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

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 article was posted online:

Tips for Billing CPT Modifier 33
The modifier 33 was created to aid compliance with the Affordable Care Act (ACA) which prohibits member cost sharing for defined preventive services for non-grandfathered health plans. The appropriate use of modifier 33 reduces claim adjustments related to preventive services and your corresponding refunds to members.

Modifier 33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier 33 will process under the member’s medical or preventive benefits, based on the diagnosis and CPT codes submitted.

Modifier 33 should be appended to codes represented for services described in the US Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) Guidelines.

The CPT® 2016 Professional Edition manual shares the following information regarding the billing of modifier 33, “When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.”

Reminder: 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 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.

Quick Reference Guide
Your state’s Quick Reference Guide (QRG) has been updated for 2017 and provides fast facts on Anthem’s 2017 plans sold on and off the exchange. You can see your state’s QRG online at www.anthem.com>Providers (enter state)>Health Insurance Exchange. Open the link titled, Health Insurance Marketplace/ACA Quick Reference Guide.

IN, KY, OH: Important information for Kentucky providers may impact providers in Indiana and Ohio
Important information for Kentucky providers is included in the Network eUPDATE, 2017 changes to PPO & HMO coverage for Individual plans purchased on and off the Kentucky exchange. The changes in coverage also may affect providers in Indiana and Ohio who see Anthem members with a Kentucky address.

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

Transgender exclusions removed from applicable health plans
In compliance with requirements of the Impact of the Nondiscrimination in Health Programs and Activities Rule (ACA Section 1557), Anthem will remove all transgender exclusions from applicable health plans beginning on 1/1/17 upon the plan start or renewal date. The medical guideline, CG-SURG-27 – Sex Reassignment Surgery, continues to apply to these services, with no discrimination based on gender or gender identity. Providers should continue to verify eligibility and benefits for all members.

Sunsetting PQM and BPR programs
In 2012, in partnership with the Blue Cross Blue Shield Association (BCBSA), Anthem implemented two physician quality transparency programs for primary care physicians – Physician Quality Measurement (PQM) and Blue Physician Recognition (BPR).

Both programs supported members in their health care decision-making through display of nationally-recognized physician performance measurements (PQM) and a logo (BPR) that identified physicians demonstrating a
commitment to quality performance. Since their implementation, quality measurement and consumer transparency and engagement have evolved. Based on this and the analyses of these programs, BCBSA decided to sunset these programs and removed these displays from their National Doctor and Hospital Finder. Anthem will remove this content from our website by April 23, 2017.

A new look is coming to provider communications

At Anthem, we are committed to continuously improving the way we do business with our contracted provider community. In that respect, we have listened to your feedback and are pleased to announce that over the next few months a new look and feel is coming to Network Update and the Communications pages on the anthem.com provider websites. The new design of Network Update will allow you to easily read and print individual articles that pertain to your practice. The Communications pages also may look a little different the next time you visit, but we hope these changes will allow you to more easily find the specific Anthem information that is important to you and your practice.

Use ICR to submit and check precert status

In addition to using the Interactive Care Reviewer (ICR) to initiate a request for precertification of inpatient and outpatient procedures, now you also may receive an immediate authorization decision. To view a complete list of services where an immediate decision is available, click here.

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

Transition to the Availity web portal now

Anthem is targeting January 20, 2017 to transition all access to Eligibility, Benefits, Claim Status Inquiry, Remittance Inquiry, Professional Fee Schedule and important proprietary information to a single website, the Availity Web Portal, our multi-payer portal solution. Note: This change does not affect the anthem.com public website or electronic transactions submitted via our Enterprise EDI Gateway; you may continue to submit all X12 transactions through your current EDI transmission channels.

If you have not already done so, contact your organization’s administrator to gain access to everything you need on Availity. If you don’t know who is your organization’s administrator, 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.

Want quick and easy access to the tools you use most?
On the Availity Web Portal, you can save a frequently used tool to your personal favorites by selecting the heart icon next to the tool. Going forward, choose My Favorites from the top menu bar to quickly and easily access your saved tools.

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.
If your organization is not registered for Availity: Your organization’s designated administrator must go to www.availity.com and select Register, then complete the online registration wizard. The administrator will receive an e-mail from Availity with a temporary password and next steps.

Free Training: Once you log into the secure portal, you’ll see many resources to help jumpstart your learning, including free live training, on-demand training, frequently asked questions, and comprehensive help topics. To view the current training resources, choose the Help menu on the Availity Web Portal.

Reminder: Medical chart reviews for members with plans on and off the exchange

Each year, Anthem asks for your assistance in our retrospective medical chart review programs. We continue to request members’ medical records in order to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS).

We will continue our chart review program for those members who have purchased our Individual and Small Group health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the exchange). This particular effort is part of Anthem’s compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased Individual or Small Group health plans on or off the exchange. The members’ medical record documentation helps support this data requirement.

To assist with our ongoing medical chart review program for members enrolled in our individual and small group exchange plans, Anthem is again collaborating with Inovalon – an independent company that provides secure, clinical documentation services – to contact providers on our behalf. Inovalon’s Web-based workflows help reduce time and improve efficiency and costs associated with record retrieval, coding and document management.

Inovalon is using the following methods of collecting medical record information:
- Provider offices send scanned or faxed medical records to Inovalon.
- Trained clinical personnel review medical records onsite.
- Automated medical record retrieval uses electronic health records (EHR) system interoperability through the provider’s EHR system.

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the providers’ offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within 30 days.

In cases where Inovalon is requesting more than six medical records to review, an Inovalon reviewer calls the provider’s office and arranges convenient time to visit the office onsite and collect the appropriate information. Before the onsite visit, Inovalon mails or faxes the provider’s office a letter to confirm the upcoming visit. The Inovalon medical record review personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, automated medical record data retrieval occurs through the provider’s EHR system. Upon receiving the provider group’s one-time authorization, Inovalon’s systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this partnership is to improve the medical record data extraction experience for Anthem’s network-participating hospitals, clinics and physician offices. Anthem and Inovalon are working together to identify facilities and providers’ offices for engagement.
Physicians of our members who have health plans on and off the exchange play a vital role in the success of this initiative and our compliance with ACA requirements. **When members visit your practice or office, we encourage you to document ALL of the members’ health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.**

By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping Anthem meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.

**Reminder: Inovalon continues outreach efforts on Anthem’s behalf**

In 2017, Anthem will continue to work with Inovalon to identify or help close gaps in care. In the event our members do not visit their physicians, Inovalon offers the option of a personal health visit that a medical professional from Inovalon conducts in members’ homes. The member may also opt to visit a retail clinic or other Inovalon location.

The SOAP Note – the standardized documentation format of a medical record – stands for Subjective, Objective, Assessment, and Plan. SOAP Notes are used with the Inovalon outreach efforts and are meant to be a supplement to providers’ usual documentation process. When submitting information to Inovalon, providers have the option of completing SOAP Notes electronically using Inovalon’s ePASS® Web-based tool or using a paper format. Here are some tips for completing SOAP Notes that we hope you find helpful:

- The exam date for the patient must match the exam date on the completed SOAP Note.
- A claim must be submitted for the exam and the date of service on the claim must match the exam date on the completed SOAP Note.
- The provider signature date should be the actual date the SOAP Note is signed.
- All “mandatory” fields on the paper SOAP Note must be completed. In addition, this makes providers eligible for incentive payment.
- Incentives are only paid once for each patient for whom a health assessment was requested.
- The exam date must always be in the current benefit year of when the member was targeted. For example: A member targeted in 2016 must have an exam date in 2016. **Also, all SOAP notes for 2016 must be submitted no later than February 15, 2017.**

For additional information about SOAP notes, incentives, the medical record review process or the outreach effort, please refer to the frequently asked questions document available on our [website](#).

**Reminder: Important update on Anthem in-network labs**

Effective February 1, 2017, Myriad Genetic Laboratories will no longer be an in-network laboratory for Anthem. Other laboratories that continue to be in-network for BRCA testing and other genetic testing services include: Ambry Genetics, Counsyl, Inc., Invitae, LabCorp, Medical Diagnostics Laboratories (MDL) and Quest Diagnostics. Please see the Network eUPDATE, **Important update on Anthem in-network labs**, for additional details. (Or go online to [www.anthem.com/Providers](http://www.anthem.com/Providers) (enter state)>Network eUPDATE.)

**IN, KY, OH: Reminder -- URMBT prepayment review**

The following information applies to the URMBT (UAW Retirees Medical Benefit Trust -- BCBSM Control group): Non-Medicare claims with a to-be-paid amount of $250,000 or greater are subject to a Prepayment Review of all submitted charges. To that end, the facility must submit an Itemized Statement matching the billed UB-04, along with complete medical records (including MAR). In this process, once Anthem receives all of the
facility's documentation, we send it to BCBSM and URMBT for the Prepayment Review. Please see the Network eUPDATE, URMBT Prepayment Review, for additional details. (Or go online to www.anthem.com/Providers (enter state)>Network eUPDATE.)

Use the Provider Maintenance Form to update your information

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

Federal Employee Plan (FEP)

2017 FEP benefit information available online

To view the 2017 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org>select Benefit Plans>Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2017. For questions please contact FEP Customer Service at:
  - IN – 800-382-5520.
  - KY – 800-456-3967
  - MO – 800-392-8043
  - OH – 800-451-7602
  - WI – 800-242-9635

Attention OB/GYN providers: Prenatal/Postpartum related HEDIS measure information

Recently, Anthem FEP mailed out a Quick Reference Guide to our OB/GYN provider community, in an effort to help provide important information about prenatal and postpartum claim submission. The mailer included guidance for providers to submit the Category II CPT codes for Prenatal services: 0050F (Initial prenatal care visit), 0501F (Prenatal flow sheet documented in medical record by first prenatal visit) and Postpartum services: 0503F (indicating a postpartum visit) and ICD-10 code Z39.2 (routine postpartum follow-up). Submitting these codes helps alleviate the need for medical record submission and less time and disruption to your office by the health plan to review patient charts. We value the relationship we have with our Anthem providers, and appreciate any and all effort put forth on this request. If your office did not receive a Quick Reference Guide to post in your office billing department, please contact the FEP Customer Service for your state. (See above phone listings.)

Health Care Management

Medical policy update

The following Anthem medical policy was recently reviewed for Indiana, Kentucky, Missouri, Ohio and Wisconsin, and was implemented on October 6, 2016.
DRUG.00081  Eteplirsen (Exondys 51™)
This new medical policy addresses Eteplirsen (Exondys 51™) an exon-skipping drug intended for the treatment of Duchenne muscular dystrophy (DMD).

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
Listed below are specialty pharmacy codes from new or current medical policies that will be added to our existing pre-service review process effective March 1, 2017. 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.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline (CG) number</th>
<th>DRUG code</th>
<th>Drug Names</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>J3590</td>
<td>Erelzi</td>
<td>New drug to existing Medical Policy</td>
</tr>
<tr>
<td>DRUG.00081</td>
<td>J3490, J3590</td>
<td>Exondys 51</td>
<td>New Medical Policy</td>
</tr>
</tbody>
</table>

Specialty pharmacy level of care medication list will expand
Listed below are the specialty pharmacy codes from our new or current medical policies and clinical UM guidelines that will be added to our existing Level of Care review process using CG-DRUG-47, effective April 24, 2017. Pre-service review will be managed by AIM. For more information, go to www.aimspecialtyhealth.com.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Name</th>
<th>Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>Inflectra</td>
<td>Q5102</td>
</tr>
<tr>
<td>DRUG.00084</td>
<td>Actimmune</td>
<td>J9216</td>
</tr>
<tr>
<td>DRUG.00086</td>
<td>Increlex</td>
<td>J2170</td>
</tr>
<tr>
<td>CG-DRUG-43</td>
<td>Tysabri</td>
<td>J2323</td>
</tr>
</tbody>
</table>

Medicare
Medicare Supplement members should use new ID cards
Anthem Medicare Supplement individual members recently received new member ID cards. Please obtain a copy of your patient’s new member ID card to file claims for dates of service December 1, 2016 and beyond. Additional information, including alpha prefixes, is available online. To view, go to anthem.com>Providers (enter state)>Answers@Anthem> Medicare Supplement System Consolidation FAQs.

December webinars feature OptiNet
All participating Medicare Advantage providers who provide imaging services must 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 echocardiography imaging services. Areas of assessment include facility specifications, technologist and physician qualifications, accreditation, equipment and technical registration. The data will be used to calculate site scores for providers who render imaging services for our individual Medicare Advantage members.
**All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, must complete the registration.** Providers who do not register, who score less than 76 or who do 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. This includes providers who have delegated risk arrangements and who may see Anthem members outside of those risk arrangements.

Participating providers who have already completed the survey but scored less than 76 can use the online registration at any time to update their information and improve their score. **All providers**, including those who score less than 76, will receive individualized information they can use to improve their score.

**Act now to avoid line-item claims denials.** Providers are strongly encouraged to register and improve their scores as needed before the line-item denials begin for claims submitted for dates of service on or after January 1, 2017. Facilities billing on a UB-04 claim form will be excluded from line item denials at this time.

The provider registration is available online at [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb).

- Select Anthem MA from the drop down menu.
- Only those providers who have completed the provider registration will be able to view their information online.
- If you have questions or need help completing the registration, please call AIM Customer Service at 800-252-2021.

You are encouraged to 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.

Please contact ronald.younger@anthem.com if you would like an invite sent to your calendar for the following webinar:

- **Dec. 7, 2016, 4-5 p.m. ET**
- Dial 866-308-0254
- Pass code 8042057402#
- Smart Phone 1-Click Dial 866-308-0254, 8042057402#

Additional information is available at [Important Medicare Advantage Updates](https://anthem.com/medicareprovider) at anthem.com/medicareprovider.

**Check if authorization required for implants**

When obtaining an authorization for a surgery that involves an implant, you must check the associated implant codes to determine if an authorization is also needed for the implant.

**2017 Medicare Advantage Individual benefits and formularies**

Summary of benefits, evidence of coverage, formularies and an overview of 2017 benefit changes for Individual Medicare Advantage plans will be available at [anthem.com/medicareprovider](https://anthem.com/medicareprovider). Notable copayment information is listed below.

**Application of copayments:** When member cost share is a copayment amount, members will be responsible for a copayment for each type of service rendered. If a member receives more than one type of service, the applicable copayment for each service will apply. Only one copayment will apply for each type of service rendered.
As an example, if a member receives three x-rays in a specialist office on the same date of service, the member would be responsible for the one x-ray copayment and one specialist office copayment.

Please note: Certain places of service, including but not limited to, inpatient hospital, outpatient hospital, emergency room and urgent care will only assess one member copayment for each visit.

**No copay for diabetes retinal exam and HbA1c testing:** Effective January 1, 2017, no co-pay will be required for HbA1c testing for individual and group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual retinal exam at no out-of-pocket cost.

**Routine physical exams are covered in 2017**

The majority of Anthem Medicare Advantage (MA) plans will continue to supplement Medicare covered preventive services and offer coverage for routine physicals in 2017 for individual and group-sponsored MA members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay or coinsurance as applicable by the member’s plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider. Please call the number on the back of the member’s ID card for specific coverage information.

Additional information is available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

**Dual eligible special needs plans – provider training required**

In 2017, Anthem is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, and vision, as well as transportation to doctors’ appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items. CMS regulations protect D-SNP members from balance billing.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans will receive notices in Q4 2016 that contain information for online, self-paced training. In addition to completing annual training, all providers contracted for our D-SNP plans are required to click the attestation within the training site stating that they have completed the training. These attestations can be completed by individual providers or at the group level with one signature.

Additional information will be available at anthem.com/medicareprovider under Important Medicare Advantage Updates.

**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.

**Verify injectable, infusion billable units approved via AIM**

Providers must submit claims for medical injectable and infusion drugs in billable units for the Healthcare Common Procedure Coding System (HCPCS) code authorized. Providers can verify the amount of billable units approved for a case by using the member ID and authorization number provided. All claims submitted for more units than approved are subject to denial. To adjust the dose of an approved AIM authorization, please contact AIM for a new drug authorization request.

Claims are submitted in billable units per the HCPCS code. The billable units are calculated based on the HCPCS code administered and the dose associated with the code.

*For example:*

One (1) HCPCS unit of Rituxan represents 100mg of drug per HCPCS code J9310 (Rituxan) is administered at 1000mg for two doses

1000mg = 10 units (HCPCS code is 100mg)

Each dose of 1000mg is 10 billable units

Two doses = 20 billable units

AIM authorization details can be obtained via phone (800-714-0040) or the provider portal ([www.providerportal.com](http://www.providerportal.com)). For AIM provider portal support, please call 1-800-252-2021, option 2.

Note: An email address and the TIN for the facility/provider are needed to register for the site. Once registered, providers can view all AIM oncology drug approvals/denials by using the member information (name, ID#, date of birth).

For all other Part B injectable and infusion approvals/denials, inquiries will be answered via email at [www.MASpecialtyPharm@Anthem.com](mailto:www.MASpecialtyPharm@Anthem.com) or phone at 1-866-797-9884, option 5.

**HCPCS codes required for Rural Health Clinic claims**

All claims from Rural Health Clinics (RHC), with dates of service April 1, 2016 and after, must contain an appropriate HCPCS code for each service line along with a revenue code on their Medicare Advantage claims. This pertains to contracted and non-contracted providers. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans, including D-SNPs and Medicare-Medicaid Plans.

**Transitional Care Management services eligibility**

A beneficiary is not eligible to receive Transitional Care Management (TCM) services until 30 days have passed since the beneficiary was discharged from an inpatient hospital setting. Anthem determines the date of discharge based on the date the beneficiary received a discharge evaluation and management (E&M) visit. TCM services will be denied by Anthem if the discharge E&M visit is not received before the TCM service.
These billing instructions apply to all individual Medicare Advantage plans, including D-SNPs and Medicare-Medicaid Plans. View more information on TCM services by clicking here or go online to www.cms.gov.

Avoid needless claims denials

Tips for avoiding unnecessary claims denials can be found online at anthem.com/medicareprovider under Important Medicare Advantage Updates. They include information on:

- Services disallowed by utilization management
- Valid Clinical Laboratory Improvement Amendments number must be submitted
- Procedure not covered by diagnosis
- Inappropriate or missing modifier
- Duplicate claim

AIM clinical 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

Clarification – Requesting authorization for certain arterial duplex imaging procedures

As communicated in the April 2016 issue of Network Update and Important Medicare Advantage Updates, Anthem is collaborating with AIM to conduct medical necessity reviews for vascular ultrasound management for our individual Medicare Advantage members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days from the day the procedure is performed, and before you submit a claim.

Please note that failure to contact AIM within the 10 day post service window for review will result in a denial of payment. See the following chart for impacted codes.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Brief Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93925</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS COMPL BI STUDY</td>
</tr>
<tr>
<td>93926</td>
<td>DUP-SCAN LXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
<tr>
<td>93930</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS COMPL BI STUDY</td>
</tr>
<tr>
<td>93931</td>
<td>DUP-SCAN UXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
</tbody>
</table>
To submit your request, go to the AIM Provider Portal at www.aimspecialtyhealth.com. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance, you also may call AIM toll-free at 800-714-0040, Monday -- Friday, 7 am -- 7 pm CT.

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

As communicated in the October 2016 issue of Network Update and Important Medicare Advantage Updates, effective January 1, 2017, for our individual Medicare Advantage members, Anthem will require prior authorization of home health services, including:

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

Beginning December 19, 2016, request a prior authorization by fax (1-844-834-2908), phone (1-844-411-9622) or 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/.

**OH: DEN program helps members better manage diabetes**

The Diabetes Education Navigation (DEN) program helps individual and group-sponsored Medicare Advantage members diagnosed with diabetes manage their condition. Members may receive a phone call from a nurse to help them make an appointment with their doctor to receive important screenings and care.

**Keep up with Medicare news**

Please continue to check Important Medicare Advantage Updates at http://www.anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- September reimbursement policy provider bulletin
- Medicare Advantage reimbursement policies
- Prior authorization requirements for Erelzi, Amjevita, Voretigene neparvovec, Nanacog and Lartruvo
- Prior authorization requirements for Cuvitru, Ocrevus and Lutathera
- Prior authorization requirements for continuous interstitial glucose monitoring
- Prior authorization requirement for Torisel
- Prior authorization changes to Interferon gamma-1b, Mecasermin, and Azacitidine
- Prior authorization requirements for Doxil and Sustol
- Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning Feb. 1, 2016
- Medicare Notices and provider requirements
- Clinical Cumulative Morphine Equivalent Dosing Point of Sale Edit effective January 1, 2017
- Diabetic Supply Coverage for Individual Medicare Advantage Members

63425MUPENMUB 10/18/2016
**Pharmacy**

**Report HCPCS code C9257 for Avastin intravitreal injection**

Anthem will now accept HCPCS code C9257 for physician reporting of Avastin for intravitreal injection. Physicians should no longer report codes J3490, J3590, J9035, or J9999 for Avastin used in intravitreal injections.

Anthem has established a reimbursement allowance for code C9257, and will allow a maximum of 5 units per injection. Use of code C9257 will ensure that the appropriate reimbursement for this specific treatment is made.

This reporting and reimbursement change impacts commercial Anthem members only.

**Anthem preferred products**

**Immunoglobulin**

Anthem has reviewed the immunoglobulin products through the Pharmacy & Therapeutics (P&T) process and has selected two preferred drugs: Gamunex-C® and Octagam®. When prescribing these products, please consider the preferred drugs for initial therapy.

<table>
<thead>
<tr>
<th>Preferred Product</th>
<th>Non Preferred Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamunex C®</td>
<td>Gammagard®</td>
</tr>
<tr>
<td>Octagam®</td>
<td>Privigen®</td>
</tr>
</tbody>
</table>

**Botulinum Toxin Agents Preferred Products**

Anthem has reviewed the botulinum toxin agents and has selected Xeomin® as the preferred agent. When prescribing a botulinum toxin, please consider Xeomin® for initial therapy.

<table>
<thead>
<tr>
<th>Product</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xeomin®*</td>
<td>Preferred</td>
</tr>
<tr>
<td>Botox®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Myobloc®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Dysport®</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

*Preferred product for the following medical indications: upper limb spasticity, cervical dystonia and blepharospasm.

**Hyaluronic Acid Preferred Products**

Anthem has reviewed the hyaluronic acid agents through the P&T process and has selected four preferred drugs: Synvisc-One®, Synvisc®, Monovisc® and Orthovisc®. Beginning September 1, 2016, an edit is in place requiring one of the preferred drugs below to be tried before a non-preferred drug. When prescribing these products, please consider the preferred agents below for patients needing hyaluronic acid therapy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Weekly Injections</th>
<th>Anthem Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synvisc-One®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Synvisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Monovisc®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Orthovisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Drug</td>
<td>Number of Weekly Injections</td>
<td>Anthem Formulary Status</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Euflexxa®</td>
<td>3</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Gel-One®</td>
<td>1</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Hyalgan®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Supartz®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

**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 2016 commercial results are in**

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) commercial data collection project for 2016. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate commercial HEDIS process improvement by:

- Responding to our requests for medical records within five days if at all possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient’s medical record

Further information regarding documentation guidelines can be found online at www.anthem.com>Providers (enter state)>Health and Wellness>Quality>HEDIS. You will find reference documents entitled “HEDIS 101 for Providers” and “HEDIS Documentation Guidelines”.

**Network Update**

December 2016
The following table shows some of our key measure rates.
- Yellow boxes indicate rates that are above the national average.
- **Bold** indicates improvement in rate over the previous year.
- NA = Not Applicable - denominator too small
- Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good

**COMMERCIAL HMO (Missouri and Wisconsin) and COMMERCIAL PPO (Indiana and Ohio)**
HMO Note: Rates are not reported for Indiana, Kentucky and Ohio due to smaller population
PPO Note: Rates are not reported for Kentucky, Missouri and Wisconsin due to smaller population

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>MO HMO</th>
<th>WI HMO</th>
<th>IN PPO</th>
<th>OH PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness of Care - Prevention and Screening</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>87.92</td>
<td>85.60</td>
<td>74.62</td>
<td>84.07</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Total</td>
<td>49.88</td>
<td>69.10</td>
<td>56.27</td>
<td>59.21</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition Total</td>
<td>55.47</td>
<td>69.60</td>
<td>61.92</td>
<td>59.95</td>
</tr>
<tr>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity Total</td>
<td>54.01</td>
<td>57.54</td>
<td>56.02</td>
<td>52.09</td>
</tr>
<tr>
<td>Childhood Immunization Status - Combo 2</td>
<td>80.66</td>
<td>82.64</td>
<td>76.04</td>
<td>74.94</td>
</tr>
<tr>
<td>Immunizations for Adolescents - Combo 1</td>
<td>49.13</td>
<td>70.98</td>
<td>75.72</td>
<td>70.22</td>
</tr>
<tr>
<td>Human Papillomavirus Vaccine for Female Adolescents</td>
<td>13.08</td>
<td>17.76</td>
<td>18.00</td>
<td>17.52</td>
</tr>
<tr>
<td>Breast Cancer Screening Ages Total</td>
<td>67.73</td>
<td>74.46</td>
<td>71.68</td>
<td>68.84</td>
</tr>
<tr>
<td>Cervical Cancer Screening ^^^</td>
<td>73.48</td>
<td>71.28</td>
<td>76.72</td>
<td>70.69</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>59.95</td>
<td>58.54</td>
<td>56.86</td>
<td>60.05</td>
</tr>
<tr>
<td>Chlamydia Screening in Women - Total</td>
<td>34.99</td>
<td>34.58</td>
<td>43.84</td>
<td>40.76</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Respiratory Conditions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Testing for Children With Pharyngitis</td>
<td>78.80</td>
<td>77.21</td>
<td>73.59</td>
<td>78.88</td>
</tr>
<tr>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>42.35</td>
<td>43.10</td>
<td>41.79</td>
<td>36.67</td>
</tr>
<tr>
<td>Asthma Medication Ratio - Total</td>
<td>80.87</td>
<td>75.17</td>
<td>81.19</td>
<td>80.75</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Cardiovascular</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>65.00</td>
<td>78.04</td>
<td>57.95</td>
<td>62.02</td>
</tr>
<tr>
<td>Persistence of Beta-Blocker Treatment after a Heart Attack</td>
<td>NA</td>
<td>75.38</td>
<td>83.44</td>
<td>83.09</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Testing</td>
<td>91.00</td>
<td>94.01</td>
<td>90.75</td>
<td>90.75</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Poor HbA1c Control (&gt;9)*</td>
<td>23.11</td>
<td>20.20</td>
<td>34.79</td>
<td>27.49</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care HbA1C Good Control (&lt;8)</td>
<td>65.69</td>
<td>65.34</td>
<td>52.31</td>
<td>59.37</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>47.45</td>
<td>54.86</td>
<td>50.61</td>
<td>48.66</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Medical attention for nephropathy</td>
<td>88.32</td>
<td>91.02</td>
<td>90.02</td>
<td>89.29</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care Blood Pressure Control &lt;140/90</td>
<td>72.51</td>
<td>82.79</td>
<td>59.37</td>
<td>66.67</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Musculoskeletal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Modifying Anti-Rheumatic Drug Therapy</td>
<td>90.67</td>
<td>91.52</td>
<td>86.26</td>
<td>86.09</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Medication Management</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications (ACE/ARB) ^^^</td>
<td>84.36</td>
<td>83.48</td>
<td>79.75</td>
<td>83.19</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications (Digoxin) ^^^</td>
<td>NA</td>
<td>31.11</td>
<td>36.72</td>
<td>36.61</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications (Diuretics) ^^^</td>
<td>82.23</td>
<td>82.74</td>
<td>79.38</td>
<td>82.58</td>
</tr>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications Total ^^^</td>
<td>83.22</td>
<td>82.91</td>
<td>79.40</td>
<td>82.75</td>
</tr>
<tr>
<td><strong>Effectiveness of Care - Overuse / Appropriateness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate Treatment for Children With Upper Respiratory Infection</td>
<td>79.08</td>
<td>91.53</td>
<td>83.96</td>
<td>86.81</td>
</tr>
<tr>
<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
<td>15.42</td>
<td>21.05</td>
<td>24.32</td>
<td>22.80</td>
</tr>
<tr>
<td>Imaging Studies for Low Back Pain</td>
<td>70.49</td>
<td>76.66</td>
<td>72.21</td>
<td>71.42</td>
</tr>
</tbody>
</table>
Overall, PPO rates tend to be better than HMO rates, and it is also worth noting that the national averages for these products are different, as well.

**Commercial HMO**

In Missouri and Wisconsin, the following rates exceed the national average:
- Adult BMI Assessment: Rates increased in both states.
- Childhood Immunizations-Combo 2: Rates increased in both states.
- Controlling High Blood Pressure: Rates increased in both states.
- Prenatal and Postpartum Care: The Postpartum Care rate increased in Wisconsin.

In Wisconsin, rates for Comprehensive Diabetes Care are above the national average; however, there was a decrease in the Diabetes Eye Exam. In Missouri, Comprehensive Diabetes Care rates are above the national average, with the exception of Diabetes Eye Exam and Attention for Nephropathy.

The HPV vaccine rate increased in both states (Missouri increased 11.51%; Wisconsin increased 37.35%). Next year, male adolescents will be added, and this immunization will be included in the Immunizations for Adolescents measure.

Missouri had significant increases:
- Childhood Immunizations-Combo 2 increased 7.22%.
- Adolescent Immunizations-Combo 1 increased 9.18%.
- Weight Assessment and Counseling for Children and Adolescents: BMI Total increased 5.12% and Counseling for Nutrition ages 12-17 increased 14.64%. While some of these rates increased, there is room for improvement for all three components (BMI, Nutrition and Physical Activity) of this measure.

Wisconsin also had significant increases: Use of Spirometry Testing in the Assessment and Diagnosis of COPD increased 7.24% and Adolescent Well Care increased 6.38%.

Opportunities for improvement include:
- Chlamydia Screening-Total (Missouri decreased 5.64%; Wisconsin decreased 6.69%)
- Persistence of Beta Blocker Treatment after a Heart Attack (Wisconsin)
- Childhood Immunizations-VZV and Breast Cancer Screening (Missouri)

**Commercial PPO**

In Indiana and Ohio, many rates are above the national average, including:
- Adult BMI Assessment: Ohio’s rate increased this year.
- Childhood Immunizations: Rates increased in both states.
- Adolescent Immunizations: Rates increased in both states.
- HPV Vaccine: Indiana increased 42.29%; Ohio increased 22.01%.
- Comprehensive Diabetes Care: All measures in both states are above the national average.
- Diabetes Retinal Eye Exam: Indiana increased 6.66%; Ohio increased 21.20%.
- Attention for Nephropathy: Indiana increased 5.71%; Ohio increased 7.93%. 

---

**Access/Availability of Services**

<table>
<thead>
<tr>
<th>Access/Availability of Services</th>
<th>86.46</th>
<th>91.67</th>
<th>90.68</th>
<th>87.81</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal and Postpartum Care - Timeliness of Prenatal Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal and Postpartum Care - Postpartum Care</td>
<td>82.97</td>
<td>87.50</td>
<td>79.21</td>
<td>78.49</td>
</tr>
</tbody>
</table>

**Utilization and Risk Adjusted Utilization - Utilization**

<table>
<thead>
<tr>
<th>Utilization and Risk Adjusted Utilization - Utilization</th>
<th>75.00</th>
<th>80.14</th>
<th>83.23</th>
<th>80.80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Child Visits in the First Fifteen Months of Life (6+ visits)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child Visits in the Third, Fourth, Fifth and Sixth Year of Life</td>
<td>68.44</td>
<td>78.01</td>
<td>75.46</td>
<td>74.81</td>
</tr>
<tr>
<td>Adolescent Well Care Visits</td>
<td>36.95</td>
<td>42.18</td>
<td>45.09</td>
<td>41.57</td>
</tr>
</tbody>
</table>

***Due to changes in the measure, it is not trendable for previous years.***
Prenatal and Postpartum Care: Indiana's prenatal rate increased this year.
Well Child Visits: Rates increased in both states.

Opportunities for improvement include:
- Childhood Immunizations-Hepatitis A (Ohio)
- Appropriate Testing for Children With Pharyngitis (Indiana)
- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (Ohio)*
- Disease Modifying Anti-Rheumatic Drug Therapy (Ohio)*
- Controlling Blood Pressure: This rate is above the national average; however, the rate decreased this year, leaving room for improvement.

*Rates increased, but there is room for improvement

Again, we thank you and your staff for demonstrating teamwork as we work together to improve the health of our members and your patients. We look forward to working with you again next HEDIS season.

Survey says patients see room for improvement

Every year, Anthem sends out the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to our HMO/POS members. The survey provides Anthem members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. The CAHPS survey is used by all HMO/POS plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

The following tables compare results from 2015 with those in 2016. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by Anthem. These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

When you’re reviewing these results, we encourage you to focus on and address those performance areas of your own practice that may have room for improvement. Addressing those areas will help our members, your patients, have a positive experience that meets their medical needs and their satisfaction with the quality of services provided.

2016 Anthem Blue Cross and Blue Shield CHAPS® Member Satisfaction Survey Results

<table>
<thead>
<tr>
<th>NCQA Quality Compass Percentile Legend</th>
<th>10th</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rating of Physician</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rating of Personal Doctor ^1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Plan</strong></td>
<td><strong>2015</strong></td>
<td><strong>2016</strong></td>
<td><strong>Trend</strong></td>
<td><strong>2015</strong></td>
<td><strong>2016</strong></td>
</tr>
<tr>
<td>IN HMO/POS</td>
<td>86%</td>
<td>84%</td>
<td>↓</td>
<td>91%</td>
<td>80%</td>
</tr>
<tr>
<td>KY HMO/POS</td>
<td>90%</td>
<td>84%</td>
<td>↓</td>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>MO HMO/POS</td>
<td>88%</td>
<td>82%</td>
<td>↓</td>
<td>81%</td>
<td>83%</td>
</tr>
</tbody>
</table>
### Getting Care Quickly

<table>
<thead>
<tr>
<th></th>
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### Doctor’s Communication with Patients

#### How often personal doctor explained things understandably to you?  

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<th>2016</th>
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#### How often personal doctor listened carefully to you?  

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<th>Trend</th>
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### Shared Decision Making

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### Continuity of Care & Health Promotion

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1. Percent responding 8, 9 or 10 (0-10, where 0 is the worst and 10 is the best).
2. Percent responding “Usually” or “Always.”
3. % responding “Yes”
4. Percentile Definition - A score equal to or greater than 75 percent of all those attained on a survey question is said to be in the 75th percentile.
NA = Number of survey respondents too low to be valid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

*The source of data contained in this report is Quality Compass © 2016 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA.*

**We believe in continuous improvement**

Commitment to our members’ health and their satisfaction with the care and services they receive is the basis for the Anthem Blue Cross and Blue Shield Quality Improvement Program. Annually, Anthem prepares a quality program description that outlines the plan’s clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated
system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of Anthem’s quality program and most current outcomes, visit us at www.anthem.com.

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem is available to offer assistance in these difficult moments with our Case Management Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>OH - 888-662-0939</td>
<td>centre gc <a href="mailto:mref@anthem.com">mref@anthem.com</a></td>
<td>Monday – Friday, 8 am - 9 pm EST Saturday, 9:30am - 5 pm EST</td>
</tr>
<tr>
<td>MO - 888-662-0939, or 866-534-4348</td>
<td>centre gc <a href="mailto:mref@anthem.com">mref@anthem.com</a></td>
<td>Monday – Friday, 8 am - 9 pm CST Saturday, 9:30am - 5 pm CST</td>
</tr>
<tr>
<td>IN - 888-662-0939</td>
<td>centre gc <a href="mailto:mref@anthem.com">mref@anthem.com</a></td>
<td>Monday – Friday, 8 am - 9 pm EST Saturday, 9:30am - 5 pm EST</td>
</tr>
<tr>
<td>WI - 888-662-0939, or 866-216-4091</td>
<td>centre gc <a href="mailto:mref@anthem.com">mref@anthem.com</a></td>
<td>Monday – Friday, 8 am - 9 pm CST Saturday, 9:30am - 5 pm CST</td>
</tr>
<tr>
<td>KY - 888-662-0939, or 800-944-0339</td>
<td>centre gc <a href="mailto:mref@anthem.com">mref@anthem.com</a></td>
<td>Monday – Friday, 8 am - 9 pm CST Saturday, 9:30am - 5 pm CST</td>
</tr>
<tr>
<td>National (IN) 1-800-737-1857</td>
<td>IN DYNat <a href="mailto:lAccts-CM@wellpoint.com">lAccts-CM@wellpoint.com</a></td>
<td>Monday – Friday, 8 am - 9:00pm EST Saturday, 9 am - 5:30 pm EST</td>
</tr>
<tr>
<td>Federal Employee Program (FEP) 800-711-2225</td>
<td>No email</td>
<td>Monday – Friday, 8 am – 7 pm EST</td>
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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.
Coordination of care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem would like to take this opportunity to stress the importance of communicating with your patient’s other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:
1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
   - Diagnosis
   - Treatment plan
   - Referrals
   - Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available online, including a Coordination of Care template and cover letters for both Behavioral Health and other Healthcare Practitioners. In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.

*Access to the forms and cover letters are available at anthem.com>Providers (enter state)>Answers@Anthem>Coordination of Care.
**Access to the Toolkit is available at anthem.com>Providers (enter state)>Health and Wellness.

Important information about Utilization Management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member’s coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem’s medical policies are available on Anthem’s website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. UM criteria are also available on the web. Just select “Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider home page at anthem.com.
We work with providers to answer questions about the utilization management process and the authorization of care. Here’s how the process works:

- Call us toll free from 8:30 am - 5 pm, Monday -- Friday (except on holidays). More hours may be available in your area. FEP hours are 8 am -- 7 pm ET.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

<table>
<thead>
<tr>
<th>State</th>
<th>To discuss UM process and authorizations</th>
<th>To discuss peer-to-peer UM denials and authorizations with physicians</th>
<th>To request UM Criteria</th>
<th>TTY/TDD</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN</td>
<td>877-814-4803</td>
<td>877-814-4803</td>
<td>877-814-4803</td>
<td>711 or TTY 800-743-3333 (V/T) Voice 800-743-3333 (V/T)</td>
</tr>
<tr>
<td>KEHP</td>
<td>844-402-5347</td>
<td>National 800-821-1453</td>
<td>FEP 800-860-2156</td>
<td>FEP 800-860-2156 FAX 800-732-8318 (UM) FAX 877-606-3807 (ABD)</td>
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<td>FEP</td>
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<td>FAX 800-732-8318 (UM) FAX 877-606-3807 (ABD)</td>
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<td>FAX 800-732-8318 (UM) FAX 877-606-3807 (ABD)</td>
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<td>866-398-1922</td>
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<td>877-814-4803</td>
<td>711 or TTY 800-750-0750 (V/T) Voice 800-750-0750 (V/T)</td>
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<td>877-814-4803</td>
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For language assistance, **members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.**

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

**Member rights and responsibilities**

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem has adopted a Members’ Rights and Responsibilities statement.

It can be found on our Web site. To access, go to anthem.com > Providers (enter state) > Health & Wellness > Quality > Member Rights & Responsibilities. Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

**Referral providers benefit by improving quality**

A key goal of the Enhanced Personal Health Care Program is to improve quality while controlling health care costs. One of the ways this is done includes giving primary care physicians (PCPs) who participate in the program quality and cost information about the health care providers to which the PCPs their Attributed Members (the Referral Provider”). A Referral Provider who is higher quality and/or lower cost should receive more referrals from PCPs. The converse should be true if Referral Providers are lower quality and/or higher cost. Upon request, Anthem will share data on which it relied in making these evaluations and will discuss this, along with any opportunities for improvement, with Referral Providers. **Any such requests should be directed to your provider network representative.**

**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.

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

Beginning with dates of service on or after March 1, 2017, we will implement the following code pair edits and have documented these edits in our future Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU reimbursement policies:

- Current Procedural Terminology (CPT®) code 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar) will not be eligible for separate reimbursement when reported with CPT code 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment;
CPT code 22614 (arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)) will not be eligible for separate reimbursement when reported with CPT codes 22600 (arthrodesis, posterior or posterolateral technique, single level; cervical below c2 segment), 22610 (arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)), 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)), 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar), and 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.

CPT codes 63081, 63082, 63085, 63086, 68087, and 63088 (vertebral corpectomies) will not be eligible for separate reimbursement when reported with CPT code 22558 (arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar). Modifiers will not override this edit.

CPT code 82542 (column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen) will not be eligible for separate reimbursement when reported with CPT code 91065 (breath hydrogen or methane test). Modifiers will not override this edit.

We consider cervical and vaginal cytopathology to be incidental to evaluation and management (E/M) services. We currently deny CPT codes 88141-88155, 88165-88167, and 88174-88175 as incidental to preventive and problem oriented E/M services identified by such CPT codes as 99381-99397 and 99201-99215 when reported by the same provider for the same patient on the same date of service. Based on our current edit, we are adding HCPCS codes G0101, G0402, G0438, G0439, S0610 and S0612 (screening exams, preventive exams, and wellness exams) as additional support codes that cervical and vaginal cytopathology will not be eligible for separate reimbursement; modifiers will not override the edit.

Taking guidance from the February 2016 CPT Assistant which states that train-of-four monitoring is bundled with the intraoperative neuromonitoring and should not be separately reported, we are adding an edit that CPT code 95937 (neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method) will not be eligible for separate reimbursement when reported with CPT codes 95940 (continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes), 95941 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour), and G0453 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes); modifiers will not over these edits.

Our current edit denies 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental when reported with 76882 (ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific). Based on our interpretation of CPT guidelines that state "Ultrasound guidance procedures also require
permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized. Use of ultrasound, without thorough evaluation of organ(s), or anatomic region, image documentation, and final, written report, is not separately reportable" we are updating our edit and will deny 76882 when reported with 76942; modifiers will not override the edit.

- The following article refers to an edit that was planned to be implemented on January 1, 2017, but has changed due to code changes/deletions in CPT: In our October 2016 issue of Network Update, we advised that for Kentucky and Missouri, 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)) and that modifiers will not override these edits. Based on CPT coding updates for January 1, 2017, 62310 – 62311 and 62318 – 62319 have been deleted and replaced with 62320, 62322, 62324, and 62326 for injection(s) of diagnostic and therapeutic substance(s) without imaging guidance and 62321, 62323, 62325, and 62327 for injection(s) of diagnostic and therapeutic substance(s) with imaging guidance. Based on CPT "do not report" instructions, 62321, 62323, 62325 and 62327 are not to be reported in conjunction with image guidance CPT codes 77003, 77012, and 76942.

- Also, please note that we are moving our Section 1 code table from our Bundled Services and Supplies policy to a separate document

Durable Medical Equipment
For claims processed on or after November 21, 2016, we updated our policy to reflect that the Health Plan will allow rental of two units per month for durable medical equipment (DME) that requires a back-up unit. These include items such as E0465 (home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)) and E0466 (home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)).

Frequency Editing
Based on changes in vial size available for J9047 (injection, Carfilzomib, 1 mg (Kypolis)), we have updated our maximum dosage amount to 150 units. This update will apply to claims with dates of service on or after July 15, 2016.

We currently apply a frequency limit of one unit per date of service to CPT code 91065 (hydrogen or methane breath test). We consider this one test per challenge regardless of the number of samples collected; therefore, beginning with claims processed on or after November 21, 2016, modifiers will not override the frequency limit for CPT code 91065.

We currently apply a frequency limit of one unit to be applicable to HCPCS codes S9140 (diabetic management program follow-up visit non-MD provider) and S9141 (diabetic management program follow-up visit MD provider) and therefore added these codes to our policy dated January 1, 2017; modifiers will not override this frequency limit.

Beginning with dates of service on or after March 1, 2017, we will implement the following frequency limits:
  - We currently apply a frequency limit of one per date of service to HCPCS code(s) H0020 (alcohol and/or drug services; methadone administration and/or service [provision of the drug by a licensed program]) and H0022 (alcohol and/or drug intervention service [planned facilitation]) as we consider these codes to be
“per day” services and therefore added the codes to our policy dated January 1, 2017. Modifiers will not override this frequency limit with dates of service on or after March 1, 2017.

- We will apply a frequency limit of one per date of service to CPT code 49185 (sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed). This limit is based on the Health Plan’s interpretation of CPT parenthetical instruction and the March 2016 CPT® Assistant Q&A which state “49185 may only be reported once per day for the treatment of multiple interconnected lesions via single access.” Modifiers will not override the frequency limit.

- Based on Center for Disease Control and Prevention (CDC) recommendation, we will apply a frequency limit of three per date of service to CPT codes 87491 (Chlamydia trachomatis, amplified probe technique) and 87591 (Neisseria gonorrhoeae, amplified probe technique).

**Global Surgery and Modifier Rules**

Taking guidance from the CMS, beginning with claims processed on or after November 21, 2016, for dates of service on or after October 1, 2016, when modifier 55 (postoperative management only) is appended to a surgical procedure with zero-post operative days, the procedure will not be eligible for reimbursement.

**Moderate (Conscious) Sedation, Bundled Services and Supplies, and Modifiers 59, XE, XP, XS, and XU**

For dates of service on or after January 1, 2017, we will continue with the concept that moderate (conscious) sedation, identified by new CPT codes 99151, 99152, 99153, 99155, 99156, and 99157, is included with the reimbursement for certain Health Plan designated surgical, diagnostic, or therapeutic procedures and such sedation is not eligible for separate reimbursement when reported by the physician or other qualified health care professional performing one of the designated procedures. These designated procedures were previously listed in the deleted CPT Appendix G and are now identified in our “Codes that Include Moderate (Conscious) Sedation” list. Modifiers will not override the edits.

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

Beginning with dates of service on or after March 1, 2017, modifiers will no longer override the following edits:

- Our current edit denies 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)) when reported with 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Based on CPT instruction that states to not report 22633 with 22612, modifiers will no longer override the edit.

- Our current edit denies 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure) when reported with 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar). The Health Plan considers this correct coding therefore modifiers will not override the denial.

- Our current edit denies CPT code 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental to 76881 (ultrasound, extremity, nonvascular, real-time with image documentation; complete). We consider this to be correct coding therefore modifiers will not override the denial.
- We have a current edit that denies CPT code 42950 (pharyngoplasty (plastic or reconstructive operation on pharynx) as mutually exclusive to CPT code 15757 (free skin flap with microvascular anastomosis), when a free flap is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy). We consider this to be correct coding therefore modifiers will not override the edit.

- Our edit denies CPT code 27275 (manipulation, hip joint, requiring general anesthesia) as incidental to procedures 27093 (injection procedure for hip arthrography; without anesthesia) and 27095 (injection procedure for hip arthrography; with anesthesia). We consider this correct coding therefore modifiers will not override the edits.

**Multiple Diagnostic Cardiovascular Procedures**

We are adding information to section B of our policy that our multiple diagnostic cardiovascular reimbursement rules are not applicable to procedures for which there are no RVUs assigned to the technical component of a code.

**Prolonged Services**

We have updated our Prolonged Services Diagnosis Coding list, dated October 1, 2016, to include additional ICD-10-CM diagnosis codes that were effective October 1, 2016 and for which prolonged services are allowed--E083211, E083212, E083213, E083219, E083311, E083312, E083313, E083319, E083411, E083412, E083413, E083419, I16, I160, I161, I169, O115, O165. In addition, we have removed the ICD-9-CM diagnosis codes, which are no longer valid for dates of service on or after October 1, 2015.

**Sleep Studies and Related Services & Supplies and Frequency Editing**

In our June 2016 issue of Network Update, we advised we would implement a one (1) 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 have removed this edit for dates of service on or after September 1, 2016.

**Unit Frequency Maximums for Drugs and Biologic Substances**

We are adding information to our policy to document that modifiers do not override our unit frequency maximums for drugs and biologic substances.

**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 December 1, 2016.

- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Duplicate Reporting of Diagnostic Services
- Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Once per Lifetime Procedures
- Physical and Manipulative Maintenance Services
- ‘Rule of Eight’ Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Three Dimensional Rendering of Imaging Studies
Significant Edits
We have updated our Significant Edits posting to reflect the 2016 analysis of claims data for significant edits. We define a significant edit as: A code pair edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial of payment for a particular CPT code or HCPCS code submitted more than two-hundred and fifty (250) times per year in the Plan’s service area.

Coding Tip: 2017 Presumptive Drug Tests
Effective January 1, 2017, CPT has deleted presumptive drug class screening codes 80300 – 80304 and has added replacement codes 80305 – 80307. The new codes 80305 – 80307 have the same description as G0477 – G0479 and HCPCS Coding Standards: Levels of Use state “… When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used.” Providers are encouraged to follow HCPCS coding guidance and report the 80305 – 80307 CPT codes for presumptive drug screening services. Do not report both 80305 – 80307 and G0477 – G0479 for same date(s) of service as this would represent a duplication of services.

Coding Tip: 2017 Modifier 95 for Telehealth Services
Effective January 1, 2017, CPT is adding modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). Based CPT instruction, modifier 95 is to be used only with the services listed in Appendix P of the CPT codebook when those services are rendered via real-time (synchronous) interactive telecommunication.

System Updates for 2017
As a reminder, our ClaimsXten and other proprietary editing software packages will be updated quarterly in February, May, August and November of 2017. These updates will:
- reflect the addition of new and revised CPT/HCPCS codes and their associated edits.
- include updates to National Correct Coding Initiative (NCCI) edits.
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits.
- include assistant surgeon eligibility in accordance with the policy.
- include edits associated with reimbursement policies including, but not limited to, preoperative and postoperative periods assigned by The Centers for Medicare & Medicaid Services (CMS).

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

CPT® is a registered trademark of the American Medical Association.

IN, KY, OH: New facility reimbursement 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.

Anthem will have a new facility reimbursement policy titled Claims Requiring Additional Documentation. This policy documents Anthem’s guidelines for claims requiring additional documentation and the facility's compliance for the provision of requested documentation. This policy is effective on January 1, 2017 for Indiana and March 1, 2017 for Kentucky and Ohio. Please refer to the policy for further details.
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

Anthem adds new membership to Interactive Care Reviewer: Register Today
Beginning January 1, 2017, with Interactive Care Reviewer (ICR), your practice can initiate precertification and prior authorization requests online more efficiently and conveniently for your Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect membership. Access ICR via the Availity Web Portal to experience a streamlined process to request inpatient and outpatient medical and behavioral health procedures for many of your patients covered by Anthem Blue Cross and Blue Shield plans.

How does a provider gain access to our Interactive Care Reviewer (ICR)?
Access our ICR tool via the Availity Web Portal. If your organization has not yet registered for Availity, go to www.availity.com and select Register in the upper right hand corner of the page. If your organization already has access to Availity, your Availity Administrator can grant you access to Authorization and Referral Request for submission capability and Authorization and Referral Inquiry for inquiry capability. You can then find our tool under Patient Registration|Authorizations & Referrals then choose the Authorizations or Auth/Referral Inquiry option as appropriate.

How can providers learn more about our Interactive Care Reviewer (ICR) tool?
Anthem offers informational webinars to help you learn more about the features and benefits of our new tool and how to navigate within. To register and review available dates and times, please click here.

Who can providers contact with questions?
For questions regarding our ICR, please contact your local Network Relations representative. For questions on accessing our tool via Availity, call Availity Client Services at 1-800-AVAILITY (1-800-282-4548). Availity Client Services is available Monday-Friday, 8 am to 7 pm ET (excluding holidays) to answer your registration questions.

Here are a few benefits and efficiencies:
- **Automated routing to ICR** - From the Availity Web Portal, you will automatically be routed to ICR to begin your precertification or prior authorization request once the migration has occurred and you go to Patient Registration|Authorizations & Referrals, then Authorizations. There is no need for you to remember the prefixes or migration dates.
- **Determine if a precertification or prior authorization is needed** - For most requests, when you enter patient, service and provider details, you receive a message indicating whether or not review is required.
- **Inquiry capability** - Ordering and servicing physicians and facilities can inquire to find information on any precertification or prior authorization they are affiliated with and the request was previously submitted via phone, fax, ICR, or other online tool, (i.e., AIM Specialty Health®, OrthoNet LLC, eReview, etc.).
- **Easy to use** – submit both outpatient and inpatient requests online for medical and behavioral health* services, using the same, easy to use functionality.
- **Reduce the need to fax** – Submit online requests without the need to fax medical records. Our ICR allows both text detail and photo and image attachments to be submitted along with the request.

- **No additional cost** – You get access to a no-cost solution that's easy to learn and even easier to use.

- **Access almost anywhere** – Submit your requests from any computer with internet access. Use browser Internet Explorer 11, Chrome, Firefox or Safari for optimal viewing.

- **Comprehensive view of all precertification requests** – You have a complete view of your UM requests submitted online, including status of your requests with views of case updates. Cases now include an imaged copy of the associated letters.

Prior authorization requirements for injectable/infusible drugs: Istodax (Romidepsin),Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb)

Effective February 1, 2017, Anthem will require prior authorizations (PA) for: Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb). Requests must be reviewed for PAs for dates of service on or after February 1, 2017. Please visit the provider website at anthem.com/inmedicaiddoc for specific detailed PA requirements.

To request a PA, please call us at 1-866-408-6132 for Hoosier Healthwise and Hoosier Care Connect or at 1-800-345-4344 for Healthy Indiana Plan. You may also fax your request to 1-866-406-2803.

If you have questions about this communication or need assistance with any other item, call the Provider Helpline at 1-866-408-6132 for Hoosier Healthwise, 1-800-345-4344 for Healthy Indiana Plan or 1-844-284-1798 for Hoosier Care Connect.

Prior authorization required for elective one- and two-vessel CABG

Effective January 1, 2017, Anthem will require prior authorization (PA) for all elective one- and two-vessel Coronary Artery Bypass Graft (CABG). All elective one- and two-vessel CABG requests must be reviewed for PA for dates of service on or after January 1, 2017.

MCG Care Guidelines medical necessity criteria for CABG will be used to review requests for these services.

Please visit the provider website at anthem.com/inmedicaiddoc for specific detailed PA requirements.

To request PA, please call us at 1-866-408-7187 for Hoosier Healthwise and Hoosier Care Connect or at 1-866-398-1922 for Healthy Indiana Plan. You may also fax your request to 1-866-406-2803. Failure to obtain a prior authorization for non-emergent one- and two-vessel CABGs will result in denial of the claims for these services.

If you have questions about this communication or need assistance with any other item, call the Provider Helpline at 1-866-408-6132 for Hoosier Healthwise, 1-800-345-4344 for Healthy Indiana Plan or 1-844-284-1798 for Hoosier Care Connect.

Updated medical policies

On May 5, 2016, the Medical Policy and Technology Assessment committee (MPTAC) approved the following medical policies applicable to Anthem. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the listing below. Note: Existing precertification requirements have not changed.
The medical policies were made publicly available on the Anthem provider website on the effective date listed above. To search for specific policies, visit www.anthem.com/cptsearch_shared.html.

### Updated Clinical UM Guidelines

On May 5, 2016, the MPTAC approved the following Clinical UM Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations committee for the Government Business Division on September 21, 2016. Note: Existing precertification requirements have not changed.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Policy number</th>
<th>Medical policy</th>
<th>Medical policy (new/revised)</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00082</td>
<td>Daratumumab (DARZALEX™)</td>
<td>New</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00083</td>
<td>Elotuzumab (Empliciti™)</td>
<td>New</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00084</td>
<td>Interferon gamma-1b (Actimmune®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00085</td>
<td>Ixabepilone (Ixempra®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00086</td>
<td>Mecasermin (Increlex®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>GENE.00045</td>
<td>Detection and quantification of tumor DNA using next generation sequencing in lymphoid cancers</td>
<td>New</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>SURG.00143</td>
<td>SpaceOAR® system</td>
<td>New</td>
</tr>
<tr>
<td>May 12, 2016</td>
<td>DRUG.00028</td>
<td>Intravitreal treatment for retinal vascular conditions</td>
<td>Revised</td>
</tr>
<tr>
<td>May 12, 2016</td>
<td>DRUG.00063</td>
<td>Ofatumumab (Arzerra®)</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00076</td>
<td>Blinatumomab (Blinycyo®)</td>
<td>Revised</td>
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<tr>
<td>May 19, 2016</td>
<td>DRUG.00077</td>
<td>Monoclonal antibodies to interleukin-17A</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>MED.00119</td>
<td>High intensity focused ultrasound (HIFU) for oncologic indications</td>
<td>Revised</td>
</tr>
</tbody>
</table>

The medical policies were made publicly available on the Anthem provider website on the effective date listed above. To search for specific policies, visit www.anthem.com/cptsearch_shared.html.

### Updated Clinical UM Guidelines

On May 5, 2016, the MPTAC approved the following Clinical UM Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations committee for the Government Business Division on September 21, 2016. Note: Existing precertification requirements have not changed.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Clinical UM Guideline number</th>
<th>Guideline title</th>
<th>New/revised</th>
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<tbody>
<tr>
<td>June 28, 2016</td>
<td>CG-DME-39</td>
<td>Dynamic low-load prolonged-duration stretch devices</td>
<td>New</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-48</td>
<td>Azacitidine (Vidaza®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-49</td>
<td>Doxorubicin hydrochloride liposome injection</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-50</td>
<td>Paclitaxel, protein-bound (Abraxane®)</td>
<td>New</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-51</td>
<td>Romidepsin (Istodax®)</td>
<td>New</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-52</td>
<td>Temsirolimus (Torisel®)</td>
<td>New</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-53</td>
<td>Drug dosage, frequency and route of administration</td>
<td>New</td>
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<tr>
<td>June 13, 2016</td>
<td>CG-SURG-55</td>
<td>Intracardiac electrophysiological studies (EPS) and catheter ablation</td>
<td>New</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-15</td>
<td>Gonadotropin releasing hormone analogs</td>
<td>Revised</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-DRUG-34</td>
<td>Docetaxel (Docefrez™, Taxotere®)</td>
<td>Revised</td>
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<tr>
<td>June 28, 2016</td>
<td>CG-SURG-27</td>
<td>Sex reassignment surgery</td>
<td>Revised</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>CG-SURG-44</td>
<td>Coronary angiography in the outpatient setting</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>CG-THER-RAD-01</td>
<td>Fractionation and radiation therapy in the treatment of specified cancers</td>
<td>Revised</td>
</tr>
</tbody>
</table>
These clinical guidelines were made publicly available on the Anthem provider website on the effective date listed above. To see the full UM Guidelines, visit www.anthem.com/cptsearch_shared.html.

**Policy reminder: Claims timely filing**
*(Policy 06-050, originally effective 02/01/2015)*
To be considered for reimbursement, the initial claim must be received and accepted by the following standard:
- 90 days for participating providers and facilities
- 12 months for nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at www.anthem.com/inmedicaiddoc.

**Policy update: Modifier usage**
*(Policy 06-006, effective 08/01/16)*
Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, Anthem Blue Cross and Blue Shield will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at www.anthem.com/inmedicaiddoc.

**Policy reminder: Split-care surgical modifiers**
*(Policy 11-005, effective 08/01/16)*
Reimbursement of surgical codes appended with “split-care modifiers” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:
- Modifier 54 (surgical care only): 90%
- Modifier 55 (postoperative management only): 10%

Anthem does not allow separate reimbursement for Modifier 56.

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member’s care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at www.anthem.com/inmedicaiddoc.
Case Management Program empowers patients
Managing chronic illness can be difficult for your patients. Knowing who to contact, what test results mean or how to obtain needed resources can be a big piece of a health care puzzle.

Anthem offers assistance through our Case Management program. Our case managers are part of an interdisciplinary team of clinicians, and other resource professionals, to support members, families, primary care providers and caregivers. The case management process utilizes the experience and expertise of our care coordination team to educate and empower our members to increase self-management skills, understand their illness and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves, or family members, to case management by calling the number below. They will be connected to a team member based on their immediate need. Physicians can also refer members via the contact information below. No issue is too big or too small. We can help with transitions across levels of care in order for patients and caregivers to be better prepared about health care decisions and goals.

How do you contact us? Call 1-866-902-1690, Monday – Friday, 8 am – 5 pm.

For KY Medicaid only
Interpreter services available for members
Anthem Blue Cross and Blue Shield Medicaid members who require interpreter services should contact Member Services at 1-855-690-7784 to request telephonic or face-to-face interpreter services. These services are available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history or health education. If a provider is coordinating the service on behalf of a member, Provider Services can assist by calling 1-855-661-2028.

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

Provider website survey
Anthem Blue Cross and Blue Shield Medicaid relies on your feedback to improve and strengthen our processes and operations. Our Provider Website Survey is a new tool to evaluate the effectiveness of our Medicaid provider website. Input about your experience with our website is essential to our goal of efficient and effective provider resources. We will use your survey responses to better understand your experiences and continue to improve our site. Providing exceptional service to providers who serve Anthem Blue Cross and Blue Shield Medicaid members is one of our strongest commitments.

Thank you in advance for taking the time to complete this brief survey. To access the survey, go to https://www.surveymonkey.com/ri/7PHY5BL.

Policy reminder: Claims timely filing
(Policy 06-050)
To be considered for reimbursement, the initial claim must be received and accepted by the following standard:
- 180 days from the date of service for participating providers and facilities
- 365 days from the date of service for nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.
For additional information, refer to the Claims Timely Filing reimbursement policy at https://mediproviders.anthem.com/ky.

**Policy update: Modifier usage**  
(*Policy 06-006, effective 08/01/16*)  
Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, Anthem Blue Cross and Blue Shield Medicaid will default to CMS guidelines.

Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://mediproviders.anthem.com/ky.

**Policy reminder: Split-Care Surgical Modifiers**  
(*Policy 11-005, effective 08/01/16*)  
Reimbursement of surgical codes appended with “split-care modifiers” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:

- Modifier 54 (surgical care only): 90%
- Modifier 55 (postoperative management only): 10%

Anthem does not allow separate reimbursement for Modifier 56.

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member’s care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://mediproviders.anthem.com/ky.

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**For WI Medicaid only**

Prior authorization requirements for injectable/infusible drugs: Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb)  
Effective February 1, 2017, Anthem will require prior authorization (PA) for Istodax (Romidepsin), Ixempra (Ixabepilone), Doxil (Doxorubicin), Torisel (Temsirolimus) and Inflectra (Infliximab-dyyb). Requests must be reviewed by Anthem for PA for dates of service on and after February 1, 2017. Please refer to the Provider Self-Service tool for detailed authorization requirements.
Please use one of the following methods to request PA:

- Call Provider Services: 1-855-558-1443
- Fax: 1-800-964-3627
- Visit the Web: https://mediproviders.anthem.com/wi

If you have questions about this communication, received it in error, or need assistance with any other item, call Provider Services at 1-855-558-1443.

Prior authorization required for elective one- and two-vessel Coronary Artery Bypass Graft

Effective January 1, 2017, Anthem will require prior authorization (PA) for elective one- and two-vessel Coronary Artery Bypass Graft (CABG). Elective one- and two-vessel Coronary Artery Bypass Graft (CABG) requests must be reviewed by Anthem for PA for dates of service on and after January 1, 2017. Please refer to the Provider Self-Service tool for detailed authorization requirements.

In review of these services, physicians should reference the MCG Care Guidelines criteria.

Please use one of the following methods to request PA:

- Call Provider Services: 1-855-558-1443
- Fax: 1-800-964-3627
- Visit the Web: https://mediproviders.anthem.com/wi

If you have questions about this communication, received it in error, or need assistance with any other item, call Provider Services at 1-855-558-1443.

Updated medical policies

On May 5, 2016, the Medical Policy and Technology Assessment committee (MPTAC) approved the following medical policies applicable to Anthem Blue Cross and Blue Shield (Anthem). These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the listing below. Note: Existing precertification requirements have not changed.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Policy number</th>
<th>Medical policy</th>
<th>New/revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00082</td>
<td>Daratumumab (DARZALEX™)</td>
<td>New</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00083</td>
<td>Elotuzumab (Empliciti™)</td>
<td>New</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00084</td>
<td>Interferon gamma-1b (Actimmune®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00085</td>
<td>Ixabepilone (Ixempra®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00086</td>
<td>Mecasermin (Increlex®)</td>
<td>New</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>GENE.00045</td>
<td>Detection and quantification of tumor DNA using next generation sequencing in lymphoid cancers</td>
<td>New</td>
</tr>
<tr>
<td>July 1, 2016</td>
<td>SURG.00143</td>
<td>SpaceOAR® system</td>
<td>New</td>
</tr>
<tr>
<td>May 12, 2016</td>
<td>DRUG.00028</td>
<td>Intravitreal treatment for retinal vascular conditions</td>
<td>Revised</td>
</tr>
<tr>
<td>May 12, 2016</td>
<td>DRUG.00063</td>
<td>Ofatumumab (Arzerra®)</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>DRUG.00076</td>
<td>Blinatumomab (Blincyto®)</td>
<td>Revised</td>
</tr>
<tr>
<td>May 19, 2016</td>
<td>DRUG.00077</td>
<td>Monoclonal antibodies to interleukin-17A</td>
<td>Revised</td>
</tr>
<tr>
<td>June 28, 2016</td>
<td>MED.00119</td>
<td>High intensity focused ultrasound (HIFU) for oncologic indications</td>
<td>Revised</td>
</tr>
</tbody>
</table>

The medical policies were made publicly available on the Anthem provider website on the effective date listed above. To search for specific policies, visit www.anthem.com/cptsearch_shared.html.
Updated Clinical UM Guidelines
On May 5, 2016, the MPTAC approved the following Clinical UM Guidelines. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing. This list represents the clinical UM guidelines adopted by the medical operations committee for the Government Business Division on June 8, 2016. Note: Existing precertification requirements have not changed.

These clinical guidelines were made publicly available on the Anthem provider website on the effective date listed above. To see the full utilization management guidelines, visit www.anthem.com/cptsearch_shared.html.

Policy reminder: Claims Timely Filing
(Policy 06-050, originally effective 07/01/2014)
To be considered for reimbursement, the initial claim must be received and accepted by the following standard:
- 180 days for participating providers and facilities
- 365 days for nonparticipating providers and facilities

If services are rendered on consecutive days, such as for a hospital confinement, the limit will be counted from the last day of service. Limits are based on calendar days unless otherwise specified. Services denied for failure to meet timely filing requirements are not subject to reimbursement unless the provider presents documentation proving a clean claim was filed within the applicable filing limit.

For additional information, refer to the Claims Timely Filing reimbursement policy at https://mediproviders.anthem.com/wi.

Policy update: Modifier usage
(Policy 06-006, effective 08/01/16)
Reimbursement for covered services provided to eligible members when billed with appropriate procedure codes and appropriate modifiers is based on the code-set combinations submitted with the correct modifiers. The use of correct modifiers does not guarantee reimbursement. The use of certain modifiers requires the provider to submit supporting documentation along with the claim. In the absence of state-specific modifier guidance, we will default to CMS guidelines.
Refer to the Exhibit A: Reimbursement Modifiers Listing for descriptions and guidance on documentation submission. For additional information, refer to the Modifier Usage reimbursement policy at https://mediproviders.anthem.com/wi.

**Policy reminder: Split-care surgical modifiers**
*(Policy 11-005, effective 08/01/16)*
Reimbursement of surgical codes appended with “split-care modifiers” is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code:
- Modifier 54 (surgical care only): 80%
- Modifier 55 (postoperative management only): 20%

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member’s care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

For more information, refer to the Split-Care Surgical Modifiers reimbursement policy at https://mediproviders.anthem.com/wi.