td>
<td>Mircera</td>
<td>Q9972 &amp; Q9973</td>
<td></td>
</tr>
</tbody>
</table>
Effective January 2, 2015, the following specialty drug will require precertification on this new medical policy:

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline Name</th>
<th>Drug Name</th>
<th>Added Drug Code</th>
<th>Removed Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00064</td>
<td>Levodopa/Carbidopa Intestinal Infusion</td>
<td>Duopa</td>
<td>J3490</td>
</tr>
</tbody>
</table>

To submit your precertification request for specialty pharmacy drugs, the preferred method is to go online to AIM Specialty Health via the Availity Web Portal. (For more information on how to access, see the article, “Important: Pre-service clinical review of specialty pharmacy drugs will transition to AIM,” in the August 2014 issue of Network Update.) You also may use the Specialty Pharmacy Clinical Data Submission tools; they serve as guides to make sure that you have submitted all necessary information for Anthem to complete the review. (Note: Tools are not available for all specialty pharmacy data submissions.) You can find the tools at anthem.com>Providers (enter state)>Answers@Anthem>Precertification>Clinical Data Submission Tools>Specialty Pharmacy Clinical Data Submission Tool.

Non-emergent ground ambulance precert

In January 2014, member certificate language was updated and will now require precertification for certain non-emergent ground ambulance services. The precertification requirement is based on where the member is being picked up and dropped off. The following non-emergent transports are now considered for precertification:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PN</td>
<td>Physician’s Office to SNF</td>
</tr>
<tr>
<td>NP</td>
<td>SNF to Physician’s Office</td>
</tr>
<tr>
<td>HR</td>
<td>Hospital to Residence</td>
</tr>
<tr>
<td>HE</td>
<td>Hospital to Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)</td>
</tr>
<tr>
<td>PR</td>
<td>Physician’s Office to Residence</td>
</tr>
<tr>
<td>RP</td>
<td>Residence to Physician’s Office</td>
</tr>
<tr>
<td>JR</td>
<td>Non-Hospital based dialysis facility to Residence</td>
</tr>
<tr>
<td>RJ</td>
<td>Residence to Non-Hospital based dialysis facility</td>
</tr>
<tr>
<td>EP</td>
<td>Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility) to Physician’s Office</td>
</tr>
<tr>
<td>HP</td>
<td>Hospital - Physician Office</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily excluded</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or service expected to be denied</td>
</tr>
</tbody>
</table>

In addition, the new non-emergent ground ambulance clinical guideline (CG-ANC-06) was approved at the May 15, 2014 Medical Policy & Technology Assessment Committee. The new guideline outlines the medically necessary and not medically necessary indications for non-emergency ground ambulance services. The policy becomes effective on January 2, 2015.

Note: If the service is not prior authorized/precertified, records will be requested for post-service review based on the same criteria listed in the medical policy or clinical guideline. Also, as a reminder: as a participating provider, you have agreed to refer members to other participating providers. Referring to participating providers is to the benefit of the member. When it is necessary to refer a member to a non-participating provider, remember to inform the member that services provided by a
non-participating provider may result in reduced benefits. The non-participating provider may bill members for amounts other than deductibles and copayments and for medical services not covered under the member’s benefit agreement.

View all medical policies online at www.anthem.com>Providers (select state)>Medical Policies and Clinical UM Guidelines.

Note: The above information does not apply to FEP.

**Medicare**

**Reimbursement policy changes**

Effective January 1, 2015, Anthem will move Individual (non-group) MA members to a new claims processing system. This new system will have some new and updated MA reimbursement policies. These policies will be in effect unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

In addition, all Individual MA members will receive new member ID cards for 2015. Please check all MA members’ ID cards as many alpha prefixes will have changed. *Note: After January 1, 2015, the following alpha prefixes will apply only to Anthem MA Employer Group Retiree business.*

<table>
<thead>
<tr>
<th>FKB</th>
<th>JQF</th>
<th>JWM</th>
<th>VZM</th>
<th>VZP</th>
<th>WGK</th>
<th>WMN</th>
<th>WSP</th>
<th>XDK</th>
<th>XDT</th>
<th>XGH</th>
<th>XGK</th>
</tr>
</thead>
<tbody>
<tr>
<td>XKJ</td>
<td>XVJ</td>
<td>XVL</td>
<td>YCG</td>
<td>YGJ</td>
<td>YGS</td>
<td>YLR</td>
<td>YLW</td>
<td>YRA</td>
<td>YRE</td>
<td>YRS</td>
<td>YRU</td>
</tr>
</tbody>
</table>

For more detail on these changes, please view the full article here. To review the actual new policies that will go into effect January 1, 2015 please click here. For additional information on Medicare Advantage, please see our bulletins posted at www.anthem.com/medicareprovider then select Important Medicare Advantage Updates.

**Code editing enhancements**

Anthem Medicare Advantage Individual and Employer Group Retiree plans of Indiana, Kentucky, Missouri, Ohio, and Wisconsin currently use a comprehensive and nationally recognized code auditing system to ensure consistent physician and facility reimbursement. Our system does this by automatically evaluating provider claims in accordance with accepted industry coding standards.

The purpose of this update is to notify you that, effective November 15, 2014, we are updating our Medicare Advantage claims editing by enhancing our code-editing technology to better align to existing payment guidelines.

Claims will be reviewed to:

- Reinforce compliance with standard code edits and rules
- Ensure correct coding and billing practices are being followed
- Determine the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Ensure compliance with industry standards
Notice of Medicare non-coverage requirements

CMS requires providers to deliver a “Notice of Medicare Non-Coverage” (NOMNC) to every Medicare beneficiary at least two days prior to the end of their skilled nursing facility (SNF), home health or comprehensive outpatient rehabilitation facility (CORF) care.

SNFs are responsible for delivering the NOMNC on behalf of Anthem to the member or representative. SNFs also are responsible for obtaining signature(s) the same day the NOMNC is received by Anthem and returning the signed NOMNC to Anthem that same day, but no later than two days before the member’s covered services end. In the event the SNF is not able to deliver the NOMNC and obtain signature(s) the same day Anthem issues the NOMNC, the SNF provider is responsible for re-issuing a NOMNC with the appropriate Last Approved Day (LAD) to give the member or the member’s representative at least two calendar days advance notice. In addition, Anthem does not provide verbal notification of NOMNC.

CMS requires 100 percent compliance. To help ensure CMS compliance, please:

- Submit Notice of Medicare Non Coverage (NOMNC) notices no later than two days before the termination of services
- Verify notices are signed and dated by the member or member’s representative and return to Anthem the same day.
- Provide complete and accurate records/documentation.

Anthem will continue to work with providers to reach the 100 percent compliance goal.

Improving quality of care for Rheumatoid Arthritis (RA) members

Evidence-based guidelines support early initiation of disease-modifying antirheumatic drug (DMARD) therapy in patients diagnosed with RA. According to the American College of Rheumatology, all patients with RA are candidates for DMARD therapy, and the majority of the newly diagnosed should be started on DMARD therapy within three months of diagnosis.

During recent quality reviews of our RA members, some challenges were noted, including:

- Members are correctly diagnosed with RA but are not receiving treatment, and
- Members were being worked up for joint pain but are incorrectly coded RA

You can help:

- Review clinical practice guidelines and treatment recommendations at www.rheumatology.org. New treatments have come a long way and -- if started early -- can prevent joint damage and promote “remission.” Early treatment has been shown to decrease the need for joint replacement and improved quality of life for those diagnosed with RA.
- Ensure your documentation is clear and coded correctly. If treating a member for unknown joint pain, there are alternates to “rule-out RA” as a diagnosis code. Until a true diagnosis is made, consider using codes for joint pain (719.40), swelling (719.0) or difficulty with walking (719.7). Attention to clinical practice guidelines and coding will allow for proper identification as well as to initiate early effective treatment for our RA members.
Important 2015 coverage changes for diabetic supplies

Effective January 1, 2015, none of our individual MA plans will cover certain diabetic supplies purchased from Durable Medical Equipment (DME) providers.

HCPC codes no longer covered when purchased through a DME provider:

- A4253 blood glucose test strips
- E0607 home blood glucose monitor
- E2100 blood glucose monitor with integrated voice synthesizer
- E2101 blood glucose monitor with integrated lancing/blood sample

Members impacted by this change will be notified in October through their Annual Notice of Change and Evidence of Coverage plan benefit materials.

To be covered for a $0 copay, members must purchase these supplies at an in-network retail or mail-order pharmacy supplier.

Covered blood glucometers and blood glucose test strips in 2015:

- LifeScan, Inc., OneTouch®
- Roche Diagnostics, ACCU-CHEK®
- A limit of 100 blood glucose test strips per month

Other blood glucometer or blood glucose test strip brands or quantities of more than 100 test strips per month are not covered unless you as the doctor or provider tell us another brand or a larger quantity is medically necessary for the member’s treatment.

- If our member is currently using LifeScan, Inc., OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products and using an in-network retail or mail-order pharmacy supplier, you don’t need to do anything.
- If our member is not using LifeScan, Inc., OneTouch® or Roche Diagnostics, ACCU-CHEK® blood test strips or glucometer products or using an in-network retail or mail-order pharmacy supplier, then our member will need to get new prescriptions for the supplies by January 1st for these claims to be covered by us.
- You should discuss these coverage changes and possible new prescriptions with your patient. If it is medically necessary to continue using a non-covered brand of blood test strips or glucometer and/or more than 100 blood test strips per month, please request an exception from us.

The benefit and brand limitations described above generally do not apply to our Group Sponsored MA Health Benefit Plans. Please contact Provider Services for benefit information.
Individual Medicare Advantage Plans included in this coverage change:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>State - Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Medicare Access Value (Regional PPO)</td>
<td>IN&amp;KY-RPPO</td>
</tr>
<tr>
<td>Anthem MediBlue Select (HMO)</td>
<td>IN-HMO</td>
</tr>
<tr>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>IN-HMO, DE-SNP</td>
</tr>
<tr>
<td>Anthem Medicare Preferred Standard (PPO)</td>
<td>IN-LPPO</td>
</tr>
<tr>
<td>Anthem Senior Advantage Value (HMO)</td>
<td>KY-HMO</td>
</tr>
<tr>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>KY-HMO, DE-SNP</td>
</tr>
<tr>
<td>Anthem MediBlue Select (HMO)</td>
<td>MO-HMO</td>
</tr>
<tr>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>MO-HMO, DE-SNP</td>
</tr>
<tr>
<td>Anthem Medicare Preferred Core (PPO)</td>
<td>MO-LPPO</td>
</tr>
<tr>
<td>Anthem Senior Advantage Basic (HMO)</td>
<td>OH-HMO</td>
</tr>
<tr>
<td>Anthem Senior Advantage Plus (HMO)</td>
<td>OH-HMO</td>
</tr>
<tr>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>OH-HMO, DE-SNP</td>
</tr>
<tr>
<td>Anthem Medicare Preferred Select (PPO)</td>
<td>OH-LPPO</td>
</tr>
<tr>
<td>Anthem Medicare Preferred Standard (PPO)</td>
<td>OH-LPPO</td>
</tr>
<tr>
<td>Blue Medicare Access Classic (Regional PPO)</td>
<td>OH-RPPO</td>
</tr>
<tr>
<td>Blue Medicare Access Value (Regional PPO)</td>
<td>OH-RPPO</td>
</tr>
<tr>
<td>Anthem MediBlue Select (HMO)</td>
<td>WI-HMO</td>
</tr>
<tr>
<td>Anthem Dual Advantage (HMO SNP)</td>
<td>WI-HMO, DE-SNP</td>
</tr>
<tr>
<td>Anthem Medicare Preferred Core (PPO)</td>
<td>WI-LPPO</td>
</tr>
<tr>
<td>Anthem Medicare Preferred Standard (PPO)</td>
<td>WI-LPPO</td>
</tr>
</tbody>
</table>

To determine whether or not a member is enrolled in one of our Individual MA plans versus an Employer or Union Sponsored plan, please check the lower right front of the ID card which reflects the contract and PBP number (example: H1234-001) and/or plan name.

**Note:** If the PBP (the last three digits of the contract-PBP number) is in the 800 series, the member is in an Employer or Union Sponsored plan and these changes do not apply to their plans.
Please contact the Provider Services department listed on the back of the member’s ID card if you have any questions about these coverage changes.

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact Anthem. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.

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**Pharmacy**

**Clarification of CoramRx/CVS Caremark change**

In the August 2014 issue of *Network Update*, the article, “CoramRx/CVS Caremark change for specialty drugs,” announced CVS Caremark’s purchase of CoramRx. This it to clarify that information in that article only applies to CVS Caremark/Coram’s internal processes when triaging medications for health plan members.

CVS Caremark’s purchase of Coram does not impact contracted home infusion/ambulatory infusion suite providers who supply specialty medications and home infusion services for health plan members through the medical benefit.
Pharmacy information available at anthem.com

For more information on 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, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit http://www.anthem.com/pharmacyinformation. 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 Customer Support, select your state, Download Forms and choose “Select Drug List.”

Quality

Pathways added to WellPoint Cancer Care Quality Program

Effective September 1, 2014, Anthem Blue Cross and Blue Shield (Anthem) added Cancer Treatment Pathways to the existing WellPoint Cancer Care Quality Program, a quality initiative which allows physicians to compare planned cancer treatment regimens against evidence-based clinical criteria. The additional Pathways include treatment regimens for Lymphoma and Chronic Lymphocytic Leukemia, Myeloma, Ovarian cancer and Pancreatic cancer. For full details, please go online to www.anthem.com>Providers (enter state)>Network eUPDATE or access information at https://wellpoint.aimoncology.com/.

Clinical practice & preventive health guidelines

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. To access the guidelines, go to www.anthem.com>Providers (enter state)>Health & Wellness>Practice Guidelines.

Reimbursement

Notice of revised professional reimbursement policies

Anthem Blue Cross and Blue Shield in Indiana, Kentucky, Missouri, Ohio, and Wisconsin (individually referred to herein as the Health Plan) reviews its professional reimbursement policies annually to determine if any changes or revisions are required.

The Health Plan revised the following professional reimbursement policies to provide further clarification and detail. These changes do not affect the outcome of the reimbursement for claims submitted. Examples of some changes include punctuation, grammatical edits, formatting, and verification of CPT/HCPC codes as well as insertions of AMA CPT Handbook terminology.
Reimbursement Policy

<table>
<thead>
<tr>
<th>Modifier Rules</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management Services and Related Modifiers -25 &amp; -57</td>
<td>10/01/2014</td>
</tr>
<tr>
<td>Telemedicine and Telehealth Services</td>
<td>11/01/2014</td>
</tr>
<tr>
<td>Screening Services with Evaluation &amp; Management Services</td>
<td>11/01/2014</td>
</tr>
<tr>
<td>Office Place of Service</td>
<td>11/01/2014</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>01/01/2015</td>
</tr>
</tbody>
</table>

Bundled Services and Supplies
There are services and supplies that are always considered part of providing another service and therefore are not eligible for separate reimbursement when reported by a professional provider. These bundled services may be performed or provided either on the same or different date of service as the primary service. The services listed below are subject to the Health Plan’s Bundled Services and Supplies policy as of January 19, 2015. As noted in the policy, not all codes are enumerated within the policy itself; the table of codes identifies some of the procedures and supplies that are bundled. The exclusion of a specific code does not indicate eligibility for reimbursement under all circumstances. The table of codes is provided as an informational tool only.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0209</td>
<td>Wheelchair van, mileage, per mile</td>
</tr>
<tr>
<td>S0215</td>
<td>Nonemergency transportation; mileage, per mile</td>
</tr>
<tr>
<td>S0265</td>
<td>Genetic counseling under physician supervision, each 15 minutes</td>
</tr>
<tr>
<td>S0320</td>
<td>Telephone calls by a registered nurse to a disease management program member for monitoring purposes; per month</td>
</tr>
<tr>
<td>S3650</td>
<td>Saliva test, hormone level; during menopause</td>
</tr>
<tr>
<td>S4026</td>
<td>Procurement of donor sperm from sperm bank</td>
</tr>
<tr>
<td>S8185</td>
<td>Flutter device</td>
</tr>
<tr>
<td>S9001</td>
<td>Home uterine monitor with or without associated nursing services</td>
</tr>
<tr>
<td>S9025</td>
<td>Omnicardiogram/cardiointegram</td>
</tr>
<tr>
<td>S9447</td>
<td>Infant safety (including CPR) classes, nonphysician provider, per session</td>
</tr>
<tr>
<td>S9982</td>
<td>Medical records copying fee, per page</td>
</tr>
<tr>
<td>S9991</td>
<td>Services provided as part of a Phase III clinical trial</td>
</tr>
</tbody>
</table>

Modifier Rules
In the June 2014 issue of Network Update, we informed you of a Material Change to Contract effective for dates of service on or after October 1, 2014 under the professional reimbursement policy E&M services and related modifiers 25 & 27. However, the article did not include a similar update to the related Modifier Rules professional reimbursement policy. The Modifier Rules policy for dates of service on or after October 1, 2014 has also been updated to reflect that if a problem-oriented evaluation and management (E/M) service is eligible for separate reimbursement on the same date of service as a preventive exam, then the maximum allowable reimbursement will be reduced by 50 percent for the reported problem oriented E/M service when Modifier 25 is appended to the claim.

Modifier 59
The Health Plan is correcting a typographical error found in our Modifier 59 (Distinct Procedural Service) professional reimbursement policy under Section III Exceptions to Modifier 59 Override. The code to code relationship Q0091 reported with 99381- 99397, 99201-99205, and S6010-S6012 will now read as Q0091 reported with 99381- 99397, 99201-99205, and
S0610-S0612. Please see our Screening Services with Evaluation & Management Services and our Bundled Services and Supplies reimbursement policies for further information.

The Health Plan, effective with dates of service on or after January 19, 2015, will no longer override the code to code relationship edits listed in the Modifier 59 (Distinct and Procedural Services) professional reimbursement policy with any modifier including the Modifier 25 (Significant, Separately Identifiable E/M Service by the Same Physician or Other Qualified health Care Professional on the Same Day of the Procedure or Other Service). Please see our Modifier 59 (Distinct and Procedural Service) for the most current list of edits.

**List of Payment Policy for Assistant Surgeon**

As stated in the April 2014 issue of *Network Update*, the List of Payment Policy Indicator includes all affected codes and is maintained by the Health Plan annually and/or quarterly for Multiple or Bilateral surgery, MPI4 and global days. This list also contains Assistant Surgery and therefore, effective July 1, 2014, the new CPT Category III code 0356T was considered not eligible for reimbursement when reported as performed by an Assistant Surgeon. The full listing is viewable online and may be accessed online via MyAnthem. See the article on page 22 for more information on how to access Anthem's reimbursement policies.

**OH: Notification of Ohio professional fee schedule update**

Anthem would like to thank you for your continued participation in the Anthem Networks. We want to make you aware of upcoming changes to the Ohio professional fee schedules for the Ohio Health Service Areas. The new fee schedules will apply to Covered Services rendered on or after January 1, 2015 for Blue Traditional®, Blue Access®, including the Pathway Network, Blue Preferred®, Blue Priority™ and Anthem Medicare Advantage members.

The changes to the fee schedule will not decrease the fees for any procedure codes. Also, please note that fee schedule adjustments after January 1, 2015 will be contingent on updating your Anthem contract language to the most current template. Please contact your Network Relations Consultant to update your Anthem contract.

The following are examples of procedure code categories receiving increases:
- Select Established Patient Office Visits
- Select Preventive Visits
- Behavioral Health Services performed by a Psychiatrist
- Select OB/GYN Procedures and Maternity Deliveries (Southern Ohio OB/GYN providers will continue to be reimbursed according to their applicable specialty specific fee schedule)
- Vaccine Administration

Drugs reimbursed on the professional fee schedule will continue to be reimbursed at ASP +6 percent and will be updated quarterly.

As a participating provider, you can access your Ohio professional fee schedule at MyAnthem via the Availity Web Portal. Go to www.anthem.com >Providers (enter state) and log in to Availity on the left side of the provider home page. Or go to www.availity.com, sign in, then select My Payer Portals, then Anthem Provider Portal from the drop down menu. For more detailed guidance on accessing MyAnthem via Availity, please see the article below or view Logging into MyAnthem at www.anthem.com>Providers (select Ohio)>Answers@Anthem.
Please note: The changes to the Medicare Advantage fee schedule do not apply to providers who participate in Medicare Advantage through the Cleveland Health Network or providers reimbursed on the CMS Medicare Part B Physician Fee Schedule.

Again, thank you for your continued support and cooperation. If you have any questions, please contact your local Network Relations consultant.

**View Anthem reimbursement policies**

Anthem’s reimbursement policies are available online at MyAnthem, which is accessible through the Availity Web Portal.* To view online reimbursement policies, you must be registered for access to Availity and MyAnthem functionality.

Non-Registered for Availity: To register for access to Availity, go to [www.availity.com/providers/registration-details/](http://www.availity.com/providers/registration-details/).

Non-Registered MyAnthem: If your organization is not registered for MyAnthem, sign onto [www.anthem.com](http://www.anthem.com), select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. If you do not have a MyAnthem user id and password, your organization’s site administrator must register you as a new user and assign required Anthem-specific functionality. Note: Effective June 21, passwords are no longer generated.

Registered MyAnthem: If you are a registered MyAnthem user, sign onto [www.availity.com](http://www.availity.com), select “My Payer Portals,” then choose “Anthem Provider Portal” to be navigated into MyAnthem without entering an additional log-in or password. Select the Administrative Support tab, then select the link labeled Procedures for Professional Reimbursement or Procedures for Facility Reimbursement.

*For more information, see “MyAnthem and the Availity Web Portal: Access both with one log-in” on page 7 of the June 2014 issue of [Network Update](http://www.anthem.com) and “Logging into MyAnthem” at [www.anthem.com>Providers](http://www.anthem.com>Providers) (enter state)>Answers@Anthem.