

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>Tools for Providers (select state)>Health Care Reform/Health Insurance Exchange..

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

New audit program

Effective July 1, 2017, Equian, one of our audit vendors, will expand its current scope of audits (DRG Validation and Hospital Bill Audits) to include a review of "Complex Duplicates" or services submitted and potentially paid multiple times for the same patient encounter. This program is a post-payment audit of outpatient facility claims for the same member/same provider/same service that appear to have duplicate payments, but need further research. Equian will work with the facility's billing department in determining whether the services were paid appropriately.

Anthem and Equian are committed to the coordinated efforts between all our programs and maintaining a professional working relationship with all providers. Should you need additional information, please contact your local Network Relations consultant.

New member identification prefixes coming in 2018

The Blue Cross and Blue Shield Association (BCBSA) assigns member ID prefixes for all Blue Cross and Blue Shield-branded Plans – Anthem Plans as well as non-Anthem Plans. There are a limited number of unused three-character, alpha-only prefixes remaining, and they are expected to be exhausted in the 2nd or 3rd quarter of 2018. When that happens, the BCBSA will begin assigning prefixes that contain a combination of letters and numbers, or alpha-numeric prefixes.

What does this mean to you?

- It will be even more important to ask your patients for their most recent identification (ID) card.
- When submitting claims, enter the identification number exactly as it appears on the member's ID card.
- Check your EDI software now to make sure it can accept alpha-numeric prefixes.
- Check any internal documents you may have and update any references of "alpha prefix" to "prefix".

Note: Current three-character, alpha-only prefixes will not be affected by this change. Current prefixes will still be valid once the new alpha-numeric prefixes are issued, unless there is another need to change or remove a prefix currently in use.

We'll send you reminders of this upcoming change in future issues of *Network Update*.

835 electronic remittance advices for cashless payments

Our members may receive services from a health care provider that is also their employer. In some cases, these employers are self-funded, administrative services only (ASO) groups who contract with us to administer health care benefits for their employees. For this type of arrangement, cashless payments apply as these self-funded employer groups pay themselves for the claim services incurred by their employees with no exchange of monies from the payer, Anthem.

On the 835 ERA, cashless payment is further defined by the Claim Adjustment Reason Code (CARC) of 139; Contracted funding agreement – Subscriber is employed by the provider of services. Review of the entire 835 ERA must be done to also account for when claims are zero paid due to uncovered services, exhaustion of benefits, or member liability.

835 Example – Subscriber paid \$20 copayment			835 Example – \$59.12 towards coinsurance		
CLP*999999999*1*246*0*20*12*CLAIMNO1*11*1~ SVC*HC:99214*246*0~ DTM*472*20160531~ CAS*PR*3*20~ CAS*CO*45*126.65**139*99.35~ REF*6R*1234567~ AMT*B6*119.35~			CLP*999999000*1*1075*0*59.12*15*CLAIMNO2*13*1~ AMT*AU*591.25~ SVC*NU:0921*1075*0**1~ DTM*472*20170119~ CAS*CO*139*532.13**45*483.75~ CAS*PR*2*59.12~ AMT*B6*591.25~		
Claims Paid Amount	\$0	CLP04	\$0		
Total Charged Amount	\$246		\$1075		
Copayment	\$20	CAS PR 3			
Coinsurance			\$59.12	CAS PR 2	
Contractual write Amount	\$126.55	CO 45	\$483.75	CO 45	
Amount we would have paid	\$99.35	CO 139	\$532.13	CO 139	
Total	\$246.00		\$1075		
835 Example – \$242.96 towards coinsurance			835 Example – \$110 towards deductible		
CLP*999123000*1*2429.58*0*242.96*15*CLAIMNO3*11*1~ CAS*CO*139*2186.62~ CAS*PR*2*242.96~ AMT*AU*2429.58~			CLP*999123000*1*200*0*110*15*CLAIMNO4*13*1~ CAS*CO*45*90~ CAS*PR*1*110 AMT*B6*110~		
Claims Paid Amount	\$0	CLP04	\$0	CLP04	
Total Charged Amount	\$2429.58		\$200		
Copayment					
Coinsurance	\$242.96	CAS PR 2			
Deductible			\$110	CAS PR 1	
Contractual write Amount			\$90		
Amount we would have paid	\$2186.62	CO 139	0		
Total	\$2429.58		\$200		

Changes for mid-June 2017

Currently, employee claim payments are combined with non-employee claims in a single 835. Changes are scheduled for mid-June to report cashless payments into a separate 835.

Transaction Handling Code (BPR01)	must = H
Monetary (Check) Amount (BPR02)	must = 0 (zero)
Payment Method Code (BPR04)	must = NON
Check/EFT Number TRN02	Begins with 'V' or 'F'

If you have questions specific to 835s, please contact your local E-Solutions Help Desk at 800-470-9630 or via email at e-solutions.support@anthem.com.

Credentialing news

Your contract with Anthem uses the CAQH ProView® system to gather and coordinate the information needed for credentialing. If you are due for an upcoming re-credentialing event and have not accessed CAQH ProView recently, please take a moment to login to CAQH ProView, update your data profile and re-attest to your information.

Re-attestation is due every 120 days, and it is very important to keep your data profile accurate and current so that Anthem can complete the credentialing process without requiring additional outreach to you.

Below are frequently asked questions regarding the CAQH ProView system.

What is CAQH ProView?

CAQH ProView is an online provider data-collection solution. It streamlines provider data collection by using a standard electronic form that meets the needs of nearly every health plan, hospital and other healthcare organization.

CAQH ProView enables physicians and other healthcare professionals in all 50 states and the District of Columbia to enter information free-of-charge into a secure central database and authorize healthcare organizations to access that information. CAQH ProView eliminates redundant paperwork and reduces administrative burden.

Does it cost anything to use CAQH ProView?

There is no cost for physicians and other health care providers to use CAQH ProView.

How do providers access CAQH ProView?

Providers can register online at <https://proview.caqh.org/>, or will receive registration instructions once Anthem notifies CAQH that the provider needs to access the database. Once registered, use the CAQH Provider ID and password to access CAQH ProView.

How do physicians and other healthcare professionals complete the CAQH ProView data collection process?

Completing the online form requires five steps:

1. Register with CAQH ProView.
2. Complete the online application and review the data.
3. Authorize access to the information.
4. Verify the data and/or attest to it.
5. Upload and submit supporting documents.

Why should providers respond to CAQH re-attestation notices?

After providers complete their CAQH ProView applications, CAQH will notify them every four months to re-attest that all information is still correct and complete. This enables a provider's contracted participating organizations to access CAQH ProView profile information based on their different re-credentialing cycles.

Who can I contact for help or if I have any questions about CAQH ProView?

Contact the CAQH Help Desk: [Log in to CAQH ProView](#) and click the chat icon at the top of any page or call: 888-599-1771.

Reminder: As previously advised, Anthem will be credentialing additional practitioner and health delivery organization (HDO) provider types who are contracted with Anthem. If you are contacted by Anthem's credentialing department, please respond with the information requested.

Anthem E-Solutions Service Desk supports EDI direct submitters

At Anthem, our knowledgeable and experienced E-Solutions Service Desk associates are available to assist if you directly submit and receive electronic data interchange (EDI) transactions.* To contact the Service Desk, call 800-470-9630 or submit to our mailbox at E-solutions.support@anthem.com. The Service Desk is open in **all** time zones, 8 am - 4:30 pm.

To assist you as quickly as possible, for the following situations, please provide the indicated information:

- **ERA Inquiries/Follow-up** -- Trading Partner/Submitter ID, REQ number if available
- **Electronic Remittance Advice (ERA) only requests** -- Link under the register tab on EDI webpage, **ERA registration E-Form**
- **Submitted claim information** -- Trading Partner/Submitter ID, Member ID and Date of Service
- **Submitted file information** -- Trading Partner/Submitter ID, Control number and File Submission Date
- **Requested research follow-up** -- Trading Partner/Submitter, the File Control number or ticket number provided by service desk if available
- **Claim receipt verification** -- Trading Partner/Submitter ID, Tax ID and Check Information
- **Batch claim status and benefit inquiry** -- Trading Partner/Submitter ID and File Submission Date
- **To register for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) or Electronic Funds Transfer (EFT) only** -- Please visit www.caqh.org/solutions/enrollhub
- **For established Electronic Funds Transactions (EFT)** -- Please contact EDI at the toll-free number or support mailbox

We also offer a Live Chat option located on the EDI web page at anthem.com/edi. Please be prepared to provide the following required components for Live Chat:

- Trading Partner/Submitter ID
- Region
- Name
- Email address
- Phone number
- TAX ID/NPI Number
- Clear description of question

** Note: If you use a clearinghouse, please use existing procedures in place for EDI questions and/or concerns.*

ICR training

Physicians and facilities can use the ICR to submit online medical and behavioral health outpatient and inpatient precertification and prior authorization requests for many members* covered by Anthem health plans. Also, ordering and servicing physicians and facilities can use the inquiry feature to find information on their organization's requests.

If you are you a new user, attend one of our FREE upcoming monthly webinars, and get a jump start on navigating the ICR tool. After you attend the webinar you will be familiar with the products and services available for authorization via ICR and will be able to:

- Access ICR through the Availity Web Portal.
- Create a precertification or prior authorization request.
- Inquire on a previously submitted authorization.

Select the following link to register for an ICR webinar today:

[Interactive Care Reviewer Webinar Registration](#)

**Note: ICR may not be available for Federal Employee Program® (FEP®), BlueCard®, and some National Account members; requests involving transplant services; or services administered by AIM Specialty Health®. For these requests, follow the same precertification process that you use today.*

IN, KY, WI: 2017 Provider Manuals are posted

Your state's updated Provider Manual has been posted online. Go here to view: [IN](#), [KY](#), [WI](#).

Reminder: 2017 Risk Adjustment Data Validation Audit

The Centers for Medicare & Medicaid Services (CMS) is conducting a Risk Adjustment Data Validation (RADV) Audit beginning **June 2017 through January 2018**. This audit is in accordance with provisions of the Affordable Care Act (ACA) and its risk adjustment data validation standards. For details, go [here](#).

KY, OH, WI: PMF reminder

We recently sent you a [reminder](#) that providers participating in Anthem network(s) must submit a Provider Maintenance Form (PMF) to notify Anthem of changes and updates to your practice.

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, closing your practice to new patients, etc. -- please notify us by completing the Anthem Provider Maintenance [Form](#) at anthem.com. Thank you for your help and continued efforts to keep our records up to date.

Health Care Management

OH: Imaging program expands to include level of care reviews

Effective with dates of service on or after September 1, 2017, for members covered by a local plan in Ohio, Anthem will require a medical necessity review of the requested level of care for computed tomography (CT) imaging and magnetic resonance imaging (MRI). A clinical guideline, Level of Care: Advanced Radiologic Imaging, CG-MED-55, will apply to the review process for dates of service beginning September 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 **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: 800-554-0580.

The expanded program applies to local fully-insured Anthem members in Ohio, 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 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 see FAQs online at 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 for Ohio providers, beginning with dates of service on or after September 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 September 1, 2017, advanced imaging providers in Ohio 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.

If you have additional questions, please contact your local Network Relations consultant.

New Radiology website includes information on the imaging program

AIM has developed an educational website focused on Radiology services provided on Anthem's behalf, including the imaging clinical site of care review. Available on the microsite are instructions about registering your site in **OptiNet**, FAQs, and program resources. Visit aimproviders.com/radiology to learn more. If you have additional questions, please contact your local Network Relations consultant.

Anthem will expand the specialty pharmacy prior authorization list

The following specialty pharmacy drugs will be added to our existing pre-service review process **effective September 1, 2017**. Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM, a separate company administering the program on behalf of Anthem.

Medical Policy or Clinical Guideline (CG) number	DRUG code	Drug Names	Comments
DRUG.00077	J3490,J3590	Siliq	New drug medical policy
DRUG.00094	J3490,J3590	Dupixent	New drug medical policy
DRUG.00095	J3490,J3590	Ocrevus	New drug medical policy

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.

Update to AIM diagnostic imaging CGs

Effective for dates of service on or after September 5, 2017, the following changes to AIM Diagnostic Imaging Clinical Appropriateness Guidelines will become effective:

Focal liver lesions (CT abdomen, MRI abdomen)

- Enhanced criteria for initial evaluation and follow up imaging of incidental liver lesions based on size or underlying risk factors

Established malignancy (CT chest, CT abdomen, CT pelvis, CT abdomen & pelvis, MRI abdomen, MRI pelvis)

- Criteria added which limit the use of CT or MRI for routine surveillance following completion of therapy for colorectal cancer, prostate cancer and breast cancer.
- Criteria added to limit the use of CT or MRI for staging of low risk breast cancer in the absence of signs or symptoms of metastatic disease.
- Criteria to restrict the use of MRI as a replacement for CT in staging or follow up of established tumor to situations where CT is contraindicated, or where MRI has been shown to be superior for evaluation (e.g., rectal cancer).

Recurrent lower urinary tract infection (CT abdomen, CT pelvis, CT abdomen & pelvis)

- Indication is being removed, as the literature does not support the use of advanced imaging in this scenario.

Venous thrombosis or occlusion (MRA abdomen, CTA abdomen, CTA abdomen & pelvis)

- Added requirement that ultrasound be performed prior to any advanced imaging to evaluate suspected hepatic, portal, splenic and renal vein thrombosis.

To submit pre-certification requests to AIM, ordering and servicing providers may access AIM's **ProviderPortal**SM directly at www.providerportal.com, available 24/7 to process orders in real time, or call the AIM Specialty Health Call Center.

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

CG Med 46 update

You were previously notified that, effective July 1, 2017, CG-Med-46 Ambulatory and Inpatient Video Electroencephalography will require precertification review when the member is in an inpatient setting. This clinical guideline also will require review if done in an outpatient setting.

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

Reminder: Prior authorization required for genetic testing

As previously communicated, 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, a separate company. Additionally, this review will now take place as a prior authorization.

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

- 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, Monday–Friday, 8:30 am–7 pm ET.

To find more information about genetic testing prior authorization at AIM, please go to the following website: <http://www.aimprovider.com/geneticstesting/>

The program applies to local Anthem fully insured members only. It excludes 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.

Medicare

No copay for HbA1c testing and diabetes retinal exam

Effective Jan. 1, 2017, no copay is required for HbA1c testing for individual and some group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual dilated retinal exam at no out-of-pocket cost. The annual retinal exam claim must include a line for measurement code 2022F to report the use of dilation during the exam for no copay to apply.

This is not applicable to Anthem Special Needs Plans or Anthem MediBlue Coordination Plus plans. Some group-sponsored plans may require a member copayment or coinsurance for these services.

Bill CLIA certification for individual MA claims

Effective July 1, 2015, Anthem began denying claims for individual Medicare Advantage members billed without the CMS-required CLIA certification number and claims billed with an invalid CLIA certification number. The CLIA number must be included on each claim billed on the ASC X12 837 professional format or Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. The CLIA number is not required on the ASC X12 institutional claim data set or its related paper Form CMS-1450. Please bill the CLIA certification in the following fields: ASC X12 837 professional claim format REF segment as REF02, with qualifier of "X4" in REF01, OR field 23 of the paper CMS-1500.

Tips for submitting MA corrected claims

When submitting a corrected claim, clearly identify that the claim is a correction to an original bill. Additional details for submitting corrected medical electronic CMS-1500 claims, paper CMS-1500 claims and facility UB-04 electronic or paper claims can be found at [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider.

Tetanus vaccine billing guidelines

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. Tetanus administered in the Emergency Room should be billed with the appropriate revenue codes (0250 or 0636 for vaccine and 0771 for the administration). 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 the member has pharmacy benefits, please bill their 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](#).

Reimbursement for code 1111F

Once the patient is discharged, medication reconciliation plays an important role in preventing adverse drug events. This should be done within 30 days of discharge from an acute or non-acute inpatient stay. Anthem reimburses providers who:

- Conduct medication reconciliation within 30 days of an inpatient hospital discharge for individual and group-sponsored Medicare Advantage members, and
- Submit the claim using the CPT Category II code 1111F.

Medication reconciliation must be completed by the prescribing practitioner, registered nurse or clinical pharmacist and noted by one of these professionals on the outpatient medical record. Additional information is available at anthem.com/medicareprovider under [Important Medicare Advantage Updates](#).

Imaging services providers must complete *OptiNet* assessments

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM's online registration tool, *OptiNet*. *OptiNet* will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiograph imaging services. Areas of assessment include facility qualifications, technician and physician qualifications, accreditation, equipment and technical registration.

The data will be used to calculate site scores for providers who render imaging services for our individual Medicare Advantage members.

All participating providers who provide imaging services, including X-rays and ultrasounds, as noted above, must complete the registration. Effective May 1, 2017, providers who do not register, who score less than 76 or who do not complete the survey will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. All facility diagnostic imaging services are excluded from line item denials *at this time*. Although there is no reimbursement impact at this time, Anthem continues to encourage facility network providers to submit imaging services data for the AIM Specialty Health initiative.

If you have already completed an *OptiNet* assessment, please ensure that you keep your registration up to date. Expiring data could lead to a negative impact in your modality scores.

HCPCS codes allow for payment for coordinating BH services

Anthem would like to remind Medicare Advantage providers of the collaborative care, case management and cognitive assessment HCPCS codes, G0502, G0503, G0504, G0505, and G0507, that became effective Jan. 1, 2017. CMS approved these codes for services provided under the Psychiatric Collaborative Care Model, which supports integration of behavioral health care into primary care treatment. These codes allow payment for the efforts to coordinate and integrate behavioral health care services by primary care providers, including key services of care management for patients receiving behavioral health treatment and psychiatric consultation to primary care treatment teams. For a list of the collaborative care codes introduced in 2017, please see [Important Medicare Advantage Updates](#) at anthem.com/medicareprovider.

MO: Home health services require PA

Effective May 1, 2017, Missouri is included in the requirement to obtain prior authorization for individual Medicare Advantage members receiving home health services. Services subject to prior authorization include skilled nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social worker.

Prior authorizations must be submitted to myNexus and may be obtained via fax: 844-834-2908; phone: 844-411-9622; portal: <https://portal.mynexuscare.com/>.

A list of frequently asked questions and answers is available at <https://www.mynexuscare.com/anthem/>. Additional information is available [here](#).

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:

[WI : Home Health Services for Medicare Advantage Individual Members to Require Prior Authorization](#)
[Prior authorization requirement change for Part B drug: Herceptin](#)

[Prior authorization requirement change for Part B drug: Bavencio](#)
[Prior authorization requirement change for Part B drug: Spinraza](#)
[Reimbursement policy – provider bulletin](#)
[Prior authorization requirements for continuous interstitial glucose monitoring](#)
[Risk adjustment and documentation guidance training offered](#)
[Retrospective medical record review program launches](#)

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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. 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

Diabetic retinal eye exam reminders

National guidelines and the National Committee of Quality Assurance (NCQA) recognize the importance of screening people with diabetes annually for diabetic retinopathy through its inclusion in one of the Comprehensive Diabetes Care (CDC) measures. Similarly, Anthem has included retinal eye exams (either by dilation or photograph) for people with diabetes as one of the measures on the Enhanced Personal Health Care scorecard.

What can you do to improve compliance rates?

- Talk to your patients with diabetes about the importance of getting an annual comprehensive eye exam including dilation. **Since the retinal eye exam (DRE) is recommended by evidenced-based clinical guidelines as a medically necessary part of a diabetic care plan, a member’s medical benefits will cover the exam, subject to his or her share of the cost, including copays and deductibles.** A diabetic eye exam does NOT require vision benefits, as it is part of the medical benefit package. Patients should call Member Services on the back of their identification card for clarification around benefits.
- *If you are a primary care doctor or endocrinologist*, refer your patients with diabetes to an in-network ophthalmologist or optometrist, if they aren’t already connected with an eye doctor. Follow-up with their eye doctor, as you would any other specialist.
- *If you are an eye doctor*, follow-up and provide the patient’s test results to their primary care doctor and/or endocrinologist.

- Keep clear documentation in the patient's medical record.
 - Clearly document referrals, eye exam and lab results.
 - Record the date of the most recent diabetic eye exam with results and name of vision provider.
 - Obtain and include a copy of diabetic eye exams performed by an optometrist or ophthalmologist.

Use the following medical procedure codes to document diabetic eye exams.

Service	Claim Submission Method	CPT codes	HCPCS Codes	CPT Category II Codes
Eye Procedures	Anthem Medical	67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228	S0620, S0621, S3000 – Diabetic indicator; retinal eye exam, dilated, bi-lateral	2022F, 2024F, 2026F, 3072F - Low Risk for Retinopathy (no evidence of retinopathy in the prior year)
Evaluation and Management Codes (by an Optometrist or Ophthalmologist Only)	Anthem Medical	92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 92213-99215, 99242-99245		

What's new for HEDIS

Here are some highlights of the HEDIS measure revisions that were implemented in 2017:

- **Human Papilloma Virus (HPV):** This measure was retired in 2017 but the vaccine requirement was added to the IMA (Immunization for Adolescents) measure.
- **Immunization for Adolescents (IMA):** The tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines were removed from this measure and the HPV vaccine was added. It is now required for both male and female members. There are two combinations.
 - *Combination 1 (Meningococcal, Tdap):* Adolescents who are compliant for both the meningococcal conjugate and Tdap vaccines.
 - *Combination 2 (Meningococcal, Tdap, HPV):* Adolescents who are compliant for all three vaccines (meningococcal, Tdap, HPV)..
- **Colorectal Cancer Screening (COL):** Two tests were added as acceptable proof of colorectal screening:
 - CT Colonography within the last five years.
 - FIT- DNA test within the last three years.

You can find more information on HEDIS at anthem.com>Tools for providers (select your state)> Health and Wellness> Quality Improvement and Standards. Scroll down to “HEDIS Information.”

Thank you for your continued cooperation and support of HEDIS.

Integrated Care Model offers continuity of care

An Integrated Care Model offers continuity of care to members with plans purchased on the Health Insurance Marketplace (also called the exchange). A single primary care nurse provides case and disease assessment and

management. This continuity provides members with assistance in working through an acute phase of their illness and then working with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals who support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician’s plan of care, not to offer separate medical advice. In order to help ensure that our service complements the physician’s instructions, we collaborate with the treating physician to understand the member’s plan of care and educate members on options for their treatment plan.

Members or caregivers can refer themselves or family members by calling the number located in the grid below.

CM Telephone Number	CM Email Address	CM Business Hours
888-662-0939	centregcmref@anthem.com	Mon –Thursday: 8 am – 9 pm ET Friday: 8 am – 8 pm ET Saturday: 9 am – 5:30 pm ET

ConditionCare program benefits members and physicians

Anthem members have additional resources available to help them better manage chronic conditions. The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of registered nurses with added support from other health professionals, including dietitians, pharmacists and health educators, work with members to help them understand their condition(s), their doctor’s orders and how to become a better self-manager of their condition.

Engagement methods vary by the individual’s risk level but can include:

- Education about their condition through mailings, email newsletters, telephonic outreach, and/or online tools and resources.
- Round-the-clock phone access to registered nurses.
- Guidance and support from Nurse Care Managers and other health professionals.

The program also benefits physicians and their staff by freeing up their valuable time. The ConditionCare team responds to patient’s questions and concerns; supports the doctor-patient relationship by encouraging participants to follow their doctor’s treatment plan and recommendations; and keeps physicians informed with updates and reports on the patient’s progress.

Please visit anthem.com to find more information, including program guidelines, educational materials, and the *Patient Referral Form*, which you can use to refer patients who may benefit from our program.

If you have any questions or comments, call 877-681-6694. Our nurses are available Monday-Friday, 8 am – 9 pm ET, and Saturday, 9 am – 5:30 pm ET.

Clinical practice and 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 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 anthem.com>Tools for providers (enter state)>Health & Wellness>[Practice Guidelines](#).

Reimbursement

Professional reimbursement policy updates

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

Assistant Surgeon Policy and Coding

We updated our policy and code list for January 1, 2017 and have posted the changes on anthem.com and Availity. The changes are based on Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS Level II) coding changes for 2017 as well as updates based on American College of Surgeons (ACS) and the Centers Medicare & Medicaid Services (CMS) information.

- Added codes: 22867, 22869, 27197, 27198, 28291, 31551, 31552, 31553, 31554, 31572, 31573, 31574, 31591, 31592, 33340, 33477, 33957, 33958, 33959, 33962, 36456, 36473, 36474, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37237, 37239, 37247, 37248, 37249, 47383, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62380, 93591, 0446T, 0447T, 0448T, 0449T, 0450T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0465T, 0466T, 0467T, and 0468T.
- Deleted codes: 11752, 11977, 15170, 15171, 15175, 15176, 20101, 21338, 22858, 27193, 27194, 27279, 28290, 31582, 35471, 35472, 35475, 35476, 39401, 39402, 62310, 62311, 62318, 62319, 69405, 0019T, 0281T, 0282T, 0283T, 0284T, 0288T, and 0289T.

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

Effective January 1, 2017, as part of our routine maintenance of existing edits, we are documenting our current edit that denies 82570 (urine creatinine) or 83986 (urine pH) when reported with 80305-80307 (presumptive drug testing) and G0659 (definitive drug testing). In addition, for claims processed on or after May 20, 2017, modifiers will not override the edits.

Our current edit denies 82542 (*column chromatography*) when reported with presumptive or definitive drug testing services. We are updating our policies for claims processed on or after May 20, 2017 to include the new CPT codes 80305-80307 and HCPCS code G0659 plus existing HCPCS codes G0480-G0483 (*drug test(s), definitive... qualitative or quantitative, all sources, includes specimen validity testing, per day*) to this edit. Modifiers will not override the edits.

When similar or identical procedures are performed, but are qualified by an increased level of complexity, only the most comprehensive service performed should be reported. Based on this logic, we are documenting, in our policies dated May 20, 2017, that our current edit denies G0480-G0483 when reported with G0659. Modifiers will not override this edit.

In the December 2016 issue of *Network Update*, we advised that for dates of service on or after March 1, 2017, arthrodesis code 22614 would not be eligible for separate reimbursement when reported with primary arthrodesis codes 22600, 22610, 22612, and 22630. Upon further review, we have reconsidered our position and have removed this edit for dates of service on or after March 1, 2017.

Claim Editing Overview

Based on extensive review, the Health Plan considers that spinal osteotomy surgery is appropriate only for the condition of advanced spinal deformities of kyphosis and scoliosis. Therefore, beginning with dates of service on or after September 1, 2017, spinal osteotomy surgical *Current Procedural Terminology* (CPT®) codes 22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22222, 22224, and 22226 will only be eligible for reimbursement when reported with a diagnosis of kyphosis or scoliosis.

Durable Medical Equipment and Place of Service

For claims processed on or after May 20 2017, a select list of specialized hospital beds (E0194, E0301, E0302, E0303, and E0304) and negative pressure wound care items (E2402; please note, A6550 and A7000 are currently allowed) will be eligible for reimbursement when reported with a skilled nursing facility (SNF) place of service (31). These select items are not considered part of the SNF per diem reimbursement rate.

Frequency Editing

We currently have frequency limits that are applied per 90 days for diabetic supplies identified by HCPCS codes A4230, A4231, A4232, A4244, A4245, A4250, A4253, and A4259. Beginning with claims processed on or after May 20, 2017, we are decreasing the day span to per 86 days. Please note that the listed frequency limits will still apply to these codes.

Effective for dates of service on or after September 1, 2017, we will be applying a frequency limit of 2 per date of service for hearing aid codes V5267 and V5298. Modifiers will not override these edits.

Other Updates

The following professional reimbursement policies were reviewed and may have word changes or clarifications; however, they do not have significant changes to the policy position or criteria and are effective July 1, 2017:

- Documentation & Reporting for Psychotherapy Services
- E/M Services and Related Modifiers -25 & -57
- Modifier 22

Coding Tip

As of May 30, 2017, the Health Plan has removed its Payment Policy Indicators list that was previously posted on the Anthem provider portal which is accessed through availability.com (see instructions below). In order to determine if a payment policy reduction will apply to a procedure, review the corresponding Anthem professional reimbursement policy posted on our provider portal.

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

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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

Indiana Medicaid

Medicaid only: Reimbursement policy reminder -- Multiple and bilateral surgery

(Policy 06-010, effective 10/03/16)

Anthem allows reimbursement to professional providers and facilities for multiple and bilateral surgery.

Reimbursement is based on multiple and bilateral procedure rules for applicable surgical procedures performed at the same session by the same provider.

Multiple surgery

Professional provider claims for applicable surgical procedures must be billed with Modifier 51 to denote a multiple procedure. Facility claims should not be billed with Modifier 51. However, the following reductions apply to both physician and facility claims. Professional reimbursement is the total of:

- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 50% for the secondary procedure.
- 25% for the third through fifth procedures, with the sixth and additional procedures only if determined to be medically necessary through clinical review.

Facility reimbursement is the total of:

- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 50% for the secondary procedure. (A maximum of two procedures are allowed.)

Anthem does not apply multiple procedure reduction reimbursement to Modifier 51-exempt (also known as MS-exempt) or to add-on procedure codes since the fee allowance and/or relative value is already reduced for the procedure itself.

Bilateral surgery

Professional provider and facility claims with applicable surgical procedures must be billed with Modifier 50 to denote a bilateral procedure. It is inappropriate to use Modifier LT or RT to identify bilateral procedures.

Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure.

Refer to *Multiple and Bilateral Surgery: Professional and Facility Reimbursement Policy* for additional information at www.anthem.com/inmedicaidoc.

CMS emergency preparedness rules notice

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Anthem seeing Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following common and well-known industry best practice standards:

1. **Emergency plan:** Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
2. **Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.

3. **Communication plan:** Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
4. **Training and testing program:** Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note: While all 17 providers/suppliers are impacted, requirements may differ between types.

Anthem does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website ([https://www.cms.gov>Medicare>Provider Enrollment & Certification>Survey & Certification - Emergency Preparedness](https://www.cms.gov/Medicare/Provider%20Enrollment%20&%20Certification/Survey%20&%20Certification-%20Emergency%20Preparedness)).

If you have questions about this communication, contact your local Provider Relations representative.

Genetic testing services require prior authorization

Effective May 1, 2017, Anthem requires prior authorization (PA) for Epidermal Growth Factor Receptor (EGFR) Testing.

Federal and state law, as well as state contract language and CMS guidelines, and including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage.

Noncompliance with the new requirement may result in denied claims. The PA requirement will be added to current CPT code 81235, and PA for the service will remain in effect, in the event of code changes corresponding to the

service.

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 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.

Case management program

Managing chronic illness can be difficult for your patients. Knowing who to contact, what test results mean or how to obtain needed resources can be a big piece of a health care puzzle. Anthem offers assistance through our Case Management program. Our case managers, part of an interdisciplinary team of clinicians and other resource professionals, support members, families, primary care providers and caregivers. The case management process utilizes the experience and expertise of our care coordination team to educate and empower our members to increase self-management skills, understand their illness and learn about care choices in order to access quality, efficient health care.

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

Members may also be referred to Case Management through:

- Utilization Management
- Discharge Planning
- Disease Management
- Health Information Line

To contact us, call 866-902-1690, Monday – Friday, 8 am – 5 pm ET.

Modifier 78 policy reminder

*Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
(Policy 06-016, originally effective 02/01/15)*

Anthem allows reimbursement for claims billed with Modifier 78 when the following criteria are met:

- A return to the operating or procedure room is unplanned.
- The procedure appended with Modifier 78 is:
 - The appropriate surgical code for the procedure performed.
 - Performed by the same physician who provided the initial procedure.
 - Related to the initial procedure.
 - Performed during the postoperative period of the initial procedure.

Anthem reimburses services appended with Modifier 78 the appropriate percentage as indicated in the *Medicare Physician Fee Schedule* database. Reimbursement is based on the surgical procedure only and does not include preoperative or postoperative care. Procedures rendered during the postoperative period and not billed with Modifier 78 are normally denied as included in the global surgical package.

Refer to *Modifier 78: Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period Reimbursement Policy*. For more information, visit www.anthem.com/inmedicaiddoc.

Access Patient360 directly through the Availity Web Portal

Patient360 is a real-time dashboard that gives you a robust picture of your Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect patients' health and treatment history as well as 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.

In addition to our secure, self-service website, you can access Patient360 within the Availity Web Portal. To begin, you must first be assigned the Patient360 role in the Availity Web Portal; administrators can make this assignment within the *Clinical Roles* options. Then, navigate to Patient360 using one of the methods outlined below:

Method one:

- Select **Patient Registration** from the top menu bar in the Availity Web Portal.
- 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's information in the required fields.

Method two:

- Select **Payer Spaces** from the top menu bar in the Availity Web Portal.
- Choose the Anthem tile.
- Select **Patient360** located on the *Applications* page.
- Enter the member's information in the required fields.

To gain access to the Availity Web Portal, go to <https://www.availity.com>. Select **Register**, then **Get Started**.

Kentucky

CMS emergency preparedness rules notice

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Anthem Medicaid, seeing Anthem Medicaid members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following common and well-known industry best practice standards:

- 1. Emergency plan:** Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
- 2. Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.
- 3. Communication plan:** Develop and maintain a communication plan that complies with federal and state laws; patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.
- 4. Training and testing program:** Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note: While all 17 providers/suppliers are impacted, requirements may differ between types.

Anthem does not have any additional requirements beyond that required by CMS. If you have questions regarding

the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website ([https://www.cms.gov/Medicare>Provider Enrollment & Certification>Survey & Certification - Emergency Preparedness](https://www.cms.gov/Medicare/Provider%20Enrollment%20&%20Certification/Survey%20&%20Certification-%20Emergency%20Preparedness)).

If you have questions about this communication, contact your local Provider Relations representative.

Help to reduce unnecessary ER visits

As a provider, you are aware that occasionally patients seek emergency care for minor conditions that do not require an ER visit, such as the common cold, sore throat, rash, mild fever, eye or ear pain, etc. In partnership with you, Anthem strives to ensure our members are seen in the most appropriate setting for their health care needs. However, in the past six months, we noted that close to 1000 Anthem Kentucky Medicaid members had four or more emergency room visits. Most of these ER visits could have been avoided because they were for minor conditions.

Our members will receive more consistent care and follow-up treatment by seeing their primary care providers for preventive, routine care, acute illness and regularly scheduled visits. Please help us get the word out that seeing their primary care physician will help our members to enjoy better health.

For more information or questions, please contact:

Anita Crenshaw

Clinical Auditor Quality Management

502-619-6800, ext. 26773

855-661-2027, ext. 26773

Claim denial Z21 provider type

Effective December 2, 2016, Anthem Medicaid turned on an edit that requires providers who bill on a CMS-1500 form with a rendering provider to bill with the appropriate provider type based on how the NPI is registered with the Department for Medicaid Services (DMS). Claims billed incorrectly will be denied with the code "Z21 — Billing/Rendering Provider Type Combo Invalid."

Billing guidance examples:

- Physician assistant claim: When the physician assistant (provider type 95) is tied to a *physician assistant group* (provider type 959), claims must be billed with a billing NPI registered with DMS that has a group provider type 95.
- Physician claim: When the physician (provider type 64) is tied to a *physician group* (provider type 659), claims must be billed with a billing NPI registered with DMS that has a group provider type 65.
- Advanced practice registered nurse (APRN) claim: When the APRN (provider type 78) is tied to an *APRN group* (provider type 789), claims must be billed with a billing NPI registered with DMS that has a group provider type 78.
- Licensed professional clinical counselor (LPCC): When the LPCC (provider type 81) is tied to an *LPCC group* (provider type 819), claims must be billed with a billing NPI registered with DMS that has a group provider type 81.

For a list of all provider types, please visit: <http://chfs.ky.gov/dms/provEnr/Provider+Type+Summaries.htm>.

If you have additional questions, please contact Provider Services at 855-661-2028 or your Provider Relations representative.

Update on 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 April 30, 2017, to July 1, 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>**Network Update - - June 2016**.

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.

Wisconsin Medicaid

Medicaid only: Reimbursement policy reminder -- Multiple and bilateral surgery

(Policy 06-010, effective 10/03/16)

Anthem allows reimbursement to professional providers and facilities for multiple and bilateral surgery.

Reimbursement is based on multiple and bilateral procedure rules for applicable surgical procedures performed at the same session by the same provider.

Multiple surgery

Professional provider claims for applicable surgical procedures must be billed with Modifier 51 to denote a multiple procedure. Facility claims should not be billed with Modifier 51. However, the following reductions apply to both physician and facility claims. Professional reimbursement is the total of:

- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 50% for the secondary procedure.
- 25% for third procedure.
- 13% for all subsequent procedures.

Facility reimbursement is the total of:

- 100% of the fee schedule or contracted/negotiated rate for the highest valued procedure.
- 50% for the secondary procedure.
- 25% for third procedure.

Anthem does not apply multiple procedure reduction reimbursement to Modifier 51 exempt (also known as MS-exempt) or to add-on procedure codes since the fee allowance and/or relative value is already reduced for the procedure itself.

Bilateral surgery

Professional provider and facility claims with applicable surgical procedures must be billed with Modifier 50 to denote a bilateral procedure. It is inappropriate to use Modifier LT or RT to identify bilateral procedures.

Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure.

Refer to *Multiple and Bilateral Surgery: Professional and Facility Reimbursement Policy* for additional information at <https://mediproviders.anthem.com/wi>.

CMS emergency preparedness rules notice

On September 8, 2016, CMS finalized a rule to establish consistent emergency preparedness requirements for health care providers participating in Medicaid, which includes providers with Anthem, seeing BadgerCare Plus members. The purpose is to increase patient safety during emergencies and establish a more coordinated response to natural and man-made disasters.

The CMS rule requires Medicaid participating providers and suppliers to meet the following common and well-known industry best practice standards:

- 1. Emergency plan:** Based on a risk assessment, develop an emergency plan using an all hazards approach that focuses on capacities and capabilities that are critical to preparedness for a full spectrum of emergencies or disasters specific to the provider/supplier location.
- 2. Policies and procedures:** Develop and implement policies and procedures based on the plan and risk assessment.
- 3. Communication plan:** Develop and maintain a communication plan that complies with federal and state laws;

patient care must be well coordinated within the facility, across health care providers, and with state and local public health departments and emergency systems.

4. Training and testing program: Develop and maintain training and testing programs (including initial and annual trainings) as well as conduct drills and exercises or participate in an actual incident that tests the plan.

The regulation went into effect November 16, 2016. Health care providers and suppliers affected by this rule have one year from the effective date to comply and implement all regulations within their practice.

The following providers and suppliers are required to comply with the emergency preparedness rule:

- All-inclusive care for the elderly
- Ambulatory surgical centers
- Clinics, rehabilitation agencies and public health agencies as providers of outpatient physical therapy and speech-language pathology services
- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Critical access hospitals
- End-stage renal disease facilities
- Home health agencies
- Hospices
- Hospitals
- Intermediate care facilities for individuals with intellectual disabilities
- Long-term care facilities
- Organ procurement organizations
- Psychiatric residential treatment facilities
- Religious nonmedical health care institutions
- Rural health clinics and federally qualified health centers
- Transplant centers

Note: While all 17 providers/suppliers are impacted, requirements may differ between types.

Anthem does not have any additional requirements beyond that required by CMS. If you have questions regarding the emergency preparedness rule or would like to view a list of specific requirements, please visit the CMS website (<https://www.cms.gov> > Medicare > Provider Enrollment & Certification > Survey & Certification - Emergency Preparedness).

If you have additional questions about this communication, contact your local Provider Relations representative.

Genetic testing services require prior authorization

Effective June 1, 2017, epidermal growth factor receptor (EGFR) testing, prothrombin coagulation (factor II) testing and fetal chromosomal aneuploidy require prior authorization (PA).

For dates of service on or after June 1, 2017, PA is required for EGFR testing, prothrombin coagulation (factor II) testing and fetal chromosomal aneuploidy covered by Anthem Blue Cross and Blue Shield for BadgerCare Plus members. Federal and state law as well as state contract language and CMS guidelines, including 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: 81235, 81240, 81420, 81507, 0009M.

To request PA, contact us by phone at 855-558-1443 or by fax at 800-964-3627.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the provider self-service website (<https://mediproviders.anthem.com/wi> >Precertification).

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

Provider website survey

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

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

Update on ClaimsCheck upgrade to ClaimsXten

Earlier this year, Anthem Blue Cross and Blue Shield 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 April 30, 2017, to July 1, 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/wi> >Provider Education>Communications & Updates>Anthem Network Updates>[Network Update - - June 2016](#).