

Network Update

CENTRAL REGION

In this issue	Page
Health Care Reform (including Health Insurance Exchange)	
• Updates and notifications	3
Administrative Update	
• Transition now to Availity	4
• Anthem to launch Care and Cost Finder	4
• LiveHealth offers easy access to therapists and psychologists	4
• IN,KY,OH,WI: OrthoNet accepts PT/OT authorizations online	5
• A better way to manage specialty drugs	5
• Reminder: Provider Manuals posted online	6
• Use the Provider Maintenance Form to update your information	6
Claims	
• Home health agency Medicaid RAP and final claims	6
• Reminder: Point of Pickup ZIP Code for ambulance claims	6
Health Care Management	
• Medical policy/clinical guideline update	7
• Specialty pharmacy prior authorization requirements will expand	9
• AIM clinical appropriateness guidelines for advanced imaging	10
• Xiaflex	10
• Reminder: Specialty pharmacy level of care clinical reviews	10
• Reminder: Review of NOC oncology and biologic drugs	12
Medicare	
• Attend an AIM <i>OptiNet</i>® webinar	12
• Follow CMS guidelines for MA Part B immunization claims filing	12
• Use JW modifier when submitting claims for discarded drugs	13
• Medicare billing requirements for TAVR and TMVR	13
• Periodic audits to ensure CMS requirements are met	13
• Medicare Part D Comprehensive Medication Review	13
• Anthem follows CMS guidelines for DME customization	14
• Self-administered drugs should not be billed to MA members	14
• Precertification requirements updated for 2017	14
• Reminder: Reach a nurse directly for prior authorizations	14
• IN, KY, OH: Home health services to require prior authorization	14
• New ID cards for Medicare Supplement members	15

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IN, KY, MO, OH, WI

<ul style="list-style-type: none"> ◦ Keep up with MA news 	15
Pharmacy	
<ul style="list-style-type: none"> ◦ Anthem tightens prescription refill timing ◦ Anthem will not cover intranasal flu vaccine ◦ Pharmacy information available at anthem.com 	15 16 16
Quality	
<ul style="list-style-type: none"> ◦ HEDIS® spotlight: Comprehensive diabetes care ◦ Clinical practice and preventive health guidelines 	16 17
Reimbursement	
<ul style="list-style-type: none"> ◦ Professional reimbursement policy updates ◦ New: Anthem Audit Policy ◦ MO: Correction to reimbursement for credentialing RNFA's ◦ View Anthem reimbursement policies 	18 19 19 19
Medicaid Notifications	
<ul style="list-style-type: none"> ◦ For IN only <ul style="list-style-type: none"> ◦ Guidelines for respiratory Syncytial Virus season ◦ Nondiscrimination and accessibility requirements update COB ◦ For KY only <ul style="list-style-type: none"> ◦ Guidelines for respiratory Syncytial Virus season ◦ New separate reimbursement for long-acting contraception devices ◦ Non-discrimination and accessibility requirements ◦ Reminder: Access and availability standards ◦ Coordination of benefits policy update ◦ For WI only <ul style="list-style-type: none"> ◦ Duplicate or subsequent services on the same date of service 	20 21 24

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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, the following articles were posted online:

Important information about billing habilitative and rehabilitative services (updated September 14, 2016)

In compliance with requirements of the Notice of Benefit and Payment Parameters for 2016 issued pursuant to the Affordable Care Act, Anthem Blue Cross and Blue Shield (Anthem) will apply separate and distinct benefit limits for habilitative and rehabilitative services for all individual and small group On-Exchange and Off-Exchange health plans beginning with dates of service on and after January 1, 2017.

This means these plans will no longer have a combined visit limit for habilitative and rehabilitative services. Habilitative services help a person keep, learn, or improve skills and functioning for daily living which have not (but normally would have) developed. Rehabilitative services help a person keep, restore, or improve skills and functioning for daily living which have been lost or impaired after an illness or injury, such as a car accident or stroke.

Beginning with dates of service on and after January 1, 2017, the appropriate use of the modifier SZ is necessary when billing habilitative services to Anthem. The SZ modifier was effective in 2014 and distinguishes between habilitative and rehabilitative services. Appropriate use of the modifier will help reduce claims issues and adjustments related to habilitative services. Please review your current coding practices as it relates to the use of modifier SZ and the billing of habilitative and rehabilitative services.

Ohio: Statewide expansion of HMO Exchange provider networks

The Health Insurance Marketplace (“exchanges”) commenced in 2014 and Anthem created new PPO networks to support those products sold on and off the exchanges in Ohio. In 2016, Ohio introduced a new HMO network to support products sold on and off the exchanges in select counties. Effective January 1, 2017, Ohio will expand the HMO Exchange networks statewide. The HMO Exchange networks are referred to as Pathway X HMO and Pathway HMO Networks. Providers that are part of the statewide expansion for the Ohio Exchange HMO networks received notice.

In most cases, members do **not** have Out of Network benefits for HMO products. To ensure the highest level of benefits and coordination of care for Anthem members and streamline the approval process for your office, it's important that you identify the appropriate member plan and refer members to in-network providers whenever possible. When you do, you will not need to contact Anthem for preapproval of those referrals unless the referral is for a service identified on the Blue Products Precertification List.

Additional information regarding ID Cards, Prefixes, etc. will be included in the December 2016 issue of *Network Update*.

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

Transition now to Availity

Effective October 14, 2016, the Availity Web Portal will be your exclusive source for valuable provider information, eliminating the need to access multiple portals. If you currently access MyAnthem for Provider, please prepare for the following changes:

- Effective October 14, 2016: The Professional Fee Schedule, Remittances and Reports via MyAnthem are accessible exclusively via the Availity Web Portal. This information will no longer be viewable on MyAnthem.
- Effective January 20, 2017: The MyAnthem for Provider portal will be permanently retired. All information will be available on the Availity Web Portal. This change will affect the MyAnthem secure site only. *Note: The public site at [anthem.com](#) will not be affected by this change. Electronic transactions submitted via our Enterprise EDI Gateway are also unaffected; you may continue to submit all X12 transactions through your current EDI transmission channels.*

Now is the time for Availity administrators to make sure that all of their organization's users are set up with the correct Availity access to ensure a smooth transition to the upcoming changes.

For questions please contact your local Anthem Network Relations consultant or Availity Client Services at 1-800-AVAILITY.

Anthem to launch Care and Cost Finder

We are pleased to update you on our strategic collaboration with Castlight Health. As we shared in late 2015, Anthem and Castlight have come together to co-develop a best-in-breed cost and quality transparency solution for Anthem's members. The first release will be launched to 27 early adopter clients in October followed by an additional 15 early adopters in January 2017. Both releases focus on large local groups and national clients. Care & Cost Finder will continue to be rolled out to Anthem's members through 2018. We will continue to share details and information as we scale Care & Cost Finder to our members.

LiveHealth offers easy access to therapists and psychologists

Launched in January of this year, LiveHealth Online Psychology is a convenient and easy way for members to use their smartphone, tablet or computer to connect one-on-one with a behavioral health provider. Through two-way video chat, members can interact with a therapist or psychologist, day or night, by appointment. Appointments are available within four days or less and the cost is the same as a regular in-person therapy office visit. The therapists available on LiveHealth Online Psychology can treat issues such as anxiety, depression, stress, grief and relationship issues. For new users, it's as simple as signing up with a name and email address. Originally available to adults, LiveHealth Online Psychology also launched its Teen edition in July, accessible by 10 to 17 year olds. To learn more, visit livehealthonline.com/psychology or call 1-844-784-8409.

IN, KY, MO, OH: OrthoNet now accepts PT/OT authorizations online

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 for its fully insured commercial members. This program requires that all outpatient and office based physical and occupational therapy services be authorized by OrthoNet following the initial evaluation. As indicated in previous communications, OrthoNet handles precertification requests for all local commercial Anthem members *except*: Medicaid, Medicare supplement, Medicare Part D, Federal Employee Program® (FEP®), BlueCard, and National Accounts. Medicare Advantage members are also managed by OrthoNet under a separate program segment.

As of August 2016, providers can set up an online account with OrthoNet that will allow them to submit precertification requests and check the status of their requests on the OrthoNet website. Providers can request an online account on the OrthoNet website by following the instructions below. *Please note: OrthoNet will continue to accept requests via fax (844-216-1599) or phone (844-282-6994).*

To request a New User Account via OrthoNet's website, www.orthonet-online.com:

- Go to www.orthonet-online.com
- Double click on the picture of the Providers.
- Click '+' next to **Anthem**
- Select **Anthem BlueCross BlueShield (Commercial)**
- Select **Your State**
- Under 'Web Portal Users' section, select **Account Request Form**

Once you have a New User Account, under the **Prior Authorization Submission and Status** box, select **Request Authorization or Check Status**. Regardless of how the precertification request was submitted (e.g. online, fax or phone), information about the status and determination of the precertification request will be available either online or via phone. *Note: Click the Web Portal [User Guide](#) for step by step instructions.*

For additional information, please access the *Frequently Asked Questions* on the OrthoNet Website.

Note for Wisconsin providers: Online precertification has been available for providers in Wisconsin since April 2016. Go [here](#) for more information.

A better way to manage specialty drugs

As specialty drugs become more widely used, we're looking for new ways to control costs while keeping members healthy. That's why we created our Right Drug Right Channel (RDRC) program.

Our Right Drug Right Channel programs ensure:

- **Better medication management** - Members are reminded about refills and have access to support programs through the specialty pharmacy provider.
- **Better cost management** - By placing drugs under the appropriate benefit.
- **Simplify access to medications** - RDRC simplifies which benefit the drug falls under based on how the medication is administered.

Effective January 1, 2017, certain self-administered medications will be covered under the member's pharmacy benefit and certain clinician administered medications will be covered under the member's medical benefit. This will depend on the member's benefit design. Providers can view the RDRC drug lists on anthem.com/pharmacy information.

If a member believes this change poses a hardship for them, he or she and/or the member's doctor can ask us to keep covering the drug(s) under the member's pharmacy benefit by submitting a request for an exception by calling

the number on the member's ID card.

Reminder: Provider manuals posted online

Anthem reviews and updates our online Provider Manuals annually. View your new version by clicking on your state: [Indiana](#), [Kentucky](#), [Ohio](#) and [Wisconsin](#). Or go to www.anthem.com>Providers (select state)>Communications>Publications. (Note: The most recent version of the [Missouri](#) Provider Manual is dated July 2015.)

Use the Provider Maintenance Form to update your information

We continually update our provider directories to help ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice – updating address and/or phone number, adding or deleting a physician from your practice, etc. -- please notify us by completing the Anthem Provider Maintenance [Form](#) at anthem.com. Thank you for your help and continued efforts to keep our records up to date.

Claims

Home health agency Medicaid RAP and final claims

Anthem will begin accepting Medicaid RAP (Request for Anticipated Payment) claims to process through BlueCard. Claims should be submitted to your local Blue Plan for processing as of October 17, 2016. The Medicaid RAP claims are in addition to Medicare Advantage (MA) claims which are processing through BlueCard today.

When billing on a RAP claim, providers are reminded to submit services with zero charges for MA and/or Medicaid. There is no longer the need to submit services as \$0.01.

For assistance on how to bill RAP claims, refer to the article, [Home Health Billing](#), found under Important Medicare Updates at anthem.com>Providers (enter state)Medicare Advantage. For more information on types of bills, revenue codes, etc. to be submitted for Home Health Agency RAP services, please click [here](#).

Reminder: Point of Pickup (POP) ZIP Code for ambulance claims

Providers are reminded of the need to pass the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) claims, both institutional outpatient and professional. These claims should be filed with the local Blue Plan in whose service area the Point of Pickup (POP) ZIP Code is located.

The POP (Point of Pick-up) ZIP Code should be submitted as follows:

- **Professional claims:** On CMS-1500 Form, POP ZIP Code is reported in item 23.
- **Institutional outpatient claims:** To report the ambulance POP ZIP Code, the Value Code of 'A0' (zero) and the related zip code of the geographic location from which the beneficiary was placed on board the ambulance should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes

Claims received after October 16, 2016 without the POP ZIP Code may be returned for this information and will delay claims processing.

Health Care Management

Medical policy/clinical guideline update

The following Anthem medical policies were reviewed on August 4, 2016 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These new policies and clinical guidelines will be implemented on January 1, 2017.

DME.00039 Prefabricated Oral Appliances for the Treatment of Obstructive Sleep Apnea.

This new medical policy addresses the use of prefabricated oral appliances for the treatment of obstructive sleep apnea (OSA).

DRUG.00087 Asfotase Alfa (Strensiq™)

This new medical policy addresses asfotase alfa (Strensiq), a tissue nonspecific alkaline phosphatase (TNSAP) recombinant isozyme developed to target underlying genetic causes of hypophosphatasia (HPP).

DRUG.00088 Atezolizumab (Tecentriq™)

This new medical policy addresses the use of atezolizumab (Tecentriq), an anti-programmed death ligand 1 (PD-L1) monoclonal antibody approved by the FDA for treatment of locally advanced or metastatic urothelial carcinoma under specific circumstances.

DRUG.00089 Daclizumab (Zinbryta™)

This new medical policy addresses the uses of subcutaneous daclizumab (Zinbryta), a humanized, monoclonal antibody used for the treatment of multiple sclerosis.

DRUG.00091 Naltrexone Implantable Pellets

This new medical policy addresses extended-release, implantable naltrexone.

DRUG.00092 Probuphine® (buprenorphine implant)

This new medical policy addresses the use of Probuphine, the first buprenorphine implant intended for maintenance treatment of opioid use disorder in individuals who have achieved and sustained prolonged clinical stability on low- to moderate-doses of buprenorphine.

DRUG.00093 Sebelipase alfa (KANUMA™)

This new medical policy addresses the use of sebelipase alfa (KANUMA), a hydrolytic lysosomal cholesteryl ester and triacylglycerol-specific enzyme administered intravenously for the treatment of the rare disease lysosomal acid lipase deficiency (LAL-D), also known as Wolman disease (WD) and cholesteryl ester storage disease (CESD).

GENE.00046 Prothrombin G20210A (Factor II) Mutation Testing

This new medical policy addresses prothrombin G20210A (factor II) mutation testing for the screening, diagnosis and management of prothrombin-related thrombophilia.

GENE.00047 Methylenetetrahydrofolate Reductase Mutation Testing

This new medical policy addresses methylenetetrahydrofolate reductase (MTHFR) gene mutation testing for the screening, diagnosis, and clinical management of a variety of diseases and disorders.

LAB.00032 Zika Virus Testing

This new medical policy addresses the current testing methods for Zika virus (ZIKV), a mosquito-borne flavivirus and member of the Flaviviridae family, which includes RNA real time reverse transcription-polymerase chain reaction (RT-PCR), immunoglobulin M (IgM) and the plaque reduction neutralization test (PRNT).

RAD.00066 Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy

This new medical policy addresses the use of a "fusion biopsy system" in which a multi-parametric prostate magnetic resonance image (mpMRI) is fused with real-time high definition prostate ultrasound images through the use of specialized equipment and software to target and biopsy areas suspicious for prostate cancer.

SURG.00144 Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia

This new medical policy addresses occipital nerve block (or blockade), as a therapy for treatment of headache syndromes.

Revisions to the following medical policies/clinical guidelines will be implemented on January 1, 2017:

ADMIN.00074 Immunizations

The revised medical policy added CPT 90672 and "Effective with the 2016-2017 influenza season, live attenuated influenza vaccine LAIV) is considered not medically necessary for all age groups."

DRUG.00015 Prevention of Respiratory Syncytial Virus Infections

The revised medical policy removed bronchodilator therapy as a medically necessary intervention in the second RSV season.

DRUG.00031 Subcutaneous Hormone Replacement Implants

The revised medical policy altered the medically necessary position statement to address the initiation of hormone replacement therapy with subcutaneous testosterone implants and added criteria for the treatment of males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism. It added medically necessary criteria for continuation of hormone replacement therapy with subcutaneous testosterone implants, medically necessary criteria for subcutaneous testosterone implants for treatment of delayed puberty, added medically necessary criteria for subcutaneous testosterone implants for transgender individuals, and revised the **Investigational and Not Medically Necessary** statement.

GENE.0026 Cell-Free-Fetal-DNA-Based Prenatal Testing

The revised medical policy added cell-free fetal DNA-based prenatal testing for fetal sex determination as medically necessary for singleton pregnancies at increased risk of a sex (X)-linked condition or congenital adrenal hyperplasia; added cell-free fetal DNA-based prenatal testing for fetal sex determination as **Not Medically Necessary** for pregnancies without an increased risk of a sex (X)-linked condition or congenital adrenal hyperplasia; added cell-free fetal DNA-based prenatal testing for fetal sex chromosome aneuploidies as **Investigational and Not Medically Necessary**; added cell-free fetal DNA-based prenatal testing for microdeletion syndromes as **Investigational and Not Medically Necessary**; and added cell-free fetal DNA-based prenatal testing as **Investigational and Not Medically Necessary** for all other uses. Code 81420 and NOC codes specified as cell-free DNA prenatal testing will now be reviewed for determination of medical necessity.

MED.00051 Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry

The revised medical policy includes a revised title; revised scope of document to include implantable ambulatory event monitors - criteria previously on CG-MED-40; addition of the use of implantable ambulatory event monitors as medically necessary for individuals who have a history of cryptogenic stroke and have had a previous non-diagnostic trial of external ambulatory event monitoring; addition of the use of mobile cardiac telemetry as medically necessary for individuals who have a history of cryptogenic stroke and have had a previous non-diagnostic trial of external ambulatory event monitoring. In addition, it revised **Investigational and Not Medically Necessary** language, added CPT and HCPCS codes 33282, 93285, E0616 for implantable monitors to be reviewed for medically necessary; and codes 93228, 93229 will now be reviewed for medically necessary (were considered **Investigational and Not Medically Necessary**).

SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions

The revised medical policy added transurethral convective water vapor thermal ablation as **Investigational and Not Medically Necessary** and acronyms to procedure names in **Investigational and Not Medically Necessary** section.

CG-SURG-53 Elective Total Hip Arthroplasty

The revised clinical UM guideline clarified that rheumatoid arthritis includes juvenile rheumatoid arthritis and revised medically necessary criteria addressing elective revision of a previous total hip arthroplasty or prior hip resurfacing.

CG-SURG-54 Elective Total Knee Arthroplasty

The revised clinical UM guideline clarified that rheumatoid arthritis includes juvenile rheumatoid arthritis; revised medically necessary clinical indications addressing elective revision of a total knee arthroplasty; and clarified "Note" addressing conservative therapy.

CG-SURG-27 Sex Reassignment Surgery

The revised clinical UM guideline added CPT 19303, 19304 and ICD-10-PCS 0HBV0ZZ, 0HBV3ZZ, 0HBV7ZZ, 0HBV8ZZ, 0HBVXZZ for mastectomy to be reviewed for medically necessary criteria; it also updated with ICD-10 diagnosis code F64.0.

Note: The complete list of our Medical Policies and Clinical UM Guidelines may be accessed online. Go to anthem.com>Provider (enter state)>Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements.

Specialty pharmacy prior authorization will expand

Anthem will expand the Specialty Pharmacy Prior Authorization list, effective January 1, 2017. See the chart on page 10 for specialty pharmacy codes from new or current Clinical UM Guidelines that will be added to our existing pre-service review process on that date. Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health®, a separate company administering the program on behalf of Anthem.

Medical Policy or Clinical Guideline (CG) number	DRUG code	Drug Names	Comments
CG-DRUG-49	Q2049	Lipodox	New Clinical UM Guideline
CG-DRUG-49	Q2050	Unspec code for doxorubicin hydrochloride liposomal	New Clinical UM Guideline
CG-DRUG-50	J9264	Abraxane	New Clinical UM Guideline
CG-DRUG-51	J9315	Isotodax	New Clinical UM Guideline
CG-DRUG-43	J2323	Tysabri	New Clinical UM Guideline
DRUG.00088	C9483	Tecentriq	New Medical Policy
DRUG.00087	J3490	Strensiq	New Medical Policy
DRUG.00089	J3490, J3590	Zinbryta	New Medical Policy
DRUG.00091	J3490, J7999	Naltrexone	New Medical Policy
DRUG.00092	J3490	Probuphine	New Medical Policy
DRUG.00093	J3490	KANUMA	New Medical Policy

AIM clinical appropriateness guidelines for advanced imaging

Effective February 18, 2017, the following changes to AIM Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

Oncologic imaging (CT, MRI and PET)

- Enhanced criteria around surveillance following completion of therapy for colorectal cancer.
- Updated criteria for appropriate use of imaging studies in the management of prostate cancer and breast cancer.
- New guidelines for appropriate use of multiparametric MRI in the diagnosis of prostate cancer

Breast MRI

- Enhanced criteria for appropriateness of MRI in DCIS, atypical ductal hyperplasia, and follow up imaging of BIRADs 3 studies.

Abdominal and pelvic imaging (CT and MRI)

- Updated criteria for appropriateness of imaging in inflammatory bowel disease.
- Guidelines for follow up of incidental liver lesions utilizing advanced imaging.
- Enhanced criteria for imaging in chronic abdominal pain and nephrolithiasis

Xiaflex

As a reminder, AIM provides pre-service review for CG DRUG-27, Clostridial Collagenase Histolyticum Injection or "Xiaflex". Anthem recently expanded the medically necessary indications for use of Xiaflex to include Peyronie's disease when criteria are met. Please reference CG DRUG-27 for more information.

Reminder: Specialty Pharmacy level of care clinical reviews began July 18

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. Additionally, in early July, Anthem notified providers via email that the implementation of level of care clinical reviews for specialty pharmacy infusions and injections would begin with dates of service on and after July 18, 2016. In this edition of *Network Update*, we are sharing these details again, as a reminder and for easy reference.

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

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

Anthem recognizes that most members prefer to receive their infusion or injection therapy in their physician's office, Ambulatory Infusion Suite (AIS) or at home by a licensed Home Infusion Therapy (HIT) Provider. This is more convenient for the member, may result in lower member financial responsibility and, in many cases, is a clinically appropriate setting.

There may be clinical circumstances that require a patient to receive infusions or injections in a hospital outpatient facility. Therefore, beginning with dates of service on and after July 18, 2016, Anthem expanded the Specialty Pharmacy program to include a review of the requested level of care. The clinical guideline **Level of Care: Specialty Pharmaceuticals CG-DRUG-47** applies to the review process beginning with dates of service on and after July 18, 2016.

The expanded program continues to be administered by AIM, and based on the information you provide, AIM reviews the drug for both clinical appropriateness and the level of care against health plan clinical criteria. The level of care review does not apply to requests for the review of drugs prescribed for oncology, hemophilia, or end stage renal disease drug indications. Physician offices that currently administer specialty drugs in the office setting were not impacted by this change.

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

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

For more information on how to access online authorizations via Availity, reference our [Quick Reference Guide to AIM Specialty Health](#).

For dates of service on and after July 18, 2016

- When providers select a hospital-based outpatient facility as the level of care, a list of alternate locations, such as Ambulatory Infusion Suites and Home Infusion Providers, is made available. Medical specialty pharmacy providers are also be listed as an alternate option to supply the infusion medication to physician offices who can administer it to the member. (See below to learn how to register as an alternate level of care location.)
- If an alternate level of care is not selected, providers are prompted to indicate the reason hospital-based level of care is medically necessary.
- If a request for hospital-based level of care does not meet medical necessity criteria upon review by a physician reviewer, the request will not be approved. We encourage you to discuss with members the alternate level of care options, such as physician office, infusion center or home infusion therapy.

The expanded program applies to local Anthem members who have specialty pharmacy services medically managed by AIM Specialty Health. The expanded program does not apply to the following plans: BlueCard, Medicare Advantage, Medicaid, Medicare Supplement, and Federal Employee Program® (FEP®).

For more information, including a [list of drugs](#) that will be reviewed for level of care, go to www.aimprovider.com/specialtyrx. You may also view our list of [frequently asked questions](#) at www.anthem.com>Providers (enter state)>Precertification>Specialty Pharmacy Program Expansion - Level of Care Review FAQs.

Register as an alternate level of care location

Beginning October 23, 2016, Ambulatory Infusion Suites, Home Infusion Providers, and other eligible provider locations can visit www.aimprovider.com/specialtyrx/optinet to register with AIM to be included as an alternate location for the administration of specialty drugs. Registration will require only three pieces of information—your practice's place of service type (e.g., Ambulatory Infusion Suite), the drugs your practice administers, and your coverage area. Additionally, providers can access an interactive training module and other helpful registration materials on the site.

Reminder: Review of NOC oncology and biologic drugs

This is a reminder that effective November 1, 2016, Anthem in partnership with AIM will expand pre-service review to the medical necessity of coverage requests for all not otherwise classified "NOC" oncology and biologic drugs. Pre-service clinical review will be based on specific medical policy or clinical guideline when available. In instances where a specific policy or guideline is unavailable, then Clinical Guideline CG-DRUG-01, Off-Label Drug and Approved Orphan Drug Use, will be used for HCPC codes J9999 and J3590. If the drug is not reviewed pre-service, then Anthem will conduct a post-service review based on the same clinical criteria and may request records as part of that review. This pre-service clinical review program will apply to our Commercial, local ASO, National Accounts and Medicare Advantage members. Please contact 800-676-BLUE (2583) to verify any pre-service review recommendations or requirements for BlueCard business.

Ordering physicians may submit a request for services on or after **November 1, 2016**, to AIM through the AIM [ProviderPortal](#) (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, 8:30 a.m.–7:00 p.m. ET.

Medicare

Attend an AIM OptiNet webinar

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. To learn how to complete your survey, attend a webinar and find out 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.

For more information and to register for one of the upcoming webinars, go [here](#). Or check [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider.

Follow CMS guidelines for MA Part B immunization claims filing

Anthem follows the Centers for Medicare & Medicaid Services (CMS) [Medicare Part B Immunization Billing](#) guidelines. Please use the following forms when filing flu, pneumonia or Hepatitis B claims for Anthem individual and group-sponsored Medicare Advantage members.

- Professional claims should be filed on the CMS 1500 form with the appropriate Current Procedural Terminology code and/or Health Care Procedural Code for the vaccine and administration.
- Institutional claims should be filed on the UB04 form with the appropriate revenue codes:
 - 0636 – vaccine (and CPT or HCPC)
 - 0771 – administration (and HCPC)
 - Rural Health Clinics and Federally Qualified Health Clinics should use the 052X revenue code series

Please refer to Institutional Providers: Additional Billing Information section of the [Medicare Part B Immunization Billing Guide](#) for specifics on institutional billing.

Use JW modifier when submitting claims for discarded drugs

Effective January 1, 2017, Anthem will follow the CMS requirement for contracted and non-contracted providers to:

- Use the JW modifier for claims with unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded (except those provided under the Competitive Acquisition Program (CAP) for Part B drugs and biologicals).
- Document the discarded drug or biological in the patient's medical record when submitting claims with unused Part B drugs or biologicals from single use-vials or single-use packages that are appropriately discarded.

Medicare billing requirements for TAVR and TMVR

When an individual or group-sponsored Medicare Advantage (MA) plan participant receives inpatient transcatheter aortic valve replacement (TAVR) or transcatheter mitral valve repair (TMVR) surgery, the MA plan is responsible for paying the claim. All other clinical trial related services to MA members must continue to be submitted to Original Medicare for processing. Coding information and [additional details](#) can be found at www.anthem.com/medicareprovider under [Important Medicare Advantage Updates](#).

Periodic audits to ensure CMS requirements are met

CMS requires providers to notify every Medicare beneficiary (including MA members) of their discharge appeal rights using the Notice of Medicare Non-Coverage (NOMNC) for skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities, and the Important Message from Medicare About Your Rights (IM) for inpatient hospitals. Providers must obtain the signature of the beneficiary or representative to indicate that the beneficiary/representative received and understood the notice.

To help providers meet CMS requirements, Anthem periodically conducts IM and NOMNC audits to proactively identify opportunities for improvement. We make recommendations and work with providers to improve processes and compliance with CMS requirements. [Additional details](#) can be found at www.anthem.com/medicareprovider under [Important Medicare Advantage Updates](#).

Medicare Part D Comprehensive Medication Review

CMS requires that plans with Medicare Part D benefits offer a Comprehensive Medication Review (CMR) as part of the Medication Therapy Management (MTM) program. A CMR is offered to members who have three or more chronic diseases and who are receiving eight or more maintenance medications. Anthem will contact our qualifying individual and group-sponsored Medicare Part D members to complete the interactive consultation. The CMR consists of a consultation followed by a written medication summary to help educate and support provider recommendations for medication adherence. Please ask these members if they have received a letter or postcard inviting them to participate in a Medication Review.

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

Anthem follows CMS guidelines for DME customization

Anthem MA programs follow CMS regulations and guidelines for durable medical equipment (DME). Anthem has noticed an increase in authorization requests for customized items, including wheelchairs. CMS has a high threshold for what it considers a reimbursable customized DME item.

Items that are measured, assembled, fitted or adapted in consideration of a patient's body size, weight, disability, period of need, or intended use (i.e., custom fitted items) or have been assembled by a supplier or ordered from a manufacturer who makes available customized features, modification, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician **do not meet the definition of customized items**. These items are not uniquely constructed or substantially modified and can be grouped with other items for pricing purposes.

To learn more please see [IOM CMS Publication, 100-04, Chapter 20, Section 30.3](#).

Self-administered drugs should not be billed to MA members

In accordance with CMS regulations, Anthem Medicare Advantage plans pay for drugs that usually are considered self-administered by the patient when such drugs are an integral component of a covered procedure or are directly related to a covered procedure. In these situations, the hospital may NOT bill the member for these types of drugs. The drugs, whether coded or uncoded with their charges, must be reported under the appropriate revenue code (cost center under which the hospital accumulates the costs for the drugs).

In situations where the member needs a prescription for medication to be used at home following the outpatient treatment, physicians and practitioners are encouraged to give written or electronic prescriptions to members rather than supplying the drug from the hospital pharmacy. [Additional details](#) can be found at www.anthem.com/medicareprovider under [Important Medicare Advantage Updates](#).

Precertification requirements updated for 2017

Please refer to your provider agreement, Medicare Advantage HMO & PPO Provider Guidebook/ Provider Manual and the [Medicare Advantage Precertification Guidelines](#) found at the [Medical Policy, UM Guidelines and Precertification Requirements](#) link on the Anthem provider home page at anthem.com for further information on existing precertification requirements and new precertification requirements for 2017. Non-contracted providers should contact the Health Plan.

Reminder: Reach a nurse directly for prior authorizations that require clinical review

Providers can speak to a nurse directly to request a prior authorization requiring clinical review for individual Medicare Advantage members. Just call the number on the back of member ID card, select "provider" when prompted and then select "precertification" to obtain prior authorization of services authorized by Anthem. For more details, please refer to the August 2016 issue of *Network Update*.

IN, KY, OH: Home health services to require prior authorization

Effective January 1, 2017, Anthem will require prior authorization of home health services for our individual Medicare Advantage members, including:

- Skilled Nursing
- Home Health Aide
- Therapies (Physical Therapy, Occupational Therapy and Speech Therapy)
- Medical Social Worker

Beginning December 19, 2016, prior authorizations can be obtained via fax, phone or portal:

Fax: 1-844-834-2908

Phone: 1-844-411-9622

Portal: Initiate a prior authorization request at <https://portal.mynexuscare.com/>

Additional details can be found at www.anthem.com/medicareprovider under [Important Medicare Advantage Updates](#) or <https://www.mynexuscare.com/anthem/>.

61516MUPENMUB 08/03/2016

New ID cards for Medicare Supplement members December 1, 2016

Anthem Medicare Supplement individual members will receive new member ID cards beginning December 1, 2016. Please obtain a copy of the new member ID cards to file claims for dates of service December 1, 2016 and beyond. Further information will be available in the spotlight section of the [provider home page](#) and at the “Answers @ Anthem” tab at the top of the Anthem provider home page.

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:

[Reimbursement policy bulletin](#)

[Prior Authorization Requirements for Elective One and Two Coronary Artery Bypass Graft](#)

[Prior Authorization for New Injectable/Infusible: Textentrig](#)

[Prior Authorization Requirements for new Injectable/Infusible Drugs: Darzalex and Empliciti](#)

[Prior Authorization Requirements for new Injectable/Infusible Drugs: Istodax, Ixempra, and Taltz](#)

[Prior Authorization Requirements for Inflectra and Cinqair](#)

[Hospital Observation Service Limits](#)

[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](#)

[Enhancements to AIM Clinical Appropriateness Guidelines for Advanced Imaging Effective November 1, 2016](#)

61516MUPENMUB 08/03/2016

Pharmacy

Anthem tightens prescription refill timing

In an effort to reduce medication waste and encourage medication dosage compliance, Anthem is updating the system logic that determines the date on which a member can refill a prescription.¹ This change will require members to refill their prescriptions closer to when their current supply ends; however, members should still have enough medication supply on hand to last until their next refill is allowed.

As always, it is important to prescribe medications with the appropriate quantity and directions so that the member has enough medication to last for the duration of each prescription fill. To provide clarity for the patient and the pharmacy, prescribers can take the following steps:

- If the dosage of a medication has changed since the initial prescription was written, a new prescription should be written for the patient, with the new directions clearly indicated.
- For as directed or as needed (PRN) prescriptions, try to be as clear as possible on your intentions for how long a prescription should last. For example, consider providing explicit directions such as: Use as directed for 15 days, or Take as needed for 30 days.²
- Prescriptions for oral contraceptives should clearly indicate when a member is not taking the inactive tablets. The table below includes examples² of how prescriptions for oral contraceptives should be written:

Quantity	Directions
28 (1 pack)	If patient only taking active tabs, directions should be: 1 tab daily x 21 days, skip the last week and start new packet on day 22.
84 (3 packs)	If patient only taking active tabs, directions should be: 1 tab daily x 21 days, skip the last week and start new packet on day 22.
21 (1 pack)	1 tab daily
63 (3 packs)	1 tab daily
28 (1 pack)	If patient taking all tabs, directions should be: 1 tab daily x 28 days.
84 (3 packs)	If patient taking all tabs, directions should be: 1 tab daily x 28 days.

¹ The new system logic requires that members use at least 75% of a prescription dispensed by Home Delivery (mail order) and 85% of a prescription dispensed by a retail pharmacy before a refill of the same medication is allowed.

² Examples are for illustrative purposes only. The prescriber must determine which directions are most appropriate for the medication prescribed.

Anthem will not cover intranasal flu vaccine for the upcoming 2016-2017 flu season

The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) has released interim recommendations that live attenuated influenza vaccine (given by intranasal spray) should not be used for the upcoming 2016-2017 flu season. For more information, go [here](#) to see the Network eUPDATE that was distributed in August. Or go online to [anthem.com>Providers \(enter state\)>Network eUPDATE](#).

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® (FEP®) 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: Comprehensive diabetes care

About 29.1 million people (about 1 in 11 people) in the United States have diabetes. In 2012, the American

Diabetes Association (ADA) reported that diabetes care cost \$245 billion, with \$69 billion attributed to a reduction in productivity as a result of diabetes.

Due to the complexity of this disease, health plans collect data for diabetes monitoring and screening for patients 18-75 years of age. The measure looks for the percentage of members with diabetes (type 1 and type 2) who had each of the following during the year:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8%)
- HbA1c control (<7%)
- Eye exam (retinal) performed
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

Nationally-recognized clinical guidelines recommend that:

- HbA1c tests are done three to four times per year;
- Retinal eye exam by an optometrist or ophthalmologist is conducted one time per year; Nephropathy screening is completed one time per year;
- Blood pressure readings are done at each outpatient medical visit, not including ones that might be done on the same day as a procedure/diagnostic screening test or an acute inpatient hospital or emergency room visit.

Reviewers looking at medical charts to report for the 2016 HEDIS rates found the following anecdotal factors to be the most common contributors to non-compliance:

- Lack of communication and continuity of care between primary care and specialists. Test results may not have been clearly recorded in the patient's medical chart.
- Member with a prescription, but no record of an office visit or lab test/result over the course of the year.
- Tests may not have been done or recommended. If the tests were recommended, patients may not have followed through.

Strategies to improve compliance rates and population health management:

- Establish and maintain a secure office registry to identify your patients with diabetes to help track lab test appointments, basic results, and specialists. Clearly document lab/test dates and results in each patient's medical record.
- Repeat tests for high results, specifically for HbA1c (over 8%) and blood pressure (over 140/90 mm HG).
- Improve communication both within the patient's care team and between the doctor and your patients.
- Work with your patients to set goals around their health and improving or maintaining their control over their diabetes.

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 policy updates

Anthem (the “Health Plan”) reviews its professional reimbursement policies annually to determine if changes or revisions are required. See below for clarification and detail of recent changes.

Assistant Surgeon and Assistant Surgery Coding List Revision

On September 1, 2016, the Assistant Surgery Services Coding Chart was updated to add new CPT codes to the existing codes that are not eligible for reimbursement for assistant at surgery services reported with modifiers 80, 81, 82, or AS. These codes were effective July 1, 2016: 0437T, 0438T, 0440T, 0441T, 0442T, 0444T and 0445T. In addition, we updated the effective date on the Assistant Surgeon policy to July 1, 2016 to align with our updated Assistant Surgery Services Coding Chart.

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

CPT describes code 95957 as digital analysis of electroencephalogram (EEG) (e.g., for epileptic spike analysis). When the service is simply the paperless acquisition and recording of an EEG via computer-based instrumentation, the Health Plan’s position is providers *should not* report 95957 with EEG testing. Therefore, beginning with dates of service on or after January 1, 2017, code 95957 will be considered incidental to EEG testing codes 95951, 95953, 95954, or 95956 and will not be eligible for separate reimbursement when reported by the same provider on the same date of service. Modifiers will not override the edit.

In addition, the Health Plan considers 95957 incidental to EEG testing codes 95950, 95951, 95953, 95954, 95955 and 95956 when reported on subsequent dates of service. Therefore, beginning with dates of service on or after January 1, 2017, digital EEG analysis procedure code 95957 will not be eligible for reimbursement when reported subsequent to the date of service for EEG testing codes 95950, 95951, 95953, 95954, 95955 and 95956. Modifiers will not override the edit.

Note: Taking guidance from CMS, Kentucky and Missouri Blue Cross and Blue Shield consider imaging guidance to be incidental to spinal injections. Therefore, beginning with dates of service on or after January 1, 2017, imaging guidance codes 76942, 77003, 77012, and 77021 will not be eligible for separate reimbursement when reported with spinal injection codes 62310-62311 (injection(s), of diagnostic or therapeutic substance(s)) and 62318-62319 (injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s)). Modifiers will not override these edits.

Modifiers 59 and XE, XP, XS, & XU

Our current bundled services edit denies CPT code 29822 (arthroscopy, shoulder, surgical; debridement, limited) when reported with 29806 (arthroscopy, shoulder, surgical; capsulorrhaphy), 29807 (arthroscopy, shoulder, surgical; repair of slap lesion), 29821 (arthroscopy, shoulder, surgical; synovectomy, complete), and 29823 (arthroscopy, shoulder, surgical; debridement, extensive) when performed on the same shoulder. The Health Plan’s position is we consider this to be correct coding; therefore, beginning with claims processed on or after November 21, 2016 we will be updating our current edit to not allow modifiers 59, XE, XP, XS, and XU to override the denial of 29822 when performed on the same shoulder as arthroscopy surgical codes 29806, 29807, 29821, and 29823.

Place of Service

As documented in our policy, there are CPT and HCPCS codes that are specific to services provided in the home setting. When such services are provided in a place of service other than the patient’s home, the service is not eligible for reimbursement. Therefore, for claims processed on or after August 22, 2016, our claims editing systems were updated to deny those codes that include the home setting in their description when such codes are reported with a place of service other than a home setting (e.g., when 99504 (home visit mechanical ventilation care) is reported with an in hospital place of service (21), the service will not be eligible for reimbursement).

Routine Obstetric Services

The Health Plan considers that evaluation and management (E/M) visits are included in the reimbursement for global obstetrical care when reported with a routine maternity diagnosis code. Beginning with dates of service on or after January 1, 2017, we are updating our policy to include ICD-10 code Z36 (encounter for antenatal screening of mother) to our list of diagnoses the Health Plan considers to be routine maternity diagnoses. In addition, because ICD-10 diagnosis codes were effective for dates of service on or after October 1, 2015, we are removing the ICD-9 codes that are currently listed in our policy. See our policy for further information.

Sleep Studies and Related Services & Supplies and Frequency Editing

In the June 2016 issue of *Network Update*, we advised we would implement a one per 60 days frequency limit to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783 for dates of service on or after September 1, 2016. Upon further review, we have reconsidered our position and are removing this edit for dates of service on or after September 1, 2016.

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 10/01/2016.

- Claim Editing Overview
- Documentation and Reporting Guidelines for Evaluation and Management
- Global Surgery
- Health and Behavior Assessment Intervention
- Moderate Sedation
- Overhead Expenses for Office Based Surgical and Diagnostic Testing
- Standby Services

New: Anthem Audit Policy

There may be times when Anthem conducts claim reviews or audits either on a prepayment or post payment basis and Anthem or its designee may request documentation, most commonly in the form of patient medical records. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the patient's plan of treatment or to confirm that charges were accurately reported in compliance with Anthem's policies and procedures as well as general industry standard guidelines and regulations.

Effective for claims with dates of service on or after January 1, 2017, Anthem will have a new professional reimbursement policy titled *Claims Requiring Additional Documentation*. This policy documents Anthem's guidelines for claims requiring additional documentation and the professional provider's compliance for the provision of requested documentation. Please refer to the policy for further details.

MO: Correction to reimbursement for credentialing RNFA's

The following is a correction to the Addendum included in our *Network Update Special Edition*, dated June 11, 2015: Registered Nurse First Assist (RNFA) was listed as an example of a non-physician provider. Please be advised that Missouri **does not** recognize Registered Nurse First Assist as an eligible provider. Therefore, Missouri does not credential or enter into a contractual agreement with Registered Nurse First Assist.

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/.

Medicaid Notifications

For IN Medicaid only

Guidelines for respiratory syncytial virus season

Respiratory syncytial virus (RSV) season begins as early as September with occurrences through April. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. All requests for Synagis require [prior authorization](#) to ensure Anthem Blue Cross and Blue Shield Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members meet medical necessity criteria based on the American Academy of Pediatrics recommended guidelines.

Vendor information: For the RSV season, Accredo Specialty Pharmacy is the preferred provider for all Synagis requests for Anthem Blue Cross and Blue Shield, Healthy Indiana Plan and Hoosier Care Connect members. Please refer to Indiana Health Coverage Pharmacy Program for Hoosier Healthwise members.

Dosage maximums: Based on the 2014 American Academy of Pediatrics (AAP) RSV guidance update, Synagis coverage will be approved for up to a maximum of five monthly doses (15 mg/kg) for high risk infants who were born before 29 weeks, 0 days gestation, have chronic lung disease of prematurity or have hemodynamically significant heart disease. Updated indications for prophylaxis can be found in the [July 2014 AAP Policy Statement](#) and on the [provider web portal](#) at www.anthem.com>Providers>State>Indiana>Enter>Plans & Benefits>State Sponsored plans.

Prior authorization process and next steps:

- The [prior authorization form](#) is available on the provider **web portal**.
- Only one Synagis request is needed for each patient throughout the RSV season.
- In cases where a higher dosage is necessary due to weight gain, documentation of the patient's new weight must be provided.

Synagis will be distributed to your office by Accredo Specialty Pharmacy after verification of scheduled appointments, eligibility and prior authorization approvals. For additional questions about Synagis, call the Provider Helpline at [1-866-408-6132] for Hoosier Healthwise, at [1-800-345-4344] for Healthy Indiana Plan and at [1-844-284-1798] Hoosier Care Connect.

Synagis is a registered trademark of MedImmune, LLC.

Nondiscrimination and accessibility requirements update COB

On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (Final Rule) to improve health equity under the Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, gender, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

How does the Final Rule apply to managed care organizations?

Anthem complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities. Anthem provides free tools and services to people with disabilities to communicate effectively with us. Anthem also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages).

We notified your Anthem patients these services can be obtained by calling the Customer Service phone number on their member ID card.

Who can I talk to if Anthem isn't following these guidelines?

If you or your patient believe that Anthem has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with our grievance coordinator via:

- Mail: P.O. Box 6144, Indianapolis, IN 46204-6144
- Phone: **1-866-408-6131** for Hoosier Healthwise and Healthy Indiana Plan; **1-844-284-1797** for Hoosier Care Connect (**TTY: 711** for all plans)

If you or your patient need help filing a grievance, the grievance coordinator is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201
- By phone at: **1-800-368-1019 (TTY/TTD: 1-800-537-7697)**.

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html. For additional details about Section 1557 and the Final Rule, visit the DHHS OCR information page at www.hhs.gov/civil-rights/for-individuals/section-1557/index.html or the frequently asked questions published by the DHHS at www.hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-fqs-508.pdf.

For KY Medicaid only

Guidelines for respiratory syncytial virus season

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

Vendor Information: For the RSV season, Accredo Specialty Pharmacy is the current provider for specialty medications, including Synagis requests, for Anthem Blue Cross and Blue Shield Medicaid members.

Dosage Maximums: Based on the 2014 American Academy of Pediatrics (AAP) RSV guidance update, Synagis coverage will be approved for up to a maximum of five monthly doses (15 mg/kg) for high risk infants who were born before 29 weeks, 0 days gestation, have chronic lung disease of prematurity or have hemodynamically significant heart disease. Updated indications for prophylaxis can be found in the [July 2014 AAP Policy Statement](#) and on the [provider web portal](#) at www.Anthem.com/KYMedicaidoc.

Prior Authorization process and next steps

- The [prior authorization form](#) is available on the provider **web portal**.
- Only one Synagis request is needed for each patient throughout the RSV season.
- In cases where a higher dosage is necessary due to weight gain, documentation of the patient's new weight must be provided.

Synagis will be distributed to your office after verification of scheduled appointments, eligibility and prior authorization approvals. For additional questions about Synagis, call Provider Services at **1-855-661-2028**.

Synagis is a registered trademark of MedImmune, LLC.

New separate reimbursement for long-lasting contraceptive devices

Anthem Medicaid members have the benefit of immediate postpartum placement of long-acting, reversible contraception (LARC) (intrauterine devices [IUDs] and etonogestrel implants) during their inpatient delivery admission.

Beginning on July 1, 2016, payment for LARC devices and professional insertion fees will be paid separately from the inpatient admission. Physicians will receive the same reimbursement as if the device were implanted on an outpatient basis.

This new separate reimbursement applies to hospital claims with dates of service on or after July 1, 2016, for LARC devices only. Providers will bill separately for their professional services. The change does not include other related services, procedures, supplies and devices which will continue to be included in the inpatient hospital diagnosis-related group (DRG) or the birthing center all-inclusive reimbursement amount.

To receive separate reimbursement for LARC devices, facility providers must include on the claim form one of the appropriate Healthcare Common Procedure Coding System (HCPCS) codes listed below:

HCPCS code	Description
J7300	Intrauterine copper contraceptive
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3-year duration
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5-year duration

For more information or if you have questions about this communication, contact Provider Services at **1-855-661-2028**.

Nondiscrimination and accessibility requirements update COB

On May 13, 2016, the Department of Health and Human Services Office of Civil Rights (DHHS OCR) released the Nondiscrimination in Health Programs and Activities Final Rule (Final Rule) to improve health equity under the Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, gender, gender identity, age or disability by providers, health programs and activities that a) receive financial assistance from the federal government, and b) are administered by any entity established under Title I of the ACA.

How does the Final Rule apply to managed care organizations?

Anthem Blue Cross and Blue Shield Medicaid (Anthem) complies with all applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, gender, gender identity, age or disability in its health programs and activities. Anthem provides free tools and services to people with disabilities to communicate effectively with us. Anthem also provides free language services to people whose primary language isn't English (for example, qualified interpreters and information written in other languages).

We notified your Anthem patients these services can be obtained by calling the Customer Service phone number on their member ID card.

Who can I talk to if Anthem isn't following these guidelines?

If you or your patient believe that Anthem has failed to provide these services, or discriminated in any way on the basis of race, color, national origin, age, disability, gender or gender identity, you can file a grievance with Kim Myers, Director of Plan Compliance, via:

- Mail: 13550 Triton Park Blvd., Louisville, KY 40223
- Phone: **1-502-619-6800, ext. 26717 (TTY: 711)**

- Fax: 1-502-212-7336
- Email: kimberly.myers2@anthem.com

If you or your patient need help filing a grievance, the Director of Plan Compliance is available to help. You or your patient can also file a civil rights complaint with the DHHS OCR:

- Online at the OCR complaint website: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.
- By mail to: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201.
- By phone at: 1-800-368-1019 (TTY/TTD: 1-800-537-7697).

Complaint forms are available at www.hhs.gov/ocr/filing-with-ocr/index.html. For additional details about Section 1557 and the Final Rule, visit the DHHS OCR information page at www.hhs.gov/civil-rights/for-individuals/section-1557/index.html or the frequently asked questions published by the DHHS at www.hhs.gov/sites/default/files/2016-05-13-section-1557-final-rule-external-faqs-508.pdf.

Reminder: Access and availability standards

As a reminder, primary care providers (PCPs) are required to abide by the following standards to ensure access to care for our members by:

- Offering telephone access for members, 24 hours a day, seven days a week. A 24-hour telephone service may be used, and the service may be answered by a designee such as an:
 - On-call physician
 - Nurse practitioner with physician backup
- Returning after-hours calls within a maximum of thirty (30) minutes.
- Providing medically necessary services as appropriate. You or another physician must offer this service.
- Following the referral/precertification guidelines. This is a requirement for covering physicians.

Additionally, PCPs are encouraged to offer after-hours office care in the evenings and on Saturdays.

It is not acceptable to automatically direct the member to the emergency room when the PCP is not available, utilize an answering machine or return after-hours calls outside of thirty (30) minutes.

Type of care	Standard
Emergency	Immediately
Urgent care	Within 48 hours
Non-urgent sick care	Within 10 calendar days
Routine or preventive care	Within 30 calendar days
Transitional health care by a PCP	Shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program

If you have questions about this communication, please contact your Provider Relations representative or the Provider Services department at 1-855-661-2028.

Coordination of benefits – policy update

Effective September 1, 2016, Anthem Blue Cross and Blue Shield Medicaid (Anthem) will apply “lesser of logic” when coordinating benefits for members with primary coverage. This means that Anthem will pay the allowable amount minus the primary carrier payment or the member’s responsibility, whichever is less. Currently, Anthem coordinates benefits for members with primary coverage by paying the allowable amount minus the primary carrier payment regardless of the member responsibility. No provider action is required at this time. If you have questions about this communication, please contact your Provider Relations representative or Provider Services at 1-855-661-2028.

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

Duplicate or subsequent services on the same date of service

(Policy 06-032, originally effective 07/01/14)

Anthem allows reimbursement of a duplicate or subsequent service provided on the same date of service if billed with an appropriate modifier or with additional units. Anthem does not allow reimbursement for services billed with modifiers GG and GH. For a list of modifiers that indicate the service was appropriately repeated or additionally billed for the same member, refer to the Duplicate or Subsequent Services on the Same Date of Service reimbursement policy at <https://mediproviders.anthem.com/wi>.