

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.

The information in this newsletter is for informational purposes only and should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for our members and enrollees is the responsibility of physicians and providers.

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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>Tools for Providers (select state)>Health Care Reform/Health Insurance Exchange. Recently, the following article was posted on our Health Care Reform Updates and Notifications page: [Anthem provides new or additional evidence considered during an appeal – February 2017](#).

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 > Tools for providers (enter state)>Network eUPDATE.

Administrative Update

Try ICR today

When you use Anthem's Interactive Care Reviewer (ICR) to initiate a request for precertification of some inpatient and outpatient procedures,* you may receive an immediate authorization decision. To see the list of services that may result in an immediate authorization decision, go online to www.anthem.com>Tools for providers (enter state)>Precertification>Immediate Authorization Decision via ICR.

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

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

Plus ICR is available almost anywhere and after normal business hours from your computer with internet access. ICR can be accessed under Authorizations & Referrals from the Availity Web Portal.

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

*Excludes: some Medicare Advantage, some Medicaid, Federal Employee Program® (FEP®), BlueCard® and some National Account members; requests involving transplant services; services administered by vendors such as AIM Specialty Health; services administered by OrthoNet LLC (Indiana, Kentucky, Missouri, Ohio, Wisconsin, California, Colorado and Nevada). For these requests, follow the same precertification process that you use today.

Remittance Inquiry search option streamlined on Availity

The Check/EFT search option has been changed to make it easier for you to find your remittances. You may choose: Search by Check/EFT which **now** only requires a Tax ID and **does not** require an NPI, or use a

date range search which requires **both** a Tax ID and NPI.

To access your remittances from the Availity Web Portal, select *Payer Spaces*, then Anthem BlueCross and BlueShield from the list of payer options, and then Remittance Inquiry. To access an imaged copy of the paper remittance for your records, select the View Remittance link, then choose the option to print or save.

If you don't see Remittance Inquiry when you log in to the Availity Web Portal, contact your Availity Administrator to request Claims Status access which includes Remittance Inquiry. If you do not know who the administrator is for your organization, log in to Availity, go to your account and select *Who controls my access?*

Introducing Patient 360

In April 2017, Patient360 will be offered on the Availity Web Portal. This online application lets you quickly retrieve detailed records about your Anthem patients.

Patient360 will replace Patient Care Summary that you have been accessing through Eligibility and Benefits on Availity. It also replaces Member Medical History Plus (MMH Plus).

Patient360 is a real-time dashboard that gives you a robust picture of a patient's health and treatment history and helps you facilitate care coordination. You can drill down to specific items in a patient's medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information and care management related activities.

This level of detail can help:

- Spot utilization and pharmacy patterns
- Avoid service duplication
- Identify care gaps and trends
- Coordinate care more effectively
- Reduce the number of communications needed between PCPs and case managers

To access Patient360 on Availity, users must be assigned to the Patient360 Role which Availity Administrators can locate within Clinical Roles options. If users already have the Patient Care Summary role, they will automatically be re-assigned to the Patient360 role. There are two ways to navigate to Patient360:

Option 1: Select Patient Registration from Availity's top menu bar.

- Choose Eligibility and Benefits.
- Complete the required fields on the Eligibility and Benefits screen.
- Select the Patient360 link on the member's benefit screen.
- Enter the member information in the required fields.

Option 2: Select Payer Spaces from Availity's top menu bar.

- Choose the Anthem Blue Cross Blue Shield tile.
- Select Patient360 located on the Applications page.
- Enter the member information in the required fields

Note: If your organization is not registered on the Availity Web Portal, go to www.Availity.com. Select **Register**, then **Get Started**, and complete the online registration form

If you have questions about Patient360, please contact your local Network Relations consultant. If you have questions regarding Availity Web Portal registration, please contact Availity Client Services at 800-AVAILITY (800-282-4548).

DRG validation audits expand to include DRG readmission

Effective April 1, 2017, Cotiviti will expand its current scope of DRG Validation audits to include a DRG Readmission audit. This program is a post-payment review of facility claims based on facility contract language for readmissions. Anthem and Cotiviti are committed to the coordinated efforts between our programs and maintaining a professional working relationship with all providers. If you have questions, please contact your local Network Relations consultant.

After-hours access requirements for your practice

Your contract with Anthem requires that your practice provide continuation of care for our members outside of regular business hours. We will conduct after-hours access studies to assess how well practices are meeting this provision, and your practice may receive a call from North American Testing Organization, a vendor in California working on Anthem's behalf. To be compliant, please verify that your messaging or answering service includes appropriate urgent care instructions. The compliant response directs callers to Urgent Care, 911, the ER or connects the call to the caller's doctor or doctor on call. In addition to these measures, but not in place of them, the messaging can give callers the option of contacting their health care practitioner (via transfer, cell phone, pager, etc.) or an opportunity to ask for a call back for urgent questions or instructions. *Is your practice compliant?*

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)

Gender reassignment surgery

The Gender Reassignment Surgery (GRS) Benefit was added January 1, 2017 to provide surgical benefits for the treatment of gender dysphoria for members age 18 or older. The Blue Cross and Blue Shield Service Benefit Plan brochure, available on [fepblue.org](#), outlines all criteria and requirements to utilize the GRS benefit.

The GRS benefit requirements include but are not limited to the following:

- A diagnosis of **Gender Dysphoria** by a qualified health professional
- A prior approval for surgeries requested
- A treatment plan with all surgeries listed and the proposed plan of care
- Inclusion of **two** referral letters from qualified mental health professionals

A Provider Toolkit for the Gender Reassignment Surgery (GRS) benefit is available that lists all prior approval requirements and includes form fields to enter name(s) and contact number(s). A list of covered procedures is included with the Toolkit. To request it, call our Utilization Management toll-free number **1-800-860-2156** to speak to a Utilization Management representative. To assist with the prior authorization of the services requested, a completed Provider Toolkit and the required documentation must be provided to the Plan.

For prior approval requests, it's important to identify the **Care Coordinator** and/or the **referring Provider** who

would be the single point of contact for all care for the member's gender reassignment. Providing this contact name will assist in the prior approval process. If you do not have the Care Coordinator or referring Provider contact information, please ask the member to call the Utilization Management department toll-free number **1-800-860-2156** to provide the name of his/her Care Coordinator to a UM Nurse or intake representative.

Health Care Management

Medical policy update

The following new Anthem medical policies were reviewed on February 2, 2017 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. These policies will be implemented on July 1, 2017

LAB.00034 - Serological Antibody Testing For Helicobacter Pylori

This new medical policy addresses the use of serological antibody testing Helicobacter pylori (also known as H. pylori), a causative agent for peptic ulcers, gastritis, dyspepsia and stomach cancer.

SURG.00146 - Extracorporeal Carbon Dioxide Removal

This new medical policy addresses the use of extracorporeal carbon dioxide removal (ECCO2R), a minimally invasive, low-flow veno-venous or venous-arterial procedure used to treat acute hypercapnic respiratory failure or as an alternative to standard extracorporeal membrane oxygenation (ECMO).

SURG.00147 -- Synthetic Cartilage Implant for Metatarsophalangeal Joint Disorders

This new medical policy addresses the use of a metatarsophalangeal synthetic cartilage implant.

The following revisions to medical policies and clinical guidelines will be implemented on July 1, 2017.

SURG.00010 -Treatments for Urinary Incontinence

Implantation of the inFlow™ intraurethral valve-pump was added as Investigational and Not Medically Necessary for all indications.

CG-BEH-04 - Substance-Related and Addictive Disorder Treatment

Criteria were added requiring member evaluation by a physician or other provider with prescriptive authority upon admission and during the continued stay to occur with a specified frequency relative to the level of care. Also clarified language addressing withdrawal symptoms for inpatient detox was added.

CG-BEH-05 - Eating and Feeding Disorder Treatment

Criteria were added requiring member evaluation by a physician or other provider with prescriptive authority upon admission and during the continued stay to occur with a specified frequency relative to the level of care.

CG-Med-46 -- Ambulatory and Inpatient Video Electroencephalography

Effective July 1, 2017, precertification review will be required when the member is in an inpatient setting.

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

MCG 21st edition

Anthem's Utilization Management/Case Management departments will upgrade to the 21st edition of MCG, effective July 1, 2017. See the following summary of some of the changes.

- MPTAC approved licensed and customized 21st edition MCG Inpatient & Surgical Care (ISC), General Recovery Care (GRC) and Chronic Care (CC) modules. Note: These are new modules.
- Goal Length of Stay (GLOS) changed for five Optimal Recovery Guidelines (ORGs) in the new ISC module.

Goal Length of Stay (GLOS) Changes for MCG Care Guidelines 20 th Edition	ORG Code (W number)	20 th Edition GLOS	21 st Edition GLOS
Orthopedics: Hip Arthroplasty	S-560 (W0105)	Ambulatory or 3 days postoperative	Ambulatory or 2 days postoperative
Orthopedics: Shoulder Hemiarthroplasty	S-633	2 days post-operative	1 day postoperative
Pediatrics: Gastrointestinal Bleeding, Hematemesis or Melena, Pediatric	P-200	Ambulatory or 2 days	Ambulatory or 1 day
Urology: Prostatectomy, Radical	S-960	1 or 2 days postoperative	1 day postoperative
Urology: Ureteroileal Conduit	S-1140	7 days postoperative	6 days postoperative

- MCG added a new Cardiovascular Surgery Optimal Recovery Guideline, Aortic Valve Replacement, Transcatheter ORG: S-1320 (W0133), which Anthem customized to refer to SURG.00121 Transcatheter Heart Valve Procedures for clinical indications for procedure.

To see a [summary](#) of customizations to MCG Guidelines, go to anthem.com>Tools for providers (enter your state). Then select Medical Policy, Clinical UM Guidelines and Pre-Cert Requirements>Medical Policies and Clinical UM Guidelines (for Local Plan members), then Continue, then Overview>Customizations to MCG Care Guidelines.

Specialty pharmacy prior authorization list

The following specialty pharmacy code will be added to our existing pre-service review process **effective July 1, 2017**. Pre-service clinical review of this specialty pharmacy drug 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.

Medical Policy or Clinical Guideline (CG) number	DRUG code	Drug Names	Comments
DRUG.00104	J3490	Spinraza	New Medical Policy

Prior authorization for genetic testing

Effective with dates of service on or after July 1, 2017, Anthem will transition the medical necessity review of all genetic testing services for local fully insured members to AIM. Additionally, this review will now take place as a **prior authorization**. The medical policies and associated codes that will be reviewed by AIM for medical necessity are as follows:

Medical Policy	Medical Policy Title	Codes
GENE.00001	Genetic Testing for Cancer Susceptibility	81404, 81405, 81406, 81437, 81438, 81445, 81450, 81455, 81479
GENE.00002	Preimplantation Genetic Diagnosis Testing	89290, 89291

Medical Policy	Medical Policy Title	Codes
GENE.00003	Genetic Testing and Biochemical Markers for the Diagnosis of Alzheimer's Disease	81401, 81405, 81406, 83520, 84999, S3852
GENE.00004	Janus Kinase 2 (JAK2)V617F Gene Mutation Assay	81270, 81403
GENE.00005	BCR-ABL Mutation Analysis	81170, 81401
GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	81235, 88365
GENE.00007	Cardiac Ion Channel Genetic Testing	81406, 81413, 81414, 81404, 81405, 81406, 81407, 81408, S3861
GENE.00008	Analysis of Fecal DNA for Colorectal Cancer Screening	81528, 81479
GENE.00009	Gene-Based Tests for Screening, Detection and Management of Prostate Cancer	81313, 81479, 81599
GENE.00010	Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	81225, 81479, 81381, 81226, 81400, 81401, 81227, 81350, 81355, G9143
GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	81519, 0008M, 81599, 84999, S3854
GENE.00012	Preconceptional or Prenatal Genetic Testing of a Parent or Prospective Parent	81200, 81209, 81220, 81221, 81222, 81223, 81224, 81241, 81242, 81251, 81252, 81253, 81254, 81255, 81256, 81257, 81290, 81330, 81412, S3841, S3842, S3844, S3845, S3846, S3849, S3853, 81403, 81404, 81405, 81406, S3800, 81479, 81415, 81416, 81417, 81425, 81426, 81427
GENE.00014	Analysis of KRAS Status	81275, 81276, 88363
GENE.00016	Gene Expression Profiling for Colorectal Cancer	81525, 81599, 84999
GENE.00017	Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)	81403, 81405, 81406, 81407, 81408, 81439, 81479, S3865, S3866
GENE.00018	Gene Expression Profiling for Cancers of Unknown Primary Site	81406, 81504, 81540, 81599
GENE.00019	BRAF Mutation Analysis	81210, 88363, 81406
GENE.00020	Gene Expression Profile Tests for Multiple Myeloma	81479, 81599
GENE.00021	Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies	81228, 81229, S3870, 81405
GENE.00022	In Vitro Companion Diagnostic Devices	Specific coding does not apply
GENE.00023	Gene Expression Profiling of Melanomas	81599, 84999
GENE.00024	DNA-Based Testing for Adolescent Idiopathic Scoliosis	0004M
GENE.00025	Molecular Profiling for the Evaluation of Malignant Tumors	81425, 81445, 81450, 81455, 81479, 81599, 88363
GENE.00026	Cell-Free Fetal DNA-Based Prenatal Screening for Fetal Aneuploidy	81507, 0009M, 81420, 81479, 81599, 81422
GENE.00027	The Panexia™ Test for Oncologic Indications	81406, 81479

Medical Policy	Medical Policy Title	Codes
GENE.00028	Genetic Testing for Colorectal Cancer Susceptibility	81288, 81292, 81293, 81294, 81295, 81296, 81297, 81298, 81299, 81300, 81317, 81318, 81319, 81403, 81435, 81436, 81201, 81202, 81203, 81401, 81406
GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	81162, 81211, 81212, 81213, 81214, 81215, 81216, 81217, 81432, 81433, 81445, 81455
GENE.00030	Genetic Testing for Endocrine Gland Cancer Susceptibility	81404, 81405, S3840, 81445, 81455, 81479
GENE.00031	Genetic Testing for PTEN Hamartoma Tumor Syndrome	81321, 81322, 81323
GENE.00032	Molecular Marker Evaluation of Thyroid Nodules	81545, 81599
GENE.00033	Genetic Testing for Inherited Peripheral Neuropathies	81324, 81325, 81326, 81403, 81404, 81405, 81406, 81440, 81479
GENE.00034	SensiGene® Fetal RhD Genotyping Test	81403
GENE.00035	Genetic Testing for TP53 Mutations (Li-Fraumeni Syndrome)	81404, 81405, 81445, 81455
GENE.00036	Genetic Testing for Hereditary Pancreatitis	81222, 81223, 81224, 81401, 81404, 81479
GENE.00037	Genetic Testing for Macular Degeneration	81401, 81405, 81408, 81479, 81599
GENE.00038	Genetic Testing for Statin-Induced Myopathy	81400
GENE.00039	Genetic Testing for Frontotemporal Dementia (FTD)	81406, 81479
GENE.00040	Genetic Testing for CHARGE Syndrome	81403, 81407
GENE.00041	Short Tandem Repeat Analysis for Specimen Provenance Testing	81479
GENE.00042	Genetic Testing for Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL) Syndrome	81406
GENE.00043	Genetic Testing of an Individual's Genome for Inherited Diseases	81479, 81599, 81403, 81404, 81405, 81406, 81408, 81410, 81411, 81415, 81416, 81417, 81425, 81426, 81427, 81430, 81431, 81434, 81440, 81442, 81460, 81465, 81470, 81471, 81479, 81493, 81506, 81599, S3800
GENE.00044	Analysis of PIK3CA Status in Tumor Cells	81404
GENE.00045	Detection and Quantification of Tumor DNA Using Next Generation Sequencing in Lymphoid Cancers	81479, 81599
GENE.00046	Prothrombin G20210A (Factor II) Mutation Testing	81240
GENE.00047	Methylenetetrahydrofolate Reductase Mutation Testing	81291

Beginning July 1, 2017, please submit genetic testing prior authorization requests to AIM through one of the following ways:

- Access AIM **ProviderPortals**SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number at 800-554-0580, Monday–Friday, 8:30 a.m.–7:00 p.m. ET.

To find more information about genetic testing prior authorization at AIM, please go [here](#).

Note: This program applies to local Anthem fully insured members only. It excludes the following: Medicare, Medicaid, FEP, Labor & Trust, National Accounts and Local ASO

For further questions regarding prior authorization requirements, please contact the Provider Services number on the back of your patient's ID card.

IN, KY, MO, WI: Imaging program expands to include level of care reviews effective July 1

Effective with dates of service on or after July 1, 2017, for members covered by local plans in Indiana, Kentucky, Missouri and Wisconsin, Anthem will require a medical necessity review of the requested level of care for computed tomography (CT) imaging and magnetic resonance imaging (MRI). A new clinical guideline, Level of Care: Advanced Radiologic Imaging, CG-MED-55, will apply to the review process for dates of service beginning July 1, 2017. The review will be administered by AIM.

AIM will evaluate the clinical criteria to determine if the imaging service requires a hospital-based outpatient setting, which offers a higher intensity of service resources, or if a free-standing imaging center is a clinically appropriate and available alternative.

There may be circumstances where a member's clinical situation requires that he or she receive an MRI or CT scan in a hospital facility. Based on the information you provide, AIM will review both the requested advanced imaging scan for clinical appropriateness and the level of care against health plan clinical criteria. The level of care review does not apply to requests for review of imaging as part of an inpatient stay or when Anthem is the secondary payer.

Physicians will continue to request authorization for MRI and CT scans in one of several ways:

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

The expanded program applies to local fully-insured Anthem members in Indiana, Kentucky, Missouri and Wisconsin, who have advanced imaging services medically managed by AIM under a full Utilization Management program. It does not apply to BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, Federal Employee Program® (FEP®), members who are covered under a self-insured (ASO) benefit plan, or those covered by DaimlerChrysler, Delphi, Ford Motor Group, and General Motors.

To view the new clinical guideline, Level of Care: Advanced Radiologic Imaging, CG-MED-55, go to anthem.com>Tools for providers (select state)>Medical Policy, Clinical Guidelines, Pre-Cert Requirements. For more information on advanced imaging and site of service requirements, please view these [FAQs](#), or go online to anthem.com>Tools for providers (select state)> Answers@Anthem>Imaging program expands to include level of care reviews – FAQs. For more information on how to initiate a request via Availity, please see our [Quick Reference Guide to AIM Specialty Health](#) at anthem.com>Tools for providers (select state)>Precertification.

What's new, beginning with dates of service on or after July 1, 2017:

- When providers select a hospital-based outpatient facility as the level of care, a list of alternate free-standing imaging centers will be made available. If providers still select the hospital-based outpatient facility, they will be prompted to indicate the reason that this location is medically necessary.
- If a request for a hospital-based level of care does not meet medical necessity criteria upon review by a physician, the request will not be approved. We encourage you to discuss the alternate sites with the

member.

Note to advanced imaging providers: The *OptiNet*® solution, which is accessed through *ProviderPortal.com*, is a proprietary, multi-faceted program designed to provide health plans with information on outpatient imaging providers. For providers that bill with place of service codes 11, 49, or 81, AIM has prepopulated the “Provider Type” selection with Freestanding Imaging Facility/Physician Groups. For providers that bill with place of service codes 19 or 22, AIM has prepopulated the “Provider Type” selection as Outpatient Hospital Department.

Prior to the start date of July 1, 2017, advanced imaging providers should review their *OptiNet* registration to ensure all information is current; the prepopulated Place of Service code is correct; and the “Provider Type” accurately reflects the site's status as a FSIC, physician group, or hospital. If you do not find the “Provider Type” field populated, you may edit the assessment. Once you have selected the applicable “Provider Type,” submit the statement of attestation to ensure that all information submitted is accurate. Provider assessments that are already complete will remain in a Completed status until an update has been applied to the assessment.

Thank you for your collaboration and ongoing support of Anthem’s Imaging program. If you have additional questions, please contact your local Network Relations consultant.

Required: Clinically equivalent agents

As we previously notified you in the February 2017 issue of *Network Update*, Anthem has selected Remicade (infliximab) to be the infliximab of choice and the clinically equivalent agent over Inflectra (Infliximab-dyyb). Synvisc, Synvisc One, Orthovisc, and Monovisc have been selected as the clinically equivalent Hyaluronic Acid agents of choice. (Please note that the revised effective implementation date is June 1, 2017 for CG.DRUG.64 and CG.DRUG.29.)

Medical Policies and Clinical Guidelines that have been updated to include the requirement of a clinically equivalent treatment are included in the chart below. Some benefit plans require the use of clinically equivalent agents, therefore when prescribing a product in these categories, please consider using these agents.

Medical Policy/Clinical Guideline	Impacted Products	Clinically Equivalent Cost Effective Products	Effective date
FDA-Approved Biosimilar Products; CG.DRUG.64	Inflectra®	Remicade®	June 1, 2017
CG.Drug.29*	Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®	Monovisc®, Orthovisc®, Synvisc®, Synvisc One®	June 1, 2017
DRUG.00017 Hyaluronan injections for indications in joints other than the knee	Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®	Monovisc®, Orthovisc®, Synvisc®, Synvisc One®	July 1, 2017

*CG.DRUG.29 is for clinically equivalent agents only.

As a reminder, information on Anthem’s Medical Policy and Clinical UM guidelines, including dosing guidelines, can be found online.

Reminder for DME providers

Active or passive cooling devices (with or without pneumatic compression) are considered investigational and not medically necessary for all uses, including but not limited to recovery after orthopedic surgery or trauma.

Active or passive devices that combine cooling and heating are considered investigational and not medically necessary for all uses.

Medicare

Reminder: Submitting CPT codes for requested services

To help ensure your patients and our members receive their medical care in a timely fashion, we would like to remind you of the following when submitting CPT codes for requested services:

1. Ensure the CPT code requested is the service that the physician/provider details in the medical record.
2. Review appropriate coding and Medicare guidelines to ensure service is a covered service and that the code is a valid code for that year.
3. If a code that is requested does not match the intended service, please be prepared to correct the error and resubmit the request.
4. Anthem relies on the information submitted from the medical record to make its determinations on your requests. It is important that all relevant information to the member's requested service be submitted.

Providers requesting authorization for services based on **incorrectly** documented CPT/HCPCS codes may receive **avoidable** denial notices where the code/service is found not medically necessary or non-covered.

Prevention service codes updated for 2017

Preventive service procedure codes have been updated. Please be sure to file claims with the new codes according to the applicable dates of service.

Abdominal Aortic Aneurysms

- Effective January 1, 2017, **76706** will replace **G0389** for Abdominal Aortic Aneurysms (AAA).
- **G0389** is used for services furnished prior to January 1, 2017.

New flu vaccines –Medicare preventive benefit – Part B immunizations

- 90674 Influenza virus vaccine, quadrivalent (cclIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use
 - This new flu vaccine code can be used for dates of service on or after August 1, 2016.
- 90682 Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use
 - Currently, this new flu vaccine has not received FDA approval; therefore, this flu vaccine will be denied. Once approved by the FDA, this vaccine will be a covered Medicare Part B Immunization.

Smoking and tobacco cessation

- Effective October 1, 2016, G0436 & G0437 are no longer valid codes for smoking and tobacco cessation counseling services. Beginning with dates of service on or after Oct. 1, 2016, CPT codes 99406 and 99407 should be used to report smoking and tobacco cessation counseling services.

CMS releases new coding guidelines for 3D mammography

When billing for mammography services, please use the following G codes for services January 1, 2017 and thereafter: G0202, G0204, and G0206. Additional information from the Centers for Medicare & Medicaid Services (CMS) is available [here](#).

Clinical information requests

Anthem requires that treating physician, clinician or supplier comply with all requests for documentation from the

Plan. Providers are responsible for providing any and all related medical records, answering questions from health plan representatives or furnishing any necessary information when requested. Information must be submitted in a timely manner, be complete and legible, and identify the provider and date of service.

CMS recently added an additional [requirement](#) for health plan peer reviewers to contact contracted and non-contracted providers to gather medical information needed to make a coverage determination. CMS expects plans “to make reasonable efforts to gather all of the information needed to make substantive and accurate decisions as early in the coverage process as possible.”

Anthem peer reviewers look forward to working with you to ensure that our members’ coverage determinations are made in a timely manner.

New G codes for home health agencies

For dates of service on and after January 1, 2017, a separate payment will be made to home health agencies (HHAs) that are reimbursed on a CMS PPS methodology and are billing for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit. To receive separate payment for NPWT, in addition to billing a claim with type of bill 32X, HHAs must bill a claim with type of bill 34X, HCPCS 97607 or 97608 and the appropriate revenue code 042X, 043X or 0559.

Effective for January 1, 2017 and thereafter, G0163 and G0164 will be retired and replaced with the following four new G-codes:

- **G0493** - Skilled services of a registered nurse (RN) for the observation and assessment of the patient’s condition, each 15 minutes (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment in the home health or hospice setting).
- **G0494** - Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient’s condition, each 15 minutes (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment in the home health or hospice setting).
- **G0495** - Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.
- **G0496** - Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

New place of service code for telehealth services

Effective January 1, 2017, Anthem is following CMS in implementing new place of service code 02. The new place of service code 02 is for use by physicians or practitioners furnishing telehealth services from a distant site. When billing telehealth services, distant site providers must bill with place of service code 02 and continue to bill modifier GT (via interactive audio and video telecommunication systems) or GQ (via asynchronous telecommunications system). Telehealth services not billed with the new place of service code 02 will be denied back to the provider. See the list of Medicare Telehealth services [here](#).

AIM OptiNet services initiative postponed

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 April 1, 2017 to May 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 **ProviderPortals**SM. To access:

1. Go to 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 a.m.-7 pm ET.

Note: Anthem continues to offer webinars to help providers complete their OptiNet® surveys. Please contact ronald.younger@anthem.com or jennifer.murillo@anthem.com if you would like an invitation sent to your calendar for the webinars or access the URL below to join the training on Thursday, April 20, at 9 am ET, 10 am ET and 1 pm ET.

Meeting link: <https://portal.056d.dedicated.lync.com/wellpoint/meet/ronald.younger/VTBZ977S>. Dial 866-308-0254. Pass code 804 205 7402# ; Smart Phone 1-Click Dial 866-308-0254,,,8042057402#

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Review high-risk medication reports

Anthem is required to monitor prescription activity for high-risk medications, as defined by CMS, to improve patient safety. To ensure providers are aware of any high-risk medications prescribed for our Medicare Advantage members, we fax a list of high-risk medication claims to providers each week. Anthem also distributes a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. In addition, we contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication fax or report from Anthem, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed on www.anthem.com/maprovidertoolkit

AccordantCare to provide support for individual MA members with HIV

Anthem works with AccordantCare to provide targeted disease management services for our individual Medicare Advantage members with a number of rare medical conditions. Effective February 1, 2017, AccordantCare added Human Immunodeficiency Virus (HIV) management to the rare condition management program.

Members in your care who may benefit from additional outreach and information may receive letters, emails or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention. Members must give AccordantCare written consent that it can communicate any medical health changes to you. If the consent is not given by the member, AccordantCare will not be able to disclose any information to you.

If you feel that an individual Medicare Advantage member would benefit from this program, please refer the member by contacting AccordantCare via phone (press #) or fax (press 6) at 1-866-247-1150.

Filing a Medicare Supplement claim

All Blue Cross Blue Shield Association plans, including Anthem, are required to process Medicare crossover claims for services covered under Medigap and Medicare Supplement products through CMS. This eliminates the need for providers to submit an additional claim directly to Anthem.

When a Medicare claim has crossed over to Anthem for secondary payment, providers should wait 30 calendar days from the Medicare remittance date before submitting another claim to Anthem. Providers can identify if a claim has been crossed over for secondary payment by the following Medicare Remittance Advice remarks:

Medicare remittance advice remark codes MA18 or N89 indicate that Medicare crossover has been forwarded to the secondary carrier:

- **MA18 Alert:** The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
- **N89 Alert:** Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.

If you use a claims clearing house to file Medicare Supplement claims, please ensure the clearing house waits 30 calendar days from the Medicare remittance date before submitting another claim to Anthem.

MA resource guide

Anthem works with a variety of different companies to help members with specific health care issues. Please see [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider for [additional information](#) about these companies and how they may be able to provide additional help to your patients.

Keep up with MA news

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

[Prior Authorization Requirements for Part B Drugs: Exondys 51 \(eteplirsen\)](#)

[Prior Authorization Requirements for Part B Drug – Evomela](#)

[Claims for Tetanus Vaccinations](#)

[Additional Information on ClaimCheck Upgrade to ClaimsXten](#)

[Hospital Observation Service Limits](#)

[Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning January 1, 2019](#)

[Tips for Improving Skilled Nursing Discharge Planning](#)

[CMS Emergency Preparedness Rule](#)

[Risk Adjustment and Documentation Guidance Training Offered](#)

[Retrospective medical record review program launches](#)

[HEDIS measure: Ensure medication reconciliation is completed after discharge](#)

[Prior Authorization Requirements for Intracardiac Electrophysiological Studies and Catheter Ablation](#)

MO: [Home Health Services for Medicare Advantage Individual Members to Require Prior Authorization](#)

OH, IN, KY: [Home Health Services for Medicare Advantage Individual Members to Require Prior Authorization](#)

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Pharmacy

Important upcoming changes to the Anthem National Drug List

Effective April 1, 2017, medications listed in the link below will be removed from the Anthem National Drug List. For a complete list of the medications removed from the National Drug List and their preferred alternatives, please go [here](#). For more details, please see the [Network eUPDATE](#) posted online, at [anthem.com>Tools for providers>Network eUPDATES](#).

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

Clinical practice & preventive health guidelines

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to [www.anthem.com>Providers \(enter state\)>Health & Wellness> \[Practice Guidelines\]\(#\)](#).

Reimbursement

Professional reimbursement policy updates

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

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

We have updated our Anesthesia Services, Bundled Services and Supplies, and Modifiers 59, XE, XP, XS, and XU policies, effective May 1, 2017, to reflect coding changes to spinal injections with imaging guidance based on January 1, 2017 Current Procedural Terminology (CPT®) code additions and deletions. However, these updates do not cause significant changes to the policies' position or criteria.

Claim Editing Overview and Frequency Editing

We are updating our Claim Editing Overview and Frequency Editing reimbursement policies, effective May 1, 2017, to further clarify that our frequency editing guidelines will apply per day unit frequency maximums based on the CPT/HCPCS codes listed on the CMS Medically Unlikely Edit (MUE) listing that have a per day MUE Adjudication Indicator (MAI) of "2." Modifiers will not override these frequency limits.

Frequency Editing

CPT codes 95925, 95926, 95938, and 95927 (*short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system...*) and 95928, 95929, and 95939 (*central motor evoked potential study (transcranial motor stimulation)...*) are currently limited to once per date of service. Based on the indication of plurality within each code's description, beginning with claims processed on or after May 20, 2017, modifiers will not override the frequency limit of one per date of service on each of these codes.

CPT code 96900 (*actinotherapy (ultraviolet light)*) is currently limited to once per date of service. The August 2006 CPT Assistant states, "Code 96900 is reported once per session... regardless of the number of anatomical areas treated." Therefore, beginning with claims processed on or after May 20, 2017 modifiers will not override the frequency limit of one per date of service.

In addition, CPT code 87483 (*infectious agent detection by nucleic acid (DNA or RNA); central nervous system pathogen... includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets*) will have a unit limit of 1 per date of service for claims processed on or after May 20, 2017. Modifiers will not override this frequency limit edit.

Injection & Infusion Administration and Related Services & Supplies

Hydration, therapeutic, prophylactic, and diagnostic injections and infusions are used for the administration of fluids and medications. The Health Plan considers such injection and infusion services to be an integral component to the performance of procedural services that require the use of injection or infusion services to complete the procedure. Therefore, effective May 1, 2017, we are updating our policy to clarify our current edits do not allow separate reimbursement for hydration, therapeutic, prophylactic, and diagnostic injections and infusions when reported with procedures that inherently include injection or infusion services to complete the procedure (e.g. 96360-96361 (*hydration infusion*) will not be eligible for separate reimbursement when reported with 92242 (*fluorescein angiography and indocyanine-green angiography*)).

Laboratory & Venipuncture Services and Modifier Rules

We are updating our policies to reflect that modifier 91 (*repeat clinical diagnostic laboratory test*) will not override our bundling edit for component codes for "Organ and Disease-Oriented Panels." This edit will be effective for claims processed on or after May 20, 2017.

Modifier Rules

We are adding modifiers Q5 (*service furnished by a substitute physician under a reciprocal billing arrangement*) and Q6 (*service furnished by a locum tenens physician*) to our Modifier Rules policy, effective May 1, 2017. These modifiers are informational only and have no effect on the maximum allowable of the reported procedure code.

Unit Frequency Maximums for Drugs and Biologic Substances

Beginning with dates of service on or after July 1, 2017, HCPCS code J9351 (*injection, topotecan, 0.1 mg*) will have a frequency limit of 40 units per date of service. Modifiers will not override the frequency limit edit.

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 May 1, 2017.

- Cancer Treatment Planning and Care Coordination
- Surgical Pathology & Related Prostate Needle Biopsy
- Screening Services with Related Evaluation & Management Services

Coding Tip: Servicing Modifiers

Claims for anesthesia should identify when a physician/anesthesiologist (MD) or non-physician anesthesia provider rendered the anesthesia service. Therefore, the Health Plan requires that a servicing modifier (as shown in the table below) must be appended to the reported anesthesia code. **See our May 1, 2017 Anesthesia Services and Modifier Rules professional reimbursement policies** which now include the HCPCS LEVEL II verbiage for QX and QY.

Modifier	Description
AA	Anesthesia services personally performed by anesthesiologist
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QX	Qualified nonphysician anesthetist with medical direction by a physician
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
QZ	CRNA without medical direction by physician

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. 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

Additional information on ClaimCheck upgrade to ClaimsXten

Anthem previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017. This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services (Hoosier Healthwise: **1-866-408-6132**, Healthy Indiana Plan: **1-800-345-4344** or Hoosier Care Connect: **1-844-284-1798**).
Anthem

Modifier 63: Procedure performed on infants less than 4 kg

(Policy 06-015, effective 09/15/2017)

Currently, Anthem allows additional reimbursement of 120% for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, Anthem will allow 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 www.anthem.com/inmedicaidoc.

Reminder: Changes in contact information

- **New address for paper claims for Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect:** Anthem Blue Cross and Blue Shield/P.O. Box 62509/Virginia Beach, VA 23466*

- **New Behavioral Health prior authorization fax numbers:** Inpatient: **1-877-434-7578**/Outpatient: **1-866-877-5229**
- **New Utilization Management and Pharmacy prior authorization intake numbers:**
 - Hoosier Healthwise Phone: **1-866-408-6132**/Fax inpatient: **1-888-209-7838**/ Fax outpatient: **1-866-406-2803**
 - Healthy Indiana Plan Phone: **1-844-533-1995**/Fax inpatient: **1-888-209-7838**/ Fax outpatient: **1-866-406-2803**
 - Hoosier Care Connect Phone: **1-844-284-1798**/Fax inpatient: **1-888-209-7838**/Fax outpatient: **1-866-406-2803**

* Note: This new claims address change does not apply to Franciscan Alliance Accountable Care Organization.

For KY Medicaid only

Behavioral health precertification reminder

In an effort to streamline and improve the precertification process for Anthem Medicaid providers and members, remember to submit all pertinent clinical information and the current treatment plan, if applicable, with requests during the precertification process. Receipt of these documents will expedite review for appropriate services for our members. Failure to submit treatment plans may result in an administrative or medical necessity denial for services due to insufficient documentation for review.

As a reminder, communication dated July 29, 2016, entitled “MCG Health, LLC criteria to determine medical necessity” notified providers of the adoption of MCG Health, LLC for medical necessity criteria to determine appropriateness of many behavioral health services.

Submit the current treatment plan, if applicable, and any other clinical information with all Outpatient Treatment Report (OTR) forms at the time of request for precertification.

For any questions about this communication, please contact Utilization Management at 1-855-661-2028.

Additional information on ClaimsCheck upgrade to ClaimsXten

Anthem Medicaid previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-855-661-2028.

Modifier 63: Procedure performed on infants less than 4 kg

(Policy 06-015, effective 09/15/2017)

Currently, Anthem Medicaid allows additional reimbursement of 120% for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, Anthem will allow 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/ky>.

Interqual guidelines to determine medical necessity

Note: The following is an update about information in the provider manual. For access to the latest manual, go online to <https://mediproviders.anthem.com/ky>.

Effective April 1, 2017, Anthem will begin utilizing Interqual guidelines for medical necessity criteria. The American Society of Addiction Medicine will be used for substance use. If Interqual does not cover a behavioral health service, Anthem will follow the standardized tools for medical necessity determinations. For adults, Level of Care Utilization System (LOCUS) will be used. For children, Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths Scale (CANS) will be used. For young children, Early Childhood Service Intensity Instrument (ECSII) will be used.

All physician-administered medications will be reviewed using Anthem's drug medical policies and clinical utilization management guidelines.

Anthem currently uses MCG Health, LLC (formerly known as Milliman Care) criteria to determine medical necessity of precertification required services.

Why is this change necessary?

At the request of the Commonwealth of Kentucky, Anthem will use the nationally recognized, peer-reviewed and evidence-based criteria, Interqual, when reviewing the medical necessity for inpatient and outpatient services.

These guidelines are written by physicians, nurses and other health care professionals and represent a compilation of best practices drawn from current medical evidence. These guidelines will assist us in making medical necessity and level-of-care determinations.

Effective April 1, 2017, state requirements mandate the use of the standardized tools noted above.

What is the impact of this change?

We are moving to a standardized, widely adopted set of medical review criteria to help providers render quality care while reducing members' underuse, overuse or misuse of medical resources.

Questions

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

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

For WI Medicaid only

Initiate your prior authorization request via ICR

We heard your feedback and now, with Interactive Care Reviewer (ICR), your practice can initiate online prior authorization (PA) requests for members enrolled in BadgerCare Plus. Access our ICR via the Availity Web Portal to experience a streamlined precertification process to request inpatient and outpatient medical and behavioral health procedures.*

Here are just a few benefits and efficiencies your office may experience:

- **Automated Routing to ICR** - From the Availity Web Portal, you will automatically be routed to ICR to begin your PA request once the migration has occurred and you go to **Patient Registration|Authorizations & Referrals**, then **Authorizations**. There is no need to remember the prefixes or migration dates!
- **Determine if a PA 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 PA they are affiliated with and the PA 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 PA requests online for medical and behavioral health* services, using the same, easy to use functionality.
- **Reduce the need to fax** - Submit online PA 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** - Access 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 PA** - 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.

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.

Anthem offers informational webinars to help you learn more about the *features and benefits* of our new tool and how to navigate within it. To register and to review the dates and times available, see more details [here](#) .

Policy update for professional anesthesia services

(Policy 07-018, effective 05/01/17)

Anthem allows reimbursement of anesthesia services rendered by professional providers for covered members.

Reimbursement is based upon:

- The reimbursement formula for the allowance and time increments in accordance with the American Society of Anesthesiologists (ASA)
- Proper use of applicable modifiers

Anesthesia services should be recorded in minutes or the claim may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time **starts** with the preparation of the member for administration of anesthesia and **stops** when the anesthesia provider is no longer in personal and continuous

attendance.

Anesthesia Modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service **must** be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on state requirements, as applicable. If there is no state requirement, Anthem will default to CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied.

NOTE: Anthem allows reimbursement for standby anesthesia services and qualifying circumstance procedure code(s) when appended with Modifier AA.

For additional information, refer to Professional Anesthesia Services reimbursement policy at <https://mediproviders.anthem.com/wi>.

Medical policy and clinical guideline updates

On November 3, 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 website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

Effective date	Medical Policy number	Medical Policy title	New or revised
12/28/2016	DME.00040	Automated Insulin Delivery Devices	New
12/28/2016	DRUG.00090	Bezlotoxumab (ZINPLAVA™)	New
11/17/2016	DRUG.00097	Olaratumab (Lartruvo™)	New
12/28/2016	DRUG.00102	Cabazitaxel (Jevtana®)	New
12/28/2016	LAB.00033	Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer	New
11/17/2016	DME.00036	Ultraviolet Light Therapy Delivery Devices for Home Use	Revised
11/17/2016	DRUG.00038	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	Revised
11/17/2016	DRUG.00041	Rituximab (Rituxan®) for Non-Oncologic Indications	Revised
11/17/2016	DRUG.00042	Ustekinumab (Stelara®) (HAE)	Revised
11/17/2016	DRUG.00048	Eribulin mesylate (Halaven®)	Revised
11/17/2016	DRUG.00057	Canakinumab (Ilaris®)	Revised
11/17/2016	DRUG.00068	Vedolizumab (Entyvio®)	Revised
12/28/2016	DRUG.00066	Antihemophilic Factors and Clotting Factors	Revised

Additional information on Claims Check upgrade to ClaimsXten

Anthem previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017. This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider *Explanation of Payment (EOP)* or *Clear Claim Connection* explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the *EOP* when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your *EOP*, please call Provider Services at 1-855-558-1443.

Prior authorization required for continuous interstitial glucose monitoring

Effective April 1, 2017, Anthem will require prior authorization (PA) for Continuous Interstitial Glucose Monitoring. Continuous Interstitial Glucose Monitoring requests must be reviewed by Anthem for PA with dates of service beginning on and after April 1, 2017. Please refer to the Provider Self-Service tool at <https://mediproviders.anthem.com/wi> for more information on authorization requirements.

To request PA, you may use one of the following methods:

- Phone 1-855-558-1443
- Fax to **1-800-964-3627**
- Visit the web at <https://mediproviders.anthem.com/wi>

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

Note: Wisconsin Medicaid providers also can initiate prior authorization requests online for members enrolled in BadgerCare Plus by accessing our ICR via the Availity Web Portal. See more details on page 24 of this issue.