Anthem BlueCross BlueShield

Working together to improve the health of our members.

April 2016

Network Update

CENTRAL REGION

In this issue

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anthem.com

CE0416
IN, KY, MO, OH, WI

Quality

Reimbursement

Specialty Services: Behavioral Health

Medicaid Notifications

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.

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)> Answers@Anthem>Sign up for Network eUPDATE.

Administrative Update

New requirements for credentialing and certification

Effective July 1, 2016, we will require credentialing for several additional practitioner and health delivery organization (HDO) provider types when those provider types are contracted by your local Anthem Plan. Credentialing involves verification of basic professional conduct and competency criteria, including licensure, education and training and sanction activity. Each provider's application will be reviewed by a local credentialing committee or medical director for approval; re-credentialing will occur every three years thereafter.

For these provider types who are *newly contracted* (i.e., initial applicants), a process to begin credentialing will start July 1. For these same provider types who already have a contract in place, a credentialing process will be developed to ensure your credentialing is complete within the next 18 months.

Following are the new practitioner and HDO provider types that will require credentialing effective July 1, 2016:

Practitioner provider types:

- Licensed genetic counselors
- Audiologists
- Acupuncturists (non-medical doctors (MD) or doctors of osteopathic medicine (DO)
- Nurse practitioners, certified nurse midwives and physician assistants
- Registered dieticians

Anthem also will require the credentialing of providers who support our Traditional products in the same manner as those that support our managed care products. This requirement is in addition to all other contracted Anthem networks. For more information, please refer to your state's 2016 Provider Manual: Kentucky , Wisconsin , or go to www.anthem.com>Providers (enter state>Communications>Publications.

Note: The 2016 Provider Manuals for Indiana Missouri, and Ohio will be available May 1 at www.anthem.com

Credentialing will be required for the above practitioners when they are:

- Contracted independently
- Contracted at a group practice level and are listed in our directories
- Licensed by the state to practice independently

HDO provider types:

- Behavioral health facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings:
  - Adult family care/foster care homes
  - Ambulatory detox
  - Community mental health centers (CMHC)
  - Crisis stabilization units
  - Intensive family intervention services
  - Intensive outpatient – mental health and/or substance abuse
  - Methadone maintenance clinics
  - Outpatient mental health clinics
  - Outpatient substance abuse clinics
  - Partial hospitalization – mental health and/or substance abuse
  - Residential treatment centers (RTC) – psychiatric and/or substance abuse
- Birthing centers
- Convenient care centers/retail health clinics/walk-in clinics
- Federally qualified health centers (FQHC)
- Intermediate care facilities
- Home infusion therapy
- Rural health clinics
- Urgent care centers

Credentialing will be required for the above HDOs when they are contracted independently by us today or are listed in our directories. (Note that the updated Provider Manual will have a list of HDO types and the corresponding accrediting agencies approved by Anthem.)

How to get started

Based on your provider type, you will either use the Council for Affordable Quality Healthcare's (CAQH) ProView online service or complete and return a HDO application along with required attachments, as explained below*.

If contracted today independently or listed in our directories, the following providers must use CAQH's ProView:

- Licensed genetic counselors
- Audiologists
- Acupuncturists (non-medical doctors (MD) or doctors of osteopathic medicine (DO)
- Nurse practitioners, certified nurse midwives and physician assistants

ProView is a free, online service that allows health care providers to fill out **one** application to meet the credentialing data needs of multiple organizations. ProView allows healthcare providers to:

- Complete and attest to multiple state credentialing applications in *one* workflow design.
- Upload supporting documents directly into ProView to eliminate the need for manual submission and to improve the timeliness of completed applications.

- Review and approve practice manager information.
- Self-register with the system before a health plan initiates the application process.

If you are already using CAQH, please keep your application updated so there is no delay in the credentialing process and your provider directory listing. We will take care of adding you to our CAQH Roster. If you don't currently use CAQH's Global Authorization, please be sure to authorize Anthem to view your credentials.

If you don't currently use CAQH, you may self-register with CAQH at **www.caqh.org.** For questions about CAQH ProView, please contact the CAQH ProView Support Desk by e-mail: providerhelp@ProView.CAQH.org or phone: (888) 599-1771.

*HDO and facility providers will not use the Practitioner CAQH ProView application process referenced above. These providers should complete the Health Delivery Organization/Facility Application located at anthem.com > Providers > (enter your state) > Answers@Anthem > HDO/Facility Form.

Certification Process
In addition to the change in the provider scope for credentialing, we will begin to verify certifications and licensure, as applicable, for the following provider types when contracted as part of a certification review process:

- Certified behavioral analysts
- Certified addiction counselor
- Substance abuse practitioners
- Clinical laboratories
- End stage renal disease (ESRD) service providers (dialysis facilities)
- Portable x-ray suppliers

The certification process will include a review of licensure or certifications, such as Medicare or CLIA, and a review of any federal sanctions.

The Credentialing team looks forward to working with you.

Changes coming to MyAnthem for Provider

Effective May 13, 2016, providers will go exclusively to Availity to access Remittance Inquiry, Fee Schedule Inquiry and Reports. From April 16 – May 13, these functions are transitioning from MyAnthem to Availity and users will be able to access them from either application. **However, after May 13, users will access this information exclusively via the Availity Web Portal from the Payer Spaces page. (**For a description of **Payer Spaces**, please see the next article.)

As a result of this transition, the following MyAnthem functions are no longer needed and will be shut down on May 13, 2016.

- Registration functions for MyAnthem
- MyAnthem Site Administrator Manage My Users
- Remit Inquiry
- Fee Schedule Inquiry
- Indiana Reports

In addition, in the coming weeks, please look for more details on upcoming enhancements, including the new **Remit Viewer** and **Fee Schedule Inquiry tool**.

Find Anthem information under Payer Spaces on Availity

Availity is making changes to its portal. Currently, providers using Availity can select **Payer Resources** to access Anthem forms and information. Going forward, providers can opt for a new tab, **Payer Spaces,** located on the right side of the top menu bar on the Availity Web Portal. From the new Payer Spaces drop down menu, providers looking for Anthem forms and information can choose Anthem Blue Cross Blue Shield from the payer options, then select **Resources** from the menu located on the page.

For now, you can navigate to **Resources** using either the **Payer Spaces** or the **Payer Resources** links. But later this summer, the Payer Resources link will be retired and no longer available. At that time, Anthem forms and information will be available exclusively under **Payer Spaces.**

Coming soon: Payer Spaces will be the starting navigation point for you to access Remittance Inquiry and Fee Schedule Inquiry.

Providing services to out-of-state BCBS Medicaid members

In the February 2016 edition of *Network Update,* we indicated that Anthem will begin mailing letters to providers when additional information is needed in order to process out-of-state Medicaid claims that are administered by a Blue Cross and Blue Shield (BCBS) health plan. Additional information may require the provider to enroll in the out-of-state member's state Medicaid program, or provide missing Medicaid encounter data. Mailed letters will begin April 18, 2016.

The following frequently asked questions provide additional detail about Medicaid provider enrollment and the billing and reimbursement of claims for out-of-state BCBS Medicaid members:

Why are providers required to enroll in some out-of-state Medicaid plans?
At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Medicaid is a state-run program, and requirements vary for each state, and thus each BCBS Plan. Some states require providers to enroll in their state Medicaid program in order to be reimbursed for claims for the out-of-state Medicaid member.

If you are required to enroll in another state's Medicaid program in order to be reimbursed, you should receive notification of this requirement when verifying eligibility and benefits for the member. Providers should enroll in the state's Medicaid program before submitting a claim for an out-of-state BCBS Medicaid member to avoid delays in processing.

To view provider enrollment requirements for each state, visit Medicaid.gov.

Which states currently require provider enrollment?
Currently, the following states require provider enrollment: Indiana, Kentucky, Pennsylvania, South Carolina, Tennessee and Virginia. Please note this list is subject to change, so it is important to always confirm if provider enrollment is required when verifying eligibility and benefits for Medicaid members.

What happens if a provider submits a claim for a Medicaid plan that requires provider enrollment, and the provider is not enrolled in the member's state Medicaid program?
If a provider submits a claim for an out-of-state BCBS Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. Beginning April 18, 2016, Anthem will send the provider a letter with information about how to enroll in the member's state Medicaid program online. If the provider does not enroll in the member's state Medicaid plan, the state law may require the member be held harmless.

How can providers identify an out-of-state BCBS Medicaid member?
Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. BCBS Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most BCBS ID cards, but will contain disclaimer language on the back of the ID card indicating benefit limitations. For example, a card may read, "*This member has limited benefits outside of [insert state name*]". Providers should always verify eligibility and benefits for these members.

How should providers submit a claim for an out-of-state BCBS Medicaid member?
Claims should be submitted to [insert plan name] in the same way you would submit a claim for other BCBS members.

What data elements should be included on the claim for a BCBS Medicaid member?
Providers can check the Medicaid website of the state where the member resides for specific information on Medicaid billing requirements, however, the following data elements should be submitted, when applicable.

DHS shares information on opioid abuse

Anthem would like to share some information from the U.S. Department of Health & Human Services concerning a recently published overview of the opioid abuse epidemic, including information on abuse prevention, treatment for addiction, and responding to an overdose. Additional information on this topic can be found in this recent White House memorandum.

IN, KY, OH: Fiat Chrysler outpatient PT carved out to TheraMatrix

Effective March 1, 2016, Fiat Chrysler transferred its outpatient physical therapy (PT) program for the Hourly Active membership to TheraMatrix. Coverage for outpatient PT services is no longer provided through the Blue Cross and Blue Shield (BCBS) medical program. For more details, click here or go online to www.anthem.com>Providers (enter state)>Network eUPDATE.

IN: New Prior Authorization/Precertification Request Form

As requested by the Indiana Department of Insurance Bulletin 214, the Indiana Standard Prior Authorization/ Precertification Request Form has been added to Availity and anthem.com. Please use this form as a cover sheet when submitting faxed prior authorization/precertification requests to Anthem's Utilization Management (UM) area. For more information, please see our Network eUPDATE here. Or go online to www.anthem.com>Providers (enter Indiana)>Network eUPDATE.

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

Process update for compound drug claims

A change in claims processing for compound drug claims that aligns with members' benefit plans is being implemented for individual and group plans upon their renewal on or after January 1, 2016. A compound drug is a customized medication prepared by a pharmacist for a specific person.

Once implemented, in order for a compound drug to be a covered benefit, *all* its ingredients must be approved by the Food and Drug Administration (FDA), with some exception for delivery adjuvants (products that are utilized to deliver an active ingredient). A prescription is also required for the drug. These control measures are in place to ensure compound drugs are safe and effective.

As a result, claims for certain compound drugs currently being paid will no longer be paid for products containing:

- Compounded bulk powders (not FDA-approved)
- Single Source, Proprietary Pharmaceutical Adjuvants (compounding vehicles, not FDA-approved)

Members utilizing compounds whose ingredients are not all FDA-approved may have to pay for the cost of the drug the next time they fill their prescription. We will continue to cover compound drugs when ingredients are FDA-approved and not otherwise excluded, as defined under the member's benefit plan.

Federal Employee Plan (FEP)

Residential treatment center – new benefit

Blue Cross Blue Shield Service Benefit Plan®, also known as Federal Employee Program, has a new Residential Treatment Center (RTC) benefit effective January 1, 2016. The new benefit provides RTC services with the following requirements:

- FEP members **must be enrolled and participating in case management** prior to RTC admission and remain in case management through post discharge.
- Facility must provide a preliminary treatment plan and a discharge plan prior to admission.
- Care must be medically necessary for treatment of a mental health, substance abuse or medical condition.
- Precertification must be obtained prior to admission or the entire admission is denied as non-covered.
- The Residential Treatment Center must be licensed and accredited.

Note: If the above requirements are not met prior to the admission, the entire residential stay will not be covered.

Additional information can be found in the Service Benefit Plan Brochure located at www.fepblue.org or call 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

Specialty Rx program expands to include level of care reviews

Anthem is committed to the Institute for Healthcare Improvement (IHI) Triple Aim Initiative -- a framework developed by the IHI that describes an approach to optimizing health system performance using the following dimensions:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care

Effective with dates of service on or after July 1, 2016, Anthem will expand the Specialty Pharmacy program to include a review of the requested level of care for infusion therapy. A new clinical guideline, **Level of Care: Specialty Pharmaceuticals CG-DRUG-47**, will apply to the review process for dates of service beginning July 1, 2016. The expanded program will be administered by AIM Specialty Health® (AIM), a separate company. In some states, providers are already identifying alternative sites of care based on member's individual needs and favorable member feedback on the impacts to care, convenience and costs.

There may be circumstances where a member's medical situation requires that he or she receive infusions in a hospital outpatient facility. Based on the information you provide, AIM will review both the drug for clinical appropriateness and the level of care against health plan clinical criteria. The level of care review does not apply to requests for review of oncology or hemophilia drug indications. Physician offices that currently administer specialty drugs in the office setting are not impacted by this change.

Providers will continue to request authorization for specialty drugs in one of several ways:

- Access AIM ***Provider****Portal*℠ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580.

For more information on how to access online authorizations via Availity, reference our **Quick Reference Guide to AIM Specialty Health.**

What's new beginning with dates of service on or after July 1, 2016:

- When providers select a hospital-based outpatient facility as the level of care, a list of alternate locations, such as infusion centers and home infusion providers will be made available. Medical specialty pharmacy providers will also be listed as an alternate option to supply the infusion medication to physician offices who can administer it to the member.

- If an alternate level of care is not selected, providers will be prompted to indicate the reason hospital-based level of care is medically necessary.
- If a request for hospital-based level of care does not meet medical necessity criteria upon review by a physician reviewer, the request will not be approved. We encourage you to discuss with members their site of care options, such as physician office, infusion center or home infusion therapy.

The expanded program applies to local Anthem members who have specialty pharmacy services medically managed by AIM. The expanded program does not apply to the following plans: Medicare Advantage, Medicaid, Medicare Supplement, and FEP. For more information, such as clinical criteria for specialty drugs and level of care, including frequently asked questions, go to www.aimprovider.com/specialtyrx.

Specialty pharmacy drugs will require precertification

As previously notified, the following new drug medical policies will be implemented on May 1, 2016 and will be subject to post claim review. Commencing July 1, 2016, the following drugs will be added to the precertification list and will require precertification for members covered by Anthem local plans.

Medical Policy or Clinical Guideline Number	Medical Policy or Clinical Guideline Name	Drug Name(s)	Drug Code(s)
DRUG.00079	Bendamustine Hydrochloride	TREANDA®	J9033
DRUG.00080	Mepolizumab	Cinquil, Nucala®	J3490, J3590

Note: 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 > Provider Home Page >Precertification> Specialty Pharmacy Precertification Drugs and Codes.

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

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

Clinical guideline updates

The following Anthem clinical guidelines were reviewed on Feb 4, 2016 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. They will be implemented on July 1, 2016.

CG-SURG-53 Elective Total Hip Arthroplasty
This new clinical guideline addresses elective total hip arthroplasty (THA) for hip damage severe enough to require

replacement, when performed as an elective, non-emergent procedure and not as part of the care of a congenital, acute or traumatic event such as fracture (excluding fracture of implant and periprosthetic fracture).

CG-SURG-54 Elective Total Knee Arthroplasty
This new clinical guideline addresses elective total knee arthroplasty (TKA) for knee damage severe enough to require replacement, when done as an elective, non-emergent procedure and not as part of the care of a congenital, acute or traumatic event such as fracture (excluding periprosthetic fracture).

CG-BEH-14 Intensive In-Home Behavioral Health Services
This clinical guideline addresses intensive in-home behavioral health services (II-HBHS) which are a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the members and others at risk of harm.

Medical policy updates

The following Anthem medical policies were reviewed on Feb 4, 2016 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. They will be implemented on July 1, 2016.

RAD.00029 CT Colonography (Virtual Colonoscopy) for Colorectal Cancer
This medical policy addresses computed tomographic (CT) colonography (virtual colonoscopy) for the screening, surveillance and diagnosis of colorectal cancer. Revision of this policy reflects the following:

- The title has been edited.
- The medically necessary section "Screening - Higher than Average Risk Individuals" has been separated into two categories -- Screening (based on family history) and Surveillance (based on personal history).

RAD.00065 Radiostereometric Analysis (RSA)
This new medical policy addresses radiostereometric analysis (RSA), which is a method for performing three-dimensional (3-D) measurement and motion analysis using implanted markers and stereoscopic radiographs.

SURG.00142 Genicular Nerve Blocks and Ablation for Chronic Knee Pain
This new medical policy addresses genicular nerve blocks and genicular radiofrequency ablation, also called genicular neurotomy, genicular denervation or cooled radiofrequency therapy, as a treatment for the management of chronic knee pain.

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. (Note that this is a change in date from what was reported in our February 2016 issue of *Network Update*.) Some additional updates to MCG are noted below.

Criteria have been updated for the following:

- Diabetes M120
- Abdominal Hysterectomy (W0109)
- Hysterectomy, Laparosocopic Hysterectomy, Vaginal, Laparoscopically-assisted (W0010)
- Hysterectomy, Vaginal (W0110)
- P-60 Asthma, Pediatric
- W0117 Diabetes, Pediatric

MCG added criteria for when a hospital admission may be needed for post-transplant complications

GRG	
MG-C Cardiology GRG	Complications of transplanted heart
MG-GAS Gastroenterology GRG	Complications of transplanted liver Complications of transplanted pancreas
SG-GS General Surgery or Procedure GRG	Management of complications of transplanted intestine needed
MG-PUL Pulmonary Disease GRG	Complications of transplanted lung
MG-SIC Systemic or Infectious Condition GRG	Complications of transplanted organ (i.e., not covered elsewhere)
MG-UD Urologic Disease GRG	Complications of transplanted kidney
W0074 Medical Oncology GRG	Complications of bone marrow or stem cell transplant

Medicare

Additional AIM *OptiNet* webinars

Anthem continues to offer webinars to help providers complete their ***OptiNet*** surveys. These surveys collect 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.

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.
April 12, 2016, 9-10 a.m. ET
April 28, 1-2 p.m. ET
May 9, 4:30-5:30 p.m. ET
May 19, 12-1 p.m. ET

As we previously notified you in the February 2016 issue of *Network Update*, AIM's online registration tool, ***Opti****Net*, will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

This data will be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. **All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, should complete the registration. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements.**

Providers who score less than 76 or who do not complete the survey by June 1, 2016 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

Anthem strongly encourages providers who score below 76 to improve their site score for the applicable modality before the line item denial of claims for dates of service on or after June 1. 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 June 1. All facility diagnostic imaging services are excluded from line item denials at this time.

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information, including Frequently Asked Questions and Answers.

Dual Eligible Special Needs Plans training

Providers are required to take annual training

In 2016, Anthem is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors' appointments. Some D-SNP plans also may include a card or catalog for purchasing over-the-counter items.

D-SNPs are a kind of Medicare Advantage plan that are approved by Medicare and also contract with the state Medicaid agency. Providers who see Anthem Medicare Advantage members in IN, MO, OH, KY and WI are "in network" and available to see Anthem D-SNP members effective Jan. 1, 2016, unless they have opted out of participating with the D-SNP plan.

Providers should understand that D-SNP members are protected from all balance billing. Anthem D-SNPs are "zero cost share" plans, meaning we only enroll dual-eligible beneficiaries (people eligible for both Medicare and Medicaid) who have Medicare cost sharing protection under their Medicaid benefits. The provider may not seek payments for cost sharing from dual-eligible members for health care services. Providers cannot bill D-SNP members for services not reimbursed by Medicaid or Anthem's D-SNP plan, nor can providers balance bill for the difference between what has been paid and the billed charges.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans received notices in January that contained information for online training, either through scheduled WebEx sessions or through self-paced training on our provider portal. All providers contracted for our D-SNP plans are required to complete an attestation stating that they have completed the annual training. These attestations are located at the end of the self-paced training document and can be completed by individual providers or at the group level with one signature along with a roster of providers that participate within the group.

To take the self-paced training and read related FAQs, please go to the Provider Training and FAQs link at www.anthem.com/medicareprovider.

Medical necessity reviews for vascular ultrasound procedures

Anthem is collaborating with AIM to conduct medical necessity reviews for vascular ultrasound management for our individual Medicare Advantage members.

Effective July 1, 2016, AIM will accept precertification requests for a number of vascular ultrasound screening and diagnostic procedures. To submit your request, go to the AIM ***Provider****Portal* at www.aimspecialtyhealth.com/goweb. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance, you may also call AIM toll free at 800-714-0040, Monday through Friday, 7 a.m. to 7 p.m. Central Time. A complete list of procedure codes can be found at www.anthem.com/medicareprovider under Important Medicare Advantage Updates. Additional information also is available at www.aimprovider.com/cardiology.

Additional radiation oncology procedures to require prior authorization

Effective July 1, 2016, providers should contact AIM to request prior authorization for the radiation therapy modalities and services listed below:

- Fractions (number of treatments) for patients with breast cancer or bone metastases
- Image Guided Radiation Therapy (IGRT)
- Special consults and procedures associated with radiation therapy (CPT codes 77370 and 77470)

Providers should continue to contact AIM to request prior authorization for the radiation therapy modalities and services listed below:

- Intensity Modulated Radiation Therapy (IMRT)
- 3D Conformal/ External Beam Radiation Therapy (EBRT)
- Brachytherapy
- Proton Beam Therapy
- Stereotactic body radiation therapy **(**SBRT) and Stereotactic radiosurgery (SRS)

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through Anthem's inpatient precertification process.

To submit your request, go to the AIM ***Provider****Portal* at www.aimspecialtyhealth.com/goweb. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 7 am – 7 pm CT.

Coverage of services will continue to be subject to all of the terms and conditions of the member's health benefit plan and applicable law.

For questions regarding these changes, please contact AIM at 800-714-0040. For other information: Go to www.aimprovider.com/radoncology.

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AIM to review oncology and oncology supportive specialty Rx for medical necessity

Effective **May 1, 2016,** all oncology and oncology supportive specialty drugs that require prior authorization for Anthem individual Medicare Advantage members will be reviewed for medical necessity through AIM's ***Provider****Portal* at www.providerportal.com or by contacting AIM at 1-800-554-0580. Prior authorization requirements also can be reviewed online at www.availity.com.

Providers may be familiar with, and participating in, the Cancer Care Quality Program (CCQP) administered by AIM. Effective May 1, 2016, CCQP reviews and prior authorizations will be performed by the same review team. Therefore, Medicare Advantage Specialty Pharmacy will no longer review oncology and oncology supportive drugs for medical necessity for **individual** Medicare Advantage members effective May 1, 2016.

The Medicare Advantage specialty pharmacy team will continue to conduct oncology and oncology supportive drug prior authorization reviews for **Medicare Advantage group-sponsored members**. Anthem Medicare Advantage member ID cards contain a CMS identifier in the lower right corner of the card. The member is in a group-sponsored plan when the CMS identifier contains eight characters and the last three digits start with an eight (8XX).

Quality programs support patient safety, health improvement

Anthem has a number of programs in place to help measure and improve the health of our Medicare Advantage members. Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.

Keep up with Medicare news

Medicare Supplement Individual members will receive new member ID cards for use with medical services beginning June 1, 2016. Please obtain a copy of the new member ID cards to file for dates of service June 1, 2016 and beyond. Additional information is available in the spotlight section of the provider home page.

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
Federally Qualified Health Center Billing Guidelines in Effect for Original Medicare
Medicare Notices and Provider Requirements
UPDATE: Contact AIM for Outpatient Radiation Oncology Prior Authorization
CMS Required CLIA Certification Number for Labs

New Prior Authorization Requirements Effective May 1, 2016
HealthMap Solutions Gathering Diabetes Screening Results
Members Incentive for Office Visit (IN, KY, OH, WI only)

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Pharmacy

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

Updates to Blue Physician Recognition program

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

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

Anthem recognizes primary care physicians practicing in the specialties of Family Practice, Internal Medicine and General Practice with a BPR designation if they have achieved recognition from either the National Committee for Quality Assurance (NCQA) or Bridges to Excellence (BTE) based on their successful completion of a care recognition program. Information regarding these recognition programs can be found at *http://www.ncqa.org* or *http://www.hci3.org*.

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

If you have questions regarding the update, please contact your local Network Relations consultant.

ConditionCare program benefits members and physicians

Anthem members have additional resources available to help them better manage chronic conditions.

The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition. Members are stratified into three different risk levels.

Engagement methods vary by risk level but can include:

- **Education** about their condition through mailings, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Coaches and other health professionals.

Physician benefits:

- **Save time** for the physician and staff by answering patient questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient's progress in the program.

To find more information about the program, including program guidelines, educational materials and other resources, please go online to www.anthem.com>Providers (select state)>Health and Wellness>Condition Care. Also on our website is the **Patient Referral Form**, which you can use to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call 877-681-6694. Our nurses are available Monday-Friday, 8 am – 9 pm, and Saturday, 9-am -- 5:30 pm.

Integrated Care Model for plans purchased on the Health Insurance Marketplace benefits members and physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the exchange) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for members to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician's plan of care, not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate members on options for their treatment plan.

Members or caregivers can refer themselves or family members by contacting us by phone or email. See contact information below.

CM Telephone Number	CM Email Address	CM Business Hours
888-662-0939	centregcmref@anthem.com	Monday – Friday, 8 am – 9 pm Saturday, 9 am – 5:30 pm

HEDIS® 2016: Comprehensive Diabetes Care - Eye Exam

One of the measures we collect is the Comprehensive Diabetes Care measure. This measure focuses on ensuring that our diabetic members (type 1 and type 2) who are between the ages of 18 to 75 receive appropriate testing and care. One of the indicators for this measure is annual eye exams: a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2015 –OR-- a *negative* retinal or dilated exam (negative for retinopathy) by an eye care professional in 2014.

Documentation in the member's medical record must include **one** of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results.
- Documentation of a negative retinal or dilated exam by an eye care professional in 2014, where results indicated retinopathy was not present.

We have found that documentation from the eye care provider is sometimes missing in the PCP record. This may be because the member has gone to an out of network eye care provider or may not have been referred for an annual eye exam. Our 2014 results show that on average, less than 50% of our diabetic members are getting annual eye exams, particularly in our Central & West States. We encourage you to refer our diabetic members for annual eye exams and request the records from the eye care provider.

For more information on HEDIS, go online to www.anthem.com>Providers (select your state)> Health and Wellness>Quality Improvement and Standards. Scroll down to "HEDIS Information".

Recent updates to the Cancer Care Quality Program

Attention Oncologists, Hematologists and Urologists

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

Effective May 1, 2016, Anthem added the following cancer treatment Pathways for the Cancer Care Quality Program.

New Pathways *added* to the Program include:

- Kidney (renal) cancer treatment pathways
- Non-small Cell Lung Cancer
  - Osimertinib will be added to 2nd line therapy for patients with EGFR T790M positive mutation
  - Nivolumab will be added to 2nd line therapy for non-squamous histology
- Multiple Myeloma
  - Bortezomib, lenalidomide, plus dexamethasone will be added to 1st line therapy
  - Elotuzumab, lenalidomide, plus dexamethasone will be added to 3rd and subsequent lines of therapy
  - Daratumumab will be added to 3rd and subsequent lines of therapy
- Breast Cancer: Endocrine therapy
  - Letrozole plus palbociclib will be added to 1st line therapy for post-menopausal, ER+ or PR+
  - Fulvestrant plus palbociclib will be added to 2nd line therapy for post-menopausal, ER+ or PR+
  - Fulvestrant, palbociclib plus ovarian suppression therapy will be added to 1st line therapy for pre-menopausal, ER+ or PR+

The following Pathways are moving from "on" pathway to "off" pathway status:

- Multiple Myeloma
  - Melphalan, prednisone, plus bortezomib (MPB) will be removed for 1st line/primary therapy in non-transplant candidates
  - Bortezomib monotherapy will be removed for 2nd line therapy
  - Bortezomib plus dexamethasone will be removed for 2nd line therapy
  - Carfilzomib will be removed for 3rd line therapy

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

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

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

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 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.

Assistant Surgeon Coding and Assistant Surgeon Services
The Assistant Surgeon Coding table has been updated to add new Current Procedural Terminology (CPT®) and Health Care Common Procedure Coding System (HCPCS Level II) codes that were effective January 1, 2016. Per policy methodology, these codes are not eligible for reimbursement for assistant at surgery services reported with modifiers 80, 81, 82, or AS:
10035, 10036, 31652-31654, 33477, 37252, 37253, 39401, 39402, 43210, 47531-47544, 49185, 50430-50435, 50606, 50693-50695, 50705, 50706, 61645, 61650, 61651, 64461-64463, 65785, 69209, 0396T-0398T, 0402T, 0404T, 0406T-0416T, 0419T-0421T, 0424T-0433T

The following codes were deleted from CPT and HCPCS as of January 1, 2016 and have been removed from the Assistant Surgeon Coding table: 21805; 31620, 37202, 37250, 37251, 39400, 47500, 47505, 47510, 47511, 47525, 47530, 47560, 47561, 47630, 50392-50394, 50398, 64412, 9597, 0099T, 0123T, 0262T, G6019, G6020, G6022-G6025, G6027, G6028, S2360, S2361

In addition we have reviewed the Assistant Surgeon Services policy. The policy update is also effective January 1, 2016 to align with the effective date of our Assistant Surgeon Coding table and includes minor language revisions that do not change the policy position or criteria.

Bundled Services and Supplies
For claims processed on or after the date of May 23, 2016, HCPCS code T2022 (case management, per month) will be added to our always bundled edit and will not be eligible for separate reimbursement. We consider this service to be included with the overall care of the patient. This code will be included in the Section 1 code examples. This information will be documented in our policy dated 05/01/2016.

For claims processed on or after the date of May 23, 2016, HCPCS code A4556 (electrodes, per pair) will not be eligible for reimbursement when reported with HCPCS code A4558 (conductive paste/gel). We consider A4556 to be mutually exclusive to A4558. This information will be included in Section 2 of our policy. This information will be documented in our policy dated 05/01/2016.

We are updating Section 2 of our policy to reflect our current edit that denies 69209 (removal impacted cerumen using irrigation/lavage, unilateral) and 69210 (removal impacted cerumen requiring instrumentation, unilateral) when reported with evaluation and management services on the same date of service. We consider the removal of impacted cerumen to be included in the Evaluation and Management services when the appropriate level of E&M service is selected. This information will be documented in our policy dated 05/01/2016.

We are updating Section 2 of our policy to reflect our current edit that denies supply codes A4206-A4209, A4212, A4213, A4215-A4217, A4221-A4223, A4244-A4248, A4550, A4649, A4657, and A4930 when reported with home infusion/specialty drug administration codes 99601 and/or 99602. This information will be documented in our policy dated 05/01/2016.

Drug screen testing
We have reviewed and updated our policy effective April 1, 2016 to reflect coding changes for 2016. As previously identified in our Bundled Services and Supplies policy dated March 15, 2016, presumptive and definitive drug screen testing are now to be reported with HCPCS codes G0477-G0483 that were effective January 1, 2016. We consider CPT codes 80300-80304, 80320-80377, and 83992 for presumptive and definitive drug screen testing to be always bundled services that are not eligible for reimbursement.

Durable Medical Equipment
Rent-to-purchase durable medical equipment (DME) is eligible for rental reimbursement up to the purchase price or 10 months rental, whichever comes first; however, certain DME is not routinely purchased up-front. We consider HCPCS codes E0470 (respiratory assist device, bi-level pressure capability, without backup rate feature), E0471 (respiratory assist device, bi-level pressure capability, with back-up rate feature), E0561 (humidifier, non-heated, used with positive airway pressure device), E0562 (humidifier, heated, used with positive airway pressure device) and E0601 (continuous positive airway pressure (CPAP) device) to be rent-to-purchase items that are only eligible for reimbursement when reported as rented items and should not be reported with DME purchase modifiers NU (new equipment) or UE (used durable medical equipment). Therefore, beginning with dates of service on or after July 1, 2016 when HCPCS codes E0470, E0471, E0561, E0562, and E0601 are reported with DME purchase modifiers NU or UE, these items will not be eligible for reimbursement. This information will also be documented in our Modifier Rules reimbursement policy.

Evaluation and Management Services and Related Modifiers -25 & -57
In accordance with the Health Plans Evaluation and Management Services and Related Modifiers 25 & 57 Reimbursement Policy modifiers will no longer override the mutually exclusive edit G0402 (initial preventive physical exam) when billed with 99381-99397 (preventive medicine services both new and established patient) for claims processed on or after the date of May 23, 2016. This code pair represents overlapping services and only one code is eligible for separate reimbursement.

Frequency Editing
Frequency and Maximum units identifies when a procedure code is reported either more than once per date of service or across dates of service, which exceeds the number of times its verbiage indicates, or when it exceeds the number of times it is clinically appropriate or clinically possible to perform.

To provide clarity on rolling day limits, the edit will use claim lines processed in history with prior, current, and subsequent dates of service to accumulate and apply the frequency limits to claims for dates of service assigned to a particular procedure, drug, or item. Counting starts from the moment the first unit of a code with a rolling day frequency limit is reported.

For example; when a provider reports procedure code 95165 more than 120 units within a 365 day period, our editing systems will only allow 120 units within that time period. The limit is 120 units per every 365 days. This means that if a member had 120 units or more for DOS within 365 of the current claim line DOS the 'new' units will deny. No units for dates of service prior to will deny for the specified time period.

Modifier 59 and XE, XP, XS, & XU (Distinct Procedural/Separate/Unusual Service)
Currently when a myomectomy procedure (CPT codes 58140, 58145, 58545, 58546 and 58561) is reported with a total hysterectomy procedure (CPT codes 58570, 58571, 58572 or 58573), the myomectomy procedure is considered mutually exclusive to the hysterectomy and the myomectomy is not eligible for reimbursement. Beginning with claims processed on or after 05/23/2016, modifiers will not override this edit. This information will be documented in our policy dated 05/01/2016.

In addition, when a total hysterectomy (CPT codes 58570, 58571, 58572 or 58573) is reported with myomectomy CPT code 58146, our claim editing system will deny the hysterectomy as mutually exclusive to 58146. Beginning with claims processed on or after 05/23/ 2016, modifiers will not override this edit. This information will be documented in our policy dated 05/01/2016.

Prolonged Services – professional
We have reviewed and updated our policy effective April 1, 2016 to add new codes 99415 and 99416 (prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision… (list separately in addition to code for outpatient evaluation and management service)) as not eligible for reimbursement. These codes were effective January 1, 2016 and were identified in our Bundled Services and Supplies policy dated January 1, 2016 as always bundled services. We consider these services to be part of the overall care of the patient and not eligible for reimbursement

Other updates
Punctuation changes, grammatical edits, formatting, as well as insertions of AMA CPT® Handbook terminology, were made to the following policies and do not affect the outcome of the reimbursement for claims submitted. The changes are effective 04/01/2016.

- Cancer Treatment Planning
- "Incident To" Services
- Modifier 22

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 a contracted provider registered for access to Availity.)

Not-Registered for Availity? To register for access to Availity, go to availity.com/providers/registration-details/.

If you are a contracted Anthem provider, sign onto availity.com, select "My Payer Portals," then choose "Anthem Provider Portal" to access MyAnthem without entering an additional log-in or password. Select the Administrative Support tab, then select the link titled **Procedures for Professional Reimbursement** or **Procedures for Facility Reimbursement.**

**For more information, see "Changes coming to MyAnthem for Provider" on page 5 of this newsletter.*

Specialty Services: Behavioral Health

Required Behavioral Health follow ups

Every year, the National Committee for Quality Assurance (NCQA) requires health plans to collect Healthcare Effectiveness Data and Information Set (HEDIS®) quality outcome measures and report the rates. These rates can then be used by individuals and employer groups to make health plan membership decisions. Within the behavioral health area, three measures are evaluated based on claims/encounter documentation submitted to Anthem.

HEDIS measure	Why is the measure important	Follow up time periods
Follow-up Care for Children Prescribed ADHD Medication (ADD): The percentage of children *newly prescribed* attention deficit/hyperactivity disorder (ADHD) medication who had *at least three follow-up care visits* within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	Patients need to be monitored regularly in face to face visits to make sure that they are receiving the right treatment and that the child's condition is being managed.	*Initiation Phase*: Within 30 days of receiving medication *Continuation and Maintenance*: At least 2 visits between 30 day initiation and 270 days (9 months) after initiation
Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were *treated* with antidepressant medication, had a *diagnosis of major depression* **and** who *remained* on an antidepressant medication treatment.	Patients may show improvement within two weeks of initiating antidepressants, but they may need longer to demonstrate full response. The likelihood of response to treatment increases if there is follow-up contact within three months of diagnosis or initiation of treatment. Most people who are treated for an initial depression episode may need to stay on medications for at least six to twelve months.	Those who remained on antidepressant medication: • For at least 84 days (12 weeks) • For at least 180 days (6 months)

HEDIS measure	Why is the measure important	Follow up time periods
Follow-up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were *hospitalized* for treatment of selected mental illness diagnoses **and** who had an *outpatient visit*, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	Access to follow-up care with a mental health provider within 7 days of hospital discharge for mental illness is a strong predictor of a reduction in hospital readmission. The facility might help stabilize the patient with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend the improvement outside of the hospital. Ensuring that there is continued care outside of the hospital and compliance with outpatient follow-up care can help detect post-hospital problems early and can provide continued support that helps to improve the treatment outcomes and reduces health care costs.	Within 7 days after hospital discharge Within 30 days after hospital discharge

Anthem is helping

- The Pharmacy team sends educational materials on depression and ADHD treatment to members who have recently initiated medication therapy.
- The Pharmacy team provides refill reminder notifications for depression medications.
- The Behavioral Health Care Management team can assist with any appointment scheduling or modifications, remind patients of their scheduled appointment, and support any ongoing case management needs.

How you can help

- Ensure that a claim or encounter is submitted for all monitoring and follow-up appointments and services and the dates of service are clearly indicated.
- Educate your patients on the importance of follow-up visits and the importance of continuing the prescribed medication(s) even if they are feeling better, as well as the importance of notifying you of any side effects.
- If a patient needs assistance finding a behavioral health provider, they can call Anthem or look on www.anthem.com, “Find a Doctor” tool. Your patients may also request case management assistance.
- For individuals who have been admitted to the hospital, connect with them and start the discharging planning early including making sure that a follow-up appointment with a behavioral health provider has been scheduled prior to discharge.
- Coordinate with the patient’s support system including family members.
- Routinely use depression assessment tools, such as the PHQ-9 (Patient Health Questionnaire), as a tool to support follow-up discussions, which can include screening for medication side effects and reinforcing treatment expectations.
- Use the Vanderbilt Assessment Scales, developed through the Attention Deficit Hyperactivity Disorder (ADHD) Collaborative as a tool to drive ADHD discussion and follow-up. The Vanderbilt Assessment scales are available & can be downloaded from the National Institute for Children’s Health Quality (NICHQ)

website: http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales. An ADHD resource tool kit is also available: http://www.nichq.org/childrens-health/adhd/resources/adhd-toolkit.

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

Reminder: Educational outreach

As a reminder, Anthem's vendor partner, EquiClaim, will be reaching out to behavioral health providers using complex office or psychotherapy codes. The intent of the outreach is to ensure billed services are supported by proper documentation. Please familiarize yourself with Anthem documentation guidelines found in our reimbursement policies for each of these services.

Medicaid Notifications

For IN, KY and WI Medicaid

Reimbursement policy updates

Reimbursement policies serve as a guide to assist providers in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan.

In IN: Use this link to access reimbursement policy updates
In KY: Use this link to access reimbursement policy updates
In WI: Use this link to access reimbursement policy updates

For IN Medicaid only

Medical policy and clinical guideline updates

On November 5, 2015, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Anthem Blue Cross and Blue Shield (Anthem). These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The medical policies were made publicly available on the Anthem provider website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies Existing precertification requirements have not changed.

Medical Policy Effective date	Medical Policy Number	Medical Policy	Medical Policy New/Revised
November 23, 2015	DRUG.00079	Bendamustine Hydrochloride (TREANDA®)	New
November 23, 2015	DRUG.00079	Bendamustine Hydrochloride (TREANDA®)	New
January 5, 2016	THER-RAD.00011	Image-guided Radiation Therapy (IGRT) with External Beam Radiation Therapy (EBRT)	New
November 23, 2015	DRUG.00039	Trastuzumab (Herceptin®)	Revised

Medical Policy Effective date	Medical Policy Number	Medical Policy	Medical Policy New/Revised
November 9, 2015	GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	Revised
January 5, 2016	LAB.0031	Advanced Lipoprotein Testing	Revised
January 5, 2016	MED.0103	Automated Evacuation of Meibomian Gland	Revised
January 5, 2016	MED.00113	Therapeutic Apheresis	Revised
January 5, 2016	SURG.00024	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Revised
January 5, 2016	THER-RAD.00008	Neutron Beam Radiotherapy	Revised
January 5, 2016	DME.00035	Electric Tumor Treatment Field (TTF)	Revised
January 5, 2016	MED.00080	Cryopreservation of Oocytes or Ovarian Tissue	Revised

Category changes

The following three medical policies have changed category placement. They were not reviewed at the **November 5, 2015**, MPTAC meeting. The new category is listed below.

Previous category and number	New category and number
RAD.00014	THER-RAD.00001 Brachytherapy for Oncologic Indications
RAD.00016	THER-RAD.00003 Intravascular Brachytherapy (Coronary and Non-Coronary)
RAD.00056	THER-RAD.00009 Intraocular Epiretinal Brachytherapy

Clinical Utilization Management Guidelines update

On November 5, 2015, MPTAC approved the following Clinical Utilization Management (UM) Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the guidelines adopted by the Medical Operations Committee for the Government Business Division on **November 18, 2015**.

On November 5, 2015, the clinical guidelines were made publicly available on the Anthem Medical Policies and Clinical UM Guidelines subsidiary website. Visit **www.anthem.com/cptsearch_shared.html** to search for specific policies. Existing precertification requirements have not changed.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	Revised or new
January 1, 2016	CG-DME-37	Air Conduction Hearing Aids	New
January 5, 2016	CG-MED-53	Cervical Cancer Screening for Women Under 21 Years of Age	New
January 5, 2016	CG-MED-54	Strapping	New
January 5, 2016	CG-SURG-52	Level of Care: Hospital-Based Ambulatory Surgical Procedures, including Endoscopic Procedures	New
January 5, 2016	CG-THER-RAD-01	Fractionation and Radiation Therapy: Bone Metastases and Whole-Breast Irradiation Following Breast-Conserving Surgery	New
January 5, 2016	CG-THER-RAD-02	Special Radiation Physics Consult and Treatment Procedure	New
January 5, 2016	CG-DRUG-45	Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)	Revised

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	Revised or new
January 5, 2016	CG-SURG-43	Knee Arthroscopy	Revised
January 5, 2016	CG-SURG-46	Myringotomy and Tympanostomy Tube Insertion	Revised
January 5, 2016	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	Revised

Please share this notice with other members of your practice and office staff. For more information on this topic or questions about this provider bulletin, call our Provider Helpline at one of the following numbers:

- 1-866-408-6132 (Hoosier Healthwise)
- 1-800-345-4344 (Healthy Indiana Plan)
- 1-844-284-1798 (Hoosier Care Connect)

AINPEC-0593-15 March 2016

Medical policy and clinical guideline updates

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January 5, 2016	DME.00035	Electric Tumor Treatment Field (TTF)	Revised
January 5, 2016	MED.00080	Cryopreservation of Oocytes or Ovarian Tissue	Revised

For KY Medicaid only

Crisis hotline
Anthem Blue Cross and Blue Shield Medicaid announces a new Anthem Medicaid Behavioral Health Crisis Hotline to assist in meeting members' needs in emergent crisis. Members with suicidal thoughts or thoughts of harming themselves or others should call 911 or the Behavioral Health Crisis Hotline at 1-855-661-2025. The Hotline is available 24 hours a day, seven days a week and staffed by professional counselors able to assess the level of individual risk and the appropriate level of service.

If you have questions about this communication, please contact the Anthem Blue Cross and Blue Shield Medicaid Provider Services department at **1-855-661-2028**.

20th edition of MCG™ guidelines to determine medical necessity
Effective May 2, 2016, Anthem Blue Cross and Blue Shield Medicaid will use the 20th edition of MCG guideline criteria to determine medical necessity for both inpatient and outpatient precertification services, except in cases where superseded by state Medicaid requirements.

Why is this change necessary?
Each year, MCG guidelines are reviewed for the latest evidence-based standards of medical necessity because best practices are constantly evolving. MCG guidelines are updated to their current edition. Having the latest research and data helps health care professionals access validated best practices that support confident clinical decision-making to improve patient care.

If you have questions about this communication, contact the Provider Services at **1-855-661-2028**.

New program on progestin therapy
To support your efforts in preventing preterm delivery in high-risk pregnant women, Anthem Medicaid is launching a new program to ensure physicians are aware of members who may benefit from progestin therapy. You will receive an alert listing members on your panel identified through our high-risk screening survey as potential candidates for progestin therapy. This alert service is optional; you may discontinue it at any time.

If you wish to prescribe progestin therapy for your patients, the following delivery and administration options are available:

- For office administration of compounded 17P, please contact a participating pharmacy. For your convenience, a list of 17P compounding pharmacies in the Anthem network is attached and is also available online at http://www.anthem.com/kymedicaiddoc.
- If you require Makena™ call Provider Services at **1-855-661-2028** to initiate a precertification request.
- If home health services are required, call an Anthem obstetrics case manager at **1-855-690-7784**.

For WI Medicaid only

Preadmission services for inpatient stays *(Policy 07-017, effective May 1, 2016)*
Anthem Blue Cross and Blue Shield allows reimbursement for all outpatient services for a covered BadgerCare Plus

member prior to admission to an inpatient hospital (referred to as the payment window), unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, when:

- The outpatient services are contiguous with the inpatient stay
- The member is granted inpatient status and subsequently counted in the midnight census

For additional information, refer to the Preadmission Services for Inpatient Stays policy at www.anthem.com/wimedicaiddoc.

Keep up with Anthem Medicaid – WI news

Please continue to check important Provider Communications and bulletins at www.anthem.com/wimedicaiddoc for the latest Wisconsin Medicaid information, including:

- Reimbursement policies https://mediproviders.anthem.com/wi/pages/reimbursement-policies.aspx
- Medical policies and utilization management guidelines https://mediproviders.anthem.com/wi/pages/manuals-directories-training.aspx
- Provider bulletins https://mediproviders.anthem.com/wi/pages/communications-updates.aspx
- Recently updated Provider manual for a comprehensive review of who to contact, member eligibility, benefits coverage, claims submission requirements, payment policy, and more https://mediproviders.anthem.com/Documents/WIWI_CAID_Provider_Manual.pdf
- Recently updated new provider orientation guide https://mediproviders.anthem.com/wi/pages/manuals-directories-training.aspx