Anthem BlueCross BlueShield

Working together to improve the health of our members.

February 2016

# Network Update

CENTRAL REGION

## In this issue


Page

**Health Care Reform (including Health Insurance Exchange)**

- Updates and notifications 3

**Account Update**

- URMBT hearing vendor will be Audionet as of March 1, 2016 3
- Reminder: URMBT benefits administered by BCBS of Michigan 3

**Administrative Update**

- Provider record verification 4
- Submit precert requests to AIM via Availity 4
- ePASS overview -- webinar schedule 5
- HCPCS drug testing codes 6
- Secure web portal user profiles and HIPAA compliance reminder 6
- WI: Infusion therapy choice – lower cost, more convenience 6
- Use the Provider Maintenance Form to update your information 7

**Claims**

- Corrected provider remittance advice available 7

**Federal Employee Program® (FEP®)**

- 2016 FEP Benefit information available online 7

**Health Care Management**

- CG-SURG-47: Precert required 8
- Precertification for certain radiation therapy services 8
- Revised clinical guidelines 9
- Medical policy update 10
- Anthem will upgrade to MCG™ 20th edition 12
- Update on precertification of cardiovascular services 13
- KY, MO, OH: Precert list additions for Individual members 13
- IN: Precert required for total hip and knee replacements 14

**Medicare**

- Learn how to complete AIM OptiNet® imaging services request 14
- Support for Individual MA members with rare conditions 15
- HIPPS codes required for SNF and HHA claims 16
- KY, OH: Update on radiation therapy precertification procedures 16



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




anthem.com


CE0216
IN, KY, MO, OH, WI

- Provider requirements and Medicare notices 17
- Contact OrthoNet for outpatient OT and PT precert 17
- Help ensure members have accurate information on your practice 17
- Please review formulary changes 17
- Keep up with MA news 18

**Pharmacy**

- CVS/Specialty is the in-network specialty pharmacy 18
- Pharmacy information available at anthem.com 18

**Quality**

- Improving documentation of blood pressure 19
- Cancer care quality program Precision Medicine 19
- Commercial HEDIS® starts early February 20
- Practice access after-hours 21

**Reimbursement**

- Revised professional reimbursement policy updates 21
- Another reminder: System updates for 2016 24
- Revised coding tip 24
- View Anthem reimbursement policies 24

**Specialty Services: Behavioral Health**

- Member satisfaction with outpatient services 25
- OH: Eating disorder programs 26

**Medicaid Notifications**

- For IN, KY, WI 27
  - Providing services to out of state Medicaid members
  - Medicaid encounter data
  - Medicaid provider enrollment
- For IN only 28
  - Let's get connected
  - New copays for Hoosier Care Connect
  - Blue Ticket to Health program
  - Home health services update: overhead billing
  - Introducing the debit card training series
  - Claims submission reminder
- For KY only 29
  - IMRT codes require precertification
  - Medicaid Special Investigations Unit update
- For WI only 30
  - Portable/hand-held mobile radiology services
    Handheld radiology

# Health Care Reform (including Health Insurance Exchange)

## Updates and Notifications

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.

**Health Care Reform Updates and Notifications**
The most recent update includes a revised list of preventive care services covered with no member cost-share.

**Health Insurance Exchange**
Recently posted articles include "ACA-compliant health plans Quick Reference Guide" and "Member ID card summary for ACA-compliant health plans." Please check this section often 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.

**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 anthem.com > Providers (enter state)> Network eUPDATE.

# Account Update

## URMBT hearing vendor will be Audionet as of March 1, 2016

The UAW Retiree Medical Benefits Trust (URMBT) has notified Blue Cross and Blue Shield their Hearing program is being transitioned to Audionet for all hearing aid and related care for dates of service of March 1, 2016 forward.

Additional information about the AudioNet America program can be found on the AudioNet America website at www.audionetamerica.com or by calling AudioNet America at 1-800-400-2619. Anthem will not be able to assist with questions regarding network participation, benefits or eligibility.

For dates of service through February 29, 2016, please continue to send claims to Anthem.

## Reminder: URMBT benefits administered by BCBS of Michigan

The following information is a reminder that members of the UAW Retiree Medical Benefits Trust living in IN, KY, and MO are eligible to participate in the Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO. These members can be identified by the alpha prefix XYL on their member ID card. For more information on this issue for Indiana and Kentucky, please see the article, "IN, KY: UAW retiree medical

benefits trust updates,**"** in the December 2012 issue of *Network Update*. Missouri providers can view more information by going to your state's information at this link: MO.

Note: We are providing this reminder as we have noticed an increase in submission of Medicare claims by paper to Anthem. The paper submission will trigger a duplicate denial on your provider voucher and also create additional work for your billing companies, as Anthem no longer administers the benefits, claims processing or inquiries for these Medicare primary members.

Supplemental claims payment will be made directly to you by Blue Cross Blue Shield of Michigan. Claim inquiries should be directed to the phone number and address printed on your payment remittance. To avoid duplicate payments, please wait at least 30 days after receiving your Medicare payment before submitting any supplemental claims.

# Administrative Update

## Provider record verification

A recent Network eUPDATE notified providers that Anthem is currently conducting a provider outreach campaign to be sure we have accurate information on file for providers participating in our networks. This information is utilized on our Provider Finder tool to assist members and providers who are searching for a health care provider. See more information here.

## Submit precert requests to AIM via Availity

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

(Please note that Anthem FEP does not require precertification. Participation, although not required, is encouraged to help promote the Anthem FEP quality program. You may also contact Anthem FEP directly for assistance. The additional functionality for servicing providers to submit an order request for Anthem FEP members is available.)

AIM precertification requests (for Ordering and Servicing Providers) can be accessed online 24 hours a day, seven days a week. Your office can save time, save money, and eliminate hassles by requesting and obtaining precertifications online for radiology, cardiology, sleep, oncology, and specialty drugs. Information is available for both ordering and servicing providers.

Ordering and servicing providers may submit online precertification requests to AIM by either of the following options:

- Access AIM ***Provider****Portal*℠ directly at www.providerportal.com, or
- Access AIM via the Availity Web Portal at www.availity.com

**To submit a precertification request through Availity**

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

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

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

## ePASS overview – webinar schedule

Anthem continues to work with Inovalon to help ensure that members who purchase Affordable Care Act (ACA) plans get their diagnoses confirmed, corrected, and updated every year, as well as have potential preventive care gaps addressed. The ePASS webinars, offered by Inovalon, provide a practical overview of how the Electronic Patient Assessment Solution Suite (ePASS) can be used by eligible providers to access a supplemental clinical profile and complete a compliant medical SOAP note for identified patients. This overview typically takes 30 minutes followed by time for questions.

**We encourage you to register in advance by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to webinar.**

**Upcoming dates (all sessions start at 3 pm ET/2 pm CT):** February 3, February 10, February 17, February 24, March 2, March 9, March 16, March 23 & March 30.

**How to join**

The following information can be used to join all webinars scheduled in February and March 2016.

- **Teleconference:** Dial 1-888-850-4523 and enter access code: 108607
- **WebEx:** Visit https://inovalon.webex.com and enter meeting number: 746707227

Once you join the call, live support is available at any time by dialing *0.

For more information on how Anthem is working with Inovalon on provider outreach efforts, please see our Network eUPDATE, "Incentive opportunity for physicians treating members with Anthem plans purchased on or off the exchange" by going to www.anthem.com>Providers (enter state)>Network eUPDATE.

For more information on the outreach process and the ePASS tool, please see our FAQs, *Anthem engages Inovalon to conduct outreach efforts for our ACA individual and small group on and off exchange business – FAQs (updated July 2015),"* posted online at our Health Exchange Information pages. Also, to help easily identify members with ACA plans and the aligned networks, see the articles titled, "ACA-compliant health plans Quick Reference Guide" and "Member ID card summary for ACA-compliant health plans."

You can access the above information for your state by going to www.anthem.com>Providers (enter state)>Health Exchange Information, or click the following link for your state: IN, KY, MO, OH, WI.

## HCPCS drug testing codes effective January 1, 2016

As you may know, CMS does not recognize the CPT codes 80300-80377 and 83992 for definitive and/or presumptive drug testing and had assigned Status Code "I"-**Not valid for Medicare purposes**-to those codes. CMS announced that effective January 1, 2016, it will use HCPCS' new "G" codes for "per day" presumptive and definitive drug testing. See more information here, or go to www.anthem.com>Providers (enter state)>Network eUPDATEs.

## Secure web portal user profiles and HIPAA compliance reminder

As part of compliance with requirements of the Health Insurance Portability and Accountability Act (HIPAA) and Anthem's Information Security Policy, secure provider portal users must NOT share User ID information on our secure site. Rather, please ensure that ALL individuals who access our secure portal have their own individual User ID registered under their names and with their own individual contact information.

In order to remain compliant with your contractual online, usage agreements, review your user lists at least quarterly to ensure all current employees have the access they need to use our secure Web portal and to disable the profiles of any individuals who are no longer employed. Please take a few moments to do this now.

## WI: Infusion therapy choice – lower cost, more convenience

For our members who require infusion therapy services, out-of-pocket expenses, the site of infusion service, safety, time and convenience are contributing factors that can impact health care quality, value and patient satisfaction. To ensure member satisfaction and to help advance positive health care outcomes, Anthem is working collaboratively with physicians in Wisconsin regarding infusion therapy options available to our members.

Here's how you can help. When possible, please consider and share with patients the range of potential options available regarding infusion therapy, including alternative locations – such as office or home – when ordering infusion therapy for patients who require these services. In addition, please inform patients of any potential self-injection alternatives, if appropriate, as members may prefer these convenient and lower-cost options

Referring those who require infusion therapy services to safe, lower-cost settings may result in significant savings in time and out-of-pocket expenses. Your patients will also appreciate the convenience and the flexibility. Those who receive intravenous infusions in a hospital outpatient setting instead of in the home or in a physician's office may pay more in out-of-pocket expenses and experience unnecessary inconveniences.

In order to make informed decisions about their health care choices, our members count on their physicians to provide comprehensive information. Your patients may have questions about alternate settings in which they can receive their intravenous infusions and costs associated with other aspects of their intravenous infusion therapy. We can assist by sharing with members ways they can maximize their benefits by providing information on comparative costs of their intravenous infusion services. To that end, we may contact members and their physicians in the near future, informing them of opportunities for quality, lower-cost options available.

As always, you should refer members who require intravenous infusions to the locations as you deem appropriate. However, we encourage you to consider lower cost settings when possible. Working together, we can help to ensure more members get their intravenous infusions safely and conveniently for less money.

*Note:* Wisconsin providers were notified of this program in a *Network eUPDATE*. To view, go to anthem.com>Providers (enter Wisconsin)>Network eUPDATE *"Important Information Concerning Infusion Therapy."*

### 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

### Corrected provider remittance advice available

As you may be aware, on some Anthem claims with paid dates between October 27, 2015 and November 7, 2015, inappropriate ANSI codes of OA 16 were populated on 835 electronic remittance advice files and explanation codes were missing on the paper remittance advice. You can find the steps that Anthem took to correct this issue here, or go to www.anthem.com>Providers (select state)>Network eUPDATE.

.

## Federal Employee Plan (FEP)

### 2016 FEP Benefit information available online

To view the 2016 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2016. For questions please contact FEP Customer Service at:

- IN – 800-382-5520
- KY – 800-456-3967
- MO – 800-392-8043
- OH – 800-451-7602
- WI – 800-242-9635

# Health Care Management

## CG-Surg 47: Precert required

Effective May 2, 2016, **CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity,** will be implemented and will require precertification.

This guideline addresses surgical procedures for the treatment of scoliosis and other spinal deformities to include spinal fusion, osteotomy, vertebrectomy (as an example, kyphectomy) and associated instrumentation procedures. Spinal fusion refers to the surgical joining of two or more vertebrae at the involved levels of the spine for the treatment of severe or progressive scoliosis and other spinal deformities in children, adolescents and adults. Osteotomy refers to the cutting of a vertebra to facilitate angular correction. Vertebrectomy implies the removal of part or all of a vertebra at the apex of a severe curve.

Determine if precertification is needed for an Anthem member by clicking your state's "Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements" link at anthem.com or by calling the precertification phone number printed on the back of the member's ID card.

For a complete listing of plans, please go online to www.anthem.com>Providers (select state)>Precertification Guidelines.

## Precertification for certain radiation therapy services

As a reminder, Anthem will expand our Radiation Therapy Program, with a revised effective implementation date of May 1, 2016. The following services will require precertification in our expanded program:*

- Image Guided Radiation Therapy (IGRT).
- Fractions (also referred to as units) for breast and bone metastases for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT).
- Special treatment procedure and special physics consult (CPT® codes 77470 and 77370) (e.g., total body irradiation, hemibody radiation, or endocavitary irradiation and special medical radiation physics consultation).

The Radiation Therapy Program will be managed by AIM, a separate company administering the program on behalf of Anthem.

**For services rendered between March 1, 2016 – April 30, 2016, providers may voluntarily pre-notify and provide requested clinical information to AIM for clinical appropriateness review.** Once clinical review is completed, a confirmation/tracking number will be issued. Servicing providers' claims will not be denied as a result of the pre-notification process. During the pre-notification period, servicing providers will be able to familiarize themselves with Anthem's new clinical policies for these radiation therapy services.

**For dates of services on or after May 1, 2016,** Anthem will transition from voluntary "pre-notification" to required precertification for those benefit plans that currently require precertification for existing radiation therapy services. This means that providers will be required to obtain precertification from AIM before rendering radiation therapy services listed above. Upon receipt of precertification and requested clinical information, clinical

appropriateness review will be performed. Servicing providers' claims will adjudicate based upon the approval or denial outcome of the clinical appropriateness review.

*There is no change in the approval process for the existing radiation therapy services that currently require precertification. *Please note that Anthem FEP members are excluded from this program.*

**AIM will host two webinars in February to provide additional information and clarification on the program enhancements.** Attend by phone or by clicking on the WebEx meeting link:

**Friday, February 19, 2016; 12:00 p.m. ET**

- Join WebEx meeting
  - Meeting number: 621 880 300
  - Meeting password: Anthem
- Join by phone: 877-668-4490 or 408-792-6300
  - Access code: 621 880 300

**Friday, February 26, 2016; 2:00 p.m. ET**

- Join WebEx meeting
  - Meeting number: 629 387 251
  - Meeting password: Anthem
- Join by phone: 877-668-4490 or 408-792-6300
  - Access code: 629 387 251

A complete list of CPT codes requiring precertification under the expanded Radiation Therapy Program can be found on the Precertification page at anthem.com. (Go to anthem.com>Providers (enter state)>Precertification.)

More details on this program can be found on page 7 of the December 2015 issue of *Network Update*. If you have further questions, please contact your local Network Relations consultant or call the provider customer service number on the member's ID card.

## Revised clinical guidelines

The following clinical guidelines were endorsed for Indiana, Kentucky, Missouri, Ohio and Wisconsin at the November 5, 2015 Medical Policy & Technology Assessment Committee (MPTAC) meeting.

**Changes to HCPCS specialty drug codes:**

| Clinical Guideline | Drug | Removed from CG | Added to CG | Effective date |
|---|---|---|---|---|
| CG-DRUG-05 | Procrit ESRD | J0886 | | January 1, 2016 |
| CG-DRUG-05 | Epogen ESRD | J0886 | | January 1, 2016 |
| CG-DRUG-16 | Granix | J1446 | J1447 | January 1, 2016 |
| CG-DRUG-09 | HyQvia | J1575 | J3490 AND J7799 | January 1, 2016 |
| CG DRUG 03 | Glatopa | | J1595 | January 1, 2016 |

**Revised clinical guideline:**

| Clinical Guideline Name & Number | MPTAC Outcome | Effective date |
|---|---|---|
| CG-DRUG-45 Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot) | MPTAC approved revision of clinical UM guideline which reflects the following:<br>• Removed medically necessary criteria for the treatment of adrenal gland tumors<br>• Added the treatment of adrenal gland tumors as not medically necessary. | May 1, 2016 |

Anthem clinical guidelines are available at ww.anthem.com > Providers (select state) > Medical Policies and Clinical UM Guidelines.

## Medical policy update

The following new medical policies were approved for Indiana, Kentucky, Missouri, Ohio and Wisconsin at the November 5, 2015 Medical Policy & Technology Assessment Committee (MPTAC) meeting. They will be implemented on May 1, 2016.

**DRUG.00079 Bendamustine Hydrochloride (TREANDA®)**
This new medical policy addresses the indications for the use of bendamustine hydrochloride (HCL), a cytotoxic, bifunctional mechlorethamine derivative with alkylator and antimetabolite activities used in the treatment of oncologic conditions.

**DRUG.00080 Mepolizumab (Nucala®)**
This new medical policy addresses the use of mepolizumab (Nucala), a humanized monoclonal antibody against interleukin-5 used for the treatment of individuals with severe eosinophilic asthma not well-controlled with inhaled corticosteroids and long-acting beta-agonists.

**THER-RAD.00011 Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT)**
This new medical policy addresses image-guided radiation therapy (IGRT) when used in combination with conformal external beam radiation therapy (EBRT).

**DRUG.00039 Trastuzumab (Herceptin®)**
The medical policy was revised to clarify the investigational and not medically necessary statement.

**GENE.00029 Genetic Testing for Breast and/or Ovarian Cancer Syndrome**
The medical policy was revised with several changes, including: 1) revision of the medical necessity criteria for BRCA1 or BRCA2 testing for individuals with a personal history of cancer and individuals with a family history of cancer, 2) clarification of the meaning of multiple primary breast cancers, 3) revision of medically necessary criteria for individuals with a history of pancreatic cancer, 4) expansion of criteria addressing at risk populations to include racial background, and 5) clarification of criteria for individuals of Ashkenazi descent who have a history of breast cancer.

**LAB.00031 Advanced Lipoprotein Testing**
The medical policy was revised to expand the scope of the document to include all other indications in addition to advanced lipoprotein testing for cardiovascular disease.

**MED.00103 Automated Evacuation of Meibomian Gland**
The medical policy was updated to revise the scope of the document to include imaging associated with the automated evacuation devices and to address tear film imaging.

**MED.00113 Therapeutic Apheresis**
The medical policy was revised to clarify the medically necessary indication for thrombotic microangiopahy and to clarify the criteria for treatment of thrombotic microangiography secondary to drugs other than ticlopidine.

**SURG.00024 Bariatric Surgery and Other Treatments for Clinical Severe Obesity**
The medical policy was revised to expand the scope of the document to include non-surgical treatments and to address the medical necessity of balloon systems and vagus nerve blocking devices.

**THER-RAD.00002 Proton Beam Radiation Therapy**
The medical policy was revised to update the medical necessity of and investigational and not medically necessary criteria for proton beam radiation therapy used for the treatment of localized prostate cancer.

**THER-RAD.00008 Neutron Beam Radiotherapy**
The medical policy medical necessity and investigation and not medically necessary criteria for neutron beam radiotherapy were revised.

In addition, the following medical policies were revised:

| Medical Policy | Drug | Removed from Medical Policy | Added to Medical Policy | Effective Date |
|---|---|---|---|---|
| DRUG.00074 | Lemtrada | Q9979 | J0202 | January 1, 2016 |
| DRUG.00058 | Ruconest | C9445 | J0596 | January 1, 2016 |
| DRUG.00070 | Sylvant | C9455 | J2860 | January 1, 2016 |
| DRUG.00068 | Entyvio | C9026 | J3380 | January 1, 2016 |
| DRUG.00066 | Eloctate | Q9975 | J7205 | January 1, 2016 |
| DRUG.00076 | Blincyto | C9449 | J9039 | January 1, 2016 |
| DRUG.00071 | Keytruda | C9027 | J9271 | January 1, 2016 |
| DRUG.00075 | Opdivo | C9453 | J9299 | January 1, 2016 |
| DRUG.00067 | Cyramza | C9025 | J9308 | January 1, 2016 |
| DRUG.00032 | Iluvien | C9450 | J7313 | January 1, 2016 |
| DRUG.00064 | Duopa | | J7340 | January 1, 2016 |
| DRUG.00066 | Obizur | | J7191 | January 1, 2016 |
| DRUG.00017 | Gel-syn | | J7328 | January 1, 2016 |
| DRUG.00017 | Genvisc | | Q9980 | January 1, 2016 |

Anthem medical policies are available at ww.anthem.com > Providers (select state) > Medical Policies and Clinical UM Guidelines. Please note that the Federal Employee Program® Medical Policy Manual may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies.

## Anthem will upgrade to MCG™ 20th edition

Anthem's Utilization Management/Case Management departments will upgrade to the 20th edition of MCG*, effective May 2, 2016. The following is a summary of some of the changes included in the MCG 20th edition

**Goal Length of Stay (GLOS).**

| Body System | Guideline | MCG Code | MCG 20th Edition GLOS | MCG 19th Edition GLOS |
|---|---|---|---|---|
| Endocrinology | Adrenalectomy, Partial or Complete | S-20 | 3 days postoperative | 4 days postoperative |
| General Surgery | Splenectomy by Laparoscopy | S-1062 | 1 day postoperative | Ambulatory or 1 day postoperative |
| Neurology | Paraplegia, Acute | M-255 | 8 days | 9 days |
| Neurology | Quadriplegia, Acute | M-305 | 9 days | 10 days |
| Neurology | Subarachnoid Hemorrhage, Nonsurgical Treatment | M-79 | 4 days | 5 days |
| Urology | Urethroplasty | S-1172 | Ambulatory or 1 day postoperative | Ambulatory or 2 days postoperative |

**New Optimal Recovery Guidelines**: Eleven Pediatrics Optimal Recovery Guidelines have been added in the 20th edition of Inpatient & Surgical Care.

| Body System | Guideline | MCG Code |
|---|---|---|
| Pediatric | Chemotherapy, Pediatric | P-87 |
| Pediatric | Cranioplasty, Pediatric | P-400 |
| Pediatric | Dehydration, Pediatric | P-123 |
| Pediatric | EEG, Video Monitoring, Pediatric | P-580 |
| Pediatric | Fundoplasty, Esophagogastric, by Laparoscopy, Pediatric | P-505 |
| Pediatric | Heart Transplant, Pediatric | P-535 |
| Pediatric | Liver Transplant, Pediatric | P-795 |
| Pediatric | Lung Transplant, Pediatric | P-1300 |
| Pediatric | Patent Ductus Arteriosus, Open, Thoracoscopic, or Transcatheter Closure, Pediatric | P-950 |
| Pediatric | Renal Transplant, Pediatric | P-1015 |
| Pediatric | Vomiting, Pediatric | P-371 |

**Guideline Name Changes:** The names of 8 Optimal Recovery Guidelines have been changed in the 20th edition of Inpatient & Surgical Care.

| Body System | New Title | Old Title | MCG Code |
|---|---|---|---|
| General Surgery | Esophageal Diverticulectomy, Endoscopic | Esophageal Diverticulectomy, Endoscopic Stapling | S-445 |
| Neonatology | Newborn Care, Routine | Newborn Care | P-357 |
| Neonatology | Newborn Care, Term, with Severe Illness or Abnormality | Full-Term Newborn Care, Severe Illness or Abnormality | P-595 |
| Neurology | Paraplegia, Acute | Paraplegia | M-255 |
| Neurology | Quadriplegia, Acute | Quadriplegia | M-305 |
| Infectious Disease | Sepsis and Other Febrile Illness, without Focal Infection | Febrile Illness, without Focal Infection | M-160 |
| Pediatrics | Apparent Life-Threatening Event | Apnea, Apparent Life-Threatening Event | P-12 |
| Pediatrics | Sepsis and Other Febrile Illness, without Focal Infection, Pediatric | Febrile Illness, without Focal Infection, Pediatric | P-410 |

*Formerly named *Milliman Care Guidelines*

## Update on precertification of cardiovascular services

Anthem recently expanded its cardiovascular program to require precertification for arterial ultrasound, cardiac catheterization, and percutaneous coronary intervention (PCI). An additional note about the program: arterial duplex imaging of the extremities (codes 93925, 93926, 93930, 93931) will only be reviewed retrospectively. The decision to perform this imaging is generally made while performing physiologic testing. The results of the physiologic testing are required in order to complete the review of duplex imaging. To initiate a retrospective review, please contact AIM within 10 business days of the duplex imaging, but prior to submitting the claim, by calling AIM at (800) 554-0580, logging on to the AIM ***Provider****Portal*℠ at aimspecialtyhealth.com/goweb , or accessing via the Availity Web Portal at availity.com.

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

For more information on this program, please see the article, "New cardiac precert requirements," in the August 2015 issue of *Network Update*, available online at www.anthem.com>Providers (enter state)>Network Update.

Thank you for your collaboration and ongoing support of the cardiology program. If you have further questions, please contact your local Network Relations consultant.

## KY, MO, OH: Precertification list additions for Individual members

Outpatient hip resurfacing and replacement, knee replacement, knee arthroscopy and cervical spine fusion will be added in April to the Anthem precertification list for our **commercial Individual members.** For more information, please see the Network eUPDATE that was distributed to providers by clicking on your state: KY, MO, OH. Or go online to www.anthem.com>Providers (enter state)>Network eUPDATE>Past Issues. Look for the Network eUPDATE under the Precertification heading.

## IN: Precert for total hip and knee replacements begins February 3, 2016

**This is a reminder that new precertification requirements for total hip and knee replacements take effect on February 3, 2016.** MCG criteria will be used for medical necessity review. For additional details, please see our Network eUPDATE here, or go online to www.anthem.com>Providers (select Indiana)>Network eUPDATE> *New precertification requirements for total hip and knee replacements.*

In addition, for Indiana, effective May 2, 2016, knee arthroscopy, hip resurfacing and cervical spine fusion will be added to the precertification list. Clinical Guidelines CG-SURG-43 Knee Arthroscopy and CG-SURG-42 Cervical Spine Fusin will be adopted as criteria for medical necessity review. The guidelines can be found here: Anthem Clinical Guidelines.

Please continue to use the normal precertification process. For this program, you can use the phone or the Interactive Care Reviewer (ICR) through Availity. For phone calls, use the phone number for precertification, located on the back of the member's identification card. Follow the prompts and the call will be routed to TurningPoint.

If you have additional questions on the precertification process, please contact TurningPoint at 855-275-4500.

# Medicare

## Learn how to complete the AIM OptiNet imaging services registration

**Medicare Advantage (MA) webinar for all imaging providers**

Anthem is collecting information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of a number of outpatient diagnostic imaging services for our individual Medicare Advantage members.

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

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

Providers who score less than 76 or who do not complete the survey by 2nd Quarter 2016 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

**Anthem strongly encourages any provider who scores below 76 to improve your site score for the applicable modality before the line item denial of claims for dates of service on or after 2nd quarter 2016. Providers**

**who have not registered and therefore have no score also will be subject to line-item denials for claims submitted for dates of service on or after 2nd quarter 2016.**

Attend one of the webinars below to learn how to:

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

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

**Thursday, Feb. 4. 2 p.m.-3 p.m. Eastern**
**Thursday, Feb. 18 12p.m.-1 p.m. Eastern**

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

## Support for individual MA members with rare conditions

**Note: The following article does not apply to providers with certain delegated risk agreements.**

Anthem will be working with Accordant Health Services to provide targeted disease management services for our individual MA members with rare medical conditions, including:

Amyotrophic Lateral Sclerosis (ALS)
Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)
Crohn's Disease
Cystic Fibrosis
Dermatomyositis
Epilepsy
Gaucher Disease
Hemophilia
Multiple Sclerosis (MS)
Myasthenia Gravis
Parkinson's Disease
Polymyositis
Rheumatoid Arthritis
Scleroderma
Sickle Cell Disease
Systemic Lupus Erythematosus
Ulcerative Colitis

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

If you feel that an individual MA member would benefit from this program, please have the member contact AccordantCare via phone or fax at 1-866-247-1150.

## HIPPS codes required for SNF and HHA claims

All claims from Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) received July 1, 2014, and after, must contain a valid HIPPS code. **This pertains to Contracted and Non-Contracted Providers.** CMS requires Anthem to include this information on **all processed claims** data that we submit, regardless of the payment methodology. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans including Medicare-Medicaid Plans. This does not apply to Dual Special Needs Plans (D-SNPs) or Medicare Supplement plans.

**SNFs**

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

**HHAs**

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

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

57943WPPENMUB 12/16/2015

## KY, OH: Update on radiation therapy precertification procedures

Precertification procedures for the following outpatient radiation therapy services for our individual Medicare Advantage members have been updated:

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

Precertification can be obtained by contacting AIM at https://www.providerportal.com/ or (800) 714-0400.

## Provider requirements and Medicare notices

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

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

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

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

## Contact OrthoNet for outpatient OT and PT precert

**Attention: SNFs, Home Health and LTC**
Anthem is collaborating with OrthoNet, LLC to conduct medical necessity reviews for outpatient physical therapy, occupational therapy for our individual Medicare Advantage members.

Effective April 1, 2016, OrthoNet will accept precertification requests for outpatient and home-based Occupational Therapy (OT) and Physical Therapy (PT) from Skilled Nursing Facilities (SNFs), home health providers and long-term care (LTC) facilities. SNF and LTC providers please note: Inpatient PT/OT services rendered as part of a Skilled Nursing level of care are excluded from this authorization process.

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

## Help ensure members have accurate information on your practice

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

## Please review formulary changes

Each year we evaluate our benefits and formulary and may make changes to update them. Formulary changes for 2016 include: tier changes, drug removals and new Prior Authorization and Quantity Limit requirements.
Our members will need your help to ensure they get their medications at the most affordable cost.

Please, encourage your patients to review the 2016 formulary information within their Annual Notice of Change (ANOC) mailing or their new member kit, or to view the information online. Ask them if the coverage for any of their prescriptions has been changed, and consider alternative medications that will meet their needs at a lower cost. Current and previous year Medicare Advantage formularies for plans sold directly to individuals are published at www.anthem.com/medicareprovider. An overview of plan changes for 2016, including notable formulary changes, can be found at www.anthem.com/medicareprovider under Important Medicare Advantage Updates. See the 2016 Medicare Advantage Plan Changes for your state dated October 1, 2015.

Drug coverage provided to members of group-sponsored Medicare Advantage Plans and Part D Pharmacy Plans varies by employer or union. Patients who have group-sponsored Medicare Advantage or Part D Pharmacy coverage receive a new formulary booklet prior to the start of each calendar year that they can bring to their appointment with you.

### Keep up with MA news

Please continue to check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for the latest Medicare Advantage information, including:
Medicare Advantage reimbursement policies
Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning June 1, 2016

57786WPPENMUB 12/11/2015

# Pharmacy

### CVS/Specialty is the in-network specialty pharmacy

The following message is a follow up to the article, *CVS/specialty is the in-network specialty pharmacy for members with medical benefit coverage for specialty medications*, included in our December 2015 issue of *Network Update*:
CVS specialty pharmacy is the dedicated in-network provider for Anthem Blue Cross and Blue Shield (Anthem) members whose specialty drugs are covered under their medical benefit **and** whose specialty drug is being shipped to your office. This includes commercial, Medicare and Medicaid lines of business.

### 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 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." Website links for the Federal Employee Program formulary Basic and Standard Options are **Basic Option:** https://www.caremark.com/portal/asset/z6500_drug_list807.pdf; and **Standard Option:** https://www.caremark.com/portal/asset/z6500_drug_list.pdf. This drug list is also reviewed and updated regularly as needed. FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies.

# Quality

## Improving documentation of blood pressure

Hypertension is the most common condition seen in primary care practices and if managed well can reduce the burden of cardiovascular disease for a patient.[1] The new Eighth Joint National Committee (JNC 8) guideline on the management of adult hypertension was released in 2014. The new changes recommend physicians treat to 150/90 mm Hg in patients over age 60 and 140/90 for everybody else, including those patients who have diabetes. Each year, health plans collect data from provider records to look at patients with hypertension to see if their blood pressure is under control. The National Committee for Quality Assurance (NCQA) made changes to the 2015 Healthcare Effectiveness Data and Information Set (HEDIS®) Controlling High Blood Pressure (CBP) measure to align with the new JNC8 guidelines.

Improvements in documentation of the diagnosis and blood pressure can make a difference in whether CBP is considered compliant or not. The 2015 medical record review findings from provider offices that contributed to decreased scores included:

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

You can take the *Journal of American Medical Association* CME course to earn a maximum of 1 *AMA PRA Category 1 Credit™* for the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults (JAMA. 2014;311(5):507-520). Register and access the course at the following link: http://jama.jamanetwork.com/cme.aspx

JNC8 guidelines can be found at this link: http://jama.jamanetwork.com/article.aspx?articleid=1791497&tab=cme

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

[1] 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, JAMA. 2014; 311(5):507-520. Retrieved on 12/10/2015 from http://jama.jamanetwork.com/article.aspx?articleid=1791497#tab1

## Cancer Care Quality Program Precision Medicine expansion

The Cancer Care Quality Program is expanding to include enhanced reimbursement for treatment planning and care coordination services provided by network providers for those eligible members who enroll in NCI-Molecular Analysis for Therapy Choice (NCI-MATCH), a National Cancer Institute clinical trial. NCI-MATCH seeks to

determine whether treating cancers according to their molecular abnormalities will show evidence of effectiveness.

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

Visit our special website to learn more about the program:

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

Go to: www.CancerCareQualityProgram.com/PrecisionMedicine

## Commercial HEDIS starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax.

The fax will contain 1) a cover letter with contact information if you have any questions; 2) a Member list, which includes the member and HEDIS measure(s) they were selected for; and 3) an instruction Sheet listing the details for each HEDIS measure. As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within **five business days**. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in the 3rd quarter provider newsletter.

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

1. Upload to our secure portal. This is quick and easy. Logon to www.submitrecords.com, enter the password: **wphedis57** and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records, **or**

2. Send a secure fax to **1-888-251-2985, or**

3. Mail via the **US Postal Service** to: Anthem, Inc., 10897 S. River Front Parkway, Suite 110H, South Jordan, UT 84095-9984

Thank you in advance for your support of HEDIS.

### Practice access after-hours

Your contract with Anthem requires that your practice provide continuation of care for our members outside of regular business hours. We will conduct after-hours access studies to assess how well practices are meeting this provision, and your practice may receive a call from North American Testing Organization, a vendor in California working on Anthem's behalf. To be compliant, please verify that your messaging or answering service includes appropriate urgent care instructions. The compliant response directs callers to Urgent Care, 911, the ER, or connects the call to the caller's doctor or the doctor on call. In addition to these measures, but not in place of them, the messaging can give callers the option of contacting their health care practitioner (via transfer, cell phone, pager, etc.) or an opportunity to ask for a call back for urgent questions or instructions. *Is your practice compliant?*

## Reimbursement

### Revised professional reimbursement policies

Anthem reviews its professional reimbursement policies annually to determine if any changes or revisions are required. Listed below are changes to the professional reimbursement policies to provide further clarification and detail.

**Bundled Services and Supplies**
Claims processed on or after the time range of February 22 through February 28, 2016, the Healthcare Common Procedure Coding Systems (HCPCS Level II) code C9257 for Avastin 0.25 mg, will be eligible for reimbursement to professional providers who report their services on a CMS 1500 claim form as an exception to our always bundled edit for HCPCS "C" codes. Based on our policy, all other HCPCS "C" codes are not eligible for reimbursement when reported by professional providers.

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

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

**Bundled Services and Supplies and Modifiers 59 and XE, XP, XS, & XU**
Effective May 1, 2016, we are adding to Section 2 of our policy that CPT codes 82570 (assay of urine creatinine) and 83986 (assay ph body fluid nos) are considered incidental to, and not eligible for, separate reimbursement when reported with presumptive and definitive drug testing CPT codes 80300-80377 and 83992. Bypass modifiers will not override the edit, therefore the information is also included in our Modifiers 59 and XE, XP, XS, & XU reimbursement policy.

**Durable Medical Equipment**
When durable medical equipment (DME) is rented by a patient, the Health Plan allows rental up to the purchase price or a maximum 10 month rental period, whichever comes first. When a patient was previously covered by another health insurance policy and such other policy covered a portion of the DME purchase price or rental period, we will apply the previous policy's allowed amount or rental months to our current purchase allowance or 10 month rental period, whichever comes first, when the DME item is procured from the same DME provider. This information may be found under the "Purchase/Rent to Purchase" section of our policy dated December 1, 2015.

As a reminder, our recent Network eUPDATE, "HCPCS drug testing codes effective January 1, 2016," advised that we will be adding CPT codes for presumptive (80300-80304) and definitive (80320-80377 and 83992) drug testing to our always bundled services edit beginning with dates of service on or after March 15, 2016. Providers are reminded to use the new HCPCS "G" codes (G0477-G0483) when reporting presumptive and definitive drug testing services for dates of service on or after March 15, 2016. (Note: See related article, "HCPCS drug testing codes", on page 5 in this issue.)

**Frequency Editing**
Beginning with dates of service on or after the time range of February 22, 2016 through February 28, 2016, with dates of service on or after January 1, 2016, we will apply a frequency limit of one per date of service for new CPT code 0403T (Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day).

In addition, we will apply a frequency limit of 24 per 365 days to CPT code 0403T beginning with dates of service on or after 01/01/2016. Note that this edit will use claim lines processed in history that have previous, current, and subsequent dates of service to accumulate and apply this frequency limit.

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

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

As a reminder, our recent Network eUPDATE, "HCPCS drug testing codes effective January 1, 2016," advised that, effective January 1, 2016, CMS will use HCPCS' new "G" codes for "per day" presumptive and definitive drug testing. Beginning with dates of service on or after January 1, 2016, we will apply a frequency limit of 1 unit per date of service on HCPCS codes HCPCS codes G0477 – G0483. We will also apply a frequency limit of 18 units per 365 days on HCPCS definitive drug testing codes G0480 –G0483. This edit will use claim lines processed in history with prior, current, and subsequent dates of service to accumulate and apply this frequency limit. (Note: See related article, "HCPCS drug testing codes", on page 5 in this issue.)

**HCPCS drug testing codes effective January 1, 2016**

| Code | Description |
|---|---|
| G0477 | Presumptive, per day, dip sticks, cups, cards, cartridges |
| G0478 | Presumptive, per day, dip sticks, cups, cards, cartridges |
| G0479 | Presumptive, per day, instrumented chemistry analyzers |
| G0480 | Definitive, per day, 1 - 7 drug classes |
| G0481 | Definitive, per day, 8 - 14 drug classes |
| G0482 | Definitive, per day, 15 - 21 drug classes |
| G0483 | Definitive, per day, 22 or more drug classes |

**Modifier Rules**

When modifiers LT, RT, or 50 are reported with a procedure code that is inherently a bilateral procedure or includes "unilateral or bilateral" in the code description, the Health Plan does not consider this correct use of modifiers. Therefore, beginning with dates of service on or after January 1, 2016, codes considered bilateral or described as "unilateral or bilateral" will not be eligible for reimbursement when reported with modifiers LT, RT, or 50. This will eliminate incorrect reimbursement and retractions. This information is also included in our Multiple and Bilateral Processing reimbursement policy

**Modifiers 59 and XE, XP, XS, & XU**

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

**Multiple and Bilateral Surgery Processing**

In our policy, effective January 1, 2016, we have updated the arthroscopic and endoscopic surgical procedures coding table to include new CPT esophogogastroduodenoscopy (EGD) code 43210. Claims processed on or after February 22, 2016 – February 28, 2016, that include 43210 and another EGD code identified in the table, will be subject to the endoscopic reimbursement reduction for second and subsequent procedure.

**Place of Service**

The Health Plan considers the provision of any vaccine and the administration of such vaccines to be included under the facility's reimbursement when the vaccines are provided in a facility setting. Therefore, beginning with claims processed on or after the time range of February 22, 2016 through February 28, 2016, when a vaccine and the vaccine administration are reported by a professional provider with a facility setting place of service code, the vaccine and vaccine administration charges will not be eligible for separate reimbursement.

Beginning with claims processed on or after May 23, 2016, when materials, supplies, or elements for enteral and parenteral therapy services represented by HCPCS "B" and "E" codes are reported by a professional provider with a facility setting place of service (19, 21, 22, 23, 24, and 31), the charges will not be eligible for reimbursement. The Health Plan considers enteral and parenteral therapy to be included under the facility's reimbursement when provided in a facility setting.

**Other updates**
Punctuation changes, grammatical edits, formatting, as well as insertions of AMA CPT Handbook terminology, were made to the following policies: Documentation Guidelines for Psychotherapy Services, Routine Obstetric Services, and Surgical Pathology for Prostate Needle Biopsy. The changes are effective February 1, 2016.

- Documentation Guidelines for Psychotherapy Services,
- Surgical Pathology for Prostate Needle Biopsy.
- TeleHealth Services (revised to add G0427 to grid under coding section)

## Another reminder: System updates for 2016

As a reminder, our ClaimsXten® and *proprietary claim editing* software packages will be updated throughout 2016. These upgrades will:

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

Notice of reimbursement policy modifications due to these updates will continue to be published in *Network Update*.

## Revised coding tip: Radiation Treatment Delivery and IGRT Professional Component

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

## 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 availity.com/providers/registration-details/.

*Non-Registered for MyAnthem*: If your organization is not registered for MyAnthem, sign onto 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 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 anthem.com >Providers (enter state)>Answers@Anthem.

# Specialty Services: Behavioral Health

## Member satisfaction with behavioral health outpatient services

Anthem conducts an annual satisfaction survey of our Member's behavioral health outpatient service experience. The random survey is conducted based on receipt of claims and asks about the member's satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member's various providers), prescriptions/medication management process (if applicable), financial and billing process, and their perceived clinical improvement. Our member is also asked to give an overall rating of the experience. We have recently reviewed the 2015 survey experience results and are pleased with our member's experience. Many of the responses were equal to or showed a slight improvement over last year's high baseline. However, there also are a few areas that reflect a decrease in member satisfaction or the responses were not as high other metrics. These areas for improvement are listed below.

**Member's access to behavioral health care:** As a participating provider, you are reminded that the following are Anthem's expectation of access to behavioral healthcare. These are based on NCQA definitions and are designed to help ensure our members have prompt access to behavioral health care:

- *Non-life threatening emergency needs* - must be seen, or have appropriate coverage directing the Member, within 6 hours. When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.
- *Urgent needs* - must be seen, or have appropriate coverage directing the Member, within 48 hours. Urgent calls concern members whose ability to contract for their own safety, or the safety of others, may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.
- *Routine office visit* - must be within 10 business days. Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

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

**Members held harmless:** As a participating provider in Anthem's behavioral health provider network, a participating provider shall look solely to Anthem for compensation for covered services and under no circumstances shall render

a bill or charge to any member except for applicable co-payments, deductibles and coinsurance, and for services that are not medically necessary or are otherwise not covered, provided that the Provider obtains the consent of the Member before providing such service. We recommend that consent be in writing and dated, in order to protect members and providers from disputes.

In addition, Anthem reminds participating providers that our members must be advised of missed or cancelled appointment policies at the onset of treatment. We recommend that the member sign a written and dated acknowledgement of the policies.

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

Thank you for your network participation and the services you provide.

Survey results by state:

| **State/Plan** | **Overall Rating of Practitioner** *(% responding 8, 9, or 10 on scale of 1-10)* |
|---|---|
| IN PPO | 89% |
| KY PPO | 88% |
| OH PPO | 86% |
| WI HMO/POS | 92% |

## OH: Eating disorder programs

Anthem recently contracted and re-contracted with the following Ohio eating disorder programs:

- Lindner Center (Mason, Ohio) http://lindnercenterofhope.org/contact-us/
- River Centre (Sylvania, Ohio) http://river-centre.org/
- The Center for Balanced Living (Columbus, OH) http://www.centerforbalancedliving.org/
- Emily Program, (Cleveland, OH) https://www.emilyprogram.com/locations/ohio
- Eating Recovery Center of Ohio (Cincinnati, OH) https://www.eatingrecoverycenter.com/programs/ohio/
- Nationwide Children's (Columbus, OH) http://www.nationwidechildrens.org/eating-disorders-program

# Medicaid Notifications

## For IN, KY, WI Medicaid

**Providing services to out-of-state Medicaid members**

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

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

**Medicaid encounter data**

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

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

| **Professional Encounter Data** | | |
|---|---|---|
| Actual ambulance mileage | Performing provider taxonomy code | Service facility location state |
| Billing provider address | Referring provider number and Referring provider number qualifier | Service facility location ZIP |
| Billing provider middle initial | Performing provider NPI | National drug code |
| Provider NPI | Service facility name | Condition code |
| **Institutional Encounter Data** | | |
| Actual ambulance mileage | Occurrence span code | Operating physician number and operating physician number qualifier |
| Attending physician number and attending physician number qualifier | Occurrence date | Performing provider taxonomy code |
| Condition code | Occurrence from date | Provider NPI |
| National drug code | Occurrence to date | Value amount |
| Occurrence code | Referring provider number | Value code |

| 837 Field Name | Claim Type |
|---|---|
| Claim or line note text | Institutional and professional |
| Certification condition applies indicator and Condition indicator - early and periodic screening diagnosis and treatment (EPSDT) | Institutional and professional |
| Service facility name and location information | Institutional |
| Ambulance transport information | Professional |
| Ordering provider identifier and identification code qualifier | Professional |

**Medicaid provider enrollment**
As noted above, beginning April 18, 2016, Anthem will notify providers by letter when additional information is needed in order to process out-of-state Medicaid claims. Additional information may require the provider to "enroll" in the member's out-of-state Medicaid program, or provide missing Medicaid encounter data.

If an Anthem provider sees a Medicaid patient from another state, and that state Medicaid program requires the provider to be enrolled, the servicing provider must enroll in that state Medicaid program in order to be paid.

## For IN Medicaid only

**Let's get connected**
In an effort to help increase your quality scores and make information exchange safer and easier, we are implementing a secure and reliable systemized process. This process allows the exchange of real time clinical data (medical records, performance reports) between your office and Anthem, all while maintaining strict HIPAA compliance. Use this link to learn more about standard file transfer protocol (SFTP).

**New copays for Hoosier Care Connect**
Effective **January 1, 2016**, Hoosier Care Connect members will have copays for a select number of services. Providers will need to collect copays upon rendering these services.

**Blue Ticket to Health program**
You may soon see an increase in call volume from our members interested in scheduling annual wellness exams. To ensure Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members stay healthy, Anthem is teaming up with the Indianapolis Colts to promote the Blue Ticket to Health program throughout Indiana. Read more about the program and member rewards!

**Home health services update: overhead billing**
Anthem performed a system update based upon IHCP bulletin, BT201535, dated **May 26, 2015**. As a result of an error in updating the system, some providers may have received denials in error for overhead billing. The error was corrected in **October 2015** and was made retroactive to **July 1, 2015**. Use this link to learn how claims are being adjudicated.

**Introducing the Debit Card training series**
As part of our ongoing effort to help train our providers and members regarding the use of the new **POWER Account Visa® Debit Card**, we are pleased to present our new online **Debit Card Training Series**. The training series consists of brief presentations to help maximize your use of the Debit Card and to help answer any questions you have. Find out how you can access the Debit Card Training Series here.

**Claims Submission Reminder**
As a reminder, providers submitting paper claims for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect services should use these addresses.

## For KY Medicaid only

**IMRT codes require precertification**
Effective **March 1, 2016**, two intensity modulated radiation therapy (IMRT) codes will require precertification. Anthem Blue Cross and Blue Shield Medicaid (Anthem) will require precertification for these IMRT codes:

- **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

Please use one of the following methods to request precertification:

- **Phone**: **1-855-661-2028**
- **Fax**: **1-800-964-3627**

For more information about prior authorization, visit http://www.anthem.com/KYMedicaiddoc and click on ***Precertification***.

**Medicaid Special Investigations Unit update for providers**
The Medicaid Special Investigations Unit (MSIU) works diligently to prevent fraud, by both providers and members. The MSIU endeavors to provide a fair and innovative environment for both providers and members. In cooperation with Anthem, the MSIU conducts numerous onsite and records-only audits per year. In many instances, we find billing and other errors made by providers with no fraudulent intent. The MSIU would like to give providers tips to ensure billing and operations are conducted lawfully and within health plan limitations and requirements. Use this link to access this important information.

## For WI Medicaid only

**Reimbursement policy update for portable/mobile/hand-held radiology services and handheld radiology instruments**

*(Policy 06-160, originally effective 07/01/14)*

Anthem allows reimbursement for portable/mobile radiology services for BadgerCare Plus members when provided in a residence used as the patient's home including a nursing home (POS codes 31, 32, or 33) and if ordered by a physician and performed by qualified portable radiology suppliers unless provider, state, federal, or CMS contracts or requirements indicate otherwise. Anthem allows reimbursement for transportation and setup of portable radiology equipment when transported to the BadgerCare Plus member's residence or nursing home. Transportation and setup costs are payable when the portable X-ray equipment used is actually transported to the location where the X-ray is taken.

The use of handheld radiology instruments is allowed. Reimbursement will be part of the physician's professional service and no additional charge will be paid. The technical components for handheld radiology are not separately reimbursable.