

# Network Update

CENTRAL REGION

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

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IN, KY, MO, OH, WI

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# Health Care Reform (including Health Insurance Exchange)

## Updates and Notifications

Please be sure to check the Health Care Reform Updates and Notifications and Health Insurance Exchange sections of our website regularly for new updates on health care reform and Health Insurance Exchanges, at [www.anthem.com](http://www.anthem.com)>[Tools](#) for Providers (select state)>Health Care Reform/Health Insurance Exchange. Recently, the following article was posted online, [Preventive care services covered with no member cost-share \(updated December 2016\)](#).

### 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](http://anthem.com) > Tools for providers (enter state)>Network eUPDATE.

## Administrative Update

### Retirement is delayed for MyAnthem provider portal

We previously announced that Anthem was targeting January 2017 to retire MyAnthem and transition all functionality to a single website, the Availity Web Portal. While most tools on MyAnthem have already been moved, the full transition has been postponed until further notice. (As a reminder, Remittance Inquiry and the Professional Fee Schedule Inquiry tools are both available now exclusively under Payer Spaces on Availity.)

In the meantime, we soon will introduce our new, secure self-service tool on the Availity Web Portal where you can access all the important proprietary information and educational materials found on MyAnthem today. After that tool is in place and you have had some time to get familiar with it, we will fully retire MyAnthem. More communications on these exciting changes will be posted soon.

### Moving toward equity in asthma care

Did you know?

- Hispanics and African Americans with asthma are less likely to take daily controllers and are more likely to visit the emergency room and be hospitalized for asthma-related conditions than non-Hispanic Whites.<sup>1</sup>
- Asian Americans are more likely to die from asthma than non-Hispanic Whites.<sup>2</sup>

Anthem is committed to achieving health equity in asthma outcomes with diverse populations and now offers the free online experience, [Moving Toward Equity in Asthma Care](#), to support providers in delivering culturally appropriate asthma care to diverse patients.

**Providers will receive 1.0 continuing Medical Education (CME) credit upon successful completion of the course and easy access to additional resources about asthma disparities.**

Key features of the course:

- Can be accessed from any mobile device, laptop, or desktop computer
- Interactive learning
- Bookmarking feature allows users to pause the course and resume it later
- Content is relevant for multiple diverse populations
- Focus on current disparities and what may contribute to them

To learn more about how providers and patients can work together to reduce asthma disparities, access this important training [here](#).

<sup>1</sup>Ethnic Disparities in the Burden and Treatment of Asthma. Report by the Asthma and Allergy Foundation of America and the National Pharmaceutical Council. January 2005

<sup>2</sup>Office of Minority Health

This Enduring Material activity, Moving Toward Equity in Asthma, has been reviewed and is acceptable for up to 1.00 Prescribed credit(s) by the American Academy of Family Physicians. Term of approval begins 09/28/2016. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Hardware/Software Requirements** – To access activities, users will need:

A computer, tablet, or smartphone with an Internet connection. Microsoft Internet Explorer (9 or later); Google Chrome (38 or later); Safari (5 or later); Mozilla Firefox (32 or later).

## Practitioners' rights during credentialing process

The credentialing process must be completed before a practitioner begins seeing enrollees and enters into a contractual relationship with a health care insurer or HMO. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application
- Correct erroneous information regarding a credentialing application
- Be notified of the status of credentialing or re-credentialing applications

The CAQH (Coalition for Affordable Quality Healthcare) universal credentialing process is used for all providers who contract with Anthem. To apply for credentialing with Anthem, go to the CAQH web site at [www.caqh.org](http://www.caqh.org) and select CAQH ProView™. There is no cost to providers to submit their applications.

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members' claims.

## Reminder: Refer your patients to in-network labs for genetic testing

Effective February 1, 2017, Myriad Genetic Laboratories is no longer an in-network laboratory for Anthem. For a list of other laboratories that continue to be in-network for BRCA testing and other genetic testing services, please see the *Network eUPDATE*, [Important update on Anthem in-network labs](#). (Or go online to [www.anthem.com/Tools for providers](http://www.anthem.com/Tools_for_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](http://anthem.com). Thank you for your help and continued efforts to keep our records up to date.

## Federal Employee Plan (FEP)

### Blood pressure monitor benefits

FEP has initiated a program to provide free blood pressure monitors\* to enrollees over age 18 who have a diagnosis of hypertension or have high blood pressure without a diagnosis of hypertension. If your patient completes the online Blue Health Assessment (BHA), available at [www.fepblue.org](http://www.fepblue.org), and reports having high blood pressure, and you and your patient discuss home monitoring, your patient is eligible to receive a free blood pressure monitor. (The BHA is a health-risk assessment and the first step in the FEP [Wellness Incentive Program](#).) In addition to the free blood pressure monitor, members can earn financial incentives for completing the BHA and for achieving goals related to a healthy lifestyle. For more detail, go to [www.fepblue.org/bha](http://www.fepblue.org/bha).

You can find more information on self-measured blood pressure monitoring online by going to <https://www.ama-assn.org/delivering-care/improving-blood-pressure-control> and at [anthem.com](http://anthem.com)>Tools for providers (enter state)>Health & Wellness >Tools and Resources for Providers>Blood Pressure Information.

For additional information on how members can receive a free blood pressure monitor, call FEP Customer Service at the number listed for your state: IN – 800-382-5520; KY – 800-456-3967; MO – 800-392-8043; OH – 800-451-7602; WI – 800-242-9635

*\*The blood pressure monitors were selected by BCBS. The AMA does not endorse any particular brand or model of blood pressure monitor.*

## Health Care Management

### Medical policy update

The following new Anthem medical policies were reviewed on November 3, 2016, for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on May 1, 2017.

#### **DME.00040 Automated Insulin Delivery Devices**

This new medical policy addresses the use of automated insulin delivery devices, also referred to as “artificial pancreas devices.”

#### **LAB.00033 Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer**

This new medical policy addresses the use of protein biomarkers, specifically the 4Kscore® test, for the screening, detection and management of prostate cancer.

The following revisions to Anthem medical policies will be implemented on May 1, 2017.

**DRUG.00051 Ziv-aflibercept (Zaltrap®)**

This policy was revised to reflect revised Medical Necessity (MN) criteria to limit anal, appendiceal and small bowel adenocarcinomas to metastatic disease.

**GENE.00002 Preimplantation Genetic Diagnosis Testing**

This policy was revised to clarify medical necessity (MN) criteria addressing PGD for the evaluation of human leukocyte antigen (HLA) status and added criteria for preimplantation genetic screening (PGS) for fetal aneuploidy (trisomy 13, 18, and 21) .

**GENE.00025 Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignant Tumors**

This policy was revised to include proteogenomic testing as Investigational and Not Medically necessary (INV&NMN) for all indications.

**MED.00057 MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications**

This policy was revised; changes include expanding the scope and revising the position statement.

**SURG.00129 Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring**

This policy was revised; changes include clarification of criteria addressing failed surgical interventions in jaw realignment surgery.

*Note:* The complete list of our Medical Policies and Clinical UM Guidelines may be accessed online. Go to [anthem.com](http://anthem.com)>Tools for providers (enter state)>Medical Policy, Clinical UM Guidelines, Pre-Cert Requirements.

**Specialty pharmacy prior authorization will expand**

The following information includes changes to prior authorization requirements related to specialty pharmacy drugs. All the changes are effective May 1, 2017. Pre-service review of the specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company administering the program on behalf of Anthem. As a reminder, information on Anthem's medical policies and clinical guidelines, including dosing guidelines, can be found online.

**DRUG codes added to prior authorization requirements**

Medical Policy or Clinical Guideline (CG) number	DRUG code	Drug Names	Comments
CG-DRUG-09	J3490	Cuvitru	New drug to existing Clinical UM Guideline
CG-DRUG-54	J0180	Agalsidase beta (Fabrazyme)	New Clinical UM Guideline
CG-DRUG-55	J1322	Elosulfase alfa (Vimizim)	New Clinical UM Guideline (includes a requirement for level of care review)
CG-DRUG-56	J1458	Galsulfase (Naglazyme)	New Clinical UM Guideline
CG-DRUG-57	J1743	Idursulfase (Elaprase)	New Clinical UM Guideline (includes a requirement for level of care review)
CG-DRUG-58	J1931	Laronidase (Aldurazyme)	New Clinical UM Guideline
CG-DRUG-62	J9395	Fulvestrant (Faslodex)	New Clinical UM Guideline
CG-DRUG-63	J0641	Levoleucovorin Calcium (Fusilev)	New Clinical UM Guideline
DRUG.00002	J3590	Adalimumab-atto (Amjevita)	New Drug to existing Medical Policy
DRUG.00090	J3490, J3590	Bezlotoxumab (Zinplava)	New Medical Policy
DRUG.00097	J9999	Olaratumab (Lartruvo)	New Medical Policy
DRUG.00102	J9043	Cabazitaxel (Jevtana)	New Medical Policy
DRUG-66	J7192	Afstyla	New Drug to existing Medical Policy

Note: View level of care drug list [here](#). For more information, see FAQs [here](#).

### New CG includes drug dosage and frequency review

A new clinical guideline, CG-DRUG-53, Drug Dosage, Frequency, and Route of Administration, will take effect beginning with dates of service on and after May 1, 2017. This will apply to the review process for Specialty Pharmacy and the expanded program will be administered by AIM. Based on the information that you provide, AIM will review the drug for clinical appropriateness, dosage, and frequency against Anthem's clinical criteria. As part of the review process, the following information will be required:

- Weight, height, age, and gender
- Dose per treatment and directions per treatment (frequency) and duration (length of therapy)

Note: Drug wastage should be reported with modifier "JW." You may be reimbursed for single dose vial drug wastage beyond the approved dosage authorized per the process outlined above. Providers are expected to utilize the most economical combination of vial sizes for the drug administered and must report the drug wastage as a separate line item on the claim form with modifier "JW" appended. Anthem reimbursement limits will apply and will take into consideration applicable wastage based on the most economical combination of vial sizes.

### Clinically equivalent requirement added to updated CGs

The chart below shows clinical guidelines and medical policies that have been updated to include the requirement of a clinically equivalent treatment, effective May 1, 2017.

Policy	Impacted Products	Clinically Equivalent/Cost Effective Products
FDA-Approved Biosimilar Products; CG.DRUG.64	Inflectra®	Remicade®
CG.Drug.29	Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®	Monovisc®, Orthovisc®, Synvisc, Synvisc One®

### Level of care review includes hemophilia drug indications

Anthem will require a level of care review for hemophilia drug indications, effective May 1, 2017. It applies to local Anthem members who have specialty pharmacy services medically managed by AIM. It does not apply to the following plans: BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, and Federal Employee Program (FEP).

### Reminder: Requesting prior authorization via AIM

Providers may request prior authorization for specialty drugs by one of the following:

- Access the AIM **ProviderPortal** <sup>SM</sup> directly at [providerportal.com](http://providerportal.com). Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at [availity.com](http://availity.com).
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday – Friday, 7:30 am – 6 pm, ET.

### Reminder for specialty drug infusion/injection providers

As previously communicated in the October 2016 issue of [Network Update](#), Anthem expanded the Specialty Pharmacy program to include level of care clinical review for specialty pharmacy infusions and injections for dates of service on and after July 18, 2016.

Ambulatory Infusion Suites, Home Infusion Providers, and physician offices can register to be included as an

alternative location for the administration of specialty drugs using the [OptiNet® registration tool](#). Providers that complete the registration process are available as an alternative provider the subsequent business day. Please note, providers *must* be contracted as an Ambulatory Infusion Suite, Home Infusion Provider, or physician office to be eligible as an alternative specialty drug infusion/injection provider. Claim payment issues (e.g. delay in payment or denial of reimbursement) can result if hospital/facility providers incorrectly register as alternative providers. Providers already registered as an alternative location can review or edit the list of drugs provided at their site by logging in [here](#).

If you have questions about your network contract status, please contact Anthem Provider Services prior to registration.

### Updated AIM sleep disorder management guidelines

Effective for dates of service on or after May 12, 2017, the following enhancement to AIM Sleep Disorder Management Diagnostic and Treatment Guidelines will become effective: An exclusion of patients with LV ejection fraction of <45% is being added to the appropriateness criteria for use of BPAP (with back-up rate feature) in established central sleep apnea. This change is based on safety concerns brought to light by the SERVE-HF study, and is aligned with recommendations from AASM.

## Medicare

### Hospitals must use MOON form

The Centers for Medicare & Medicaid Services (CMS) requires that all hospitals and critical access hospitals (CAHs) provide written notification and an oral explanation to individuals receiving observation services as outpatients for more than 24 hours.

Hospitals should use the OMB-approved standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611. **All hospitals and CAHs are required to provide this statutorily required notification no later than March 8, 2017.** The notice and accompanying instructions are available at: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>

The MOON was developed to inform all Medicare beneficiaries, including Anthem Medicare Advantage members, when they are an outpatient receiving observation services, and are not an inpatient of the hospital or CAH. The notice must include the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post-hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated or sooner if the individual is transferred, discharged or admitted.

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## Postponed: AIM *OptiNet* imaging services initiative

Recent issues of *Network Update* and previous Important Medicare Advantage Updates have included information about an initiative administered by AIM Specialty Health to collect information about imaging capabilities of our Medicare Advantage providers. This initiative has been postponed from Jan. 1, 2017 to April 1, 2017. Medicare Advantage providers will not be subject to the requirement to have a specific *OptiNet* score to be reimbursed for outpatient diagnostic imaging services at this time. Although there is no reimbursement impact at this time, Anthem continues to encourage network providers to submit imaging services data for the AIM Specialty Health initiative.

If you have not yet registered, registration is available online via the AIM *ProviderPortal*<sup>SM</sup>. To access:

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

For additional assistance with registration or your score, you may also call AIM toll free at 800-252-2021, Option #3, Monday-Friday, 8 am -7 pm ET.

### Learn more: Attend a webinar

Anthem continues to offer webinars to help providers complete their *OptiNet* assessments. Attend one of the webinars below to learn how to:

- Access the *OptiNet* assessment.
- Copy previously completed *OptiNet* Assessments to your Anthem Medicare Advantage account.
- Complete a new AIM *OptiNet* registration.
- Interpret and improve your site score.

Webinars will be conducted Feb. 2 and 23 from 4:30 – 5 pm ET.

Please email [ronald.younger@anthem.com](mailto:ronald.younger@anthem.com) to have an invitation for the webinar delivered directly to your calendar.

Additional information will be available at [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider) under Important Medicare Advantage Updates.

## Payment reduction for X-rays using film

Effective for services furnished beginning Jan. 1, 2017, we will follow the CMS requirement for providers to bill modifier FX when billing for X-rays using film. A payment reduction of 20 percent will apply to the technical component (and the technical component of the global fee) for X-ray services furnished using film for which payment is made under the Medicare Physician Fee Schedule.

## Claims for tetanus vaccinations

Effective Jan. 1, 2016, tetanus vaccine (90703) was deleted by Medicare. Effective for dates of service Jan. 1, 2016 and after, providers who have administered a tetanus vaccine for an open wound or laceration should bill 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to the administration 90471 and/or 90472; with the appropriate diagnosis to indicate open wound or laceration. Please submit the claim to the member's Medicare Advantage or Medicare Medicaid Plan.

If a tetanus vaccine is administered for a reason other than puncture wound or laceration and your patient has pharmacy benefits, please bill the member's Medicare Part D plan. This applies to the vaccine and the administration charges.

To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse at the web site (<http://www.transactrx.com>) or call Customer Service at 866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of \$2.50 for check payments on claims.

CMS provides more information on Part D vaccines [here](#).

### **Include NPI in surgical procedure bills**

When billing a surgical procedure code for a Medicare Advantage or Medicare-Medicaid Plan (MMP) member, identify the operating provider NPI in box 77 on the facility UB04 CMS 1450 claim form.

### **Retrospective medical record review program**

Our retrospective medical record review initiative is a risk adjustment program **intended to identify and capture previously undocumented or new diagnosis data that might have been missed** due to coding and/or technical limitations. We contract with Verscend Health, formerly Verisk, to conduct provider outreach requesting medical records with dates of service **for the target year (2016) thru present day**, then review and code the record.

**Jaime Marcotte, Retrospective Risk Program Lead, is managing this initiative.** Should you have any questions regarding this program please do not hesitate to contact **Jaime at [Jaime.Marcotte@anthem.com](mailto:Jaime.Marcotte@anthem.com)** or 314-925-6094. Additional information, including FAQs, is available at [Important Medicare Advantage Updates](#) found at [anthem.com/medicareprovider](http://anthem.com/medicareprovider).

### **Correction: Transitional Care Management services eligibility**

*This is a correction to the December 2016 Network Update:* A beneficiary is eligible to receive TCM services beginning on the date they are discharged from the inpatient hospital setting and continues for the next 29 days. Anthem determines the date of discharge based on the date the beneficiary received their 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 Dual Special Needs Plans, and Medicare-Medicaid Plans. For more information on TCM services refer to <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>.

### **Reminder: Individual MA members should use Hearing Care Solutions**

As a reminder, members enrolled in individual Medicare Advantage plans that provide routine hearing exam and/or hearing aid benefits must use Hearing Care Solutions for their hearing benefits. When the member contacts Hearing Care Solutions to use hearing benefits, Hearing Care Solutions staff helps members find a provider in their area that will best meet their needs. Providers interested in joining the Hearing Care Solutions network should call 1-855-312-2545. Hearing claims will deny for members who see a provider not contracted with Hearing Care Solutions.

If you have questions, please call provider services on the number on the back of the member's ID card.

## KY, MO, OH, WI: Radiation therapy

### Contact AIM for delivery, Anthem for planning

Prior authorization of outpatient radiation therapy services is required for Anthem individual Medicare Advantage and Medicare Medicaid Plan members. Providers should request prior authorization for the radiation therapy modalities and services listed below:

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

The type of review needed will determine the prior authorization steps to be taken:

- 1) Planning – Prior authorization is administered by contacting Anthem through Availity.
- 2) Planning and Delivery – Prior authorization is administered by AIM Specialty Health® (AIM).
- 3) Delivery - Prior authorization is administered by AIM Specialty Health® (AIM).

If you are ready to **deliver** any of the services listed above, please contact AIM. AIM reviews authorizations for **delivery and planning** services under the umbrella of radiation therapy modalities. To submit your request, go to the AIM **ProviderPortal** at [www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb). From the dropdown menu, select Anthem MA. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 8 am – 8 pm ET.

### Keep up with MA news

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

[Medicare risk adjustment and documentation guidance training offered](#)

[Prior authorization requirements for intracardiac electrophysiological studies and catheter ablation](#)

[December Reimbursement Policy Provider Bulletin](#)

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## Pharmacy

### Pharmacy information available at anthem.com

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit [www.anthem.com/pharmacyinformation](http://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](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf); and **Standard Option:** [https://www.caremark.com/portal/asset/z6500\\_drug\\_list.pdf](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](http://www.fepblue.org) > Benefit Plans > Brochures and Forms > Medical Policies.

# Quality

## Commercial HEDIS 2017 starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax. The fax will contain 1) a cover letter with contact information your office can use to contact us if there are any questions; 2) a member list, which includes the member and HEDIS measure(s) the member was selected for; and 3) an instruction sheet listing the details for each HEDIS measure. As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c)(4)]. For more information, visit [www.hhs.gov/ocr/privacy](http://www.hhs.gov/ocr/privacy).

HEDIS review is time sensitive, so please submit the requested medical records within **five business days**. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in the 3<sup>rd</sup> quarter provider newsletter.

To return the medical record documentation back to us in the recommended five-day turnaround time, do one of the following:

1. Upload to our secure portal. This is quick and easy. Logon to [www.submitrecords.com](http://www.submitrecords.com), enter the password: **wphedis57** and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.
2. Send a secure fax to **1-888-251-2985**.
3. Mail via the **US Postal Service** to: Anthem, Inc., 66 E. Wadsworth Park Drive, Suite 110H, Draper, UT 84020

Thank you in advance for your support of HEDIS.

## 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](http://www.anthem.com)>Providers (enter state)>Health & Wellness> [Practice Guidelines](#).

# Reimbursement

## Professional reimbursement policy updates

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

### Bundled Services and Supplies

The following Healthcare Common Procedure Coding System (HCPCS Level II) codes were effective January 1, 2017. The Health Plan considers these codes to be inclusive in the overall care of the patient and not eligible for separate reimbursement therefore we are adding these new codes to our always bundled edit and they will be added

to the Section 1 code list effective for claims processed on or after February 20, 2017. Modifiers will not override the edit.

- G0500 (*moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports... patient age 5 years or older...*)
- G0501 (*resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service)*)
- G0502 (*Initial psychiatric collaborative **care management**, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional*)
- G0503 (*Subsequent psychiatric collaborative **care management**, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional*)
- G0504 (*Initial or subsequent psychiatric collaborative **care management**, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional*)
- G0505 (*Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home*)
- G0506 (*Comprehensive assessment of and care planning for patients requiring chronic **care management** services (list separately in addition to primary monthly care management service)*)
- G0507 (*psychiatric collaborative **care management***)

The following HCPCS codes were effective January 1, 2017 for Medicaid services and will be added to our always bundled edit for claims processed on or after February 20, 2017 and will be added to the Section 1 code list.

Modifiers will not override the edit.

- T1040 - *Medicaid certified community behavioral health clinic services, per diem*
- T1041 - *Medicaid certified community behavioral health clinic services, per month*

### Drug Screen Testing

In our policy dated January 1, 2017, we have updated our policy to include new *Current Procedural Terminology* (CPT®) codes 80305, 80306, and 80307 (*presumptive drug testing*) that became effective January 1, 2017, which we will accept because HCPCS codes G0477, G0478, and G0479 (*drug test(s), presumptive*) have been deleted. In addition, we have added a new code HCPCS code G0659 for definitive drug testing, any number of drug classes. When G0480, G0481, G0482, or G0483 are reported with G0659, we consider this to be duplicate services and G0480, G0481, G0482, or G0483 will not be eligible for separate reimbursement; modifiers will not override the edit. Please review the policy in its entirety.

### Frequency Editing

We are updating our frequency limit for J1750 (injection, iron dextran (Infed), 50 mg) from 20 units per date of service to 40 units per date of service. This edit will be effective for claims processed on or after February 20, 2017 for dates of service on or after March 1, 2016.

For claims processed on or after February 20, 2017, we are adding frequency limits for the following HCPCS codes that were effective January 1, 2017:

- J7320 (*hyaluronan or derivative, Genvisc 850, for intra-articular injection, 1 mg*) will have a limit of 50 units per date of service
- J7322 (*hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg*) will have a limit of 48 units per

date of service

As stated in the December 2016 issue of *Network Update*, in the article titled “Avastin for intravitreal injections,” we will allow a maximum of five units per injection of C9257 (*injection, bevacizumab, 0.25 mg*); therefore, for dates of service on or after March 1, 2017, we are adding a frequency limit of 10 units per date of service for HCPCS code C9257.

For claims with dates of service on or after May 1, 2017, we are adding a limit of one per date of service for breast pumps E0602, E0603, and E0604.

### Telehealth Services

We updated our Telehealth Services policy to include new coding that was effective January 1, 2017. Updates include the addition of modifier 95 (*synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system*) which is to be used only with the services listed in the new Appendix P of the CPT® 2017 Professional Edition codebook when those services are rendered via real-time (synchronous) interactive telecommunication (this information is also included in our *Modifier Rules Reimbursement Policy*); the addition of new for 2017 place of service code “02” that identifies the place of service for the distant site telehealth provider; and new for 2017 HCPCS telehealth codes G0508 and G0509 (*telehealth critical care consults*). Please refer to our policy dated January 1, 2017 to view these updates.

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

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

### View Anthem reimbursement policies

To view Anthem’s reimbursement policies, sign onto the Availity Web Portal at [availity.com](http://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/](http://availity.com/providers/registration-details/).

## Specialty services – Behavioral Health

### Reminder: Submit your behavioral health precert request via ICR

This is a reminder that you can use the Interactive Care Reviewer (ICR) to initiate a request for precertification of behavioral health services and you also may receive an immediate authorization decision. To view a complete list of services where an immediate decision is available, click [here](#).

Now with ICR, your practice can initiate precertification and prior authorization requests online more efficiently and conveniently for many Anthem members. 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](http://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.

*Are there any specific services Behavioral Health practices can precert using ICR?*

ICR can be used to submit or inquire on a precertification or prior authorization for many behavioral health services, including: Intensive Outpatient Program, Partial Hospital Program, Inpatient, Residential, Adaptive Behavioral Treatment (formerly known as ABA), Transcranial Magnetic Stimulation and even Electroconvulsive Therapy and Psychiatric Testing where precert is necessary.

*Are there any services where an immediate decision can be obtained?*

Yes! Starting mid-January 2017, requests for Transcranial Magnetic Stimulation (TMS), will be eligible for an immediate decision when the completed provider tool within ICR is part of the submitted request.

*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 just a few of the many 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.

## Member satisfaction with behavioral health outpatient services

Anthem conducts an annual satisfaction survey of our member's behavioral health outpatient service experience. The random survey is conducted based on receipt of claims. We have recently reviewed the 2016 survey experience results and wanted to share highlights with our network of behavioral health providers. The survey inquires about the member's satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member's various providers), prescriptions/medication management process (if applicable), financial and billing process, and the member's perceived clinical improvement. Our member is also asked to give

an overall rating of the experience. The following 2016 overall practitioner ratings include, by state: IN -- 83% ; KY -- 88%; MO -- 89%; OH -- 87%; WI -- 84%

We were pleased to see improvement in two areas of focus over the last year: prescriptions and coordination of care. Members responding to the survey indicated that conversations with their prescribers were in depth and covered aspects, positive and negative, about taking the medication, along with alternative and supplemental treatments to address behavioral health issues. In addition, many respondents indicated that care was being coordinated among their providers, including medical. Care coordination and collaboration, particularly medical-behavioral integration, is a key area of our 2017 initiatives.

While we are pleased with our member's experience with our participating provider network and thank you for your network participation and the services you provide, two areas offer opportunities for improvement:

#### **Member access to behavioral health care**

As a participating provider, you are reminded of the following Anthem expectations concerning access to behavioral healthcare, based on NCQA definitions:

- **Non-life threatening emergency needs - must be seen, or have appropriate coverage directing the member, within 6 hours.** When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.
- **Urgent needs - must be seen, or have appropriate coverage directing the member, within 48 hours.** Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.
- **Routine office visit - must be within 10 business days.** Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

We use several methods to monitor adherence to these standards:

- a) assessing the availability of appointments via phone calls and surveys by our staff or designated vendor to the provider's office
- b) analysis of member complaint data
- c) analysis of member satisfaction.

Providers are expected to make best efforts to meet these access standards for all members. Anthem continues to look at gaps, barriers and alternative options to improve access to behavioral healthcare including tele-health services among network providers.

#### **Members held harmless**

A participating provider shall look solely to Anthem for compensation for covered services and under no circumstances shall render a bill or charge to any member except for applicable co-payments, deductibles and coinsurance and for services that are not medically necessary or are otherwise not covered, provided that the provider obtains the consent of the member before providing such service. We recommend that consent be in writing and dated, in order to protect our members and providers from disputes.

In addition, Anthem also reminds our participating providers that Anthem members must be advised of missed or cancelled appointment policies at the onset of treatment. We also recommend that the advisement be acknowledged by the member in writing, and that the acknowledgement is dated.

Thank you again for the services that you provide to our members.



# Medicaid Notifications

## For IN Medicaid only

### New policy: Corrected claims

(Policy 16-001, effective 05/15/2017)

Anthem allows reimbursement for a Corrected Claim when received within the applicable timely filing requirements of the original claim. The Corrected Claim must be received within the timely filing limit due to the initial claim not being considered a clean claim. Anthem follows the standard of:

- Within 60 days from the date on the Explanation of Benefit (EOB) for participating and nonparticipation providers and facilities

Providers resubmitting paper claims for corrections must clearly mark the claim “**Corrected Claim.**” Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate.

For additional information, refer to the Corrected Claims reimbursement policy at

[www.anthem.com/inmedicaiddoc](http://www.anthem.com/inmedicaiddoc).

### Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) update

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the DSM-5.

When transitioning from the DSM-IV-TR to the DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in DSM-5.

Although formatted differently, the same information is found within the DSM-5 diagnostic system. DSM-5 combines DSM-IV-TR axes I-III diagnoses into one list, as shown in Table 1.

**Table 1: DSM-5 diagnosis**

DSM-IV multiaxial system	DSM-5 nonaxial system
Axis I: clinical disorder (d/o) and other conditions that are focus of treatment Axis II: personality d/o and mental retardation Axis III: general medical conditions	Combined attention to clinical disorders, including personality disorders and intellectual disability; other conditions that are the focus of treatment; and medical conditions.
Axis IV: psychosocial and environmental stressors	Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.
Axis V: Global Assessment of Functioning (GAF)	Disability included in notation.  World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis V GAF was removed from DSM-5. Alternatively, WHODAS 2.0 is included in section III of DSM-5.

We understand that providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and

documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at <http://psychiatryonline.org>. Select View the DSM-5® Update (September 2016).

**Table 2**

<b>Disorder</b>	<b>Codes effective October 1, 2016</b>
Avoidant/Restrictive Food Intake Disorder	F50.89
Binge-Eating Disorder	F50.81
Disruptive Mood Dysregulation Disorder	F34.81
Excoriation (Skin-Picking) Disorder	F42.4
Gender Dysphoria in Adolescents and Adults	F64.0
Hoarding Disorder	F42.3
Obsessive-Compulsive Disorder	F42.2
Other Specified Depressive Disorder	F32.89
Other Specified Feeding or Eating Disorder	F50.89
Other Specified Obsessive-Compulsive and Related Disorder	F42.8
Pica, in adults	F50.89
Premenstrual Dysphoric Disorder	F32.81
Social (Pragmatic) Communication Disorder	F80.82
Unspecified Obsessive-Compulsive and Related Disorder	F42.9

Some resources that may best help you include:

- *American Medical Association, Professional Edition CPT (current procedural terminology), 2016.*
- *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Arlington, VA, American Psychiatric Association, 2013.
- *ICD-10-CM and ICD-10-PCS Coding Handbook , 2016.*

### **Medical policies and clinical management guidelines update**

On August 4, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Anthem. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The medical policies were made publicly available on the Anthem provider website on the effective date listed below. Visit [www.anthem.com/cptsearch\\_shared.html](http://www.anthem.com/cptsearch_shared.html) to search for specific policies. **Existing precertification requirements have not changed.**

The Medical Operations Committee also adopted the Interqual Coronary Bypass Procedures Criteria for use in review of the 1-2 vessel coronary artery bypass grafting (CABG) procedures on September 11, 2016.

Please share the following notice with other members of your practice and office staff.

Effective date	Medical Policy number	Medical Policy title	New or revised
10/4/2016	DME.00039	Prefabricated Oral Appliances for the Treatment of Obstructive Sleep Apnea	New
10/6/2016	DRUG.00081	Eteplirsen (Exondys 51™)	New
8/18/2016	DRUG.00087	Asfotase Alfa (Strensiq™)	New
8/1/2016	DRUG.00088	Atezolizumab (Tecentriq™)	New
8/18/2016	DRUG.00089	Daclizumab (Zinbryta™)	New
8/18/2016	DRUG.00091	Naltrexone Implantable Pellets	New
8/18/2016	DRUG.00092	Probuphine® (buprenorphine implant)	New
8/18/2016	DRUG.00093	Sebelipase alfa (KANUMA™)	New
10/4/2016	GENE.00046	Prothrombin G20210A (Factor II) Mutation Testing	New
10/4/2016	GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing	New
8/18/2016	LAB.00032	Zika Virus Testing	New
8/1/2016	RAD.00066	Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy	New
10/4/2016	SURG.00144	Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia	New
8/18/2016	BEH.00002	Transcranial Magnetic Stimulation	Revised
10/4/2016	DRUG.00002	Tumor Necrosis Factor Antagonists	Revised
8/18/2016	DRUG.00024	Omalizumab (Xolair®)	Revised
8/18/2016	DRUG.00058	Pharmacotherapy for Hereditary Angioedema (HAE)	Revised
8/1/2016	GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	Revised
10/4/2016	GENE.00026	Cell-Free Fetal DNA-Based Prenatal Testing	Revised
10/4/2016	MED.00051	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Revised
8/18/2016	RAD.00042	SPECT/CT Fusion Imaging	Revised
8/18/2016	SURG.00014	Cochlear Implants and Auditory Brainstem Implants	Revised
8/18/2016	SURG.00020	Bone-Anchored and Bone Conduction Hearing Aids	Revised
10/1/2016	SURG.00028	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions	Revised
8/18/2016	SURG.00055	Cervical Total Disc Arthroplasty	Revised
8/18/2016	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Revised
8/18/2016	SURG.00121	Transcatheter Heart Valve Procedures	Revised

**Online peer support**

Anthem will offer Online Peer Support, a clinically moderated, evidence-based, digital behavioral health platform provided by Big White Wall, to all Hoosier Healthwise and Healthy Indiana Plan members. The program is currently offered to Hoosier Care Connect members. Refer your Anthem patients with behavioral health or substance abuse needs you believe would benefit to <https://bigwhitewall.us/supportIN>. Available 24/7, Online Peer Support is completely private and free.

**Intercardiac electrophysiological studies – catheter ablation**

Effective April 1, 2017, Anthem will require prior authorization (PA) for Intracardiac Electrophysiological Studies and Catheter Ablation. All requests for Intracardiac Electrophysiological Studies and Catheter Ablation must be reviewed for PA for dates of service on or after April 1, 2017.

Please refer to the Provider Self-Service tool for detailed PA requirements. Go to <https://medproviders.anthem.com>, select your state, then under Precertification, and select Precertification Lookup Tool.

Federal and state law, as well as Centers for Medicare & Medicaid Services guidelines and definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

To request PA, please call 1-866-408-7187 for Hoosier Healthwise and Hoosier Care Connect or 1-866-398-1922 for Healthy Indiana Plan. You may also fax your request to 1-866-406-2803. To request PA via ICR, go to the Availity Web Portal at [www.availity.com](http://www.availity.com) and select Authorizations & Referrals and Authorizations under Patient Registration from the top menu bar on the Availity Web Portal home page. If you don't have access, contact your organization's Availity administrator to request the Authorization and Referral Request role.

**PA required for Continuous Interstitial Glucose monitoring**

Effective April 1, 2017, Anthem will require prior authorization (PA) for continuous interstitial glucose monitoring. All continuous interstitial glucose monitoring requests must be reviewed for dates of service beginning on and after April 1, 2017. For more information on PA requirements, please visit [www.anthem.com/inmediadoc](http://www.anthem.com/inmediadoc).

To request PA, please use one of the following methods:

Phone: 1-866-408-7187 for Hoosier Healthwise and Hoosier Care Connect

Phone: 1-866-398-1922 for Healthy Indiana Plan

Fax: 1-866-406-2803 for Hoosier Healthwise, Hoosier Care Connect and Healthy Indiana Plan

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.

**Behavioral health medication management program**

The Anthem Behavioral Health (BH) Medication Management program targets the specific needs of Anthem members using BH medications. Our goals are to specifically improve the quality of care provided to our members and promote member adherence to prescribed medication treatments.

Anthem conducts proactive outreach and education programs that focus on:

- Reducing polypharmacy
- Promoting age appropriate use of BH medications
- Providing new start and adherence education

The outreach and education programs also support BH-related HEDIS®\* measures such as:

- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

To learn more about the BH Medication Management program, call Pharmacy Operations at 1-800-719-4871 Monday –Friday, 8:30 am -- 4 pm ET.

### **Modifier 91: Repeat clinical diagnostic laboratory test**

*(Policy 06-020, effective 07/01/17)*

Anthem allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at [www.anthem.com/inmedicaiddoc](http://www.anthem.com/inmedicaiddoc).

### **Modifier 26 and TC: Professional and technical component**

*(Policy 15-004, effective 07/01/17)*

Anthem allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC.

#### **Professional component (Modifier 26)**

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

#### **Technical component (Modifier TC)**

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at [www.anthem.com/inmedicaiddoc](http://www.anthem.com/inmedicaiddoc). The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable X-ray suppliers should bill **only** for the technical component by appending Modifier TC.

#### **Global procedure**

In the absence of Modifier TC and Modifier 26, if the same physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Anthem does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test

Anthem reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

### **Clinical practice, preventive health and behavioral health guidelines are online**

As part of our commitment to providing you with the latest clinical information and educational materials, Anthem has 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 medical evidence and reviewed for content accuracy, current primary sources, newest technological advances and recent medical research. All guidelines are reviewed annually and updated as needed.

The current guidelines are available on our website at [www.anthem.com/inmedicaiddoc](http://www.anthem.com/inmedicaiddoc). Go to the Provider Support tab and click on the Quality Assurance page to access guidelines.

### **For KY Medicaid only**

#### **New policy: Corrected claims**

*(Policy 16-001, effective 05/15/2017)*

Anthem allows reimbursement for a Corrected Claim when received within the applicable timely filing requirements of the original claim. The Corrected Claim must be received within the timely filing limit due to the initial claim not being considered a clean claim. Anthem follows the standard of:

- Within the 180 days claim timely filing submission period for participating providers and facilities

Providers resubmitting paper claims for corrections must clearly mark the claim “**Corrected Claim**.” Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate. For additional information, refer to the Corrected Claims reimbursement policy at <https://mediproviders.anthem.com/ky>.

#### **Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) update**

In an effort to keep our providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the DSM-5.

When transitioning from the DSM-IV-TR to the DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in DSM-5.

Although formatted differently, the same information is found within the DSM-5 diagnostic system. DSM-5 combines DSM-IV-TR axes I-III diagnoses into one list, as shown in Table 1.

**Table 1: DSM-5 diagnosis**

<b>DSM-IV multiaxial system</b>	<b>DSM-5 nonaxial system</b>
Axis I: clinical disorder (d/o) and other conditions that are focus of treatment	Combined attention to clinical disorders, including personality disorders and intellectual disability; other conditions that are the focus of treatment; and medical conditions.
Axis II: personality d/o and mental retardation	
Axis III: general medical conditions	

DSM-IV multiaxial system	DSM-5 nonaxial system
Axis IV: psychosocial and environmental stressors	Reason for visit and psychosocial and contextual factors via expanded list of V codes and Z codes.
Axis V: Global Assessment of Functioning (GAF)	Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.

Additional conditions and problems relevant to the presenting symptoms, diagnoses and treatment are also listed as ICD-10-CM Z codes. These can be found in the section of DSM-5 entitled Other Conditions That May Be a Focus of Clinical Attention. In addition, Axis V GAF was removed from DSM-5. Alternatively, WHODAS 2.0 is included in section III of DSM-5.

We understand that providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM-5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs and syndrome combinations; the durations require clinical expertise in order to differentiate psychiatric disorders from normal life variations and transient responses to stress.

Revisions to the DSM-5 may continue to take place. In September 2016, updates were made to the codes used for the diagnoses listed in Table 2. Detailed information about these updates may be viewed in an online supplement published by the American Psychiatric Association located at <http://psychiatryonline.org>. Select View the DSM-5® Update (September 2016).

**Table 2**

Disorder	Codes effective October 1, 2016
Avoidant/Restrictive Food Intake Disorder	F50.89
Binge-Eating Disorder	F50.81
Disruptive Mood Dysregulation Disorder	F34.81
Excoriation (Skin-Picking) Disorder	F42.4
Gender Dysphoria in Adolescents and Adults	F64.0
Hoarding Disorder	F42.3
Obsessive-Compulsive Disorder	F42.2
Other Specified Depressive Disorder	F32.89
Other Specified Feeding or Eating Disorder	F50.89
Other Specified Obsessive-Compulsive and Related Disorder	F42.8
Pica, in adults	F50.89
Premenstrual Dysphoric Disorder	F32.81
Social (Pragmatic) Communication Disorder	F80.82
Unspecified Obsessive-Compulsive and Related Disorder	F42.9

Some resources that may best help you include:

- *American Medical Association, Professional Edition CPT (current procedural terminology), 2016.*



- *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* Arlington, VA, American Psychiatric Association, 2013.
- *ICD-10-CM and ICD-10-PCS Coding Handbook, 2016.*

#### **Update to the ClaimsCheck upgrade to ClaimsXten**

Earlier this year, Anthem Medicaid announced plans for an upgrade from ClaimsCheck to McKesson's next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

With the new software functionality, edits will be applied with greater accuracy. The new software functionality will also allow for greater flexibility with rule development and configuration.

For additional details regarding this software update, please refer to the original communication posted at <https://mediproviders.anthem.com/ky> > Provider Education > Communications & Updates > Anthem Network Updates > Current Network Update > [Network Update - - June 2016](#).

#### **Intercardiac electrophysiological studies – catheter ablation**

Effective April 1, 2017, Anthem will require prior authorization (PA) for Intracardiac Electrophysiological Studies and Catheter Ablation. All requests for Intracardiac Electrophysiological Studies and Catheter Ablation must be reviewed for PA for dates of service on or after April 1, 2017.

Please refer to the Provider Self-Service tool for detailed PA requirements. Go to <https://mediproviders.anthem.com> select your state, then under Precertification select Precertification Lookup Tool.

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

To request PA, please contact Provider Services at 1-855-661-2028. PA may also be requested through our web portal at [www.availity.com](http://www.availity.com) Select Authorizations & Referrals and Authorizations under Patient Registration from the top menu bar.

If you have questions about this communication or need assistance with any other item, call the Provider Services at 1-855-661-2028.

#### **Modifier 91: Repeat clinical diagnostic laboratory test**

*(Policy 06-020, effective 07/01/17)*

Anthem Medicaid allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100% of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91, and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at <https://mediproviders.anthem.com/ky>.



## **Modifier 26 and TC: Professional and technical component**

*(Policy 15-004, effective 07/01/17)*

Anthem allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC.

### **Professional component (Modifier 26)**

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

### **Technical Component (Modifier TC)**

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at <https://mediproviders.anthem.com/ky>. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable x-ray suppliers should bill **only** for the technical component by appending Modifier TC.

### **Global procedure**

In the absence of Modifier TC and Modifier 26, the same physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Anthem does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test

Anthem reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

The Modifier 26 and TC: Professional and Technical Component reimbursement policy can be found at <https://mediproviders.anthem.com/ky>.

## **Behavioral health medication management program**

The Anthem Behavioral Health (BH) Medication Management program targets the specific needs of Anthem members using BH medications. Our goals are to specifically improve the quality of care provided to our members and promote member adherence to prescribed medication treatments.

Anthem conducts proactive outreach and education programs that focus on:

- Reducing polypharmacy
- Promoting age appropriate use of BH medications
- Providing new start and adherence education

The outreach and education programs also support BH-related HEDIS® measures such as:

- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

To learn more about the BH Medication Management program, call Pharmacy Operations at 1-800-719-4871 Monday –Friday, 8:30 am -- 4 pm ET.

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

## For WI Medicaid only

### **New policy: Corrected claims**

*(Policy 16-001, effective 05/15/2017)*

Anthem allows reimbursement for a Corrected Claim when received:

- Within 180 days of the date of service for participating providers and facilities
- Within 365 days of the date of service for nonparticipating providers and facilities

Providers resubmitting paper claims for corrections must clearly mark the claim “**Corrected Claim.**” Corrected Claims submitted electronically must have the applicable frequency code. Failure to mark the claim appropriately may result in denial of the claim as a duplicate. For additional information, refer to the Corrected Claims reimbursement policy at <https://mediproviders.anthem.com/wi>.

### **Update to the ClaimsCheck upgrade to ClaimsXten**

Earlier this year, Anthem announced plans for an upgrade from ClaimsCheck to McKesson’s next generation claim auditing software, ClaimsXten. Due to the complexity of the software conversion, along with the expansion of software functionality that is now available, the target effective date has been moved from November 1, 2016, to April 30, 2017.

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### **Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5®) update**

In an effort to keep providers well-informed of changes occurring in the behavioral health community, we wanted to share some updates from the DSM-5.

When transitioning from the DSM-IV-TR to the DSM-5, the provider community moved from use of a multiaxial system to the current use of a nonaxial system upon diagnosis. While the information included in the diagnosis remains much the same, the axes are not included in DSM-5.

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- *ICD-10-CM and ICD-10-PCS Coding Handbook 2016.*

### Medical policies and clinical management guidelines update

On August 4, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Anthem. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The medical policies were made publicly available on the Anthem provider website on the effective date listed below. Visit [www.anthem.com/cptsearch\\_shared.html](http://www.anthem.com/cptsearch_shared.html) to search for specific policies. **Existing precertification requirements have not changed.** The Medical Operations Committee also adopted the Interqual Coronary Bypass Procedures Criteria for use in review of the 1-2 vessel coronary artery bypass grafting (CABG) procedures on September 11, 2016.

Please share this notice with other members of your practice and office staff.

Effective date	Medical Policy number	Medical Policy title	New or revised
10/4/2016	DME.00039	Prefabricated Oral Appliances for the Treatment of Obstructive Sleep Apnea	New
10/6/2016	DRUG.00081	Eteplirsen (Exondys 51™)	New
8/18/2016	DRUG.00087	Asfotase Alfa (Strensiq™)	New
8/1/2016	DRUG.00088	Atezolizumab (Tecentriq™)	New
8/18/2016	DRUG.00089	Daclizumab (Zinbryta™)	New
8/18/2016	DRUG.00091	Naltrexone Implantable Pellets	New
8/18/2016	DRUG.00092	Probuphine® (buprenorphine implant)	New
8/18/2016	DRUG.00093	Sebelipase alfa (KANUMA™)	New
10/4/2016	GENE.00046	Prothrombin G20210A (Factor II) Mutation Testing	New
10/4/2016	GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing	New
8/18/2016	LAB.00032	Zika Virus Testing	New
8/1/2016	RAD.00066	Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy	New
10/4/2016	SURG.00144	Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia	New
8/18/2016	BEH.00002	Transcranial Magnetic Stimulation	Revised
10/4/2016	DRUG.00002	Tumor Necrosis Factor Antagonists	Revised
8/18/2016	DRUG.00024	Omalizumab (Xolair®)	Revised
8/18/2016	DRUG.00058	Pharmacotherapy for Hereditary Angioedema (HAE)	Revised
8/1/2016	GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	Revised

Effective date	Medical Policy number	Medical Policy title	New or revised
10/4/2016	GENE.00026	Cell-Free Fetal DNA-Based Prenatal Testing	Revised
10/4/2016	MED.00051	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Revised
8/18/2016	RAD.00042	SPECT/CT Fusion Imaging	Revised
8/18/2016	SURG.00014	Cochlear Implants and Auditory Brainstem Implants	Revised
8/18/2016	SURG.00020	Bone-Anchored and Bone Conduction Hearing Aids	Revised
10/1/2016	SURG.00028	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions	Revised
8/18/2016	SURG.00055	Cervical Total Disc Arthroplasty	Revised
8/18/2016	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Revised
8/18/2016	SURG.00121	Transcatheter Heart Valve Procedures	Revised

#### **Intercardiac electrophysiological studies – catheter ablation**

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Please refer to the Provider Self-Service tool for detailed PA requirements. Go to <https://mediproviders.anthem.com>, select your state, then under Precertification Precertification Lookup Tool.

Noncompliance with new requirements may result in denied claims. PA requirements will be added to the following codes: 93600, 93602, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641, 93642, 93644, 93650, 93653, 93654, 93656 and 93660.

Please use one of the following methods to request PA: Call Provider Services at 1-855-558-1443, fax your request to 1-800-964-3627, or submit online at <https://mediproviders.anthem.com/wi>

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

#### **Modifier 91: Repeat Clinical Diagnostic Laboratory Test**

*(Policy 06-020, effective 07/01/17)*

Anthem allows reimbursement of claims for repeat clinical diagnostic laboratory tests appended with Modifier 91 and is based on 100% of the applicable fee schedule or contracted/negotiated rate.

Medical documentation may be requested to support the use of Modifier 91 and failure to use the modifier appropriately may result in denial of the repeated laboratory test as a duplicate service. It is inappropriate to use Modifier 91 when only a single test result is required.

Refer to the Modifier 91: Repeat Clinical Diagnostic Laboratory Test reimbursement policy at <https://mediproviders.anthem.com/wi>.

## **Modifier 26 and TC: Professional and Technical Component**

*(Policy 15-004, effective 07/01/17)*

Anthem Blue Cross and Blue Shield (Anthem) allows reimbursement of the professional component and technical component of a global procedure or service when appended with Modifier 26 and Modifier TC.

### **Professional component (Modifier 26)**

The professional component:

- Is used to indicate when a physician or other qualified health care professional renders only the professional component of a global procedure or service
- Includes the supervision and interpretation portion of a procedure and the preparation of a written report

### **Technical component (Modifier TC)**

The technical component includes the technician, equipment, supplies and institutional charges associated with the performance of the service or procedure.

Unless otherwise indicated in the policy, when a physician or other qualified health care professional performs a service in a facility, only the facility may be reimbursed for technical component of the service; facility is defined in exhibit A. To view Exhibit A, refer to the Modifier 26 and TC: Professional and Technical Component reimbursement policy at <https://mediproviders.anthem.com/wi>. The physician or other qualified health care professional should make an arrangement with the facility for reimbursement to perform any technical components of a service.

Please note that portable x-ray suppliers should bill **only** for the technical component by appending Modifier TC.

### **Global procedure**

In the absence of Modifier TC and Modifier 26, the same physician or other qualified health care professional will be reimbursed for the global procedure if they performed both the professional component and technical component of that service.

Anthem does not allow reimbursement for use of Modifier 26 or Modifier TC when:

- It is reported with an Evaluation and Management (E&M) code
- There is a separate standalone code that describes the professional component only, technical component only or global test only of a selected diagnostic test

Anthem reserves the right to perform post-payment review of claims submitted with Modifier 26 or Modifier TC.

The Modifier 26 and TC: Professional and Technical Component reimbursement policy can be found at

<https://mediproviders.anthem.com/wi>.

## **Modifier 63: Procedure performed on infants less than 4 kg**

*(Policy 06-015, originally effective 07/01/2014)*

Anthem allows reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100% of the applicable fee schedule or contracted/negotiated rate. Please note the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

*Key Definition*

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure.

In applicable circumstances, Anthem does **not** allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants Less Than 4 kg reimbursement policy at <https://mediproviders.anthem.com/wi>.