

Network Update

CENTRAL REGION

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

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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)>Network eUPDATE.

Administrative Update

Summer is heating up and so is the Availity Web Portal

Look for a great new look and sizzling hot new features to improve your experience on the Availity Web Portal debuting throughout the summer.

Availity redesign

Navigation on the Availity Web Portal will be even easier with the upcoming changes to the Availity menu options. Designed with input from providers, links on the left navigation menu will be moved to the top of the page and the main landing page will include easy access to the functions you use the most.

Remittance Inquiry

Get quick and simple access to your remittance advices online with the new Remittance Viewer. From the Availity Web Portal home page, select *Payer Spaces*, next choose **Anthem BlueCross BlueShield** from the list of payer options, and then select **Open** located below **Remittance Inquiry**.

Professional Fee Schedule

Retrieve and print contracted amounts for up to 50 procedure codes at a time with the new Fee Schedule application. From the Availity Web Portal home page, select *Payer Spaces*, next choose **Anthem BlueCross BlueShield** from the list of payer options, and then select **Open** located below **Fee Schedule**.

Research Procedure Code Edits

Prescreen or inquire retrospectively clinically based information along with documented source information for approximately 2 million claim edits. Sources referenced include: the American Medical Association Current Procedural Terminology (CPT), the CPT Assistant, the CPT Coding Symposium, Specialty Coding Guidelines and Medicare Guidelines. Note: This tool is moving from the left navigation menu on Availity to *Payer Spaces*. From the Availity Web Portal home page, select *Payer Spaces*, next choose **Anthem BlueCross BlueShield** and under **Resources** select the link for **Research Procedure Code Edits (Clear Claim Connection)**.

Make sure your access is in tip top shape for the summer. If you cannot locate any of these new features, contact your organization's Availity administrator (formally known as Primary Access Administrator) to determine if these features are currently available in your state and to request access.

BlueCard® program claim filing reminder

BlueCard is a national program that enables members traveling away from home or living in another Blue Cross and Blue Shield (BCBS) Plan area to receive health care services through a single, electronic claim processing reimbursement network. The program links participating health care providers and independent BCBS Plans around the world.

Anthem participating providers that are located in contiguous counties to an Anthem state (CA, CO, CT, GA, IN, KY, ME, MO, NH, NV, NY, OH, WI or VA) are being reminded to limit the claims being filed to Anthem members only. For example, a provider rendering services in an Illinois county that is contiguous to Missouri who is participating with the Missouri Anthem plan, should **not** file claims to Anthem BCBS of Missouri for patients that do not have Anthem coverage. Claims for services provided to all other BlueCard members must be filed to the Illinois Blue Plan, as they are the correct Local Plan.

Anthem will process claims submitted to us for Anthem members only – claims for all other BlueCard members will be rejected with instructions to submit to the correct Local Blue Plan. While some claims for non-Anthem BlueCard members may have processed previously, effective June 18, 2016 this will not continue. Claims incorrectly filed to Anthem will not be processed, but will be rejected. Please make necessary changes to ensure you file claims to the appropriate Local Blue Cross and Blue Shield Plan.

For more information on claim filing in contiguous counties and overlapping service areas, please see Chapter 4 of the *BlueCard Provider Manual* on our public provider website by going to www.anthem.com>Providers (select state) then select the Communications tab from the horizontal menu. Click General Information, then the BlueCard Provider Manual link, or contact your local Network Relations representative.

Important announcement: Risk adjustment data validation audit

The Centers for Medicare & Medicaid Services (CMS) is conducting a Risk Adjustment Data Validation (RADV) Audit beginning **July 2016 through December 2016**. This audit is in accordance with provisions of the Affordable Care Act (ACA) and its risk adjustment data validation standards. For additional details, go [here](#). Or go online to anthem.com>Providers (enter state)> Network eUPDATE.

Reminder: OrthoNet PT/OT precert requests

As a reminder, in late 2015, Anthem selected OrthoNet, LLC, a leading musculoskeletal management company, to administer a physical and occupational therapy utilization management program.

The program requires that all outpatient and office based physical and occupational therapy services following the initial evaluation be authorized by OrthoNet. As indicated in previous communications, OrthoNet handles precertification requests for certain Commercial Anthem members. Note: Medicare Advantage members are also managed by OrthoNet under a separate program segment.

OrthoNet can accept authorization requests by fax (844-216-1599) or phone (844-282-6994).

For additional information, please access the *Frequently Asked Questions* on the OrthoNet website. Follow the navigation instructions to the state specific page referenced above, and select the link titled **See Frequently Asked Questions**.

OH: Reminder for providers referring HMO members

As you may know, effective January 1, 2016, Anthem introduced an Ohio HMO product that includes very limited out-of-network benefits. The names of the provider networks that support this product are Pathway X HMO and Pathway HMO. A subset of Anthem's participating doctors, hospitals and other health care professionals are participating in the Pathway X HMO and Pathway HMO networks.

In most cases, members covered by these HMO products do not have out-of-network benefits (except for medically necessary urgent or emergency services). To ensure the highest level of benefits and coordination of care for these members, it's important that you refer them to providers participating in the HMO networks. Services rendered by providers outside this network are processed as out-of-network.

This is a reminder that providers should always review the network name indicated on the member ID card and confirm that the provider participates in the network that supports the member's health plan.

For more information on Ohio's Pathway and Pathway X HMO, please click [here](#) to see the article "Important Update about Anthem's new 2016 ACA-compliant health plans in Ohio," or go to www.anthem.com>[Providers](#) (select Ohio)>Health Insurance Exchange. For additional information on Ohio's ACA-compliant plans, see these [articles](#).

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.

Federal Employee Plan (FEP)

Change in breast cancer screening benefit

The Blue Cross Blue Shield Service Benefit Plan®, also known as Federal Employee Program, or FEP, has had a recent benefit change for digital breast tomosynthesis (DBT). Effective January 1, 2016, this service is now covered as a preventative benefit and is limited to one breast cancer screening service per benefit year. If you have any 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

Medicare

UPDATE: Medicare Supplement member ID card change

Medicare Supplement individual members will receive new member ID cards for use with medical services beginning Nov. 1, 2016, not June 1, 2016, as reported in the April 2016 *Network Update*. Please obtain a copy of the new member ID cards to file for dates of service Nov. 1, 2016 and beyond. Additional information will be available in the spotlight section of the [provider home page](#) and the [Answers@Anthem](#) section of the provider home page.

Postponed: AIM OptiNet imaging services initiative

Recent issues of *Network Update* have included information about an initiative administered by AIM Specialty Health to collect information about imaging capabilities of our MA providers. **This initiative has been postponed until further notice.** MA providers will not be subject to the requirement to have a specific *OptiNet* score to be reimbursed for outpatient diagnostic imaging services. Although there is no reimbursement impact at this time, Anthem continues to encourage network providers to submit imaging services data for the AIM Specialty Health initiative. The provider registration is available online at www.aimspecialtyhealth.com/goweb. To register:

1. Go to www.aimspecialtyhealth.com/goweb
2. Select Anthem Medicare Advantage from the drop down menu
3. Log in to **ProviderPortal**
4. Select "Access My OptiNet Registration" from the **ProviderPortal** home page to begin your registration

For additional assistance with registration or your score, you may also call AIM toll free at 800-714-0040, Monday -- Friday, 7 am -- 7 pm CT.

Learn more: Attend a webinar

Anthem continues to offer webinars to help providers complete their *OptiNet* assessments. 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: [July 12, 12-1 p.m. ET](#) or [July 28, 4-5 p.m. ET](#).

Attention Outpatient Part B Nursing and Long-Term-Care Facilities: Contact OrthoNet for OT and PT Prior Authorizations

Anthem is collaborating with OrthoNet, LLC to conduct medical necessity reviews for outpatient physical therapy (PT) and occupational therapy (OT) for our individual MA members.

Effective July 1, 2016, OrthoNet will accept precertification requests for outpatient occupational therapy and physical therapy from outpatient Part B therapy providers (nursing and long-term care facilities). Outpatient Part B Therapy providers, please note: Inpatient PT/OT services rendered as part of a Skilled Nursing level of care are excluded from this authorization process.

What does this mean to you?

As communicated in the February 2016 issue of *Network Update*, the following **outpatient** services/treatment requests for residents of nursing and long-term care facilities must be reviewed by OrthoNet for prior authorization:

- Physical therapy
- Occupational therapy

Prior authorizations can be obtained at the following numbers: **Fax 1-844-340-6419/Phone 1-844-340-6418**

Prior authorization guidelines can be found at the [Provider Forms](#) section of the Anthem Medicare Advantage Public Provider Portal at www.anthem.com/medicareprovider.

Detailed prior authorization requirements for individual MA members are available to the contracted provider by accessing the Provider Self-Service Tool within Availity (www.availity.com). Go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link and Patient360, which can be found under the Patient Information tab. Providers will find precertification requirements there as well as via the Precertification look-up tool.

To verify member eligibility, benefits or account information, please call the telephone number listed on the back of the member's identification card.

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Inpatient stays and observation: Please help members maximize health benefits

Anthem individual and group-sponsored MA members have coverage for a limited number of inpatient days (90 days per benefit period plus 60 lifetime reserve days). Many times the member can be treated while in observation vs. a full admission. Doing so does not use the member's limited in-patient benefit. Check [Important Medicare Advantage Updates](#) at www.anthem.com/medicareprovider for [additional information](#) to help ensure that those inpatient days are used appropriately and available to the member when needed.

Non-emergency ambulance transport to and from dialysis treatment

Note: The following information does not apply to delegated providers.

To ensure alignment with the Centers for Medicare & Medicaid Services ("CMS") payment methodologies and guidelines, Anthem will require prior authorization of non-emergency ambulance transport for individual MA members, Medicare-Medicaid Program members and D-SNP members to and from dialysis treatment.

Effective July 1, 2016, prior authorization will be required for the following HCPCS codes and Modifier G hospital-based dialysis facility. Modifier G is a new requirement. Modifier J non-hospital-based dialysis facility is already subject to prior authorization.

Code	Description
A0426	Advanced Life Support Non-Emergency Transport
A0428	Basic Life Support Non-Emergency Transport
A0425	Ground Mileage Billed with A0426 or A0428

Claims with Modifier G for hospital-based dialysis or Modifier J for non-hospital based dialysis with any of the above codes shall be suspended from further adjudication for Prior Authorization if there is no Prior Authorization in the system.

Detailed prior authorization requirements are available to contracted providers by accessing the Provider Self-Service Tool within Availity (www.availity.com). Go to Auths and Referrals/Authorizations from the left navigation menu. Select Anthem Medicare Advantage from the drop down box. You will be directed to the Medicare Advantage Precertification site which includes the precertification submissions and inquiries link. Providers will find precertification requirements there as well as via the Precertification look-up tool. Contracted and non-contracted providers should contact Anthem if they are not able to access Availity.

If a request for non-emergency ambulance transport is determined to be not medically necessary and reasonable and the member has no other means of transportation to dialysis treatment, Anthem customer service is prepared to help those members find alternate transportation on or after July 1, 2016 through My Advocate.

Members also can contact My Advocate directly at <https://myAdvocatehelps.com>, or call 866-705-8936. Members also may call the dialysis center and ask if the dialysis center arranges transportation.

Check [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider for [additional information](#), including prior authorization information.

Reminder: Bill CLIA Certification for Individual MA

Effective July 1, 2015, Anthem Individual MA began denying claims billed without the CMS-required CLIA certification number: Clinical Laboratory Improvement Amendment (CLIA) certification is missing or invalid, based on the laboratory code billed.

As previously communicated, a message has been added to the remittance of applicable claims to remind providers this value should be billed in Box 23 on the claim form.

Check [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider for additional information, including a list of [Frequently Asked Questions and Answers](#).

HCPCS codes required for RHC claims

All claims from Rural Health Clinics (RHC), with dates of service April 1, 2016 and after, must contain an appropriate HCPCS code for each service line, along with a revenue code on their MA claims. **This pertains to Contracted and Non-Contracted Providers.**

These billing instructions apply to all individual and group-sponsored MA plans, including Medicare-Medicaid Plans. This does not apply to Dual Special Needs Plans (D-SNPs) or Medicare Supplement plans.

OH: Care program available for individual MA members facing advance illness

Effective June 1, 2016, Aspire Health is available to Anthem individual MA members who are facing an advanced illness. The program will allow members and their care givers timely access to appropriate care 24/7 through the Aspire care management team. Aspire uses member claims data to identify and contact members who may benefit from this program. Members who choose to participate will receive in-home services as soon as possible.

Aspire *does not replace* the care of PCPs and specialists. Members enrolled in this program keep their PCP and other specialists and may continue to seek treatment. The Aspire clinical team will also consult regularly with PCPs and other specialists to discuss any significant changes to care plans or medications.

If you have questions or need to contact Aspire regarding a member's care, call the Aspire 24/7 toll-free line at 844-326-3119.

Call Anthem for questions on member cost-share

After their doctor's visit, our members may have questions about their out-of-pocket costs. It can be confusing when complex procedures are billed as multiple services or when a routine preventive visit turns into a procedure or treatment. Many billing concerns can be resolved at the doctor's office by going over the member's cost-share right then and there. If your staff has trouble getting cost-share information about services, just call us at the number listed on the back of the member's ID card.

Precertification requirements updated for 2016

Please refer to your Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at www.anthem.com for further information on existing precertification requirements and new precertification requirements for 2016. Non-contracted providers should contact the Health Plan.

Keep up with MA news

Please continue to check [Important Medicare Advantage Updates](http://www.anthem.com/medicareprovider) at <http://www.anthem.com/medicareprovider> for the latest Medicare Advantage information, including:

[Medical Record Documentation and Coding Tips Link Available on Provider Website](#)

[Medicare Advantage reimbursement policies](#)

[AIM to review oncology and oncology supportive specialty drugs for medical necessity](#)

[Contact Medicare Part B Specialty Pharmacy before injectable, infusion drug prior authorizations expire](#)

[Part D drugs must be prescribed for FDA-supported indications, supported by Medicare compendiums](#)

[Additional Radiation Oncology Prior Authorizations Should Be Directed to AIM Effective July 1, 2016](#)

[Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning August 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](#)

[New Prior Authorization Requirements Effective May 1, 2016](#)

[HealthMap Solutions Gathering Diabetes Screening Results](#)

[Reminder to include the "Rendering Provider Location" for Radiology Services](#)

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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

HEDIS spotlight: Imaging for low back pain

Choosing Wisely® recommends that in the absence of "red flags," there is strong evidence to **avoid X-Ray, CT, or MRI imaging** among patients with non-specific low back pain within the first 6 weeks of diagnosis.¹ Imaging of the lower spine does not improve outcomes, but does increase costs. People who get an imaging test for their back pain do not necessarily get better faster, and they might even feel worse.²

The National Committee for Quality Assurance (NCQA) collects Healthcare Effectiveness Data and Information Set (HEDIS) on imaging among patients with low back pain. The HEDIS measure is determined by the percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-Ray, MRI, CT scan) *within 28 days of diagnosis*.

While the guidance is to avoid imaging for low back pain and to offer conservative symptom relief, most Anthem health plan compliance rates for low back imaging are lower than the 75% of the rates when compared to all reporting health plans, nationally.

Generally, imaging or other diagnostic tests should not be obtained by your patients with non-specific low back pain, especially the first time you see them for complaints of low back pain, regardless of where the patient is seen (i.e., outpatient, observation, emergency room, or osteopathic manipulation treatment). Most people with lower back pain feel better in about a month, whether or not they have an imaging test.

General treatment guidelines can be found at the following resources:

- American Academy of Family Physicians. Clinical Practice Guideline: "Low Back Pain." <http://www.aafp.org/patient-care/clinical-recommendations/all/cw-back-pain.html>.
- Choosing Wisely: "Imaging tests for lower-back pain." <http://www.choosingwisely.org/patient-resources/imaging-tests-for-back-pain/>.

Choosing Wisely® is an initiative of the ABIM Foundation.

¹ <http://www.aafp.org/patient-care/clinical-recommendations/all/cw-back-pain.html>. American Academy of Family Physicians, Choosing Wisely. "Imaging for Low Back Pain." February 2011.

² <http://www.choosingwisely.org/patient-resources/imaging-tests-for-back-pain/>. Choosing Wisely. "Imaging tests for lower-back pain." April 2012.

Reminder: 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?*

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.

Bundled Services and Supplies and Evaluation and Management Services and Modifiers -25 & -57

Healthcare Common Procedure Coding System (HCPCS Level II) code G0402 (initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment) and *Current Procedural Terminology* (CPT) codes 99381-99397 (preventive medicine evaluation and management) describe services for preventive medicine. The Health Plan considers code G0402 to be an overlapping service when reported with codes 99381-99397; therefore, with claims processed on or after May 23, 2016, G0402 is denied as mutually exclusive when reported with 99381-99397. Modifiers will not override this edit. This information is documented in our policies dated May 23, 2016

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

According to the American Academy of Orthopaedic Surgeons (AAOS) and the Centers for Medicare & Medicaid Services (CMS), the work associated with knee arthroscopy CPT code 29876 (synovectomy, major, two or more compartments) is inclusive to more extensive arthroscopic knee procedures (29880, 29881, 29882 and 29883) performed in the same anatomic site (the same knee) and 29876 is not separately reportable. Therefore, beginning with dates of service on or after September 1, 2016, when CPT code 29876 is not eligible for separate reimbursement with arthroscopic knee surgery CPT codes 29880-29883 performed on the same knee modifiers will

not override the edit unless the services are performed on opposite knees and each knee is identified with the appropriate site specific modifiers LT and RT or when reported with an approved AAOS diagnosis.

Claim Editing Overview

Across our claims editing platforms, beginning with claims processed on or after May 23, 2016, Anthem will phase in the removal of our gender edits that previously denied a procedure or diagnosis when a gender specific procedure and/or diagnosis code was assigned to a patient of the opposite sex. We are updating our Claim Editing Overview policy to reflect this change.

Revised Durable Medical Equipment Notice

In the April 2016 issue of *Network Update*, we advised that beginning with dates of service on or after July 1, 2016 that HCPCS codes E0470, E0471, E0561, E0562, and E0601, which are classified as rent-to-purchase items, would not be eligible for reimbursement when reported with DME purchase modifiers NU and UE. Also included in our edit is purchase modifier NR-- new when rented (use the NR modifier when DME which was new at the time of rental is subsequently purchased), which was left out of our original notice in error. We apologize for any confusion this may have caused.

Durable Medical Equipment, Modifier Rules, and Place of Service

Our current Durable Medical Equipment and Place of Service reimbursement policies state that DME rental reported with an office place of service (11) is not eligible for reimbursement. However, we are updating our policies and adding that, for claims processed on or after May 23, 2016, when DME is reported as rental with an urgent care facility place of service (20), our system will deny the rented DME item as not eligible for reimbursement. The DME rental place of service restriction information will also be included in our Modifier Rules reimbursement policy under the applicable rental modifiers. In addition, we have clarified information under our "Purchase/Rent to Purchase (P/RTP)" section for when there is a three month break in rental of a P/RTP DME item.

Modifiers 59 and XE, XP, XS & XU

Beginning with dates of service on or after September 1, 2016, modifiers will not override the denial of CPT code 29871 (arthroscopy, knee, surgical; for infection, lavage and drainage) when reported with CPT code 29876 (major synovectomy) unless reported with the appropriate site specific modifier LT and RT or with an approved AAOS diagnosis.

In addition, we have added language to the reimbursement policy, under section III Exceptions to Distinct Procedure Modifier Override, to further support the Health Plan's denial that is documented in AMA CPT® parenthetical language.

Multiple Diagnostic Cardiology Services

A new policy on Multiple Diagnostic Cardiology Services is available for reference as a future policy link on anthem.com that describes when Multiple Procedure Payment Reduction (MPPR) is applied to multiple diagnostic cardiology services. Effective for dates of service on or after October 17, 2016, we will apply a MPPR of 25% to the technical component of diagnostic cardiology services that have a Multiple Procedure Indicator (MPI) of six (6) in the multiple procedure column of the Centers for Medicare & Medicaid National Physician Fee Schedule (NPFSS). Please refer to the full text of this policy for further information.

Multiple Diagnostic Ophthalmology Services

A new policy on Multiple Diagnostic Ophthalmology Services is now available for reference as a future policy link on anthem.com that describes when Multiple Procedure Payment Reduction (MPPR) is applied to multiple diagnostic ophthalmology services. Effective for dates of service on or after October 17, 2016, we will apply a MPPR of 20% to the technical component of diagnostic ophthalmology services that have a Multiple Procedure Indicator (MPI) of

seven (7) in the multiple procedure column of the CMS National Physician Fee Schedule (NPFs). Please refer to the full text of this policy for further information.

Ohio: Office place of service

Effective September 1, 2016, Anthem Blue Cross and Blue Shield of Ohio (herein after known as the Health Plan) is adopting a new Commercial Professional Reimbursement policy that documents how the Health Plan defines an office place of service (POS). The Health Plan follows CPT's definition of an office place of service and further defines the office setting as one that is located within a hospital or facility, a professional building attached to and owned by a hospital or facility, or an offsite professional building owned by a hospital or facility when one or more of the documented conditions within the policy are present.

The policy is applicable to services provided by a professional provider or private practice group in an office setting and reported on a Form CMS-1500. The services documented within the policy are only eligible for reimbursement when reported with an office place of service (POS code 11). Please refer to our Commercial Professional Reimbursement policy, Office Place of Service, for further detail.

Sleep Studies and Related Services & Supplies and Frequency Editing

Beginning with dates of service on or after September 1, 2016, we are updating our policy to document that we will apply a frequency edit of one (1) per 60 days to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783. This limit is based on billing guidelines addressed in the *American Academy of Sleep Medicine* FAQs, which state that there is no separate CPT code for a split night study; therefore, it is not appropriate to bill the diagnostic portion and titration portion of a study separately. Doing so would be billing for two procedures, when only one was performed. 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. This information will also be included in our Frequency Editing reimbursement policy.

Unit Frequency Maximums for Drugs and Biologic Substances

We are posting a new policy titled Unit Frequency Maximums for Drugs and Biologic Substances. The policy outlines our maximum units and our rationale for the maximum units allowed for the drugs and biologic substances listed below. The noted maximum units will be applied to the listed codes for dates of service on or after September 1, 2016. Please refer to our policy for additional information.

Code	Description	Clinical pharmacy maximum dosing	Calculated maximum dosage	Rationale	Maximum HCPCS units (per date of service unless otherwise noted)
J0180	Injection, agalsidase beta, 1 mg (Fabrazyme)	1 mg/kg	136 mg	weight=136 kg	140
J0490	Injection, belimumab, 10 mg (Benlysta)	10 mg/kg	1360 mg	weight=136 kg	144
J1602	Injection, golimumab, 1 mg (Simponi)	2 mg/kg	272 mg	weight=136 kg	300
J1745	Injection infliximab, 10 mg (Remicade)	10 mg/kg	1360 mg	weight=136 kg	140
J2796	Injection, romiplostim, 10 mcg (Nplate)	10 mcg/kg	1360 mcg	weight= 136 kg	137

Code	Description	Clinical pharmacy maximum dosing	Calculated maximum dosage	Rationale	Maximum HCPCS units (per date of service unless otherwise noted)
J9035	Injection, bevacizumab, 10 mg (Avastin)	15 mg/kg	2040 mg	weight=136 kg	210
J9041	Injection, bortezomib, 0.1 mg (Velcade)	1.3 mg/m ²	3.4 mg	BSA=2.6m ²	35
J9055	Injection, cetuximab, 10 mg (Erbix)	400 mg/m ²	1040 mg	BSA=2.6m ²	105
J9171	Injection docetaxel 1 mg (Docetaxel)	100 mg/m ²	260 mg	BSA=2.6m ²	260
J9206	injection irinotecan 20 mg (Camptosar)	350 mg/m ²	910 mg	BSA=2.6m ²	46
J9228	Injection, ipilimumab, 1 mg (Yervoy)	10 mg/kg	1360 mg	weight=136 kg	1400
J9263	Injection, oxaliplatin, 0.5 mg (Eloxatin/Oxaliplatin)	130 mg/m ²	338 mg	BSA=2.6m ²	700
J9305	Injection pemetrexed 10 mg (Alimta)	600 mg/m ²	1560 mg	BSA=2.6m ²	160
J9310	Injection, rituximab, 100 mg (Rituxan)	500 mg/2	1300 mg	BSA=2.6m ²	13

Other updates

Punctuation changes, grammatical edits, formatting, as well as insertions of AMA CPT® Handbook terminology, were made to the following policies. These changes, effective June 1, 2016, do not affect the outcome of the reimbursement for claims submitted.

- After Hours, Emergency, and Miscellaneous E/M Services
- Pharmaceutical Waste

OH: New facility reimbursement policy

Effective September 1, 2016, Anthem Blue Cross and Blue Shield of Ohio (herein after known as the Health Plan) will implement a new facility reimbursement policy regarding facility reimbursement for services provided outside of the primary structure on the campus of a hospital or institutional providers and for Evaluation & Management (E&M) services provided within the primary structure on the campus of a hospital or institutional provider.

Services that are rendered in an office, professional building, medical office building, clinic or space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or institutional provider, must be billed on a CMS-1500 claim form and are not reimbursable if they are billed on a UB-04 claim form. For full details, please see the following policy on MyAnthem: Place of Service and Evaluation & Management Facility Reimbursement, Policy E0009.

View Anthem reimbursement policies

Anthem's reimbursement policies are available online at MyAnthemSM; 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, 2016, 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.

Medicaid Notifications

For IN, KY and WI

New Reimbursement Policy for Medicaid Providers

Medical Recalls (Policy 06-111, effective 10/01/2016)

Anthem does not allow reimbursement for repair or replacement of items due to a medical recall. The following are applicable items:

- Durable medical equipment
- Supplies
- Prosthetics
- Orthotics
- Drugs/vaccines

Anthem will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Anthem will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Payment will be reduced by the amount of the device credit.

For KY, WI Medicaid only

ClaimCheck[®] upgrade to ClaimsXten[™]

Anthem appreciates your participation in our Medicaid network. Anthem uses ClaimCheck[®] 10.2, a comprehensive nationally recognized code auditing system, to ensure consistent physician and facility reimbursement by automatically evaluating provider claims in accordance with accepted industry coding standards. The purpose of this update is to notify you that we are upgrading ClaimCheck 10.2 to ClaimsXten[™], McKesson's next generation code

auditing system. As with ClaimCheck 10.2, ClaimsXten uses rules derived from a combination of CMS coding guidelines, AMA/CPT, Specialty Society guidelines and Anthem policy. The upgrade will become effective November 1, 2016.

What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that in combination with claims processing systems:

- Reinforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed
- Determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes
- Processes those services according to industry standards

Why are we upgrading from ClaimCheck 10.2 to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes

How will the upgrade to ClaimsXten affect you?

Providers will continue to see similar edits as under ClaimCheck® 10.2. ClaimsXten™ has enhanced audit logic and the ability to analyze claims submission history. Outpatient services will be analyzed for such issues as:

- Rebundled or unbundled services
- Multi-channel services
- Mutually exclusive services
- Incidental procedures
- Incorrect use of CPT codes
- Fragmented billing of pre- and postoperative care
- Diagnosis to procedure mismatch
- Upcoded services

Other procedures and categories that are reviewed include:

- Cosmetic procedures
- Obsolete or unlisted procedures
- Age/gender mismatch procedures
- Investigational or experimental procedures
- Procedures being billed with inappropriate modifiers

What types of edits appear on my explanation of payment (EOP) when an edit is applied by ClaimsXten to a service I submitted?

The following list, which is not all inclusive, contains edits that may appear on your EOP when a rule is triggered in ClaimsXten:

Rule	Provider type	Description
Inappropriate age	Professional/facility	Procedure code is either inappropriate for the member's age or an age-specific CPT code does not match the member's age
Deleted code	Professional/facility	Procedure code has been deleted from CPT
Invalid diagnosis code	Professional/facility	Procedure submitted with an invalid diagnosis code
Inappropriate gender	Professional/facility	Procedure code is either inappropriate for the member's gender or a gender-specific CPT code does not match the member's gender
Invalid modifier-procedure	Professional/facility	Modifier used is invalid with the submitted procedure code

Multiple radiology reduction	Facility	Reduction applied to multiple contiguous radiology procedures using the same modality on the same DOS
Assistant surgeon	Professional	Assistant surgeon not eligible for procedure
Base code quantity	Professional	Base code with units>1, where add-on code would be appropriate
Bundled services	Professional	Services incidental to the primary procedure
Multiple surgery reduction	Professional	Reduction applies to multiple procedures on the same DOS. Procedure with highest reimbursement paid as primary.
Global surgical edits	Professional	Pre-op visit, post-op visit, procedure or other service considered part of the global surgical period
Maximum units	Professional	Medically unlikely number of units on the same DOS
Global component	Professional/facility	Audits across multiple providers to ensure that professional and technical components are not reimbursed more than once for the same member, procedure and date of service.
Anesthesia not eligible	Professional	Audits claim lines containing non-anesthesia services submitted by an anesthesiologist as described by the American Society of Anesthesiologists
Outpatient consultations	Professional	Audits for claim lines containing an outpatient consultation when another outpatient consultation was billed for the same member by the same provider with at least one matching diagnosis within a six-month period
Inpatient consultations	Professional	Audits for claim lines containing an inpatient consultation when another inpatient consultation was billed by the same provider for the same member with at least one matching diagnosis within a five-day period
New patient code for established patient	Professional	Audits for claim lines containing a new patient E&M code when another claim line containing any E&M code was billed within a three-year period
Duplicate line items	Professional	Audits for claim lines that match a previously submitted claim line on a different claim for the same member, provider, procedure, modifier, date of service, quantity and billed amount

For IN Medicaid only

Medical policies and clinical guidelines update

Medical policies-- On February 4, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to 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)
April 5, 2016	RAD.00065	Radiostereometric Analysis (RSA)	New
April 5, 2016	SURG.00142	Genicular Nerve Blocks and Ablation for Chronic Knee Pain	New
February 11, 2016	DME.00035	Electric Tumor Treatment Field (TTF)	Revised
February 11, 2016	DRUG.00052	Pertuzumab (Perjeta®)	Revised
February 11, 2016	DRUG.00077	DRUG.00077 Secukinumab (Cosentyx®)	Revised
April 5, 2016	RAD.00029	CT Colonography (Virtual Colonoscopy) for Colorectal Cancer	Revised

Clinical Utilization Management Guidelines -- On February 4, 2016, the 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 February 29, 2016.

On February 4, 2016, 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 (new/revised)
April 5, 2016	CG-BEH-14	Intensive In-Home Behavioral Health Services	New
April 5, 2016	CG-DME-38	Continuous Interstitial Glucose Monitoring	New
May 2, 2016	CG-SURG-53	Elective Total Hip Arthroplasty	New
May 2, 2016	CG-SURG-54	Elective Total Knee Arthroplasty	New
April 5, 2016	CG-DRUG-04	Use of Low Molecular Weight Heparin Therapy, Fondaparinux (Arixtra®), and Direct Thrombin Inhibitors in the Outpatient Setting	Revised
April 5, 2016	CG-DRUG-20	Enfuvirtide (FUZEON®)	Revised
April 5, 2016	CG-LAB-09	Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain	Revised
February 11, 2016	CG-MED-35	Retinal Telescreening Systems	Revised
February 11, 2016	CG-MED-54	Strapping	Revised
February 11, 2016	CG-SURG-27	Gender Reassignment Surgery	Revised
April 5, 2016	CG-SURG-36	Adenoidectomy	Revised
To be determined	CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting	Revised
February 11, 2016	CG-SURG-47	Surgical Interventions for Scoliosis and Spinal Deformity	Revised

Archived Clinical Utilization Management Guidelines -- The following two Clinical UM Guidelines have been archived on the effective date listed below. These guidelines will no longer appear on the site and the criteria should no longer be used.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title
April 5, 2016	CG-BEH-08	Employee Assistance Program Outpatient Treatment
April 5, 2016	CG-DRUG-07	Hepatitis C Pegylated Interferon Antiviral Therapy

MPG Guidelines -- For health plans utilizing MCG (Milliman Care Guidelines), the MCG 20th edition care guidelines were discussed at the February 4, 2016, MPTAC meeting. The MCG 20th edition care guidelines will be available for use upon release through MCG.

For more information -- 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)

Hoosier Care Connect requirements

Anthem would like to share some key reminders about your contract with Hoosier Care Connect.

Your Contract: If you're contracted with Anthem for Hoosier Healthwise, you are also contracted for Hoosier Care Connect. Your Anthem Provider Contracting Specialist can assist you with any contracting and/or enrollment inquiries.

Standards for Access Appointments: All Anthem providers must maintain the standards for access listed below.

General Appointment Scheduling	
Emergency examination	Immediate access during office hours
Urgent examination	Within 24 hours of request
Non-urgent "sick" visits	Within 72 hours as clinically indicated
Non-urgent routine exams*	Within 21 days of member's request
Specialty Care Exam	Within 3 weeks of request
Initial Health Assessment	Newborns: Within 14 days of enrollment Children: Within 60 days of enrollment Adults (18-21): Within 8 weeks of Enrollment Adults (21 and over): Within 90 days of enrollment
Office wait times	Within 45 minutes
Waiting time phone triage	Within 30 minutes
Outpatient behavioral health examination	Within 14 days of request
Routine behavioral health visit (BH)	Within 10 days of request
Outpatient treatment (BH)	Within 7 days of discharge
Post-psychiatric inpatient care (BH)	Within 7 days of discharge
Non-life-threatening Emergency (BH)	
Prenatal Visits	
1st trimester	Within 14 calendar days of request
2nd trimester	Within 7 calendar days of request
3rd trimester	Within 3 business days of request

High-risk pregnancy	Within 3 business days of identification or immediately if an emergency exists
Postpartum exam	3 to 8 weeks after delivery

After-hours Requirements

To help ensure services are appropriately available to our Hoosier Care Connect members, Anthem primary medical providers (PMP) must:

- Provide or arrange coverage of services 24 hours a day, seven days a week.
- Have a toll-free number for members for direct, 24/7 contact with their PMP or qualified clinical staff.
- Be available to see members at least three days per week for a minimum of 20 hours per week at any combination of no more than two locations.
- Provide “live voice” coverage after normal business hours. After-hour coverage for the PMP may include an answering service or a shared-call system with other medical providers.

If you have any questions regarding Hoosier Care Connect, contact your Anthem Network Relations Representative.

Home health services clarifications

In an effort to provide clarification on home health services provided to our Medicaid members, please note the following:

Grace Period (Occurrence Code 50)

- Providers can perform home health services without prior authorization (PA) following an Anthem member’s discharge from a hospital if the parameters meet those outlined in Indiana Administrative Code 405 IAC 5-22-2.
- This code states PA is required for all nursing services, except services ordered in writing by a physician prior to the recipient's discharge from an inpatient hospital.
- This period may not exceed 120 units within 30 days of discharge without PA. Anthem Medicaid recognizes this grace period with notification from the home health provider, and no medical necessity determination will be performed.
- Once the grace period is over, the provider must submit a PA request to Anthem to determine the ongoing medical necessity.
- Effective July 15, 2016, in order to ensure appropriate member discharge planning and coordination of care once the member is discharged from the hospital, Anthem requires home health providers give notification.
- Notification will be entered into Anthem’s claims system and clean claims, billed with occurrence code 50 with the member’s corresponding date of hospital discharge in the occurrence code and occurrence date fields 31-34, a-b on the UB-04 claim form, will pay without PA.
- For additional information, reference the provider reference modules at <http://provider.indianamedicaid.com/general-provider-services/provider-reference-materials.aspx>, specifically modules that outline claims billing and home health services.

Payment of Overhead and Span Dates

- Providers may report overhead; however, it must be only one per provider, per member, per day, as outlined in the Indiana Health Coverage Programs (IHCP) Provider Reference Module for Home Health Services.

- Code 61 indicates the one encounter with the member occurred on the date shown. If the dates of service billed are not consecutive, the provider should enter the occurrence code corresponding to each date of
- If the dates of service billed are consecutive, and one encounter was provided per day, enter occurrence code 61 and the dates of service being billed in the occurrence span code field.

PA Requests

- A copy of the current plan of treatment, developed by the attending physician, therapists, and agency personnel, and signed by the attending physician, must also be included with the PA request for home health services per the IHCP Provider Reference Module for Home Health Services.
- To request PA, provide notification, report a medical admission or ask questions regarding PA, contact Anthem's Utilization Management Department at <1-866-408-7187> for Hoosier Healthwise and Hoosier Care Connect and <1-866-398-1922> for Healthy Indiana Plan. You may also fax PA requests to <1-866-406-2803>.

If you have any questions regarding Hoosier Care Connect, feel free to contact your Anthem Network Relations representative.

Online peer support for Hoosier Care Connect members

Anthem is proud to announce **Online Peer Support**, the newest service for our Hoosier Care Connect members. In partnership with Big White Wall, Online Peer Support provides a vast array of self-paced online tools, anonymous peer support and trained counselors to help your patients with their behavioral health needs in a secure digital environment.

Online Peer Support provides professionally facilitated, evidence-based behavioral and emotional health interventions to complement your treatment. Available 24 hours a day, 7 days a week, Online Peer Support can:

- Connect your patients with their peer community
- Offer a safe, clinically moderated, anonymous platform
- Support your patients with low or moderate acuity issues
- Provide behavioral support for chronic health conditions

Online Peer Support is available to all Anthem Hoosier Care connect members 18 and older. Members can access the service at www.bigwhitewall.us/supportIN and need only have access to a computer and email.

Tear-off cards are available to refer your patients if you feel they may benefit from Online Peer Support, particularly those who may be experiencing depression, anxiety, stress, chronic pain, insomnia, perinatal/postpartum depression, grief and bereavement, relationship issues, chronic medical conditions, alcohol/drug use, challenges with smoking cessation.

To find out more about Online Peer Support and Big White Wall, visit bigwhitewall.us or email info@bigwhitewall.us.

For more information or questions, contact your local network relations representative or the Hoosier Care Connect Provider Helpline at 1-844-284-1798.

New reimbursement policy

Multiple Procedure Payment Reduction (Policy 15-002, effective 10/01/2016)

We allow reimbursement for multiple procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

When services are performed on the same date of service during the same patient encounter, and are performed by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- "Always therapy" services
- Cardiovascular procedures
- Ophthalmology procedures

For specific information regarding reimbursement for these services and procedures, refer to the Multiple Procedure Payment Reduction policy at www.anthem.com/inmedicaiddoc.

Reimbursement policy update

Modifier 77: Repeat Procedure by another Physician or other Qualified Health Care Professional (Policy 06-019, effective 08/15/2016)

We allow reimbursement for applicable procedure codes appended with Modifier 77 to indicate a procedure or service was repeated by another physician.

Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of Modifier 77:

- For a nonsurgical procedure or service: 100 % of the applicable fee schedule or contracted/negotiated rate
- For a surgical procedure: 100 % of the applicable fee schedule or contracted/negotiated rate for the surgical component only **limited** to a total of two surgical procedures

Professional services, other than radiology which is excluded from this requirement, will be subject to clinical review for reimbursement consideration. Providers must submit supporting documentation with the claim when using Modifier 77. If a claim is submitted with Modifier 77 without supporting documentation, the claim will be denied. Providers will be asked to submit the required documentation for reimbursement reconsideration. Failure to use Modifier 77 when appropriate may result in denial of the procedure or service.

For additional information, refer to the Modifier 77 reimbursement policy at www.anthem.com/inmedicaiddoc.

Reimbursement policy reminder

Facility Take Home DME and Medical Supplies (Policy 06-081, originally effective 02/01/2015)

Anthem does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Anthem allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- No more than 72 hours of medical supplies if the provider was not able to obtain supplies from a vendor by discharge

Refer to the Facility Take Home DME and Medical Supplies reimbursement policy at www.anthem.com/inmedicaidoc

For KY Medicaid only

Sanctioned provider edit -- summary

Effective June 1, 2016, Anthem Blue Cross and Blue Shield Medicaid will deny all claims billed with an attending, ordering or rendering physician who has been identified as a sanctioned or debarred provider. Claims will deny with an explanation code of GA5, "Sanctioned provider, no payment."

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

Behavioral Health Medicaid billing guidance

This is a change to the billing guidance for rendering NPI and taxonomy code effective immediately. Behavioral health providers, billing for professional services provided by licensed or non-licensed practitioners, must submit claims with the license-level modifier that represents the rendering provider's license level. Additionally, the appropriate National Provider Identification (NPI) number must be documented in the applicable fields on the CMS-1500 form:

- For licensed practitioners, the individual NPI should be entered into box 24J on the CMS-1500 form
- For non-licensed practitioners, the supervising clinician should be entered into box 24J of the CMS-1500 form

For more information regarding the CMS-1500 or to access the claim form, visit the NUCC website at www.nucc.org. **If you have questions about this communication, please call Provider Services at 1-855-661-2028 or your local Provider Relations representative.**

The following is effective immediately:

Behavioral health providers billing for professional services provided by licensed or non-licensed practitioners must submit claims with the license-level modifier that represents the rendering provider's license level. Additionally, the appropriate National Provider Identification (NPI) number must be documented in the applicable fields on the CMS-1500 form:

- For licensed practitioners, the individual NPI should be entered into box 24J on the CMS-1500 form
- For non-licensed practitioners, the supervising clinician should be entered into box 24J of the CMS-1500 form

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 Provider Services at **1-855-661-2028**.

Crisis hotline

Anthem 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**.

New reimbursement policy

Multiple Procedure Payment Reduction (Policy 15-002, effective 10/01/2016)

We allow reimbursement for multiple procedures unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

When services are performed on the same date of service during the same patient encounter, and are performed by the same physician or health care professional with the same National Provider Identifier (NPI) or multiple providers in the same group practice with the same group NPI, the following will be subject to Multiple Procedure Payment Reductions (MPPR):

- "Always therapy" services
- Cardiovascular procedures
- Ophthalmology procedures

For specific information regarding reimbursement for these services and procedures, refer to the Multiple Procedure Payment Reduction policy www.anthem.com/KYMedicaidDoc.

Reimbursement policy update

Unlisted or Miscellaneous Codes (Policy 06-004, originally effective 01/01/2014)

Anthem allows reimbursement for unlisted or miscellaneous codes in accordance with specified guidelines unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. We allow:

- Community Mental Health Centers to bill unlisted psychiatric service or procedure codes with an applicable modifier without documentation of a written description, office notes, or operative report.
- Child Advocacy Centers to bill unlisted evaluation and management services without documentation of a written description, office notes or operative report.

Unlisted or miscellaneous codes should only be used when an established code does not exist to describe the service, procedure, or item rendered. Reimbursement is based on review of the unlisted or miscellaneous code(s) on an individual claim basis. Claims submitted with unlisted or miscellaneous codes **must** include documentation for consideration during review.

Refer to the Unlisted or Miscellaneous Codes reimbursement policy for more information.

Reimbursement policy reminder

Facility Take Home DME and Medical Supplies (Policy 06-081, originally effective 07/01/2014)

Anthem does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Anthem allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

Refer to the Facility Take Home DME and Medical Supplies reimbursement policy at www.anthem.com/KYMedicaidDoc.

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

For WI Medicaid only

Medical policies and clinical UM guidelines update

On February 4, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to 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.

Medical policies -- 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)
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April 5, 2016	SURG.00142	Genicular Nerve Blocks and Ablation for Chronic Knee Pain	New
February 11, 2016	DME.00035	Electric Tumor Treatment Field (TTF)	Revised
February 11, 2016	DRUG.00052	Pertuzumab (Perjeta®)	Revised
February 11, 2016	DRUG.00077	DRUG.00077 Secukinumab (Cosentyx®)	Revised
April 5, 2016	RAD.00029	CT Colonography (Virtual Colonoscopy) for Colorectal Cancer	Revised

Clinical guidelines -- On February 4, 2016, the 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 February 29, 2016.

On February 4, 2016, 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 (new/revised)
April 5, 2016	CG-BEH-14	Intensive In-Home Behavioral Health Services	New
April 5, 2016	CG-DME-38	Continuous Interstitial Glucose Monitoring	New
May 2, 2016	CG-SURG-53	Elective Total Hip Arthroplasty	New
May 2, 2016	CG-SURG-54	Elective Total Knee Arthroplasty	New
April 5, 2016	CG-DRUG-04	Use of Low Molecular Weight Heparin Therapy, Fondaparinux (Arixtra®), and Direct Thrombin Inhibitors in the Outpatient Setting	Revised
April 5, 2016	CG-DRUG-20	Enfuvirtide (FUZEON®)	Revised
April 5, 2016	CG-LAB-09	Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain	Revised
February 11, 2016	CG-MED-35	Retinal Telescreening Systems	Revised
February 11, 2016	CG-MED-54	Strapping	Revised
February 11, 2016	CG-SURG-27	Gender Reassignment Surgery	Revised
April 5, 2016	CG-SURG-36	Adenoidectomy	Revised
To be determined	CG-SURG-44	Coronary Angiography and Cardiac Catheterization in the Outpatient Setting	Revised
February 11, 2016	CG-SURG-47	Surgical Interventions for Scoliosis and Spinal Deformity	Revised

Archived clinical guidelines -- The following two Clinical UM Guidelines have been archived on the effective date listed below. These guidelines will no longer appear on the site and the criteria should no longer be used.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title
April 5, 2016	CG-BEH-08	Employee Assistance Program Outpatient Treatment
April 5, 2016	CG-DRUG-07	Hepatitis C Pegylated Interferon Antiviral Therapy

MCG guidelines -- For health plans utilizing MCG (Milliman Care Guidelines), the MCG 20th edition care guidelines were discussed at the February 4, 2016, MPTAC meeting. The MCG 20th edition care guidelines will be available for use upon release through MCG.

For more information, 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 Provider Services at **1-855-558-1443**.

Policy Update: Preadmission services for inpatient stays

(Policy 07-017, effective May 1, 2016)

Anthem allows reimbursement for all outpatient services for a covered BadgerCare Plus member prior to admission to an inpatient hospital when:

- The outpatient services are contiguous with the inpatient stay, and
- 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 mediproviders.anthem.com/wi.

Changes to claims submission requirements for outpatient hospital services

Effective January 1, 2016, BadgerCare Plus implemented ForwardHealth Update No. 2016-02, "Changes to Claims Submission Requirements for Outpatient Hospital Services." The health plan will adopt new place of service (POS) code 19 (off-campus outpatient hospital) and revised POS code 22 (on campus-outpatient hospital) for professional claims, and modifier PO (services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments) on facility claims.

For services provided in an off-campus provider based outpatient clinic, the health plan will reimburse only a professional charge, consistent with state policy. Professional providers are required to indicate POS 19 on claims submitted for services performed in an off-campus provider-based clinic. In accordance with Wisconsin Department of Health Services payment policy for POS 22, the health plan will apply the site-of service payment differential to services reported with POS 19 for specified codes that are typically office based. This policy will become effective with claims for dates of service on and after June 15, 2016.

Additionally, modifier PO is required on institutional claims to indicate the facility charge for services provided in off-campus provider-based outpatient clinics. In alignment with Wisconsin Department of Health Services policy the health plan will not reimburse claims submitted with modifier PO.

Sanctioned provider edit

As of April 2016, Anthem implemented a front end edit to the claim system, that will deny BadgerCare Plus claims submitted with an attending, ordering or referring provider NPI that is on the sanctioned or debarred provider lists. Claims will deny with the EX code GA5 sanctioned provider, no payment.

Knee and hip arthroplasty to require PA

Effective May 1, 2016, knee and hip arthroplasty will require prior authorization (PA) for dates of service on or after May 1, 2016. Providers may request PA by calling BadgerCare Plus Provider Services at 1-855-558-1443 or faxing requests to 1-800-964-3627. Please visit the BadgerCare Plus provider website at mediproviders.anthem.com/wi for detailed authorization requirements.

Cultural competency

Anthem recognizes the roles age, culture, socioeconomic status, and ethnicity play in our members' lives and is committed to maintaining a culturally competent network that acknowledges and incorporates the following values at all levels: diversity, vigilance about understanding the dynamics resulting from cultural differences, continuous expansion of cultural knowledge, consistent adaptation of services to meet culturally unique needs, and assisting providers with meeting the cultural and linguistic needs of their patients.

Anthem's commitment includes working with our contracted health care providers to continually increase their knowledge of and sensitivity to diverse cultures. As part of this effort, providers are encouraged to review the PowerPoint presentation "Cultural Competency Training" on the provider website, which can be accessed from the quick link "[Manuals, Directories, Training & More.](#)"

New dental vendor is DentaQuest – Effective May 1, 2016

DentaQuest is the new dental vendor that will administer dental benefits for BadgerCare Plus members, effective May 1, 2016. Contact information:

www.dentaquestgov.com

DentaQuest (ATTN: Claims)
12121 N. Corporate Parkway
Mequon, WI 53092
Provider Services: 1-855-453-5287

Reimbursement policy update

Modifiers LT and RT: Left Side/Right Side Procedures (Policy 07-022, effective 07/01/2014)

Anthem Blue Cross and Blue Shield (Anthem) allows reimbursement for procedure codes appended with Modifier LT and/or RT when indicating the side of the body for which the item, supply or procedure will be used unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based on 100% of the fee schedule or contracted/negotiated rate for the procedure. Modifiers LT and RT are informational modifiers; therefore, do not increase or decrease reimbursement for the procedure.

For more detailed information, refer to the Modifiers LT and RT: Left Side/Right Side Procedures reimbursement policy at <https://mediproviders.anthem.com/wi/pages/reimbursement-policies.aspx>.

Reimbursement policy reminder

Facility Take Home DME and Medical Supplies (Policy 06-081, originally effective 07/01/2014)

Anthem does not allow reimbursement of Durable Medical Equipment (DME) and medical supplies dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Facility claims submitted for DME and medical supplies billed with revenue codes denoting take-home use will be denied.

To be considered for reimbursement, claims for take-home DME and medical supplies should be submitted by a DME/supply vendor. Reimbursement is based on the:

- Contract or negotiated rate for participating vendors
- Out-of-network fee schedule or negotiated rate for non-participating vendors

Anthem allows reimbursement of facility claims for medical supplies dispensed to the member at discharge and billed with revenue codes other than take-home for the following items:

- Crutches
- Medical supplies for no more than 72 hours if the provider was not able to obtain supplies from a vendor by discharge

Refer to the Facility Take Home DME and Medical Supplies reimbursement policy at <https://mediproviders.anthem.com/wi/pages/reimbursement-policies.aspx>.