Anthem BlueCross BlueShield

Working together to improve the health of our members.

February 2018

Network Update

CENTRAL REGION

In this issue

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

anthem.com

CE0218
IN, KY, MO, OH, WI

Medicaid Notifications

Health Care Reform (including Health Insurance Exchange)

Updates and Notifications

Update regarding Shingrix shingles vaccine

Anthem updated its Affordable Care Act (ACA) preventive care coverage to include Shingrix, the new zoster (shingles) vaccine, based on a new recommendation by the Advisory Committee on Immunization Practices (ACIP).

This coverage update is effective for all ACA-compliant commercial health plans for dates of service on and after January 1, 2018. Shingrix will pay at 100% with no member cost share for members who use an in-network provider. Providers should continue to verify eligibility and benefits for all health plans prior to rendering services.

Shingrix is recommended for the prevention of herpes zoster and related complications for immunocompetent adults age 50 years and older as well as those who may have previously received Zoster Vaccine Live (Zostavax).

Note: 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,>Menu>Providers> Find Resources for Your State. Select your state, then 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 > Menu>Providers>Find Resources for Your State. Select your state, then Network eUPDATE.

Administrative Update

Important information about filing Home Infusion Therapy claims

To assist in the accurate and timely processing of Home Infusion Therapy (HIT) claims, it is important for HIT Providers to file *professional* HIT claims to the correct Blue Plan. The following information applies to professional HIT claims for all Blue-branded health plans.

Professional claims from a HIT Provider should be filed to the Blue Plan *where the service was rendered* (which may be the member's home or equivalent setting). Even if a HIT Provider employs traveling health care professionals or renders services in multiple states, professional HIT claims should submitted to the state Blue Plan where the service was rendered.

The following example illustrates appropriate filing of a professional HIT claim:

- *HIT Provider A* regularly renders services in multiple states and service areas.
- *Provider A renders* services to a member using a traveling home health nurse in the member's home.
- The member's home is located in the service area for *Blue Plan XYZ*.
- *Provider A* submits the professional HIT claim to *Blue Plan XYZ*, even though *Provider A* may be located in a different service area than the member's residence.

Please note, professional HIT claims that are not submitted to the Blue Plan where the service was rendered may be denied which will require the provider to resubmit the claim to the correct Blue Plan.

Palliative health support services for commercial members

Beginning April 2, 2018, Aspire Health will supply palliative care support services to our fully insured commercial members with advanced illness. Aspire Health already provides services for members with advanced illness enrolled in our Medicare and Medicaid health plans and has demonstrated improvement in quality and cost of care savings.

Aspire does not replace the care of PCPs and specialists, but provides an extra layer of support with an interdisciplinary team that includes Palliative care physicians, Palliative care nurse practitioners, registered nurses, social workers, chaplains and patient care coordinators.

Specific palliative care services include:

- Comprehensive assessments including symptoms, spiritual and psychosocial needs
- Expert symptom management
- Supporting patients in defining their goals, values and preferences and in advance care planning
- Empowering patients to execute advance directives
- 24/7 access to urgent clinical support from an Aspire interdisciplinary team member
- Securing needed resources
- Education on palliative services and hospice care services

An initial telephonic outreach to identified members will be made by a palliative care professional to determine the appropriate level of palliative services in one of the following three models:
1. Home based visits by Aspire's interdisciplinary team for patients with a high symptom burden, increased risk of hospitalization or other complex issues (available in certain geographic areas)
2. An Aspire palliative care team embedded within an outpatient medical oncology clinic to provide services to targeted patients (available in certain geographic areas)
3. Provision of telephonic/telehealth services and support at routine intervals to patients by palliative trained providers

If you are an Anthem contracted network provider, an Aspire Health palliative physician may reach out to your practice to introduce themselves in order to establish a physician to physician relationship. They may also discuss developing an individualized mechanism by which to share information regarding patients that have been identified for palliative care services. Aspire will provide updates to your practice on a regular basis to facilitate the best possible co-management of your patient.

If you have questions regarding Aspire Health or palliative care, please email palliativecareaspirehospice@anthem.com

Clinical data sharing requirements

Providers and Anthem have a shared goal to improve the quality of health care. To support this goal, it is critical that both providers and Anthem have access to up-to-date clinical and administrative data. As a result, Anthem will update its clinical data sharing requirements effective April 1, 2018.

Examples of clinical data sharing include using Electronic Medical Record (EMR) data to provide a more complete clinical picture of a member's condition (for more targeted and comprehensive treatment plans), facilitate the collection of risk data, improve HEDIS scores and other quality improvement initiatives.

When clinical data is required, Anthem will request this information. For more information about clinical data sharing, review the policy here.

Are you using ICR to submit your PA requests?

Improve the efficiency of your preauthorization process by using our online authorization tool, the Interactive Care Reviewer (ICR), to submit your Anthem inpatient and outpatient medical and behavioral health requests. Access ICR exclusively on the Availity Portal and discover all the great benefits your organization will gain by submitting your authorizations online, including:

- Time savings
  - Reduce and practically eliminate the need to fax or phone in your requests.
  - Spend no time waiting on hold.
  - Save an average of 15 minutes per case compared to fax or phone.
  - Access precertifications in one place, at any time, by designated staff.

- Ease of use and improved efficiency
  - View the ICR dashboard lists for current status of your organization's cases.
  - Track status on cases submitted via phone or fax.
  - Attach and submit clinical notes and supporting images.
  - View and print case determination letters.

- Automated responses
  - ICR is able to provide a decision on whether an authorization is required.
  - For some procedures, ICR is able to deliver immediate decisions.

If you are accessing the Availity Portal for the first time, contact your Availity Administrator and request to be assigned the *Authorization and Referral Request* role. Once you have the role assignment, you can immediately access ICR by logging onto Availity and selecting the **Patient Registration | Authorizations & Referrals**. Then choose **Authorizations**.

If you need training, we've got it covered. Check out our ICR Help Page, and on Availity select **Payer Spaces | Education and Reference Center** for educational resources.

Reimbursement policies are now under Answers@Anthem

We're making it easier for you to find the information you need. Professional and Facility reimbursement policies, previously on the secure provider portal, MyAnthem, have now moved to Answers@Anthem on anthem.com.

To view a policy, go to anthem.com>Menu>Providers>Resources for Your State. Select your state, then Answers@Anthem, then click the link, Reimbursement Policies – Professional or Reimbursement Policies – Facility. If you are in the Availity Portal and wish to navigate to the policies through Availity, go to **Payer Spaces | Education and Reference Center | Administrative Support** to find a link that will take you to the policies. Either way, the steps are quick and easy and will get you to the information you need.

Revised professional Provider Maintenance Form coming soon!

In the first quarter of 2018, we will launch a revised online professional Provider Maintenance Form (PMF) for demographic update submissions. Online update options will include:

- Add an address location
- Name change
- Tax ID changes
- Provider leaving a group or a single location
- Phone/fax numbers
- Closing a practice location

Please note: Until the new form is launched, please continue to use the current Provider Maintenance Form at anthem.com. Once the revised PMF is launched, it will simply replace the current form in the same location on our website. If you have saved the current PMF url as a favorite, you'll receive a message that the old form was replaced and will be provided a link to the new form. In addition, the PMF can be found on the Availity Portal by selecting your state > Payer Spaces > Anthem Blue Cross and Blue Shield > Resources > Provider Maintenance Form.

Important information about updating your practice profile

- Change requests must be submitted using the online Provider Maintenance Form.
- Change requests must be submitted with advance notice.
- With the launch of the new PMF, you will receive an auto-reply e-mail acknowledging receipt of your request and another email when your submission has been processed.
- For change(s) that require submission of an updated IRS Form W-9 or other documentation, you'll be able to attach it to the form online prior to submitting.
- Contractual agreement guidelines may supersede effective date of change request.

Ensure accuracy of practice information on our Find a Doctor tool

Our Find a Doctor online tool is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To help ensure we have the most current and accurate information, please take a moment to access the Find a Doctor tool and review how you and your practice are being displayed. To report discrepancies, please make any necessary corrections using the online Provider Maintenance Form.

Reminder: In-network laboratories

Effective January 1, 2018, Exact Sciences Laboratories, LLC, is no longer an in-network provider for Anthem in Indiana, Kentucky, Missouri, Ohio and Wisconsin. Providers should use in-network laboratory providers, such as LabCorp and Quest Diagnostics, for non-invasive colon cancer screening testing for your Anthem patients beginning January 1, 2018. Using an in-network laboratory helps your patients maximize their laboratory benefits and minimize their out-of-pocket expenses.

If you have specific questions regarding non-invasive colon cancer screening tests performed by in-network labs, please see contact information below. For a complete list of in-network providers, go to our Find a Doctor online tool, located on anthem.com.

LabCorp: 800-LABCORP (800-522-2677) or www.LabCorp.com
Quest Diagnostics: 866-MY-QUEST (866-697-8378) or
https://secure.questdiagnostics.com/ViewsFlash/servlet/viewsflash?cmd=page&pollid=contactus!physician

Medical policy update

The following Anthem medical polices were reviewed on November 2, 2017 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.
Several medical policies were converted to clinical guidelines. Please see the effective dates below:

New Clinical Guideline	Content Moved From Medical Policy	Effective date
CG-DME-40 Electrical Bone Growth Stimulation	DME.00004 Electrical Bone Growth Stimulation	12/27/2017
CG-DME-41 Ultraviolet Light Therapy Delivery Devices for Home Use	DME.00036 Ultraviolet Light Therapy Delivery Devices for Home Use	12/27/2017
CG-GENE-01 Janus Kinase 2 (JAK2) V617F Gene Mutation Assay	GENE.00004 Janus Kinase 2 (JAK2) V617F Gene Mutation Assay	12/27/2017
CG-GENE-02 Analysis of KRAS Status (Added 81479 NOC code for extended RAS panel (e.g., Praxis test) The added code, 81479, will require review beginning 5/1/2018	GENE.00014 Analysis of KRAS	12/27/2017
CG-GENE-03 BRAF Mutation Analysis	GENE.00019 BRAF Mutation Analysis	12/27/2017
CG-GENE-04 Molecular Marker Evaluation of Thyroid Nodules	GENE.00032 Molecular Marker Evaluation of Thyroid Nodules	12/27/2017
CG-MED-63 Treatment of Hyperhidrosis	MED.00032 Treatment of Hyperhidrosis	12/27/2017
CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	12/27/2017
CG-MED-65 Manipulation Under Anesthesia of the Spine and Joints other than the Knee	MED.00079 Manipulation Under Anesthesia of the Spine and Joints other than the Knee	12/27/2017
CG-MED-66 Cryopreservation of Oocytes or Ovarian Tissue	MED.00080 Cryopreservation of Oocytes or Ovarian Tissue	12/27/2017
CG-MED-67 Melanoma Vaccines	MED.00083 Melanoma Vaccines	12/27/2017
CG-MED-68 Therapeutic Apheresis Descriptor change for 36516 includes service coded as 36515 which is deleted 12/31/17; Added diagnosis codes for plasmapheresis and leukapheresis to pend for Medical necessity criteria (A81.2, G04.81, G61.82, G61.89, M31.7, C82.00-C82.99, C83.30-C83.39, C85.20-C85.29) This Clinical guideline was effective 12/27/17. The additional diagnoses codes will pend for review beginning 5/1/2018	MED.00113 Therapeutic Apheresis	12/27/2017
CG-SURG-61 Cryosurgical Ablation of Solid Tumors Outside the Liver In addition: New CPT code 32994 active 01/01/18 replacing 0340T for cryoablation of pulmonary tumors	SURG.00025 Cryosurgical Ablation of Solid Tumors Outside the Liver	12/27/2017
CG-SURG-62 Radiofrequency Ablation to Treat Tumors Outside the Liver	SURG.00050 Radiofrequency Ablation to Treat Tumors Outside the Liver	12/27/2017

New Clinical Guideline	Content Moved From Medical Policy	Effective date
CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure	SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure	12/27/2017
CG-SURG-65 Recombinant Human Bone Morphogenetic Protein	SURG.00059 Recombinant Human Bone Morphogenetic Protein	12/27/2017
CG-SURG-66 Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)	SURG.00060 Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)	12/27/2017
CG-SURG-67 Treatment of Osteochondral Defects	SURG.00093 Treatment of Osteochondral Defects	12/27/2017
CG-SURG-68 Surgical Treatment of Femoracetabular Impingement Syndrome	SURG.00109 Surgical Treatment of Femoracetabular Impingement Syndrome	12/27/2017
CG-SURG-69 Meniscal Allograft Transplantation of the Knee	TRANS.00015 Meniscal Allograft Transplantation of the Knee	12/27/2017

The new policy below was implemented on November 9, 2017:

Policy Number	Policy Title and Description
MED.00123	Axicabtagene ciloleucel (YescartaTM) This document addresses the uses of axicabtagene ciloleucel autologous chimeric antigen receptor (CAR) T-cell, CD3/CD28-based therapy, that targets the CD19 surface antigen expressed in B cell malignancies, in particular, non-Hodgkin's lymphoma (NHL).

The following are revisions to current Medical Policies or Clinical Guidelines; please see effective dates below.

Policy Number	Policy Title and Description	Effective date
CG-MED-46	Ambulatory Electroencephalography and Video Electroencephalography revision of this clinical UM guideline which reflects the following: • Revised title • Added not medically necessary statement for outpatient video EEG testing	5/1/2018
GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment New CPT codes 81520 active 01/01/18 replacing 0008M for Prosigna Breast Cancer Assay; 81521 for MammaPrint active 01/01/18 (81521 will pend for review beginning 5/1/2018)	12/27/2017
SURG.00028	Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions New HCPCS code C9748 active 01/01/2018 for convective water vapor thermal ablation (Investigational &Not Medically necessary)	5/1/2018
SURG.00089	Balloon and Self-Expanding Absorptive Sinus Ostial Dilation Revised position statement from Investigational &Not Medically Necessary to Medically Necessary for the use of balloon sinus ostial dilation when criteria are met. New CPT code 31298 active 01/01/18 for balloon dilation of frontal and sphenoid sinus ostia; added existing code C1726 for balloon device; changed codes 31295, 31296, 31297 from deny to pend for sinusitis diagnoses	5/1/2018

Policy Number	Policy Title and Description	Effective date
SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts) Clarified MN statement for VADs when used in accordance with FDA approval when criteria are met New CPT codes 33927, 33928, 33929 active 01/01/18 replacing 0051T, 0052T, 0053T for artificial heart systems	12/27/17
CG-ANC-04	Ambulance Services: Air and Water Added existing HCPCS code A0888 for excess mileage beyond closest facility as NMN	5/1/2018
MED.00124	Tisagenlecleucel (Kymriah™) New HCPCS code Q2040 active 01/01/18 replacing NOC J3490, J3590 for Kymriah; added existing ICD-10-PCS codes XW033C3, XW043C3	5/1/2018
GENE.00033	Genetic Testing for Inherited Peripheral Neuropathies New CPT code 81448 active 01/01/18 for panel test (INV&NMN	5/1/2018
RAD.00002	Positron Emission Tomography (PET) and PET/CT Fusion New CPT code 0482T active 01/01/18 for PET quantitation of blood flow	5/1/2018
SURG.00128	Implantable Left Atrial Hemodynamic Monitor Post edit - CPT Category III codes 0293T, 0294T deleted 12/31/17; replaced by NOC code 93799	12/27/2017
SURG.00143	Perirectal Spacers for Use During Prostate Radiotherapy New CPT code 55874 active 01/01/18 replacing 0438T	12/27/2017
GENE.00009	Gene-Based Tests for Screening, Detection and Management of Prostate Cancer New CPT codes 81541, 81551 for Prolaris and ConfirmMDx tests	5/1/2018
GENE.00010	Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status New CPT Tier 1 genetic codes 81230 (CYP3A4), 81231 (CYP3A5), 81232 (DPYD) and 81346 (TYMS) replacing Tier 2 codes	12/27/2017
GENE.00012	Preconception or Prenatal Genetic Testing of a Parent or Prospective Parent New Tier 1 genetic codes 81361, 81362, 81363 81364 (HBB) and 81257, 81258, 81259, 81269 (HBA1/HBA2) replacing Tier 2 codes	12/27/2017
GENE.00023	Gene Expression Profiling of Melanomas New genes LINCOO518, PRAME added to Tier 2 code 81401 for melanoma	5/1/2018
GENE.00033	Genetic Testing for Inherited Peripheral Neuropathies New CPT code 81448 active 01/01/18 for panel test (INV&NMN)	5/1/2018
GENE.00036	Genetic Testing for Hereditary Pancreatitis New gene CTRC added to Tier 2 code 81405 for pancreatitis	5/1/2018
GENE.00038	Genetic Testing for Statin-Induced Myopathy New Tier 1 81328 for SLCO1B1 replacing Tier 2 code	12/27/2017
GENE.00043	Genetic Testing of an Individual's Genome for Inherited Diseases New Tier 1 genetic codes 81361, 81362, 81363 81364 (HBB) and 81257, 81258, 81259, 81269 (HBA1/HBA2) replacing Tier 2 codes	12/27/2017
MED.00081	Cognitive Rehabilitation New CPT code 97127 replacing 97532 for cognitive rehabilitation	12/27/2017
MED.00111	Intracardiac Ischemia Monitoring CPT category III codes 0302T, 0303T, 0304T, 0305T, 0306T, 0307T deleted 12/31/17; replaced by NOC code 93799	12/27/2017
SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting New HCPCS codes Q4176, Q4177, Q4178, Q4179, Q4180, Q4181, Q4182 for wound healing products	5/1/2018

Policy Number	Policy Title and Description	Effective date
SURG.00020	Bone-Anchored and Bone Conduction Hearing Aids New HCPCS code L8694 for replacement device	5/1/2018
SURG.00037	Treatment of Varicose Veins (Lower Extremity) New CPT codes 36465, 36466 for microfoam sclerotherapy replacing NOC code	12/27/2017
SURG.00054	Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection New CPT codes 34701, 34702, 34703, 34704, 34705, 34706, 34709, 34710, 34711, 34712, 34715 replacing 34800, 34802, 34803, 34804, 34805, 34806, 34825, 34826, 75952, 75953	12/27/2017
SURG.00111	Axial Lumbar Interbody Fusion CPT category III code 0309T deleted 12/31/17, replaced by NOC code 22899	12/27/2017
SURG.00121	Transcatheter Heart Valve Procedures New CPT category III codes 0483T, 0484T for mitral valve replacement	5/1/2018
SURG.00137	Focused Microwave Thermotherapy for Breast Cancer CPT category III code 0301T deleted 12/31/17, replaced by NOC code 19499	12/27/2017
THER-RAD.00004	External Beam Intraoperative Radiation Therapy New CPT code 19294 for placement IORT applicator for breast during mastectomy	5/1/2018
TRANS.00009	Lung and Lobar Transplantation New CPT category III codes 0494T, 0495T, 0496T for preparation of cadaver donor lung	5/1/2018
CG-MED-53	Cervical Cancer Screening and Human Papillomavirus Testing New CPT category III code 0500T for HPV testing; code 88154 deleted 12/31/17	5/1/2018
CG-REHAB-04	Physical Therapy New CPT code 97763 for subsequent orthotic management; new CPT modifiers for habilitative and rehabilitative services (-96 and -97) replacing –SZ. The new codes (coding) will be available for use (or active) on 01/01/2018.	12/27/2017
CG-REHAB-05	Occupational Therapy New CPT code 97763 for subsequent orthotic management; new CPT modifiers for habilitative and rehabilitative services (-96 and -97) replacing -SZ; The new codes (coding) will be available for use (or active) on 01/01/2018.	12/27/2017
CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS) New CPT codes 31253, 31257, 31259 for ethmoidectomy; The new codes (coding) will be available for use (or active) on 01/01/2018.	5/1/2018

Note: For a complete listing of medical policies and clinical guidelines go to www.anthem.com, select Menu>Providers>Find Resources for Your State. Choose your state, then Anthem Medical Policies and Clinical UM Guidelines under self-service and support. You may also call the Customer Service number on the member ID card to see if the specific requested code is subject to medical policy or clinical guideline criteria.

Important update to Anthem's commercial drug list

Effective with dates of service on and after April 1, 2018, and in accordance with Anthem's Pharmacy and Therapeutic (P&T) process, Anthem will update its commercial plan drug lists. Updates may include changes to drug tiers or the removal of a drug. To help ensure a smooth transition and minimize member costs, providers should review these changes and consider prescribing a drug on formulary or on a lower tier, if appropriate.

Please note, this update does not apply to the Select Drug List and does not impact Medicare and Medicaid plans. To view a summary of changes, click here.

Anthem expands Specialty Pharmacy prior authorization list

Effective for dates of service on and after May 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be added to our existing prior authorization review process. Anthem's clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company. The following clinical guidelines or medical policies will be effective May 1, 2018.

Medical Policy or Clinical Guideline	Code	Drug	Comment
CG-DRUG-78	J7195	Rebinyn	New Drug to Existing Policy
CG-DRUG-78	J7178	Fibryna	New Drug to Existing Policy
DRUG.00112	J9203	Mylotarg	New Drug Policy
DRUG.00118	J3590, J9999	Aliqopa	New Drug Policy
CG-DRUG-61	C9016, J3490	Triptodur	New Drug to Existing Policy

AIM Diagnostic Imaging clinical Appropriateness Guidelines

Beginning with dates of service on and after May 1, 2018, Expanded indications for use of Fractional Flow Reserve (FFR) will be added to AIM Diagnostic Imaging Clinical Appropriateness Guidelines. These incorporate the most recent literature regarding the use of Coronary CT Angiography (CCTA) (with or without FFR) as a first-line test in patients with suspected coronary artery disease.

Ordering and servicing providers may submit precertification requests to AIM in one of the following ways:

- Access AIM *ProviderPortal*℠ 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 Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday–Friday, 8:30 am – 7 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Hyaluronic injections in joints other than knee (DRUG.00017)

Medical policy DRUG.00017 addresses the use of injections of hyaluronan in joints other than the knee, including osteoarthritis and temporomandibular joint disease. This therapy may also be referred to as viscosupplementation.

Effective for dates of service on and after May 1, 2018, intra-articular injections of hyaluronan for the treatment of pain due to reducing and non-reducing disc displacement disease of temporomandibular joint disorders, are considered not medically necessary. No precertification or prior authorization for these agents will be required, but rather will be reviewed post-service. The following codes will be subject to review under this medical policy:

Hyaluronic Acid	Euflexxa	J7323
Hyaluronic Acid	Gel-One	J7326
Hyaluronic Acid	Gel-Syn	J7328
Hyaluronic Acid	Genvisc	J7320
Hyaluronic Acid	Hyalgan	J7321
Hyaluronic Acid	Hymovis	J7322
Hyaluronic Acid	Monovisc	J7327
Hyaluronic Acid	Orthovisc	J7324
Hyaluronic Acid	Supartz	J7321
Hyaluronic Acid	Synvisc	J7325
Hyaluronic Acid	Synvisc-One	J7325

Clinically equivalent immune globulin agents

Effective for dates of service on or after May 1, 2018, Gamunex-C® and Octagam® will be the immune globulin agents of choice over Bivigam®, Carimune NF® Flebogamma®, Gammagard®, Gammagard S/D®, Gammaplex®, and Privigen®.

Some health plans require the use of clinically equivalent agents. When prescribing a therapy in these categories, please consider using a preferred clinically equivalent agent. Anthem has a process in place to consider requests for continuing members on existing agents. To inquire about this process, please call the provider service number on the back of the member ID card.

The following clinical guideline has been updated to include the requirement of a clinically equivalent agent, effective May 1, 2018.

Clinical Guideline	Impacted Agent	Clinically Equivalent Agent
CG-DRUG-09 Immune Globulin (IG) Therapy	Bivigam®, Carimune NF®, Flebogamma®, Gammagard®, Gammagard S/D®, Gammaplex®, Privigen	Gamunex-C® Octagam®

Medicare

Updates to medical policies and clinical guidelines

The Anthem Medical Policy and Technology Assessment Committee (MPTAC) has approved additional medical policies. These medical policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only. Visit Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements at anthem.com/medicareprovider to review specific policies.

Improve member medication regimen

Anthem and the Centers for Medicare & Medicaid Services (CMS) consider medication review and reconciliation a top priority to help ensure members take their medications safely. Our pharmacists use medication review and reconciliation to help members understand their medications and the appropriate way to take them.

Anthem may contact you to discuss members' medications as part of either the Medication Therapy Management (MTM) or the Medication Reconciliation Post Discharge (MRPD) programs:

- The MTM program starts with a letter welcoming members to participate in a private medication review with one of our pharmacists over the phone. This free service gives members the opportunity to ask questions about the medicines they are taking and to review prescription and over-the-counter drugs to prevent drug reactions, and helps members get the most benefit from their medications at the lowest cost. At the end of the discussion, your patients are encouraged to share with you a written summary of their medication list and any medication-related concerns.
- Medication Reconciliation Post Discharge is a HEDIS and CMS star ratings measure for 2018. The MRPD program helps members with their medications after they have been discharged from an inpatient hospital stay. Anthem pharmacists will work with you and the member to identify and correct any medication related problems to reduce the risk of readmission. To complete this measure per HEDIS specifications, it is necessary that the appropriate documentation in the member's chart include:
    - Date medication reconciliation was performed.
    - Notation stating that current medication and discharge medication lists were reviewed.
    - Signature of prescribing care provider, clinical pharmacist or registered nurse who performed medication reconciliation. If medications were provided at discharge, documentation also should include the member's next steps such as:
        a. Take new medications as prescribed.
        b. Discontinue all discharge medications.
        c. Notation if no medications were prescribed at discharge.

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 injectable drugs: Brineura, Tremfya and Zinplava

Prior authorization requirements for Part B drugs: Rebinyn, Fibryna and Hemlibra

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Pharmacy

Pharmacy information available at anthem.com

IN, OH and WI: 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 anthem.com/pharmacyinformation. The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October). FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the 2018 Specialty Drug List or call us at 888-346-3731 for more information.

KY and MO: 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 anthem.com/pharmacyinformation. The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October). To locate "Marketplace Select Formulary" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List." This drug list is also reviewed and updated regularly as needed. FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the 2018 Specialty Drug List or call us at 888-346-3731 for more information.

Quality

HEDIS® 2018 starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax that will include:

- A cover letter with information your office can use to contact us if there are any questions.
- A member list that includes the member and the HEDIS measure(s) for which the member was selected.
- An instruction sheet listing the details for each HEDIS measure.

As a reminder, under HIPAA, releasing PHI for HEDIS data collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c) (4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within **five business days**. Meeting this timeframe will make your office eligible for a drawing to win a small prize, and the winners will be announced in a later issue of this newsletter.

To send us the medical record documentation within the recommended 5-day turnaround time, simply choose one of these options:

1. Upload to our secure portal. This is quick and easy. Log on to www.submitrecords.com, enter the password included with your HEDIS Member List and select the files to be uploaded. Once uploaded you will receive

a confirmation number to retain for your records.
2. Send a secure fax to 888-251-2985.
3. Mail to: Anthem, Inc., 66 E. Wadsworth Park Drive, Suite 110H, Draper, UT 84020

Please contact your local Network Relations consultant if you have a specific person in your organization who we should contact for HEDIS medical records.

Note: Centauri Health Solutions is the contracted vendor to gather member medical records on behalf of the Blue Cross and Blue Shield Federal Employee Program®. Centauri Health will work with you to obtain records via fax, mail, remote electronic medical record (EMR) access, or onsite scanning/EMR download (as necessary). We ask that you please promptly comply within five (5) business days the record requests. If you have any questions, please contact Catherine Carmichael with Blue Cross Blue Shield Federal Employee Program at (202) 942-1173 or Carol Oravec with Centauri at (440)793-7727.

Thank you in advance for your support of HEDIS.

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

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 www.anthem.com. Select Menu>Providers>Find Resources for Your State. Then select your state, then Health & Wellness>Practice Guidelines.

Reimbursement

Professional reimbursement policy updates

Frequency editing

Beginning with dates of service on or after January 1, 2018 for Indiana, Kentucky and Wisconsin, and February 1, 2018 for Missouri and Ohio, the frequency limits were removed for definitive drug testing HCPCS codes G0482 and G0483.

Policy Reviews

The reimbursement policy, Place of Service, received an annual review and includes minor language revisions; however, there were no changes to the policy position or criteria.

Reminder: Global billing for the Professional and Technical Component

When the professional and the technical components of a global diagnostic procedure are performed separately by the same provider or associate providers in the same practice for the same patient for the same date of service, the services must be reported as a global procedure. When reporting the global service, the Health Plan considers the day the professional component (the reading) was rendered to be the date of service even if the technical component was performed on the same date or performed on a date that is prior to the professional component.

Additionally, when the professional component is performed in a location separate from the location where the technical component was rendered, the service location for the global service should be reported as the location where the professional component was rendered.

Reminder: Evaluation and management services and related modifiers 25 and 57

Anthem shared upcoming changes to the Evaluation and Management Services and Related Modifiers 25 and 57 Professional Reimbursement Policy. (The notice appeared in the October 2017 issue of *Network Update* for Kentucky, Ohio and Wisconsin, in the November 2017 Special Edition of *Network Update* for Missouri, and in the December 2018 issue of *Network Update* for Indiana.) The notice indicated that evaluation and management services that are eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery would be reduced by 50%. Please note, as shared in a *Network eUPDATE* distributed on January 10, 2018, the following information replaces the previously published policy information.

Beginning with dates of service on or after March 1, 2018, Evaluation and Management Services (CPT codes 99201-99215) that are eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery will be reduced by 25%. Minor surgeries have a global period of 0 or 10 days, and the impacted CPT codes are 10000-69999, excluding CPT 36415, 36416, and 69210. As a reminder, please review the guidelines on reporting Modifier 25 in Anthem's reimbursement policy.

Bundled services and supplies modifiers 59 XE, XP, XS, XU

Anthem considers technology used to assist in the performance of a procedure to be part of the surgical procedure. Beginning with dates of service on and after May 1, 2018, Anthem will update its policy to reflect that ultrasonic guidance, CPT code 76942, will not be eligible for separate reimbursement when reported with tendon injection services represented by CPT codes 20550 (injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")) and 20551 (injection(s); single tendon origin/insertion). The following modifiers will not override this edit: 59, XE, XP, XS, and XU.

Facility reimbursement policy update

Definitive drug testing

Beginning with dates of service on or after May 1, 2018, definitive drug testing codes (CPT 80320-80377 and 83992), will be considered always bundled codes and will not be eligible for separate reimbursement. The CPT codes will be replaced with HCPCS codes G0480-G0483 and G0659. This coding requirement is already included in the Commercial Outpatient Prospective Payment System (COPPS) methodology. Facilities reimbursed according to COPPS will not experience any changes.

View reimbursement policies online at anthem.com

To view Anthem's reimbursement policies, go to anthem.com>Menu>Providers>Find Resources for Your State. Select your state>Answers@Anthem> Reimbursement Policies – Professional or Reimbursement Policies -- Facility.

Medicaid Notifications

Indiana Medicaid

Update to medical policies and clinical UM guidelines

On August 3, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The medical policies were made publicly available on the Anthem provider website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies.

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

Note: CG-DRUG-29 Hyaluronan Injections in the Knee was implemented as investigational and not medically necessary on December 1, 2017. RAD.00035 will be archived effective September 15, 2017. CG-MED-58 was effective September 15, 2017.

Effective date	Medical Policy number	Medical Policy title	New or revised
8/17/2017	DRUG.00111	Guselkumab (Tremfya™)	New
9/27/2017	LAB.00035	Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis	New
8/17/2017	DRUG.00040	Abatacept (Orencia®)	Revised
8/17/2017	DRUG.00058	Pharmacotherapy for Hereditary Angioedema	Revised
8/17/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
8/17/2017	DRUG.00082	Daratumumab (DARZALEX™)	Revised
8/17/2017	DRUG.00099	Cerliponase Alfa (Brineura™)	Revised
8/17/2017	DRUG.00107	Avelumab (Bavencio®)	Revised
8/17/2017	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
8/17/2017	MED.00051	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	Revised
8/17/2017	MED.00081	Cognitive Rehabilitation	Revised
8/17/2017	RAD.00035	Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Fractional Flow Reserve derived from Computed Tomography (FFRCT), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI)	Revised
8/17/2017	RAD.00066	Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy	Revised
8/17/2017	SURG.00055	Cervical Total Disc Arthroplasty	Revised
8/17/2017	SURG.00121	Transcatheter Heart Valve Procedures	Revised

On August 3, 2017, the MPTAC approved the following Clinical Utilization Management (UM) Guidelines applicable to Anthem. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the *Clinical UM Guidelines* adopted by the Medical Operations Committee for the Government Business Division on August 24, 2017.

On August 3, 2017, the clinical guidelines were made publicly available on the Anthem *Medical Policies* and *Clinical UM Guidelines* subsidiary website. Visit www.anthem.com/cptsearch_shared.html to search for specific guidelines.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	New or revised
9/27/2017	CG-ADMIN-02	Clinically Equivalent Cost Effective Services – Targeted Immune Modulators	New
9/27/2017	CG-MED-57	Cardiac Stress Testing with Electrocardiogram (ECG)	New
8/17/2017	CG-ANC-06	Ambulance Services: Ground; Non-Emergent	Revised
8/17/2017	CG-SURG-27	Sex Reassignment Surgery	Revised

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

Post-service reviews of certain modifiers and services

Beginning in the first quarter of 2018, Anthem will conduct post-service reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Anthem will conduct post-service reviews of Evaluation and Management services billed during a global surgery period.

As part of the review, Anthem may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Anthem will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

For more information about post-service reviews, contact Provider Services at 866-408-6132 (Hoosier Healthwise), 844-533-1995 (Healthy Indiana Plan) or 844-284-1798 (Hoosier Care Connect).

Update to provider payment frequency

Starting in 2018, more claim payments and remittance advice issued by Anthem will be made on a weekly basis to providers. Additionally, non-Federal Employee Program® (FEP®) payments under $5 will be held for a maximum of 14 days to allow for additional claims to combine to increase the payment amount.

This change is being made for efficiency and to ensure consistency between professional and facility claim payments for commercial, FEP, Medicare and Medicaid members. Please note, this will not affect payments made from our national account system.

If you are a provider that receives paper claim checks or electronic fund transfer payments from Anthem on a daily basis, you will be able to schedule posting on a weekly cycle after this change.

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 866-408-6132 (Hoosier Healthwise), 844-533-1995 (Healthy Indiana Plan) or 844-284-1798 (Hoosier Care Connect).

New review process for NOC drug codes

Effective February 1, 2018, Anthem is implementing a new review process for not otherwise classified (NOC) drug codes. Our Reimbursement Policy for “Unlisted or Miscellaneous Codes” requires NOC drug codes be submitted with the correct national drug code (NDC). As a large number of NOC drug claims do not contain the NDC, we will review claims to ensure the presence of a NDC, and claims without an NDC will be denied.

The scope of review will include both professional and facility claims for Medicaid members. The NOC drug codes listed below will suspend and be routed for review. Note, to ensure billed drugs are a benefit and covered per our medical policies or state policies, Anthem may request that you submit medical records.

NOC drug codes and descriptions as of May 4, 2017:	
A9150	Nonprescription drug
A9152	Single vitamin/mineral/trace element — oral, per dose, not otherwise specified (NOS)
A9153	Multiple vitamins (with or without minerals and trace elements) — oral, per dose, NOS
C9399	Unclassified drug or biological
J1566	Immune globulin injection — intravenous, lyophilized, NOS (500 mg)
J1599	Immune globulin injection — intravenous, nonlyophilized, NOS (500 mg)
J3490	Unclassified drug
J3590	Unclassified biological
J7199	Hemophilia clotting factor — NOC
J7599	Immunosuppressive drug — NOC
J7699	NOC drugs — inhalation solution administered through durable medical equipment (DME)
J7799	NOC drugs — drugs (other than inhalation drugs) administered through DME
J7999	Compounded drug — NOC
J8498	Antiemetic drug — rectal/suppository, NOC
J8499	Prescription drug — oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug — oral, NOS
J8999	Prescription drug — oral, chemotherapeutic, NOS
J9999	Antineoplastic drugs — NOC
S5000	Prescription drug — generic
S5001	Prescription drug — brand name
90749	Unlisted vaccine/toxoid

If you have questions about this communication or need assistance with any other item, call Provider Services at 866-408-6132 (Hoosier Healthwise), 844-533-1995 (Healthy Indiana Plan) or 844-284-1798 (Hoosier Care Connect).

Changes to the Healthy Indiana Plan (HIP)

Anthem would like to inform you of a number of changes impacting Healthy Indiana Plan (HIP) members that go into effect in the coming months as a result of the HIP waiver extension.

Effective January 1, 2018:

- Chiropractic services are offered to HIP Plus members. Services are self-referral and include six spinal therapy visits per benefit year.
- HIP POWER Account contributions (PACs) are no longer based on 2% of a member's annual income. PAC amounts will now fall into one of five tiers:

Federal poverty level tiers	Monthly PAC — single person	Monthly PAC — spouses
Less than 22%	$1	$1
23% to 50%	$5	$2.50
51% to 75%	$10	$5
76% to 100%	$15	$7.50
101% to 138%	$20	$10

- HIP Plus members who use tobacco products will have a 50 percent surcharge added to their PAC in their second year of coverage.

Effective February 1, 2018:

- Members have an $8 copay for all nonemergent visits to the ER. Currently, members have an $8 copay for the initial visit and then $25 copays for all subsequent visits.
- For enrollment periods after February 1, 2018, members who qualify for HIP and are pregnant or become pregnant while in HIP will be enrolled in the HIP Maternity Plan with an enhanced benefits package. Prior to February 1, 2018, pregnant members in HIP can choose to stay in their current HIP plan or move to HIP

Maternity Plan.

Annually November 1 through December 15:
HIP now matches a member's choice of managed care entity (MCE) to the calendar year. Each fall, there will be a health plan selection period from November 1 to December 15 when members can choose the MCE they will be enrolled with the following year. Members will remain with their chosen MCE and POWER Account for a new benefit year from January to December. Should members inquire about this, they can make their MCE choice by calling the enrollment broker at 877-GET-HIP-9 (877-438-4479). Members who wish to remain with Anthem do not need to take any action and will be automatically re-enrolled with Anthem.

For questions, contact Provider Services at 866-408-6132 for Hoosier Healthwise, 844-533-1995 for HIP or 866-284-1798 for Hoosier Care Connect.

Complex case management program

Anthem offers assistance to providers helping patients manage chronic illness through our case management program. Our case managers, part of an interdisciplinary team of clinicians and other resource professionals, support members, families, primary medical providers and caregivers. The case management process uses the experience and expertise of our Care Coordination team to educate and empower our members to increase their 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. 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:

- Medical Management program referral.
- Discharge planning referral.
- Member or caregiver referral.
- Practitioner referral.

To contact Anthem Case Management, call 866-902-1690, Monday through Friday, 8am to 5 pm ET.

Pharmacy information

Anthem provides information about pharmacy benefits online at www.anthem.com/inmedicaiddoc. Select the Member Eligibility & Benefits tab at the top, then Pharmacy Benefits. Under *Preferred Drug & Formulary Search*, select one of the *Preferred Drug List (PDL)* introductions for the following information:

- Drug lists
- Prior authorization criteria
- Procedures for generic substitution
- Step therapy
- Exception requests (use the forms located on the *Pharmacy Benefits* webpage)
- Other management methods subject to prescribing decisions
- Other requirements, restrictions or limitations that apply to using certain drugs

Information about *PDL* changes is located under *Provider Resources* under the *Communications and Updates* section. For information about copayment/coinsurance requirements and their applicable drug classes, see the Indiana Medicaid provider manual listed under *Manuals, Directories, Training & More*.

Practitioners' rights during credentialing process

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

Practitioners can request to:

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

The Council for Affordable Quality Healthcare (CAQH) universal credentialing process is used for all providers who contract with Anthem. To apply for credentialing with Anthem, go to the CAQH website at http://www.caqh.org and select CAQH ProView™. There is no cost to providers to submit their applications. We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members' claims.

Important information about Utilization Management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the coverage according to the member's health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Anthem's medical policies are available on Anthem's website at www.anthem.com/inmedicaiddoc. Under *Provider Support*, select Quality Improvement Program and then Medical Policies.

You can also request a free copy of our UM criteria from our Medical Management department, and providers may discuss a UM denial decision with a physician reviewer by calling us toll free at 877-814-4803. Anthem's UM criteria are also available on Anthem's website at www.anthem.com/inmedicaiddoc under *Quality Improvement Program*.

UM staff are available at least eight hours a day on normal business days to answer UM-related calls from members or providers. UM staff identify themselves by name, title and organization when initiating or returning calls regarding UM issues. For more information, call: 866-408-6132 for Hoosier Healthwise, 844-533-1995 for HIP or 866-284-1798 for Hoosier Care Connect.

After normal business hours, an answering service is available to take UM-related messages. If a provider opts to request an authorization for admission for post-stabilization care or behavioral health care after normal business hours, we are available 24/7 to Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect providers.

Members have a right to get information in their own language at no cost. If you're helping a member who needs language assistance, you can speak with an interpreter by calling 866-408-6131 for Hoosier Healthwise and Healthy Indiana Plan or 844-284-1797 for Hoosier Care Connect. For the hearing impaired, call TTY 711.

Member rights and responsibilities

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem has adopted Member Rights and Responsibilities available on our provider website at www.anthem.com/inmedicaiddoc. Under Provider Support, click on Member & Health Education, and then go to Member Rights and Responsibilities. The rights and responsibilities are also available in the Provider Manual on

the provider website under Manuals, Directories Training & More.

Healthy Indiana Plan Plus

Do you have patients enrolled in Healthy Indiana Plan (HIP) Basic? If so, they may be eligible to enjoy all the benefits and value of upgrading to HIP Plus.

HIP Plus provides members with a more robust benefits package, which includes dental, vision, enhanced pharmacy and, starting January 2018, chiropractic services. In addition, Anthem offers value-added benefits, like memberships to Weight Watchers® and the YMCA®, exclusively to qualifying HIP Plus members. We've found that extra benefits, such as these, can lead not only to healthier patients but better performance outcomes as well. About twice as many of our HIP Plus members are compliant with HEDIS-related care compared with our HIP Basic members.

Another key feature to HIP Plus is patient cost sharing. Instead of copays,* HIP Plus members make monthly payments as low as $1 to their POWER Account — You don't need to collect all the copays you do now for HIP Basic members.

HIP Basic members are eligible to choose HIP Plus within 60 days of enrollment or renewal as well as at the time of POWER Account reconciliation. Anthem invoices members with instructions on switching to HIP Plus. If you have patients you think would benefit from HIP Plus, have them call 866-408-6131 or visit www.anthem.com/gethipplus for more information.

To learn more about HIP Plus, see our online presentation *The Value of Healthy Indiana Plan (HIP) Plus* available at www.anthem.com/inmedicaiddoc > Provider Support > Education & Resources > Manuals, Training & More > Presentations > The Value of Healthy Indiana Plan Plus presentation.

** All HIP members have copays for nonemergent use of the ER.*

Kentucky

Update to medical policies and clinical guidelines

On November 28, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Anthem. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing.

The *Medical Policies* were made publicly available on the Anthem provider website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies. **Existing precertification requirements have not changed.**

Medical Policy effective date	Medical Policy number	Medical Policy	Medical Policy (new/revised)
9/29/17	DRUG.00110	Inotuzumab ozogamicin (Besponsa®)	New
9/29/17	DRUG.00043	Tocilizumab (Actemra®)	Revised

Anthem Medical Advisory Committee approved the following policies, which are applicable to Anthem effective January 1, 2018. These 14 clinical policies edits/claims processing edits are aligned with correct-coding initiatives, as well as these national benchmarks and industry standards. The guidelines are available and transparent for providers on our website: https://www.anthem.com/wps/portal/ahpculdesac?content_path=medicalpolicies/noapplication/f1/s0/t0/pw_034471.htm&na=onlinepolicies. Visit www.anthem.com/cptsearch_shared.html to search for specific policies.

Medical Policy number	Medical Policy title	Web location
CG-MED-42	Maternity Ultrasound in the outpatient setting	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c159215.htm
CG-MED-52	Allergy Immunotherapy (Subcutaneous)	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c183207.htm
CG-DRUG-34	Docetaxel (Docefrez™, Taxotere®) Cancer Drug	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c176089.htm
DRUG 00038	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications (Cancer)	https://www.anthem.com/medicalpolicies/policies/mp_pw_b078445.htm
RAD.00002	PET scans	https://www.anthem.com/medicalpolicies/policies/mp_pw_a053258.htm
CG-SURG-32	Pain Management: Cervical, Thoracic & Lumbar Facet Injections	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160721.htm
CG-MED-44	Ambulatory ECG Holter monitor	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160710.htm
CG-MED-46	Ambulatory and Inpatient Video Electroencephalography	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160712.htm
CG-MED-49	Auditory Brainstem Responses (ABRs) and Evoked Otoacoustic Emissions (OAEs) for Hearing	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160719.htm
MED.00005	Hyperbaric Oxygen Therapy (Systemic/Topical)	https://www.anthem.com/medicalpolicies/policies/mp_pw_a049925.htm
DRUG 000028	Intraviteal Treatment for Retinal Vascular Conditions	https://www.anthem.com/medicalpolicies/policies/mp_pw_a050295.htm
CG-MED-48	Scrotal Ultrasound	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160718.htm
CG-LAB-09	Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain	https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c166612.htm
DRUG.00079	Bendamustine Hydrochloride	https://www.anthem.com/medicalpolicies/policies/mp_pw_c184878.htm

On August 3, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Anthem. These policies were developed or revised to support clinical coding edits. Several policies were revised to provide clarification only and are not included in the below listing. The medical policies were made publicly available on the Anthem provider website on the effective date listed below. Visit www.anthem.com/cptsearch_shared.html to search for specific policies. Existing precertification requirements have not changed.

Note: CG-DRUG-29 Hyaluronan Injections in the Knee were implemented as investigational and not medically necessary on December 1, 2017.

Effective date	Medical Policy number	Medical Policy title	New or revised
8/17/2017	DRUG.00111	Guselkumab (Tremfya™)	New
8/17/2017	DRUG.00040	Abatacept (Orencia®)	Revised
8/17/2017	DRUG.00058	Pharmacotherapy for Hereditary Angioedema	Revised
8/17/2017	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
8/17/2017	DRUG.00082	Daratumumab (DARZALEX™)	Revised
8/17/2017	DRUG.00099	Cerliponase Alfa (Brineura™)	Revised
8/17/2017	DRUG.00107	Avelumab (Bavencio®)	Revised

Transportation Services: Ambulance and non-emergent transport

(Policy 07-036, effective 02/16/18)

Anthem allows reimbursement for medical transport to and from covered services or other services. This policy provides reimbursement guidelines for nonemergent medical transport services, ambulance services and transportation modifiers. Separately reimbursable from the ambulance base rate are oxygen and disposable supplies.

For additional information, please refer to the Transportation Services: Ambulance and Nonemergent Transport reimbursement policy at https://mediproviders.anthem.com/ky > Claims > Reimbursement Policies. Due to the complex nature of transportation services, Anthem recommends that providers also review state guidelines for coverage requirements.

Vaccines for children

(Policy 05-022, effective 09/15/16)

Anthem allows reimbursement for vaccinations provided by the Vaccines for Children (VFC) Program for eligible members under the age of 19. Medicaid providers who participate in the VFC Program and immunize children shall comply with all of the reporting requirements and procedures.

What's New?

Modifier SL is now required for VFC supplied serum. (See table below.)

VFC requirements for eligible members

VFC supplied serum	Private stock serum (state supply shortages)
Modifier SL	No requirement

For additional information, refer to the Vaccines for Children (VFC) Program Reimbursement Policy at https://mediproviders.anthem.com/ky.

New electronic PA tool

Anthem has partnered with CoverMyMeds to offer an electronic prior authorization (ePA) request tool that simplifies the process for requesting medications and checking the status of your submissions.

These new features help simplify the prior authorization process. You will be able to:

- Submit requests for general pharmacy medications (medications dispensed directly to a member from a retail pharmacy or shipped from a specialty pharmacy).
- Check ePA status.
- Upload supporting documents and review appeal status.

The tool will be available beginning April 1, 2018.

To access the tool, visit https://www.covermymeds.com or locate the existing link within your electronic medical records tool if available.

For additional information and support on using ePA through CoverMyMeds, visit the Support Center at https://www.covermymeds.com/main/help, activate the chat window in the bottom right of the webpage, or call 866-452-5017.

Anthem is focused on providing new tools to help make your job a little easier. We appreciate the compassion and dedication with which you care for your patients and our members.

Radiology benefit management

Effective March 1, 2018, clinical appropriateness precertification reviews for radiology benefit management will be managed by AIM Specialty Health (AIM) on behalf of Anthem Blue Cross and Blue Shield Medicaid. AIM works with leading insurers to improve health care quality and manage the cost of complex and prevalent tests and treatments. AIM helps promote care that is appropriate, safe and affordable.

Providers must contact AIM at 800-714-0040 to obtain an order number prior to rendering for the following member services:

- Clinical appropriateness review
  - CT scan:
    - Computerized tomographic angiography
  - Magnetic resonance imaging:
    - Magnetic resonance angiography
    - Magnetic resonance microscopy
    - Magnetic resonance spectroscopy
    - Functional magnetic resonance imaging
  - Nuclear cardiology
  - Positron emission tomography scan
  - Stress echocardiography
  - Resting echocardiography
  - Transesophageal echocardiography
- Provider decision support:
  - Cost and capability transparency:
    - Real-time decision support that enables ordering physicians to optimize servicing recommendations to patients.

Contact AIM to request clinical appropriateness at least 72 hours before performing the procedure. AIM does not review any retrospective requests. Please fax all retrospective review requests to 844-285-1165. Include all pertinent clinical information with retrospective eligibility information.

ProviderPortal®, an online application, offers a convenient way to enter order requests and check on the status of previous orders. Go to www.providerportal.com to begin. Registration is required.

For questions regarding an online order, please contact the AIM *ProviderPortal* Support Team at 800-252-2021.

Effective March 1, 2018, the Radiology Benefit Management Program will utilize AIM's clinical guidelines in place of Change Healthcare (formerly McKesson Interqual) criteria. AIM's clinical guidelines are developed and revised through a rigorous review process using a comprehensive assessment of existing guidelines, evidence-based standards, and literature and feedback from the AIM External Physician Specialty Advisory Panel, which includes board-certified physicians from both community and academic practices. The guidelines can be accessed at http://www.aimspecialtyhealth.com.

Specialty-specific websites are available to provide you valuable information and tools, including Order-entry checklists, a step-by-step tutorial, clinical guidelines and FAQ.

If you have questions about this communication, contact your local Provider Relations representative or call Provider Services toll free at 855-661-2028.

Post-service review of certain modifiers and services

Effective March 1, 2018, Anthem will conduct post-service reviews of professional claims billed with the following modifiers: 25, 62, 80, 81, 82, AS and 91. Additionally, Anthem will conduct post-service reviews of Evaluation and Management services billed during a global surgery period.

As part of the review, Anthem may contact providers to request additional documentation related to the services. If billing discrepancies are identified, Anthem will provide a written report of the findings to providers and initiate recoupments as appropriate. Findings may assist your office with quality improvement efforts.

For more information about post-service reviews, contact Provider Services at 855-661-2028.

Update to CG-MED-53 (cervical cancer screening and HPV)

Effective January 1, 2018, coverage guideline CG-MED-53 that applies to cervical cancer screening and human papillomavirus (HPV) testing was updated.

Important items to note:

- Cervical cancer screening with cytology, with or without HPV testing, for women under 21 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed (i.e., organ transplant recipients or seropositive for HIV).
- Cervical cancer screening with HPV testing, alone or in combination with cytology, for women younger than 30 years of age is considered not medically necessary with the exception of women who are chronically immunosuppressed.
- Cervical cancer screening with cytology, with or without HPV testing, is considered medically necessary for women under 30 years of age who are chronically immunosuppressed.
- There is no change to the medical necessity criteria for cervical cancer screening with cytology and without HPV testing for women ages 21-65 years of age.

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

Certain J codes to require pharmacy PA

Effective March 1, 2018, Anthem will require prior authorization (PA) for certain J code requests. Please refer to the Precertification Lookup Tool for detailed authorization requirements. To access the Precertification Lookup Tool, go to https://mediproviders.anthem.com/ky and select Precertification. Under *Participating Providers*, select Precertification Lookup Tool.

Noncompliance with the new requirements may result in denied claims. PA requirements will be added to the following J codes: J0596, J0800, J2278, J2315, J2355, J2860, J3285, J3315, J3357, J3380, J7311, J7312, J7313, J7316, J9020, J9035, J9039, J9266, J9271, J9299, J9302, J9305, J9306 and J9308.

Please use one of the following methods to request pharmacy PA:

- Phone -- 855-661-2028
- Medical Injectables Fax -- 844-487-9289
- Web -- https://www.availity.com

Federal and state law and state contract language, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage.

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

New PA requirements

Levoleucovorin calcium, elosulfase alfa, histrelin acetate, idursulfase and fulvestrant will require prior authorization (PA) for dates of service beginning on or after April 1, 2018. Please refer to the provider self-service tool for detailed authorization requirements at https://mediproviders.anthem.com/ky > Precertification > Precertification Lookup Tool.

Please note: These drugs may not be covered in all states. Providers must review their specific state for coverage because not all drugs in this update will apply to the state in which you participate.

Noncompliance with the new requirements may result in denied claims. PA requirements will be added to the following codes: J0641 — Injection, levoleucovorin calcium, 0.5 mg; J1322 — Injection, elosulfase alfa, 1mg; J1675 — Injection, histrelin acetate, 10 mcg; J1743 — Injection, idursulfase, 1 mg; J9395 — Injection, fulvestrant, 25 mg.

Please use one of the following methods to request PA:

- Phone -- 855-661-2028
- Fax -- 800-964-3627
- Web -- https://www.availity.com

Federal and state law, as well as state contract language (this includes definitions and specific contract provisions/exclusions) take precedence over these PA rules and must be considered first when determining coverage.

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

Wisconsin Medicaid

Update to medical policies and clinical guidelines

On December 6, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies. 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. We made these medical policies publicly available on our 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
9/27/17	DRUG.00110	*Inotuzumab ozogamicin (Besponsa®)*	New
9/27/17	MED.00124	*Tisagenlecleucel (Kymriah™)*	New
9/27/17	DRUG.00043	*Tocilizumab (Actemra®)*	Revised

On December 6, 2017, the MPTAC approved the following *Clinical Utilization Management (UM) Guidelines* for Anthem. These guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing.

The *Clinical UM Guidelines* on this list represent those adopted by the Medical Operations Committee for the Government Business Division on October 19, 2017. We made these guidelines publicly available on the *Medical Policies and Clinical UM Guidelines* page on the effective date listed below.

Visit www.anthem.com/cptsearch_shared.html to search for specific guidelines. **Existing precertification requirements have not changed.** Please share this notice with other members of your practice and office staff.

Effective date	Clinical UM Guideline number	Clinical UM Guideline title	New or revised
9/27/17	CG-LAB-11	*Screening for Vitamin D Deficiency in Average Risk Individuals*	New
9/27/17	CG-MED-59	*Upper Gastrointestinal Endoscopy for Diagnosis, Screening or Surveillance*	New
9/27/17	CG-SURG-59	*Vena Cava Filter*	New
9/27/17	CG-DME-31	*Wheeled Mobility Devices: Wheelchairs —Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)*	Revised

New PA requirements

Levoleucovorin calcium, elosulfase alfa, histrelin acetate, idursulfase and fulvestrant will require prior authorization (PA) for dates of service beginning on or after April 1, 2018. Please refer to the provider self-service tool for detailed authorization requirements at https://mediproviders.anthem.com/wi > Precertification > Precertification Lookup Tool.

Please note: These drugs may not be covered in all states. Providers must review their specific state for coverage because not all drugs in this update will apply to the state in which you participate.

Noncompliance with the new requirements may result in denied claims.

Please use one of the following methods to request PA:

- Phone: 1-855-558-1443
- Fax: 1-800-964-3627
- Web: https://www.Availity.com

Federal and state law, as well as state contract language (this includes definitions and specific contract provisions/exclusions) take precedence over these PA rules and must be considered first when determining coverage.

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