

Network Update

CENTRAL REGION

In this issue

	Page
Health Care Reform (including Health Insurance Exchange)	
• Updates and notifications	2
Administrative Update	
• Introducing TogetherWorks	3
• DBT is not a covered benefit	3
• IN, KY: Anthem offers members the Ornish Reversal Program	3
• Update provider demographic information	4
• WI: 2015 Expo was a "classic"	4
Claims	
• ICD-10 updates	5
Health Care Management	
• Medical policy update	7
• Specialty pharmacy drugs will require precert	7
• Revised AIM guideline	8
• Revised clinical guideline for gender reassignment surgery	8
• Clinical information is required for inpatient cardiac services	8
• Reminder: Outpatient cardiac services require precert	8
Medicare	
• Routine physical exams are covered in 2016	9
• Administrative denials may be appealed	9
• Precertification requirements updated for 2016	9
• HRM program designed to reduce risk for MA members	9
• KY, OH: Brachtherapy, IMRT CPT codes to require authorization	10
• Keep up with MA news	10
Pharmacy	
• Pharmacy information available at anthem.com	10
Quality	
• Members compare facility costs for surgical procedures	10
• Clinical practice and preventive health guidelines	11

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

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

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare"), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

anthem.com

CE1015
IN, KY, MO, OH, WI

Reimbursement

- [Revised professional reimbursement policies](#) 11
- [View Anthem reimbursement policies](#) 14

Specialty services – Behavioral Health

- [Outpatient coding](#) 15
- [Revised CG-BEH-02](#) 15
- [Central nervous system \(CNS\) assessments](#) 16

Medicaid Notifications

- For IN, KY, WI
 - [Medical policy and clinical UM guidelines update](#) 17
 - [Provider self-service tools](#) 17
 - [ICD-10 documentation and coding tips](#) 18
- For IN, KY only
 - [Synagis guidelines for RSV season](#) 18
 - [CDC predicts moderately severe flu season](#) 18
- For IN, WI only
 - [Changes to Behavioral Health authorization requirements](#) 18
- For KY only
 - [Crossover encounter update](#) 19

Special Section

- [Wisconsin Expo Exhibitors](#) 20

Health Care Reform (including Health Insurance Exchange)

Updates and Notifications

Health Care Reform Updates and Notifications

Please check our website regularly for new updates on health care reform at www.anthem.com>Providers (select state)>Health Care Reform/Health Insurance Exchange.

Health Insurance Exchange

Please check this section of our website for updates on the networks that support Health Exchange products, how the Health Exchange works, who is affected, Plan names, how to identify members covered by a Health Exchange plan and much more.

- Ohio providers: Click [here](#) for new information on 2016 ACA-compliant Individual health plans in Ohio.

Network Update

Administrative Update

Introducing Anthem Togetherworks

At Anthem, we look for ways to get results and achieve goals together. Every day we bring our tools, information, and expertise to the table in ways that benefit our members and providers. With this effort, we introduce Anthem Togetherworks – a new name for our provider collaboration strategy. Anthem Togetherworks refers to a broad spectrum of partnership options already in place at Anthem, and includes programs like Enhanced Personal Health Care (EPHC) and the Quality in Sights®: Hospital Incentive Program (QHIP®). Anthem Togetherworks also includes tools we offer, such as our web-based Provider Care Management Solutions and Care Delivery Transformation support. Through Anthem Togetherworks, we'll continue to offer a wide range of provider collaboration programs and offerings based on your needs, to help us work together to meet the challenges of a new era in health care.

DBT is not a covered benefit

Important information about coverage for Digital Breast Tomosynthesis (DBT) or 3-D mammography

In 2015, the USPSTF reviewed screening recommendations for breast cancer and concluded in a [draft recommendation statement](#) that Digital Breast Tomosynthesis (DBT) or 3-D mammography does not meet evidence level A or B and should not be recommended in place of digital mammography for routine breast cancer screening. The draft statement also notes that DBT may expose women to approximately twice the radiation of 2-D digital mammography.

Based on the USPSTF conclusion and Anthem's independent review of the available evidence, Anthem considers Digital Breast Tomosynthesis **investigational and not medically necessary** for all indications.

Please note that two imaging vendors currently have FDA approval for DBT and actively promote their services to academic centers and private hospitals or imaging centers. As marketing and adoption of DBT increases, we expect an increase in interest and use of this service, which is why ***it is important for providers to be aware that DBT is a non-covered service.***

Anthem has extensively reviewed the available evidence addressing the use of Digital Breast Tomosynthesis and presented this data to the Medical Policy and Technology Assessment Committee (MPTAC) for discussion and evaluation. The MPTAC agrees with the USPSTF concerns and recommendations.

To read more about the USPSTF's conclusion, please see the [USPSTF Breast Cancer Screening Draft Recommendation Statement](#). Providers can also review Anthem's [medical policy for Digital Breast Tomosynthesis](#).

IN, KY: Anthem offers members the Ornish Reversal Program

Available at three hospitals

Dr. Ornish's Program for Reversing Heart Disease™ is being offered in conjunction with Healthways® at the following hospitals: Memorial Hospital of South Bend, Elkhart General Hospital, and Medical Center Jewish Northeast (Louisville).

Dr. Dean Ornish, a leader in preventive medicine, created the program. He has researched coronary artery disease for 30 years. The methods he developed are scientifically proven to slow the progress, and in some cases, even reverse the effects of heart disease. Dr. Ornish's program is based on nutrition, exercise, stress reduction and emotional support. In addition to

Network Update

helping reduce the risks of heart attack, the program also helps reduce health risks for those suffering from other health conditions, including diabetes, heart failure, stroke, high blood pressure, high cholesterol and obesity. The program is Medicare-approved.

Anthem is reaching out to our members who may be eligible to participate in this program. Criteria include but are not limited to: 1) the member is enrolled in Anthem's Care Management Program and 2) the member qualifies for cardiac rehabilitation after an acute coronary event.

Update provider demographic 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](#). Note: If you are the Primary Access Administrator (PAA) or PAA assistant for your organization, you can now submit changes for your practice via Availity. To access, go to [www.availity.com](#) and enter your Availity User ID and password. The form can be found under the **Payer Resources Page | Anthem | Physician Change Requests | Provider Maintenance Form**.

Thank you for your help and continued efforts to keep our records up to date.

WI: 2015 Expo was a “classic”

On September 2, Wisconsin providers attended a very special “Classic Rhythm and Blues” Provider Expo celebrating 10 years of Expos and our 75th anniversary as the local Blue plan. The day started with a retrospective of the past 10 years and recognized the following providers who attended in 2005 and 2015: Paula Acker, Wheaton Franciscan Healthcare; Karen Block, Endeavor Testing Center; Rebecca Bognar, Urology Associates, Ltd. SC; Trisha Monis, ProHealth Care; Jan Schmidt, South Street Clinic; Debbie School, BayCare Clinics, Tammy Stollenwerk, Endeavor Testing Center and Donna Tyus, Froedtert Hospital.

Colin Drozdowski, Vice President National Provider Solutions, traveled from Virginia to deliver opening remarks on provider collaboration and its importance to a sustainable healthcare future for providers and payers. Larry Schreiber, President and General Manager, Anthem Blue Cross and Blue Shield of Wisconsin, shared the secret to aging “well” during the first general session of the day and surprised attendees by giving them copies of one of his favorite books, *Younger Next Year* by Chris Crowley and Henry S. Lodge MD.

Providers were treated to a “blues” themed lunch and entertained by our own Blue Cross and Blue Shield “brothers,” Dr. Michael Jaeger (aka Jake) and Jim Sawaya (aka Elwood) during the Name That Blue Tune lunch game. After lunch, Jeff Schultz, Vice President of BeneCo of Wisconsin, Inc., helped us understand employer perception of health plans and providers and how collaborative solutions can help us navigate the headwinds employer health plans face. Dawn Metzler from Bellin Health-Oconto Hospital won the top door prize.

Most attendees completed an expo evaluation. 96% rated the entire event as Excellent or Good. Comments included:

- “Very worth our time to come. Book giveaway was fantastic. Thank you!!”
- “Great speakers. Knowledgeable staff.”
- “Take advantage of Expos such as Anthem's. Healthcare is changing always. Stay informed.”
- “Great information to take back to our facility.”

Attendees said the topics offered were important. If you were not able to join us, you can find the Expo presentations online on the [Provider Education page](#). (Visit anthem.com>Provider (enter Wisconsin)>Communications>Provider Education.)

A special “shout out” to all our sponsors and exhibitors. The Expo would not be possible without their support. Our sponsors and exhibitors are shown on page 20. Descriptions of products and services were provided by the exhibitors.

Please contact your Network Relations Consultant if you would like additional information or have suggestions for 2016 Expo sessions.

Claims

ICD-10 updates

Effective October 1, 2015

The U.S. Department of Health and Human Services (HHS) mandated October 1, 2015 as the compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

Effective October 1, 2015, Anthem begins accepting and processing ICD-10 diagnosis and inpatient procedure codes for claims with dates of service/discharge on or after the October 1, 2015 compliance date. Our systems, supporting business processes, policies and procedures are now compliant with ICD-10.

The ICD-10 web page for your state* contains reference materials and other information for your use:

- Coding Guidelines for Preauthorization and Claims Submission Reference Chart
- Claims Billing by Service Type Reference Chart
- Link to EDI Edits for ICD-10
- Guidance on paper claims containing ICD-10 codes
- Our Response to the CMS/AMA Announcement on ICD-10 in July 2015
- FAQs with Anthem-specific Information
- Our medical policies and clinical UM guidelines have been updated to include ICD-10 coding.

Please note: once ICD-10 is live on October 1, 2015 and providers are ready, the following preparation tools and resources will no longer be available on our webpage:

- TIBCO Validator claims file acceptance testing
- Coding Practice Tool for Professional Providers
- e-Cast on *Preparing for ICD-10: A Provider's Perspective*
- Dedicated email box for ICD-10 inquiries and surveys

All questions and claims inquiries regarding ICD-10 should now be handled as any other questions and claims inquiries are handled today. **Contact the PROVIDER SERVICES UNITS first.** The Provider Services units have been trained to handle questions on ICD-10 and resolve ICD-10 claims issues.

Guidance on Interim Claims

Interim claims are a set of continuous claims filed at interim periods of time for prolonged inpatient stays. See the following for guidance for how to handle interim claims for inpatient stays that span the ICD-10 compliance date of October 1, 2015.

Anthem will not accept claims for inpatient stays with both ICD-9 and ICD-10 codes, or mixed code claims.

When previous claims for services up to September 30, 2015 have been filed with ICD-9 codes prior to discharge, the next continuing claim will require ICD-10 codes because the service THROUGH date is on or after the ICD-10 compliance date of October 1, 2015. With that, the entire inpatient stay must be coded in ICD-10.

To manage the payment of these claims, if the interim period begins before October 1, 2015, and continues after October 1, 2015, Anthem will require a single replacement claim coded in ICD-10 for the entire inpatient stay, from admission to discharge, including services previously filed on interim claims.

Here are two examples of how to bill the interim claims:

Example 1: Admit Date 8/25 – Discharge Date 11/5

First Claim	Bill type 112	DOS: From 8/24 Through 9/24	Interim claim filed with ICD-9 and processed
Second Claim	Bill type 113	DOS: From 9/25 Through 10/24	Hold this claim until discharge
Third Claim (final claim)	Bill type 117	DOS From 8/24 Through 11/5 (Entire inpatient stay)	File final claim coded in ICD-10 with the entire inpatient stay from admit to discharge, including services filed on First Claim

Example 2: Admit Date 8/29 – Discharge Date 10/8

First Claim	Bill type 112	DOS: From 8/29 Through 9/28	Interim claim filed with ICD-9 and processed
Second Claim (final claim)	Bill type 117	DOS From 8/29 Through 10/8 (Entire inpatient stay)	File final claim coded in ICD-10 with the entire inpatient stay from admit to discharge, including services filed on First Claim

Splitting bills could cause overpayments

As noted above, Anthem is requiring that outpatient services with dates of service spanning from September 30, 2015 to October 1, 2015 be split so services rendered up to September 30, 2015 are filed with ICD-9 codes on one claim and services rendered on/after October 1, 2015 are filed on a separate claim with ICD-10 codes.

However, some provider reimbursement agreements limit the reimbursement amounts for certain outpatient services, such as when combined services are negotiated as a case rate. Splitting the claim could cause these episodes of care to be overpaid.

Should you receive any overpayments, here is how you can help resolve these claims quickly.

Be Proactive – Should you discover an overpayment for services due to splitting into ICD-9 and ICD-10 coded claims, notify Anthem immediately and refund the overpaid amount back to us.

Be Responsive – Anthem will request a refund of any overpayment amounts discovered. Please remit refunds promptly once notified.

Working together, we can resolve these overpayments in a timely manner as we partner for a smooth transition to ICD-10.

* IN - [Anthem's ICD-10 webpage](#), KY - [Anthem's ICD-10 webpage](#), MO - [Anthem's ICD-10 webpage](#), OH - [Anthem's ICD-10 webpage](#), WI - [Anthem's ICD-10 webpage](#).

Health Care Management

Medical policy update

The following Anthem medical policies were reviewed on August 6, 2015 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on January 1, 2016.

DRUG.00077 Secukinumab (Cosentyx™)

This new medical policy addresses the indications for use of secukinumab (Cosentyx), a biologic drug used for the treatment of chronic moderate to severe plaque psoriasis in individuals 18 years of age or older.

DRUG.00078 Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors

This new medical policy addresses the use of PCSK9 inhibitors to reduce serum low-density lipoprotein cholesterol (LDL-C) levels in individuals with primary hypercholesterolemia.

SURG.00141 Doppler-Guided Transanal Hemorrhoidal Dearterialization

This new medical policy addresses transanal hemorrhoidal dearterialization (THD) which is a minimally invasive procedure utilizing Doppler guidance to interrupt the blood supply by ligation of the hemorrhoidal arteries in the lower rectum.

MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)

The medical policy was revised to clarify the medical necessity criteria for the treatment of atrial fibrillation and was updated to address transcatheter radiofrequency ablation or cryoablation for the treatment of atrial flutter.

To view online, go to www.anthem.com>[Providers](#) (select state)>Medical Policies and Clinical UM Guidelines.

Specialty pharmacy drugs will require precert

As a follow up to the preceding article, two new medical policies, which will be implemented January 1, 2016, for Secukinumab (Cosentyx™) and Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors, will include precertification requirements.

As a reminder, 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, which help you make sure that all necessary information has been submitted so that Anthem can complete the review. You can find the tools at www.anthem.com>[Providers](#) (select state)> Precertification>[Commercial Specialty Pharmacy Clinical Data Submission Tools](#). (Note: Tools are not available for all specialty pharmacy data submissions.)

Note: In most cases, the changes do not apply to Blue Traditional®, National Accounts, Medicare Advantage (MA), or Federal Employee Program® (FEP).

For a complete listing of plans, please go online to www.anthem.com>Providers (select state)> [Precertification Guidelines](#).
For a complete listing of drugs and codes, including specialty pharmacy medications, please go online to www.Anthem.com > Providers (select state) >Precertification> [Specialty Pharmacy Precertification Drugs and Codes](#).

Revised AIM guideline

An important component of the AIM Sleep Disorder Management program focuses on the management of Obstructive Sleep Apnea (OSA) through the use of custom made oral appliances. These appliances include mandibular repositioning appliances that are billed using HCPCS E0486.*

Effective **January 1, 2016**, AIM will implement a revised guideline to ensure that oral appliances used in the treatment of OSA meet the criteria established by the Centers for Medicare and Medicaid Services (CMS) for mandibular repositioning appliances. CMS will now specify that to be coded as E0486, custom fabricated mandibular advancement devices must:

- Have a fixed mechanical hinge at the sides, front or palate.
- Have a mechanism that allows the mandible to be advanced in increments of one millimeter or less.
- Be able to protrude the mandible beyond the front teeth at maximum protrusion.
- Be adjustable by the beneficiary in increments of one millimeter or less.
- Retain the adjustment setting when removed.
- Maintain mouth position during SLEEP so as to prevent dislodging the device.

Plus the following new question will be added on the preauthorization request: *Does the mandibular repositioning device requested comply with CMS criteria?* Cases in which the provider responds “No” or “I don’t know” will be routed for review.

**Prefabricated oral appliances (HCPCS code E0485) are not considered appropriate therapy for OSA in any clinical situation.*

Revised clinical guideline for gender reassignment surgery

CG-SURG-27, Gender Reassignment Surgery, has been revised, effective December 29, 2015. Revisions include clarification of medically necessary criteria. To view online, go to www.anthem.com>Providers (select state)>Medical Policies and Clinical UM Guidelines.

Clinical information is required for inpatient cardiac services

For providers who request cardiac procedures such as coronary artery bypass grafts, valve replacements, valvuloplasty and aorta-iliac-femoral bypass, please note that the Utilization Management Nurses will be reviewing for goal length of stay, discharge needs and case management referrals for members. (This is not an all-inclusive listing.)

Reminder: Outpatient cardiac services require precertification

This is a reminder that Anthem will expand our cardiovascular program to include precertification requirements for arterial ultrasound, cardiac catheterization, and percutaneous coronary intervention (PCI) beginning Oct. 1, 2015. For details, please click [here](#).

Medicare

Routine physical exams are covered in 2016

Anthem MA plans will continue to offer coverage for routine physicals in 2016 for individual and group-sponsored MA members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay as applicable by the member's plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider.

Additional details can be found at [the Important Medicare Advantage Updates](#) link at www.anthem.com/medicareprovider.

Administrative denials may be appealed

For providers to receive a benefit payment under the terms of the contract, the health plan must authorize or precertify the covered services prior to being rendered. As previously communicated, please notify Anthem as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

If you do not notify us within the required timeframe, you may file an appeal. As part of the appeal, providers must demonstrate that they did notify Anthem or attempted to notify Anthem AND that the service was medically necessary. Anthem also reminds all providers – network physicians and facilities -- that they cannot bill the member if the services are denied for the failure to obtain a required precertification.

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook and the [Medicare Advantage Precertification Guidelines](#) found at the [Medical Policy, UM Guidelines and Precertification Requirements](#) link on the Anthem provider home page at www.anthem.com for further information on existing precertification requirements and provider appeals.

Precertification requirements updated for 2016

This is a reminder to check the above-cited resources for information on existing precertification requirements and new precertification requirements for 2016. Non-contracted providers should contact the customer service number located on the back of the member ID card.

HRM program designed to reduce risk for MA members

Anthem is working to decrease the amount of High Risk Medications (HRM) prescribed by primary care providers. A HRM contains a heightened risk for causing significant harm when MA members use them in error. Examples of commonly prescribed HRMs include zolpidem (Ambien®) and zaleplon (Lunesta®). Falls and fractures may occur when these HRMs are used.

Anthem identifies providers who have prescribed HRMs and will contact the prescriber's office to validate the prescriber/patient relationship. Anthem then will schedule an appointment for an Anthem pharmacist to speak with the provider about HRMs.

KY, OH: Brachytherapy, IMRT CPT codes to require prior authorizations

Effective **November 1, 2015**, Anthem will require prior authorization of the following outpatient radiation therapy CPT codes for our individual MA members:

- Brachytherapy 77316, 77317 and 77318
- Intensity Modulated Radiation Therapy (IMRT) 77386, G6016

Prior authorization requests will be handled by AIM. Prior authorization can be obtained by contacting AIM at <https://www.providerportal.com> or (800) 714-0400. Additional information, including required information for radiation therapy requests, can be found [here](#) or go to [the Important Medicare Advantage Updates](#) link at www.anthem.com/medicareprovider.

Keep up with MA news

Please continue to check the [Important Medicare Advantage Updates](#) link at www.anthem.com/medicareprovider on for the latest Medicare Advantage information, including [Precertification Change for Scoliosis/Spine Deformity](#).

55290WPPENMUB 08/11/2015

Pharmacy

Pharmacy information available at [anthem.com](http://www.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

Members compare facility costs for surgical procedures

This is a reminder that Anthem offers an integrated management program to help members compare facility costs for some surgical procedures. The program is administered in partnership with AIM. For more information, view [here](#) or go to www.anthem.com>Providers (select state)>Network eUPDATES.

Network Update

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

Revised professional reimbursement policies

Anthem 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.

Listed below are changes to the professional reimbursement policies. As a reminder, we are phasing in new claim editing systems. As a result, the effective date of some new edits implementing in November will differ, depending on whether the claim will be processed according to McKesson Inc.'s ClaimsXten® or another proprietary editing system.

Updates to policies

Changes effective October 1, 2015, for policy **Modifier 22**, do not affect the outcome of the reimbursement for claims submitted. Examples of some changes include punctuation, grammatical edits, formatting, as well as insertions of AMA CPT® Handbook terminology.

Bundled Services and Supplies

We are continuing to review and add Healthcare Common Procedure Coding System (HCPCS Level II) "S" codes to our always bundled services edit. According to the Health Plan, unless there are specific, specialized contracts or criteria for a provider to report their services using a HCPCS temporary "S" code, the Health Plan will consider "S" codes to be always bundled codes.

- Effective with date of service January 1, 2016, code S9480 will not be eligible for reimbursement. This information will be included in Section 1 of our policy.
- Based on coding changes effective January 1, 2014, providers should no longer separately report CT guidance, represented by CPT code 77014 (Computed tomography guidance for placement of radiation therapy fields), when reporting simulation services represented by codes 77280-77290. The use of CT guidance is considered integral to the simulation procedure; therefore, beginning for some claims processed November 1, 2015 and applicable for all claims processed on or after November 16, 2015, CPT code 77014 will no longer be eligible for separate reimbursement when reported with CPT codes 77280-77290. This information is included in our Modifiers 59, XE, XP, XS, and XU policy since modifiers will not override this edit.
- The Health Plan reimburses only one venipuncture per service; therefore, beginning for some claims processed November 1, 2015 and applicable for all claims processed on or after November 16, 2015, any claims processed for S9529 will deny mutually exclusive to G0471. This information is included in our Bundled Services and Supplies policy.
- Based on correct coding, procedure codes S0395 (casting), A4580 (cast supplies) and A4590 (special casting materials) are considered mutually exclusive when billed with L3000, L3010, L3020 and L3030 (custom foot

Network Update

orthotics); therefore, beginning for some claims processed November 1, 2015 and applicable for all claims processed on or after November 16, 2015, codes S0395 and A4580 are no longer eligible for separate reimbursement when billed with L3000, L3010, L3020 and L3030. This information is included in our Bundled Services and Supplies policy.

Bundled Services and Supplies and Modifier 59 and XE, XP, XS & XU

For dates of service beginning for some claims processed November 1, 2015 and applicable for all claims processed on or after November 16, 2015, CPT code 76098 (radiologic exam for breast surgical specimen) will not be eligible for separate reimbursement when reported with breast biopsy surgery codes to include breast localization devices 19081 – 19086. Modifiers will not override this edit therefore this information is included in our Modifiers 59 and XE, XP, XS, & XU reimbursement policy.

Frequency editing

As a reminder and based on CPT Appendix A - Modifiers, when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the applicable procedure code.

In our June 11, 2015 [issue](#), *Network Update Special Edition*, we posted with an effective date of September 11, 2015 for CPT codes 87530 and 87539. Please note that these services process as single units whether they are billed on a single line or multiple lines. For more information, please refer to our Frequency Editing reimbursement policy.

Laboratory and venipuncture services

80076 (hepatic function panel) was added to the list of laboratory panels identified in the “Description” section of the policy.

Code	Description
80047	Basic metabolic panel (calcium, ionized)
80048	Basic metabolic panel (calcium, total)
80050	General health panel
80051	Electrolyte panel
80053	Comprehensive metabolic panel
80055	Obstetrical panel
80061	Lipid panel
80069	Renal function panel
80074	Acute hepatitis panel
80076	Hepatic Function Panel

Modifiers 59 and XE, XP, XS, and XU

Our current bundling edit logic denies CPT code 76098 (radiological examination, surgical specimen) as mutually exclusive when reported with CPT codes 19081 – 19086 (breast biopsy with placement of breast localization device(s)). Based on CPT instructions which state “Do not report 76098 in conjunction with 19081 – 19086,” beginning for some claims processed November 1, 2015 and applicable for all claims processed on or after November 16, 2015, modifiers will no longer override the mutually exclusive edit.

For claims processed on or after October 9, 2015, the Health Plan will process modifiers XE, XP, XS, XU the same as Modifier 59 with dates of service January 1, 2015.

Unit frequency maximums for drugs and biologic substances

In the August 2015 issue of *Network Update*, we advised that we would implement a maximum units limit on specific drugs and biologic substances. Please note we will be delaying the implementation of this edit and will post updated information in a future *Network Update*.

Coding tip for reporting Modifiers 54, 55, and 56: Split Surgical Care

According to CPT Surgical Package Definition, the global surgical package includes pre-operative care, the surgical care, and typical postoperative care. When a provider renders care that does not include all the components of the global surgical package, the following modifiers should be used with the reported surgical procedure code to indicate which portion of the care was rendered:

- Modifier 54---surgical care only
- Modifier 55---postoperative management only; postoperative care begins on the next day following the surgical procedure
- Modifier 56---preoperative management only; preoperative care begins on the day before and/or the day of the surgical procedure

For example, when an emergency room (E/R) provider reports the surgical service for the closed treatment of a radial shaft fracture; without manipulation (CPT code 25500), and postoperative care is transferred to another provider, the E/R provider should report the surgical procedure code 25500 with modifiers 54 and 56 on one line to indicate surgical care only and preoperative management only. The provider who accepts the patient for postoperative management only should report the surgical procedure code 25500 with modifier 55 to indicate the postoperative care only.

Coding tip for reporting imaging guidance with Intensity Modulated Radiation Treatment (IMRT)

Effective January 1, 2015, the American Medical Association (AMA), with input from the American Society for Therapeutic Radiology and Oncology (ASTRO), released the following new CPT codes for Intensity Modulated Radiation Treatment delivery (IMRT) services:

- **77385** – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
- **77386** – Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
- **77387** – Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

With the release of the new CPT codes, ASTRO also released the following coding guidance: The nomenclature for the new IMRT delivery CPT codes (77385 and 77386) includes the following language: “includes guidance and tracking, when performed”.

The technical component of the image guidance and tracking (IGRT) part of the procedure is now packaged into the IMRT delivery CPT codes 77385 and 77386, and is not reported or allowed separately. Consequently, the total component for CPT code 77387 is not separately reimbursed with CPT codes 77385 and/or 77386.

When the professional component of IGRT (77387 -26) is a separately identifiable service, the most appropriate modifier that designates the service as a distinct procedural service should be used.

Coding tip for reporting a separate procedure with a related procedure

According to CPT, some procedures or services that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." 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 the same time, the "separate procedure" may be reported by itself, or in addition to other procedures/services by appending the most appropriate modifier to the code to indicate that the procedure 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.

For example, when 99195 (phlebotomy, therapeutic (separate procedure)) is reported with 36415 (collection of venous blood by venipuncture), 99195 must include the most appropriate modifier that designates the service as a distinct procedural service.

CPT® is a registered trademark of the American Medical Association

****Notice of Material Changes to Contract may apply to the above information.***

View Anthem reimbursement policies

Anthem's reimbursement policies are available online at MyAnthem; access via the Availity Web Portal.* (Note: 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/.

Non-Registered for MyAnthem: If your organization is not registered for MyAnthem, sign onto 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 for MyAnthem: If you are a registered MyAnthem user, sign onto 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](#) and "[Logging into MyAnthem](#)" at www.anthem.com>Providers (enter state)>Answers@Anthem.

Specialty Services – Behavioral Health

Outpatient coding

In 2013, behavioral health outpatient CPT codes were updated and new coding guidelines for their use were issued. The new guidelines included *CPT code 90834, 45-53 minutes face to face with the patient*, and *CPT code 90837, 53-60 minutes with the patient*.

Prior to 2013, the psychotherapy “hour” was billed using a code for 45-50 minutes of time with the patient. With the release of the new CPT codes, Anthem has observed that over half of the billing for this type of psychotherapy is now claiming 53-60 minutes spent face to face with the patient at each session.

Anthem would like to remind you of specific guidelines per the AMA CPT codebook for commonly billed codes:

If you use an E/M code:

- The type and level of an E/M service is selected based on key components of history, examination and medical decision-making, therefore, time may not be used as the basis of E/M code selection.
- Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy add-on service.

If you use a psychotherapy code which is defined by time:

- Documentation should include the time spent face to face with the patient and give specific details to what was done in the session
- The American Psychological Association 2013 guidelines state: *“When billing a private insurer that does not require authorization for 90837 and has not indicated that this code should be used infrequently, you should bill this code if your session time falls into the 53-minute or more time frame that pertains to 90837. We recommend, however, that you record your exact session start and stop times in your clinical note (for example, 1:02 to 1:57) when billing the new codes, as Medicare providers must do. At any point, a company can ask you for appropriate documentation or explanations. Also be mindful that if you have historically billed a company primarily the 45-50 minute code and switch to primarily using the new 60-minute code, that company may ask you to explain this change.”*

As always, Anthem retains the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the AMA’s CPT codebook for further code definitions and details.

Revised CG-BEH-02

As of October 6, 2015, the name of the clinical guideline, CG-BEH-02 Applied Behavioral Analysis for Autism Spectrum Disorder, will change to CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder. The following changes were also made:

- Revised and reformatted clinical indications section.
- Updated Description, Discussion, Definition, Reference and Index sections.

Please see the full clinical guideline [here](#) or go online to www.anthem.com>Providers (select state)>Behavioral Health Provider Resources>Behavioral Health Clinical UM Guidelines. Then select BEH, then CG-BEH-02.

Central nervous system (CNS) assessments

To ensure that billed services include proper documentation, an education and audit program for central nervous system (CNS) assessments begins later this fall.

Central nervous system (CNS) assessments and/or tests involve the analysis of cognitive processes, visual motor responses and abstractive abilities and are accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate useful information for treating and caring for the patient, including psychological and aphasia assessments; neuropsychological, and developmental testing; and a neurobehavioral status exam.

Neuropsychological testing uses standard techniques to objectively evaluate behavioral and cognitive abilities of patients by comparing the patient's results to established normal results. Neuropsychological testing generally involves the use of paper/pencil and mechanical procedures and carries little, if any, risk to the patient. A complete neuropsychological evaluation includes:

- a. Review of information from the referral
- b. Face-to-face evaluation with the patient and/or the family, at which time some screening tests may be done
- c. Administration of various neuropsychological tests tailored to the patient's condition
- d. Test scoring and interpretation, which is reviewed with the referring clinician and/or the patient, for example Halstead-Reitan, LURIA, and WAIS-R testing

Per Anthem requirements, the medical record documentation for CNS assessments/tests should be legible, signed and dated, and contain, at a minimum, the following elements:

- a. Relevant medical and personal history
- b. Results of initial evaluation determining the need for testing
- c. Suspected mental illness and/or neuropsychological abnormality/dysfunction
- d. Types of testing indicated
- e. Previous testing (if conducted) by same or different provider and efforts to obtain those results
- f. Tests administered, scoring, and interpretation
- g. Time involved for each test performed
 - ✓ when the testing is done over several days, the testing time should be reported all on the last date of service
- h. Treatment report and recommendations

The time spent in interpreting and preparing the report and any explanation of the report to the patient and family are to be billed with the applicable code used to perform the test.

Code	Description
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.

96103	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report.
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report.
96111	Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report.
96116 (See also our Frequency Editing Policy.)	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.
96118	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
96119	Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
96120	Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report.
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

As always, Anthem appreciates the care provided to our members.

Medicaid Notifications

For IN, KY, WI Medicaid

Medical policies and clinical UM guidelines update

The Medical Policy and Technology Assessment Committee (MPTAC) approved Anthem Blue Cross and Blue Shield Medicaid medical policies and clinical utilization management (UM) guidelines, which are developed or revised to support clinical coding edits for Medicaid members. These approved medical policies and clinical UM guidelines are publicly available on the provider website:

Indiana: Use this link to [access](#) updates.

Kentucky: [Use this link to access updates.](#)

Wisconsin: [Use this link to access updates.](#)

Provider self-service tools make it easy to do business

The provider self-service web portal offers 24/7 access to simple to use tools - making it easier than ever to get information. The secure provider self-service site gives providers access to:

Network Update

- PCP member panels
- Submit and check authorization status
- Patient 360 tool for quick patient record retrieval
- Check eligibility and benefits
- Check claims status
- Submit claims

You must be a registered user to access the secure provider self-service tool. Through the Medicaid provider website, click on *Login* and use your Availity username and password. If you do not have a login, go to www.availity.com, select the *Register Now* option and follow the Availity registration process instructions.

ICD-10 documentation and coding tips

This handy reference sheet puts ICD-10 formatting, structure, official outpatient services guidelines, documentation concepts and more, right at your fingertips:

Indiana: [Get the coding tips reference sheet here.](#)

Kentucky: [Get the coding tips reference sheet here.](#)

Wisconsin: [Get the coding tips reference sheet here.](#)

For IN, KY Medicaid only

Synagis guidelines for RSV season

Respiratory syncytial virus (RSV) season begins as early as September with occurrences through April. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. All requests for Synagis require [prior authorization](#) to ensure Medicaid members meet medical necessity criteria based on the American Academy of Pediatrics recommended guidelines.

Indiana: [Read more about dosage, preferred specialty pharmacy and prior authorization.](#)

Kentucky: [Read more about dosage, preferred specialty pharmacy and prior authorization.](#)

CDC predicts moderately severe flu season

Anthem Blue Cross and Blue Shield is launching an annual member outreach campaign to encourage high-risk Medicaid members to visit their providers for a flu vaccine. Outreach includes automated outbound telephone calls, text messages and newsletter articles. Providers may experience an increase in phone calls and early appointments for the flu vaccine as a result of this outreach campaign.

Indiana: [Read more about the impacts of flu season on your practice.](#)

Kentucky: [Read more about the impacts of flu season on your practice.](#)

For IN, WI Medicaid only

Changes to Behavioral health authorization requirements

Effective **November 1, 2015**, authorization requirements for psychological and neuropsychological testing will change:

Indiana: [Use this link to access the codes that have been updated.](#)

Wisconsin: [Use this link to access the codes that have been updated.](#)

Network Update

For KY Medicaid only

Crossover encounter update

The Department for Medicaid Services (DMS) recently provided an update about crossover encounters that were denied for being on the incorrect claim. After further evaluation, it was determined that these encounters are actually denying because of an invalid taxonomy code. Anthem Blue Cross and Blue Shield Medicaid does not edit or review the taxonomy code. DMS edits the code against their provider file.

DMS will accept Federally Qualified Health Center/Rural Health Clinic encounters in a UB04 or 1500 format; however, the taxonomy code must be correct. [Use this link for additional information.](#)

Anthem Blue Cross and Blue Shield Medicaid is the trade name of Anthem Kentucky Managed Care Plan, Inc., independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Special Section

Wisconsin Expo Exhibitors

Promotions Sponsor

Overture Premiums and Promotions (overturepromotions.com)

Product/Service: Promotional products

595 North Lakeview Parkway

Vernon Hills, IL 60061

Phone: **1-847-573-6080** Fax: **1-847-680-1114**

Company Representatives: Michelle Boettcher and Madeleine Ehrhardt

Overture is a promotional products distributor located in northern Illinois. They are dedicated to the health care field and focus on compliant products that carry your message and branding to your customers

Silver Sponsor

Availity (availity.com)

Product/Service: Revenue Cycle Management, Patient Access, Portal Services

10752 Deerwood Park Blvd South, Suite 110

Jacksonville, FL 32256

Phone: 1-800-282-4548

Company Representatives: Maegan Clark, Leslie Kennedy and Dave Pape

Explore new ways to generate cash and improve the efficiency for your practice. Availity will have two exhibits, one to help your staff better use our provider portal and one to help you explore, with experts, ways to improve your cash-collection efficiency from both patients and payers.

Exhibitors

AIM Specialty Health® (aimspecialtyhealth.com)

Product/Service: Specialty benefits management of radiology, cardiology, oncology, sleep management and specialty drugs.

8600 W Bryn Mawr Avenue South Tower Suite 800

Chicago, IL 60631

Phone: **1-847-564-8500** Fax: 1-773-864-4601

Company Representatives: Paula Inches, Ryan Pape and Matt Zimmerman

AIM Specialty Health is focused on driving appropriate, safe and affordable care through the health care system. For more than 40 million members across 50 states, Washington D.C. and U.S. territories, AIM targets the quality and cost of clinical services including radiology, cardiology, oncology, specialty drugs and sleep medicine. As a national leader in specialty benefits management, AIM helps health plans, providers and employers focus on the value of health decisions with an integrated suite of solutions combining clinical excellence, technology and superior customer service.

BPI Solutions LLC (bpi.us.com)

Product/Service: Medical Billing, Practice Management & Consulting, Revenue Cycle Analysis, Physician Credentialing

4465 N Oakland Avenue #300 lower level

Shorewood WI 53211-1662

Phone: 1-414-837-6391 Fax: 1-414-837-6393

Company Representatives: Barbara Piaskoski and David Tran

BPI Solutions can provide all the support your medical practice needs from practice start-up and credentialing, to practice management, medical billing & revenue cycle analysis. Stop by our booth to learn how we can make a difference in the efficiency of your practice and improve your revenue!

Federal Employees Health Benefit Program (FEP®) (febblue.org)

Product/Service: Benefit and claims administration of the Federal Employees Health Benefits Program

Anthem Blue Cross and Blue Shield of Wisconsin

P.O. Box 105557

Atlanta, GA 30348-5557

Phone: 1-800-242-9635

Company Representative: Denece Ellis

The Blue Cross and Blue Shield Service Benefit Plan, also known as the Federal Employee Program or FEP, has been part of the U.S. Federal Employees Health Benefits Program (FEHBP) since its inception in 1960. Nationwide, it covers roughly 4.6 million Federal employees, retirees and their families out of the nearly 8 million people who receive their benefits through the FEHBP. Of those 4.6 million FEP members nationwide, we serve the 1.3 million members who live in our designated service areas.

LiveHealth Online® (livehealthonline.com)

Product/Service: Telehealth tools

6000 Lombardo Center

Cleveland, OH 44131

Phone: 1-855-603-7985

Company Representatives: Erica Terry and Matthew Blackburn

LiveHealth Online is a telehealth tool that enables two-way live video interaction between providers and their patients. The Practice Edition is a fully customized online practice for your current patients and enables your practice to offer a new channel of care for your existing population.

SVA Healthcare Services (sva.com)

Product/Service: AR Resolution, Credentialing, ICD-10 Readiness, Professional Coder Staffing, Clinical Documentation Improvement, Revenue Cycle Management, HIPAA Compliance and Consulting.

18650 W. Corporate Drive, Suite 200

Brookfield, WI 53405

Phone: 1-262-641-6888 Fax: 1-262-641-6880

Company Representative: Marcy Marquis

From technology to communication to compliance, SVA understands every facet of the operation. We speak the language of HIPAA compliance, payer contracting, and denial resolution. SVA's experience will make a difference in your organization.

Wisconsin Medical Society (wisconsinmedicalsociety.org)

Product/Service: Physician member organization, educational services

330 E. Lakeside Street

Madison, WI, 53701-1109

Phone: 1-866-442-3800 Fax: 1-608-283-5424

Company Representative: Todd Wuerger

The Wisconsin Medical Society is the largest association of medical doctors in the state, representing more than 12,500 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 does not advocate the use of any specific product or activity identified in the program or otherwise endorse the content of the material provided by any sponsor or exhibitor.