

Network Update

CENTRAL REGION

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IN, KY, MO, OH, WI

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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. Recently, updated [preventive care guidelines](#) were posted online.

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

Use the ICR to submit and check precert status

When you use ICR to initiate a request for precertification of some inpatient and outpatient procedures,* you may receive an immediate authorization decision. To find out more about this exciting new feature, go [here](#).

Need to check the status of an authorization? No need to call or fax!

Also use ICR to inquire on a previously submitted case and find out right away what is the status of the precertification request. Ordering and servicing physicians and facilities can inquire to find information on a precert previously submitted via phone, fax, ICR or other online tool.

Plus check out one of ICRs newer features: You can find decision letters associated with your precertification requests. The letters are viewable and *printable*.

Attend one of our upcoming webinars and learn about the features that will help you to optimize your ICR experience! Register now by clicking [here](#).

*Excludes: Medicare Advantage, Medicaid, Federal Employee Program® (FEP), BlueCard® and some National Account members; requests involving transplant services; services administered by AIM Specialty Health®; services administered by OrthoNet LLC. For the above requests, follow the same precertification process that you use today.

Is your Availity Web Portal access up-to-date?

Anthem continues to transition tools to the Availity Web Portal which offers ease of use, broad functionality and breadth of services. So make sure that your access is up to date so you can get the information you need, including:

- Eligibility
- Claims Inquiry
- Claims Submission
- Secure Messaging
- Remittance Inquiry
- Research Procedure Code Edits
- Online Provider Maintenance Form (Access only available to Administrators)
- Professional Fee Schedule
- Find Remittances, Research Procedure Code Edits and the Fee Schedule under the new Payer Spaces link.

See something you need but can't access it?

Contact your organization's administrator to request the role you need. To determine who your organization's administrator is, select "Who controls my access" from your account drop down box located in the upper right corner of the Availity Web Portal's top menu bar.

Do you have all of your tax IDs registered on the Availity Web Portal?

If not, now is the time to register. Your organization's administrator can add additional tax ids by selecting Maintain Organization from the Admin Dashboard.

New webinar schedule for ePASS and SOAP Notes

Anthem continues to work with Inovalon - an independent company that provides secure, clinical documentation services - to conduct outreach efforts on our behalf for our health care exchange business. As a result, Anthem network providers - usually primary care physicians - may receive letters from Inovalon, requesting that physicians perform patient assessments, followed by submission of a Subjective, Objective, Assessment and Plan (also called SOAP Note or Encounter Facilitation Form). *Webinars assist eligible providers in completing a SOAP Note and utilizing the ePASS® electronic tool.* For more information and to register for a webinar, go [here](#).

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.

Health Care Management

Medical policy and clinical guideline update

The following Anthem medical polices and clinical guidelines were reviewed on May 5, 2016 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on November 1, 2016:

Note: These updates apply to all Anthem fully Insured plans, although variation may exist with some self-funded plans. For a complete listing of impacted plans, please go online to www.anthem.com>Providers (select state)>Precertification Guidelines.

GENE.00045 Detection and Quantification of Tumor DNA Using Next Generation Sequencing in Lymphoid Cancers

This new medical policy addresses next generation sequencing (which includes, but is not limited to high-throughput and deep sequencing) of tumor DNA to assist in determining the success of the treatment, forming a prognosis, monitoring disease progression and choosing therapies for individuals with lymphoid cancer.

SURG.00143 SpaceOAR® System

This new medical policy addresses the use of SpaceOAR, an injectable liquid hydrogel product intended to create distance and serve as a spacer between the prostate and the anterior rectal wall in individuals undergoing radiotherapy for prostate cancer.

DRUG.00028 Intravitreal Treatment for Retinal Vascular Conditions

The medical policy position was revised to clarify the medical necessity criteria to for the treatment of proliferative diabetic retinopathy, with or without diabetic macular edema, for bevacizumab, ranibizumab, and aflibercept.

MED.00119 High Intensity Focused Ultrasound (HIFU) for Oncologic Indications

The medical policy title was revised, the scope was expanded to include all oncologic indications, including but not limited to, prostate cancer, and the use of HIFU for pain palliation was added.

SURG.00037 Treatment of Varicose Veins (Lower Extremities)

The medical policy was revised to address coil embolization as a treatment of lower extremity varicose veins. Also CPT code 37241 was added.

SURG.00098 Mechanical Embolectomy for Treatment of Acute Stroke

The medical policy was revised to remove the age requirement for treated individuals and to add criteria indicating the procedure must be performed with a stent retriever device.

CG-SURG-27 Sex Reassignment Surgery

CPT hysterectomy codes 58570, 58572 were added.

CG-DRUG-16 White Blood Cell Growth Factors

The clinical UM guideline was revised to reflect the following:

- Revised medically necessary criteria addressing primary prophylaxis of developing febrile neutropenia (FN) when greater than or equal to 10% and less than 20% for all products.
- Added pegfilgrastim (Neulasta) as medically necessary after accidental or intentional total body radiation of myelosuppressive doses (greater than 2 Grays [Gy]) (such as Hematopoietic Syndrome of Acute Radiation Syndrome)
- Added tbo-Filgrastim (Granix) as medically necessary:
 - After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) when criteria are met
 - To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT)

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.

Note: To see a list of specialty pharmacy medications that require precertification, please go online to www.Anthem.com > Providers (enter state)>Answers at Anthem>Precertification> Specialty Pharmacy Precertification Drugs and Codes.

Precert changes for NOC oncology drugs

Effective November 1, 2016, we will expand pre-service review to the medical necessity of coverage requests for not otherwise classified “NOC” oncology and biologic drugs. This pre-service review program will apply to our Commercial, Local ASO, National Accounts and Medicare Advantage members.

Anthem implements Opioid Analgesic UM policies

In September 2016, Anthem will implement revised clinical policies for opioid analgesics to help improve patient safety through enhanced coordination and to reduce the misuse and abuse of opioid analgesics. The opioid analgesics utilization management (UM) clinical policies apply to all Anthem health plans and include requirements for both the short-acting opioid analgesics and the long acting opioid analgesics that are based on CDC Guideline for Prescribing Opioids for Chronic Pain: <http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

- Short-acting opioid analgesics: Members not currently using short-acting opioid analgesics on a regular basis will be limited to a 7 days’ supply per fill and 14 days’ supply per 30 days before requiring a prior authorization. Members actively being treated for cancer and those who are terminal and undergoing palliative care will be automatically approved. Requests for a days’ supply greater than the noted 7 or 14 days’ supply will require additional review.
- Long-acting opioid analgesics: Members who are new starts and are not currently using a long-acting opioid analgesic will require prior authorization. Members currently using a long-acting opioid analgesic will not require prior authorization. Members who are newly prescribed a long-acting opioid and are actively treating for cancer or those who are terminal and undergoing palliative care will be automatically approved.

If you have any questions, please contact the Provider Service phone number on the back of the member ID card.

SGLT2 Step Therapy program

On August 1, 2016, Anthem is updating the Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor Step Therapy program, to include Farxiga, Invokana, Invokamet, and Xigduo XR. The SGLT2 Inhibitor Step Therapy Program applies to all Anthem health plans.

When a drug that is part of the step therapy program is prescribed, the member’s pharmacy will receive a message that the member must try a different, similar drug that’s covered by the member’s plan as the “first step”. The member or the pharmacist will then have to call the prescriber’s office to get a prescription for that drug.

Based on a cardiovascular outcomes study in over 7,000 members with Type 2 diabetes and established cardiovascular disease, Jardiance and Synjardy were superior to the placebo when added to the standard therapy for the primary cardiovascular composite endpoint.¹ Based on this data, we have selected Jardiance or Synjardy as our first step SGLT2 Inhibitor drugs.

Members currently taking Farxiga, Invokana, Invokamet, and Xigduo XR will be required to switch to Jardiance or Synjardy when their current prior authorization expires. These members will be mailed a letter advising them of the update to the SGLT2 Step Therapy Program. If one of your patients is currently taking Farxiga, Invokana, Invokamet, and Xigduo XR, you will receive a letter as well.

Drugs that are part of the step therapy program are proven to work well for most people, and they may cost less. However, you can ask for a review of the current drug for medical necessity if:

- The member has tried Jardiance or Synjardy before and they didn't work well.
- The member tries Jardiance or Synjardy now and they don't work.
- You feel the member needs to stay on the current drug for any other reason.

The prescriber will just need to call the Provider Services number on the back of the member ID card to request that we cover the current drug. If you have questions regarding the SGLT2 Inhibitor Step Therapy Program, please contact the Provider Service phone number on the back of the member ID card.

¹ Zinman B, Wanner C, Lachin JM, et al; EMPA-REG OUTCOME Investigators. Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes. *N Engl J Med*. 2015 Nov 26;373(22):2117-28.

Expansion of precert requirements for radiation therapy fractions

Effective October 31, 2016, Anthem is expanding its Radiation Therapy Program CG-THER-RAD-01 precertification requirements for Fractions (also referred to as units) to now include non-small cell lung cancer for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT).

The Radiation Therapy Program is managed by AIM Specialty Health® (AIM), a separate company administering the program on behalf of Anthem.

All Anthem local members who currently require precertification for non-emergency outpatient radiation therapy are included in this program. These precertification requirements do not apply to the following plans: Medicare Advantage (MA), Medicare Supplement, Medicaid, Federal Employee Program® (FEP®)*, National Accounts, members with Anthem as secondary coverage, Unicare, HealthLink, Healthy Indiana Plan (HIP), Hoosier Healthwise, Hoosier Care Connect, Anthem BlueCross BlueShield Medicaid (Kentucky), and BadgerCare Plus.

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

Ordering physicians may submit a precertification request for these additional requirements for services starting 10/31/16 or after to AIM through the AIM [ProviderPortalsSM](#) (available 24/7 to process orders in real-time), through the [Availity Web Portal](#) or by calling the AIM call center at 800-554-0580, Monday–Friday, 7:30 a.m.–6:00 p.m. ET.

Note: Retrospective requests received more than 2 business days after the date of service will not be accepted by AIM for precertification review. Any post-service clinical review would be handled by Anthem according to the terms of the applicable health benefit plan and/or provider agreement.

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

Thank you for your collaboration and ongoing support of the Radiation Therapy Program. If you have further questions, please contact your local Network Relations consultant or call the provider customer service number on the member's ID card.

Updates to AIM's clinical guidelines for high tech radiology

On November 1, 2016, the following changes to the AIM Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

Radiology guidelines

- New guidelines to address pretest requirements for advanced imaging and ordering of multiple exams
- Head and Neck imaging
 - Enhanced criteria for evaluation of cerebral aneurysm and imaging following head trauma
 - Restructure of hearing loss and acoustic neuroma guidelines with addition of threshold values
- Chest, abdomen and pelvis
 - Broadened exclusions for staging or surveillance of certain tumor types across all CT and MRI modalities
 - Updated appropriateness criteria for nephrolithiasis
- Spine imaging
 - Enhanced criteria for conservative management prior to imaging for neck pain and radiculopathy

Cardiology guidelines - Echocardiography

- Enhanced criteria to limit surveillance of asymptomatic patients with reduced LV function
- Allow for annual surveillance in asymptomatic complex congenital heart disease
- Clarify appropriate use of resting echo in evaluation of chest pain

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click [here](#) to access and download a copy of the current guidelines.

Reminder: Most inpatient stays require authorization

Please remember that most inpatient stays require authorization. For details on the process, please see our Network eUPDATE [here](#).

Precertification changes for Specialty Pharmacy drugs

Anthem will expand the Specialty Pharmacy Prior Authorization list, effective October 1, 2016. Click [here](#) to see a list of specialty pharmacy codes from new or current Medical Policies that will be added to our existing pre-service review process.

Specialty Pharmacy level of care clinical reviews

The April 2016 [issue](#) of *Network Update* shared information about the expansion of the Specialty Pharmacy program to include level of care clinical review for specialty pharmacy infusions and injections beginning with dates of service July 1, 2016. In the June 2016 [issue](#) of *Network Update*, we notified providers of a delay in the implementation of level of care clinical reviews and indicated that we would advise providers of the revised implementation date in an upcoming notification. **Please note that Specialty Pharmacy level of care clinical reviews began with dates of service on and after July 18, 2016.** See more details [here](#).

KY/MO: New clinical guidelines take effect on September 1

Effective September 1, 2016, new Clinical Guidelines, CG-SURG-53 Elective Total Hip Arthroplasty and CG-SURG-54 Elective Total Knee Arthroplasty, will be adopted for medical necessity review. See the full Missouri communication [here](#). See the full Kentucky communication [here](#).

Medicare

Medicare Supplement individual members to receive new ID cards

All Anthem Medicare Supplement individual members will receive new member ID cards beginning November 1, 2016. Please obtain a copy of the new member ID cards to file claims for dates of service November 1, 2016 and beyond. Medicare will be notified of these changes for Anthem Medicare Crossover claim purposes.

If you need to submit a claim that is not reflected as a Medicare Crossover claim, please use the correct member ID number beginning November 1, 2016. Please ask our members to present their most current ID cards each time they receive services – especially on or after November 1. This helps ensure appropriate claims routing and processing. Provider offices should carefully review member ID numbers when filing claims.

Payments will be processed daily. Remittances that may have been sent out only once a week will be received earlier.

All individual Medicare Supplement members will have a new group ID number and new member ID number on their new member ID cards.

Further information can be found in the spotlight section of the [provider home page](#) and at the “Answers @ Anthem ab at the top of the Anthem provider home page.

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Reach a nurse directly

Effective July 15, 2016, providers can speak to a nurse directly to request a prior authorization requiring clinical review for individual Medicare Advantage (MA) members. Just call the number on the back of the member ID card for prior authorization of services authorized by Anthem. The nurse may be able to make the clinical review immediately if the necessary clinical information is available. We hope this increased access to clinicians will streamline the prior authorization process for you and for our members.

Webinars offered on AIM *OptiNet* imaging services registration

The implementation of the AIM *OptiNet* imaging services initiative has been delayed until January 1, 2017. However, we encourage all providers to take the *OptiNet* survey early.

All participating providers who provide imaging services should complete registration for AIM's online registration tool, *OptiNet*. *OptiNet* 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.

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

Providers who score less than 76 or who did not complete the survey by January 1, 2017 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only.

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 January 1, 2017. All facility diagnostic imaging services are excluded from line item denials at this time. *OptiNet* scores are used for all radiology services for facility and non-facility based providers during the AIM provider selection process.

Please remember even if you have registered your radiology equipment for commercial business, you must also register for the MA individual line of business. AIM can help you transfer your commercial registration information to the MA registration site.

To register for Anthem MA:

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

For additional assistance, call AIM toll free at 800-714-0040, Monday through Friday, 7 am to 7 pm CT.

Learn more: Attend a webinar

Anthem continues to offer webinars to help providers complete their *OptiNet* surveys. 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 webinar sessions below to register:

[Aug. 8, 2016, 4:30-5:30 p.m. ET](#)

[Aug. 25, 2016, 1-2 p.m. ET](#)

[Sept. 16, 2016, 12-1 p.m. ET](#)

[Sept. 26, 2016, 4-5 p.m. ET](#)

[Oct. 12, 2016, 1-2 p.m. ET](#)

[Oct. 28, 2016, 3:30-4:30 p.m. ET](#)

[Nov. 9, 2016, 12-1 p.m. ET](#)

[Dec. 17, 2016, 4-5 p.m. ET](#)

Improve MA member medication adherence

To help improve medication adherence and outcomes among Anthem individual and group-sponsored MA members, Anthem will contact providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins,

to request that you convert the member's prescription to a 90-day supply. This helps improve the adherence of our MA members by reducing the number of times members must travel to their pharmacy. Please note that we do *not* intend to transfer these prescriptions to a mail-order or specialty pharmacy. The member will obtain the 90-day supply medication at the same pharmacy where he or she previously obtained the 30-day supply prescription.

Alendronate added to \$0 copay tier for MA members

Individual MAPD plans in 2016 have added alendronate for osteoporosis to the \$0 copay tier and continue to offer select drugs at a \$0 member copay for the following conditions: high blood pressure, high cholesterol and diabetes. The 2016 medication list includes: alendronate, glipizide, lisinopril, losartan, metformin, simvastatin, benazepril, enalapril, enalapril-hctz, lisinopril-hctz, glimepiride, glipizide ER, losartan-hctz, metformin ER, atorvastatin, lovastatin and pravastatin.

Part D drugs must be prescribed for medically accepted indications

Anthem is responsible for ensuring that the Medicare Part D drugs that it covers are prescribed for medically accepted indications supported by FDA-approved labeling and/or supported by at least one Medicare-approved compendium. If not, then by definition the drug is not considered a Part D drug. Please see Chapter six of the Medicare Prescription Drug Benefit Manual (<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf>) for additional information.

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Anthem offers in-home bone mineral density test

Anthem is working with a vendor to conduct in-home bone mineral density (BMD) testing for individual and group-sponsored female MA members, age 67-85, who have claims that indicate a bone fracture and who are not on an osteoporosis medication and/or have not had a BMD scan in the last 24 months. These members are offered the opportunity to have an in-home screening by way of a letter about osteoporosis and subsequent phone calls. The screening takes about 10 minutes. The resulting T-Score is faxed to the attributed primary care provider (PCP). If the vendor cannot reach the member, a registered nurse may follow up with the PCP to request assistance with scheduling a BMD appointment for the member or inquire about medication therapy for the member.

Program helps members with RA

According to the American College of Rheumatology, Disease Modifying Anti-Rheumatic Drugs can help prevent long term disability and damage to persons with Rheumatoid Arthritis (RA). If you see an individual or group-sponsored MA member who has been diagnosed with RA and that member has not received or filled a prescription for a DMARD, Anthem will send you a fax with that member's contact information and a request to help ensure that the member has this important medication. A registered nurse also may follow up with the physician or the member to assist with appointments or prescriptions as needed.

Cumulative morphine equivalent dosing edit

Beginning January 1, 2017, most MA plans will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale. This MEq dosing edit will identify members taking a cumulative dose that exceeds the daily dose that Anthem sets. This is a patient safety edit intended to reduce the risk from high dose opioid use. There is a higher risk for overdose when exceeding the set MEq dosing limit. The claim(s) will reject at the point of sale and

require a prior authorization review if the cumulative dosing is over the set daily limit. Certain members may be excluded from the edit, such as members with cancer. The edit supports the Centers for Medicare and Medicaid Services (CMS) guidance mandating that Medicare plans implement a cumulative dosing edit. Anthem anticipates that this edit will impact a fairly high number of claims.

Check contract before rendering supplemental benefits

Our Medicare Advantage (MA) HMO & PPO Plans may include supplemental benefits which are items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the MA plan. Please refer to each MA plan's benefit materials to locate any supplemental benefit coverage. Most of these benefits are required to be rendered by providers within the vendor network associated with that supplemental benefit or they are considered non-covered benefits. For example, the MA plan may cover routine hearing services when the member goes to a provider participating in a hearing services network. Another example: routine eye exams may be covered as an optional supplemental benefit but members must use a provider participating in the vision network.

Providers **contracted with the network** associated with that supplemental benefit must bill that vendor directly.

Providers **not contracted with the network** to render such a benefit will be reimbursed or able to bill a member only if:

- For an HMO member, you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's MA plan. This will ensure that the member will receive a notice of denial of medical coverage and accompanying appeal rights. As per the Medicare Advantage HMO & PPO Provider Guidebook, CMS has stated that the use of an Advanced Beneficiary Notice or a similar document is not sufficient in many instances with MA members. Therefore you are required to seek a coverage determination prior to rendering such services.
- For a PPO member, you notify the member up front you are not contracted for the Supplemental Benefit and therefore out of network cost share will apply.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

Complying with medical record documentation requests

As outlined in the Medicare Advantage HMO & PPO Provider Guidebook, the facility, treating physician, clinician or supplier must comply with all requests for documentation from the Plan. Providers are responsible for providing any and all related medical records, answer questions from health plan representatives or furnish any necessary information when requested. Information must identify the provider and date of service, be submitted in a timely manner, and be complete and legible. Records can be requested by the Plan for reviews such as:

- Compliance with Medicare laws, audits and record retention requirements
- Provider medical record audits/reviews
- Precertification requests
- Medicare appeals

Additional information can also be located in your provider contract. Please remember that your performance in submitting records impacts you as well as our members in some situations. Provider compliance with requests will also be monitored.

Ensure accuracy of your information in the provider directory

We conduct quarterly verifications of provider demographic and participation information in order to meet CMS requirements that Anthem ensure the information in our provider directories is accurate. You may receive a fax, email or letter requesting confirmation of your information.

Upon receipt of your verification form, please validate your demographic information for the specific location identified and indicate if changes are required. If we need to verify information for your other locations or plans, we will contact you separately.

For reference, Anthem will ask you to fax back any changes to the following information: *Provider Name, Provider Specialty, Street Address, Phone Number, Accepting New Patients, NPI, Fax Number, Email*. Upon receipt, Anthem will include those changes in the provider directory within 30 days. We appreciate your continued cooperation.

Medicare notices and provider requirements

CMS requires providers to notify every Medicare beneficiary of their discharge appeal rights. Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must use the Notice of Medicare Non-Coverage (NOMNC). Inpatient hospitals must use the notice, Important Message from Medicare About Your Rights (IM). Download NOMNC and IM notices and instructions from the CMS website:

- **NOMNC Notice:** <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html>
- **IM Notice:** <http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

Important Reminder: Make sure the Medicare notices have the correct Beneficiary and Family Centered Care (BFCC) Quality Improvement Organization (QIO) contact information. Locate your QIO at <http://www.qioprogram.org/contact>.

For more information about CMS guidelines for delivery and retention of the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Clinical Compliance Department by phone: 317-287-0196, fax: 877-261-2134, or email: carol.bossingham@anthem.com.

Claim adjustments may change member cost share

Anthem reminds providers to please check the explanation of payments on claims. There are situations in which a claim may be adjusted and this may change a member's cost-share. If you receive a claim adjustment from Anthem, please ensure the member cost-share is still accurate. Basic member cost-share information is located on the front right-side of the member ID card but please note that not all cost shares are listed. If you have any questions about a member's cost share, please call the number on the back of the member ID card.

Please use Medicare billing guidelines

When filing claims for Anthem individual and group-sponsored MA members, please use the same billing guidelines as set forth by Medicare for preventive service claims. This applies to both professional and institutional billing.

- Professional claims should be filed on the CMS 1500 form with the appropriate Current Procedural Terminology (CPT) code and/or Health Care Procedural Code (HCPC) for the preventive service. The required primary and/or secondary diagnosis must also be listed with the appropriate CPT and/or HCPC.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes. The Medicare Preventive Services Chart does not list revenue codes. Please be sure to follow UB04 billing guidelines.

Examples:

Revenue Codes (except Rural Health Clinics and Federally Qualified Health Centers):

- 0636 – vaccine (and CPT or HCPC)
- 0771 – administration (and HCPC)

Rural Health Clinics and Federally Qualified Health Clinics – 052X revenue code series

Please refer to the [Medicare Preventive Services Chart](#) for specifics on billing found at <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/Downloads/MPS-QuickReferenceChart-1TextOnly.pdf>.

Follow Home Health billing instructions

All claims from home health agencies (HHAs) must follow CMS billing instructions. These billing instructions pertain to providers contracted to Medicare pricing and non-contracted providers. Check [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider for additional information.

naviHealth coordinating prior authorizations for Highmark MA members

Anthem wants our PPO Medicare Advantage network providers to be aware of a recent mailing from Highmark, a Blue Cross and Blue Shield Association plan in Delaware, Pennsylvania and West Virginia. Highmark has initiated a partnership with naviHealth (www.navihealth.us), a national post-acute care management company, to support its Medicare Advantage members. naviHealth began coordinating long-term acute care, inpatient rehabilitation and skilled nursing facility utilization and overseeing proper care transitions to and from these facilities July 1, 2016.

As a courtesy to our participating providers, Anthem shares the following information from Highmark: Anthem participating providers caring for Highmark Medicare Advantage members through the Blue Cross and Blue Shield PPO network sharing program must obtain prior authorization from naviHealth for admissions and concurrent stays to a Skilled Nursing Facility (SNF), Long Term Acute Care Hospital (LTAC) and Inpatient Rehabilitation Facility (IRF).

naviHealth will send additional information to providers when an authorization is requested. Anthem also will make additional information available at www.anthem.com/medicareprovider under [Important Medicare Advantage Updates](#).

Keep up with MA news

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

[June reimbursement policy provider bulletin](#)

[Medicare Advantage reimbursement policies](#)

[2016 Diabetic Supply Coverage for Individual Medicare Advantage Members](#)

[Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning Feb. 1, 2016](#)

[Contact Medicare Part B Specialty Pharmacy before Injections, Infusion Drug Prior Authorization Expire](#)

[Routine cervical cancer screening coverage guidelines](#)

[Prior authorization requirements for injectable/infusible drugs](#)

Also look for “AIM Clinical Appropriateness Guidelines for Advanced Imaging Effective November 1, 2016” and “Home health services to require prior authorizations.”

60509WPPENMUB 06/09/2016

Pharmacy

Anthem's Pharmacy Home Program

To help improve patient safety through enhanced coordination and reduce the misuse and abuse of prescription drugs, as set forth in the Certificate of Coverage, Anthem implemented the Pharmacy Home program in April 2016. The Pharmacy Home program applies to all Anthem health plans. Members with an increased safety risk are identified for the Pharmacy Home program when a retrospective drug utilization review (DUR) indicates a member has one of the following claim scenarios within a 90 day period:

- Filled five or more controlled-substance prescriptions, or 20 or more prescriptions not limited to controlled substances
- Visited three or more health care providers for controlled substance prescriptions, or 10 or more providers not limited to controlled substances
- Filled controlled substances at three or more pharmacies, or 10 or more pharmacies not limited to controlled substances

Members are mailed a letter advising them that they meet one of the above criteria. If their claim activity does not change over the following 60 days, they will receive an enrollment letter requesting them to select a single pharmacy location to fill all of their medications for a period of one year. The use of a single pharmacy will help improve the member's coordination of care and reduce the potential risk for prescription abuse or misuse.

If one of your patients is identified for the Pharmacy Home program, you also will receive a letter. This notification can help you assist with medication reconciliation, including reviewing the medications your patient is taking. Medication reconciliation looks for possible duplication of therapy to help ensure members are not at risk for negative drug interactions or possible prescription abuse or misuse.

If you have additional questions regarding the Pharmacy Home program, please feel free to contact us at rxhomeprogram@anthem.com, or fax: (855) 212-1249.

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

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit 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 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 receive enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway. The Program is administered by AIM, a separate company.

Effective August 1, 2016, Anthem added the following cancer treatment Pathways to the Cancer Care Quality Program:

- Classical Hodgkin Lymphoma
- Mantle Cell Lymphoma
- Colorectal Cancer
 - FOLFOXIRI plus bevacizumab will be added to 1st or 2nd line therapy
 - Trifluridine/tipiracil will be added to 3rd line therapy

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

- Colorectal Cancer
 - Regorafenib will be removed from 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 CancerCareQualityProgram.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.

Commercial HEDIS 2016: Provider incentive winners

We have completed the HEDIS data collection for 2016 and want to thank all of the provider offices and their staff who assisted us. For the fifth year, our incentive program acknowledges some of the providers who either responded in a timely manner or went "Above & Beyond" to help make our HEDIS data collection successful. Any practices that responded within five business days of our initial request or took additional steps to help us with data collection were entered in a drawing to receive a gift. In the event an office was not able to accept a tangible gift, a special written recognition was given. We are pleased to announce the following incentive winners:

Fax/Mail Drawing

Indiana

Clown Pediatrics PC
Columbus Internal Medicine
Howard County Health Department
Jonathan Alley D.O. PC
Methodist Physicians Group

Kentucky

Family Practice Clinic PSC
Nephrology Associates of Kentuckiana Ps
Pikeville Medical Center ROI
Robert G. Drake MD
Three Rivers Immediate Care

Missouri

BJC Medical Group at St Peters
Doctors Clinical Group Inc.
Gateway Womens Health Obgyn
Prevention First LLC
Salem Memorial District Hospital Emr

Ohio

City of Ironton Health Department
New Beginnings Peds
Richard J. Koletsky MD
Stark County Medical Group Inc.
Vandalia Family Care

Wisconsin

Allegiance Internal Medicine Specialists Sc
Clifford R. Poplar, MD
Family Care of The Fox Cities Sc
Ministry Medical Group
Physicians of Obstetrics and Gynecology Ltd.

Above & Beyond

Indiana

Northpoint Pediatrics
Parkview Physicians Group

Kentucky

Norton Healthcare

Missouri

CoxHealth
SSM Physicians Organization
University of Missouri
Womens Health Associates

Ohio

Central Ohio Primary Care
Christ Hospital Physicians
Cleveland Clinic Foundation

Wisconsin

Affinity Medical Group
Aspirius
Bellin Health
Eye Care Specialists
Marshfield Clinic
Wheaton

Thanks again to all of the provider offices and their staff who assisted us in collecting HEDIS data. Your collaboration in this process allows us to achieve the best HEDIS results possible and our HEDIS results reflect the care you provide to our members. An overview of our HEDIS rates will be published in the fourth quarter. In addition more information on HEDIS can be found online at www.anthem.com > Providers (enter State)>Health & Wellness > Quality Improvement and Standards. Scroll to [HEDIS Information](#).

We look forward to working with you next HEDIS season!

HEDIS spotlight: Appropriate antibiotic use

Antibiotic stewardship has been identified as a national priority. The first known superbug, or bacterial infection that is resistant to antibiotics of last resort, was recently discovered in the United States. The Center for Disease Control (CDC) estimates that drug resistant bacteria cause two million illnesses and 23,000 deaths annually. Studies indicate that up to 50% of antibiotic use is either unnecessary or inappropriate across all types of health care settings (Dellit, Timothy H., et al. "Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America Guidelines for Developing an Institutional Program to Enhance Antimicrobial Stewardship." Clinical Infectious Diseases. January 15, 2007; 44: p 159-177.). Misuse occurs for a variety of reasons including the use of antibiotics when they aren't needed or clinically indicated; continuing treatment when it is no longer needed; the wrong dose of the antibiotic; the use of a broad-spectrum antibiotic to treat a susceptible agent; and, the use of the wrong antibiotic to treat the infection. In 2011, a national survey found that 60% of infectious disease physicians had seen a pan-resistant, untreatable infection in the last year (Spellberg, Brad and David N. Gilbert. "The Future of Antibiotics and Resistance: A Tribute to a Career of Leadership by John Barlett." Clinical Infectious Diseases. October 15, 2014; 59 (Supplement 2): p S71-S75.). *Inappropriate antibiotic use adversely impacts patients and society and is leading to a pandemic of antimicrobial resistance.*

To further underscore the focus on prescribing and using antibiotics appropriately, the National Committee for Quality Assurance (NCQA) has identified three Health Effectiveness Data and Information Set (HEDIS) measures around antibiotic use:

- Children (2 to 18 years) who present with *Pharyngitis* who are first given a group A streptococcus (strep) test and then appropriately receive an antibiotic.
- Children (3 months to 18 years) with a diagnosis of *Upper Respiratory Infection* who are not given an antibiotic prescription.
- Adults with a diagnosis of *Acute Bronchitis* who are not given an antibiotic prescription.

The ratings for each of these metrics are determined by claims data only. And, it only takes one time of an antibiotic being inappropriately prescribed (and filled) in the one year measurement period to lower the scores.

In an effort to help slow the emergence of antibiotic resistant bacteria and prevent the spread of antibiotic resistant infections, please **commit** to the following actions:

- **Avoid prescribing antibiotics inappropriately.** Write a prescription for symptom relief instead of an antibiotic and educate patients on comfort measures that may work without antibiotics.
- **Communicate with patients.** Discuss realistic expectations for recovery time, explain that antibiotics do not significantly reduce the duration of symptoms, and that unnecessary use of antibiotics may cause adverse effects that lead to antibiotic resistance.
- **Test for bacterial infections.** If a child presents with a sore throat, do a strep test and prescribe accordingly. Don't send a script home with the patient "just in case," but rather offer to call it in if the test comes back positive.
- **Code claims correctly and accurately.** If your patient has comorbidities, bacterial infections, or competing diagnoses, the standard codes for adults with acute bronchitis (AAB) and upper respiratory infection (URI) may not be applicable. Ensure proper documentation is in the medical record and use correct diagnosis and procedure codes on claim/encounter.

See below for some additional resources:

- Anthem one-minute video: www.anthem.com/cold
- Choosing Wisely—www.choosingwisely.org: [5 Patient Questions to ask Before Taking Antibiotics and Antibiotics: When you Need them and When you Don't in English](#) and [Antibiotics: When you Need them and When you Don't in Spanish](#)
- AWARE program materials-- [Physician-Patient Resources in English and Spanish](#)
- CDC “Get Smart about Antibiotics”-- [Patient and Provider Materials and References including Clinical Guidelines](#)
- [National Quality Forum Antibiotic Stewardship in Acute Care: A Practical Playbook](#)
- [CDC Core Elements of Hospital Antibiotic Stewardship Programs](#)

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

Professional reimbursement policies

Anthem reviews its professional reimbursement policies annually to determine if changes or revisions are required. See below for clarification and detail of recent changes.

After Hours, Emergency, and Miscellaneous E/M Services and Place of Service

We have updated our policies dated June 1, 2016 to reflect that after hours Current Procedural Terminology (CPT®) codes 99050 and 99051 may be eligible for separate reimbursement when reported with an urgent care place of service (place of service code “20”) in addition to an office place of service (place of service code “11”).

Durable Medical Equipment (DME) and modifier rules

Healthcare Common Procedure Coding Systems (HCPCS Level II) modifier EX was developed by CMS to allow suppliers to bill Medicare for purchased only DMEPOS items that are furnished to expatriate beneficiaries (those patients whose residence is outside the United States) while the beneficiary was in the United States. Suppliers should submit these claims based on their supplier locality, not based on the beneficiary address. By attaching the EX modifier to DMEPOS codes, the supplier is attesting that the patient is an expatriate beneficiary and that the DMEPOS was delivered/furnished while the patient was present in the U.S., and all other billing criteria has been met. For claims processed on or after August 22, 2016, our claims systems will accept modifier EX when appended to all lines for submitted expatriate beneficiary DME claims.

In addition, we are updating language under our *Purchase and Rent to Purchase (P/RTP)* section of our DME policy to clarify information regarding our 10 month rental limit guidelines.

We added the following to our policy July 1, 2016: Modifiers BP (patient has been informed of the purchase and rental options and has elected to purchase the item), BR (patient has been informed of the purchase and rental options and has elected to rent the item), KI (DMEPOS item, 2nd or 3rd month rental), KR (Rental item, billing for partial month) and LL (Lease/Rental (Used when DME equipment rental is to be applied against the purchase price).

We corrected information in our policies for DME modifier NR dated July 1, 2016. Modifier NR was identified as a DME rental modifier in error. Modifier NR is a DME purchase modifier and is included in any DME purchase modifier edits that were effective for dates of service on or after July 1, 2016.

Frequency Editing

Taking guidance from CMS's Medically Unlikely Edits (MUEs), we are adding a limit of 4 units per date of service for CPT code 86160 (complement; antigen, each component) when reported by the same provider for the same patient. This limit will be applied to claims processed on or after August 22, 2016. Modifiers will not override this frequency limit.

Injection and Infusion

In our policy dated August 1, 2016, we have added CPT codes 99601 and 99602 (home infusion/specialty drug administration) to document our current edit that supplies are not eligible for separate reimbursement when reported with these home infusion services. The revisions do not change the policy position or criteria.

Laboratory and Venipuncture Services and Modifier Rules

In our policies dated August 22, 2016, we are removing information that modifier 91 (repeat clinical diagnostic laboratory test) will override frequency limits for drug screen testing. Our *Frequency Editing* reimbursement policy currently documents that modifiers will not override frequency limits identified in the policy, including but not limited to, drug screen testing.

Modifiers 59 and XE, XP, XS, & XU (Distinct Procedural/Separate/Unusual Service)

For claims processed on or after August 22, 2016, we are updating language under the "Exceptions" section of our policy to reflect that when the denial of a code is supported by CPT parenthetical language that indicates a code is not reportable "with" specific other code(s) (e.g., do not report xxxxx with yyyy...), modifiers will not override the denial.

Modifier Rules

On January 1, 2016, a new modifier, "CT," was established by CMS. According to the HCPCS definition, the CT modifier must be used when reporting diagnostic computed tomography services that are rendered using equipment that does not meet each of the four attributes of the National Electrical Manufacturers' Association (NEMA) xr-29-2013 standard.

Taking guidance from CMS, we will apply a 5% reduction for dates of service beginning November 1, 2016 through December 31, 2016 and a 15% reduction for dates of service on or after January 1, 2017 to the technical component of diagnostic computed tomography services for the head/brain, abdomen, pelvis, upper extremity, lower extremity, etc. in the following code ranges and any succeeding codes: 70450-70498, 71250-71275, 72125-72133, 72191-72194, 73200-73206, 73700-73706, 74150-74178, 74261-74263, and 75571-75574.

Physician Extender

Anthem will move to Administrative Policies for any local or regional professional reimbursement policy and procedure. For additional information, please refer to the Physician Extenders Professional Administrative Policy

available on MyAnthemSM; access via the Availity Web Portal under My Payer Portals. (Note: This message was sent on July 1, 2016 to Wisconsin providers via a [Network eUPDATE](#).)

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 08/01/2016.

- Drug Screen Testing
- Three-Dimensional (3D) Radiology Services

Coding tip: low dose Computed Tomography lung cancer screening

All In January 2016, CMS published new Healthcare Common Procedure Coding Systems (HCPCS Level II) code G0297 for low dose computed tomography (LDCT) lung cancer screening as a replacement for the temporary “S” code S8032 (low dose computed tomography for lung cancer screening) . Based on the new “G” code, which we have accepted as of the effective date of the code, we are adding temporary “S” code S8032 to our always bundled edit for claims with dates of service on or after August 22, 2016.

OH: Medically necessary OB ultrasounds during pregnancy

In a *Network eUPDATE* distributed on June 30, 2016, providers in Ohio were notified that no more than two ultrasounds are medically necessary during a routine low-risk pregnancy and according to the provider agreement, providers are not permitted to bill Anthem members for non-medically necessary ultrasounds. For more information, see the *Network eUPDATE* [here](#).

WI: Reimbursement for physician extenders

Effective October 1, 2016, for commercial business, Wisconsin will reimburse Physician Extenders (Physician Assistants (PA), Nurse Practitioners (NP) and Nurse Midwives (NM)) the same as Medicare Advantage business: 85% of the charge for services listed in the Central Region's applicable provider fee schedule. For more information, see our *Network eUPDATE* [here](#).

View Anthem reimbursement policies

To view Anthem's reimbursement policies, sign onto the Availity Web Portal at [availity.com](#). From the Availity Home page, select More, then Provider Portal (Anthem). Click the Administrative Support tab, then the link labeled **Procedures for Professional Reimbursement** or **Procedures for Facility Reimbursement**.

(Note: To view online reimbursement policies, you must be registered for access to Availity.)

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

Specialty Services: Behavioral Health

Appointment access

Your contract with Anthem requires that your practice provide our members with timely access to care. To assess how well practices are meeting this provision, Anthem performs an annual access assessment of Behavioral Health prescribers and non-prescribers. As a part of this assessment, your practice may receive a call from North American Testing Organization, a vendor in California working on Anthem’s behalf. To be compliant, your practice must offer access within Anthem’s timelines as outlined below. Please verify that your staff is familiar with these timelines.

Note: Anthem may use prescribing nurse practitioners for availability as licensed independent practitioners, if they are in the scope of credentialing. These same professionals will be included in the access assessment.

BH Appointment Type	Compliance
<p>Emergency Care</p>	<p><u>24/7 access</u> <i>Immediate access at a facility, ER, 911 or Crisis Center, as appropriate.</i></p>
<p>Non-life threatening Emergent appointment - Members under acute distress, whose ability to conduct themselves for their own safety, or the safety of others, may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Situation has the potential to escalate into an emergency without clinical intervention.</p>	<p><u>Within 6 hours</u></p> <ul style="list-style-type: none"> ▪ <i>Patient can be seen in the office by their BH Practitioner, another participating Practitioner in the practice or a covering Practitioner; or</i> ▪ <i>Patient directed to 911, ER or 24 hour crisis services, as appropriate.</i>
<p>Urgent Care appointment - Non-emergent care with significant psychological distress and symptoms. Calls are urgent when the severity or nature of presenting symptoms is intolerable but not life threatening to the member.</p>	<p><u>Within 48 hours</u> (except MO -- 24 hours)</p> <ul style="list-style-type: none"> ▪ <i>Patient can be seen in the office by their BH Practitioner, another participating Practitioner in the practice or a covering Practitioner; or</i> ▪ <i>Patient directed to 911, ER or 24 hour crisis services, as appropriate.</i>

<p>Routine initial appointment - New patient non-urgent appointment.</p>	<p><u>Within 10 business days -</u> <i>New patient can be seen in the office by a BH Practitioner within the timeframe.</i> (After the intake assessment.)</p>
<p>Routine follow-up appointment – New or existing patient: Evaluation of progress or members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.</p>	<p><u>Within 30 calendar days -</u> <i>Patient can be seen in the office by their BH Practitioner, another participating Practitioner in the practice or a covering Practitioner within the timeframe.</i></p>
<p>(MO only) Routine appointment - Non-urgent appointment, <i>with</i> symptoms</p>	<p><u>Within 5 business days -</u> <i>Patient can be seen in the office by their BH Practitioner, another participating Practitioner in the practice or a covering Practitioner within the same timeframe.</i></p>
<p>After Hours Urgent Access – Contacting BH Practitioners for emergency & urgent instructions.</p>	<p><u>24X7 phone access -</u></p> <ul style="list-style-type: none"> ▪ <i>Recording or live person refers patient to ER/911/ 24-hour crisis services;</i> ▪ <i>Caller is directed to contact a BH professional (via cell, pager, beeper, transfer system) or get a call back for instructions or consultation.</i> <p>060116</p>

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

Medicaid Notifications

For IN/KY/WI Medicaid

Routine cervical cancer screening

We recently communicated with you regarding cervical cancer screening coverage for women younger than 21 years of age. The following provides new coverage information on the frequency of cervical cancer screening of women at average risk. It does not address women with a history of prior abnormal results, pre-cancerous cervical lesions, cervical cancer or those who are immunocompromised.

As previously communicated, routine screening pap testing will not be reimbursed for women younger than 21 years of age. In addition, effective **October 30, 2016**, routine screening frequency for women age 21 to 65 will be reimbursed no more frequently than once every three years. Also, reimbursement for routine pap testing for women 66 and older, with prior negative screening results, will be denied.

The U.S. Preventive Services Task Force¹, the American College of Obstetricians and Gynecologists², the American Cancer Society³, the American Society for Colposcopy and Cervical Pathology and the American Society for Clinical Pathology all agree that the optimal screening interval is not more frequently than every three years.

Population	Recommended screening
Women younger than 21 years	No screening
Women aged 21-29 years	Cervical pap alone every three years
Women aged 30-65 years	Human papillomavirus (HPV) and Cervical pap co-testing every five years or Cervical pap alone every three years
Women older than 65 years	No screening is necessary after adequate negative prior screening results
Women who underwent total hysterectomy (with no residual cervix).	No screening is necessary

We encourage you to adopt this medical society and industry recommendation in the interest of improving patient quality and reducing harm from unnecessary follow up.

1. United States Preventive Services Task Force. Cervical Cancer. March 2012.
2. American College of Obstetricians and Gynecologists. Practice Bulletin Number 157: Screening for Cervical Cancer. Obstet Gynecol. 2016; 127:e1-20.
3. Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin 2012; 62:147-72.

For IN/WI Medicaid only

Vascular embolization or occlusion services to require prior authorization

Effective September 1, 2016, Anthem Medicaid will require prior authorization (PA) for vascular embolization or occlusion services. Please refer to the provider self-service tool at <https://mediproviders.anthem.com/wj> for more information on authorization requirements. You may request PA by phone: 855-558-1443 or fax: 800-964-3627. If you have questions about this communication or need assistance with any other item, please call Provider Services at 855-558-1443.

For IN Medicaid only

Durable Medical Equipment (Rent to Purchase)

(Policy 06-052, effective 01/01/2017)

Anthem Medicaid allows reimbursement for Durable Medical Equipment (DME). Reimbursement is based on the rental price up to the maximum allowed of the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 15 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances affecting rental reimbursement:

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days.
- If a member changes suppliers during the rental period, a new rental period will not start over.

NOTE: Oxygen and oxygen equipment are not considered capped rental items and have no reimbursement limit. For additional information, refer to Durable Medical Equipment (Rent to Purchase) policy at www.anthem.com/inmedicaidoc.

DME Modifiers for New, Rented and Used Equipment

(Policy 06-053, effective 3/14/16)

Anthem Medicaid allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For more information, refer to the DME Modifiers for New, Rented and Used Equipment reimbursement policy at www.anthem.com/inmedicaidoc.

Reimbursement for Maximum Units per Day

(Policy 15-003, effective 01/01/2017)

Anthem Medicaid allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

Refer to the Reimbursement for Maximum Units per Day reimbursement policy at www.anthem.com/inmedicaidoc for additional information.

Advance practice nurses may now serve as primary medical providers

Advanced practice nurses (APNs) serving members in Hoosier Healthwise and Hoosier Care Connect will be reimbursed at 75% of the current Indiana Medicaid fee schedule for office visits. APNs serving members in the Healthy Indiana Plan will be reimbursed at 85% of the current Indiana Medicare fee schedule for office visits. For full details, please click [here](#), or go to www.anthem.com/Providers (select Indiana)/Network eUPDATES.

For KY Medicaid only

Durable Medical Equipment (Rent to Purchase)

(Policy 06-052, effective 01/01/2011)

Anthem Medicaid allows reimbursement for Durable Medical Equipment (DME). Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased after the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement period limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances affecting rental reimbursement:

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days.
- If a member changes suppliers during the rental period, a new rental period will not begin.

Anthem allows reimbursement for oxygen equipment for a maximum of 36 months; however, Anthem will continue to reimburse for oxygen contents.

For additional information, refer to Durable Medical Equipment (Rent to Purchase) policy at www.anthem.com/KYMedicaidDoc.

DME Modifiers for New, Rented and Used Equipment

(Policy 06-053, effective 3/14/16)

Anthem Medicaid allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For more information, refer to the DME Modifiers for New, Rented and Used Equipment reimbursement policy at www.anthem.com/KYMedicaidDoc.

Reimbursement for Maximum Units per Day

(Policy 15-003, effective 01/01/2017)

Anthem Medicaid allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

Refer to the Reimbursement for Maximum Units per Day reimbursement policy at www.Anthem.com/KYMedicaiddoc for additional information.

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For WI Medicaid only

Durable Medical Equipment (Rent to Purchase)

(Policy 06-052, effective 01/01/2017)

Anthem Medicaid allows reimbursement for Durable Medical Equipment (DME). Reimbursement is based on the rental price up to the maximum allowed for the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied.

Circumstances affecting rental reimbursement:

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days.
- If a member changes suppliers during the rental period, a new rental period will not start over.

Anthem allows reimbursement for oxygen equipment for a maximum of 36 months; however, Anthem will continue to reimburse for oxygen contents.

For additional information, refer to Durable Medical Equipment (Rent to Purchase) policy at www.anthem.com/WIMedicaidDoc.

DME Modifiers for New, Rented and Used Equipment

(Policy 06-053, effective 3/14/16)

Anthem Medicaid allows reimbursement for new and rented equipment when billed with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment

Anthem Medicaid does not reimburse durable medical equipment appended with modifier UE.

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For additional information, refer to the DME Modifiers for New, Rented and Used Equipment reimbursement policy at <https://mediproviders.anthem.com>.

Reimbursement for Maximum Units Per Day

(Policy 15-003, effective 01/01/17)

Anthem Medicaid allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

Refer to the Reimbursement for Maximum Units Per Day reimbursement policy at www.anthem.com/WIMedicaidDoc for additional information.