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- **Indiana**
  - Update to medical policies and clinical UM guidelines
  - Post-service reviews of certain modifiers and services
  - Update to provider payment frequency
  - New review process for NOC drug codes
  - Changes to the Healthy Indiana Plan (HIP)
  - Complex case management program
  - Pharmacy information
  - Practitioners’ rights during credentialing process
  - Important information about Utilization Management
  - Member rights and responsibilities
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  - Update to medical policies and clinical guidelines
  - Transportation Services: Ambulance and non-emergent transport
  - Vaccines for children
  - New electronic PA tool
  - Radiology benefit management
  - Post-service review of certain modifiers and services
  - Update to CG-MED-53 (cervical cancer screening and HPV)
  - Certain J codes to require pharmacy PA
  - New PA requirements

- **Wisconsin**
  - Update to medical policies and clinical guidelines
  - New PA requirements

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (“BCBSWi”) underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (“Compcare”) or Wisconsin Collaborative Insurance Company (“WCIC”); Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees 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 the registered marks of the Blue Cross and Blue Shield Association.
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
### Health Care Management

**Medical policy update**

The following Anthem medical policies 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:

<table>
<thead>
<tr>
<th>New Clinical Guideline</th>
<th>Content Moved From Medical Policy</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DME-40 Electrical Bone Growth Stimulation</td>
<td>DME.00004 Electrical Bone Growth Stimulation</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-DME-41 Ultraviolet Light Therapy Delivery Devices for Home Use</td>
<td>DME.00038 Ultraviolet Light Therapy Delivery Devices for Home Use</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-GENE-01 Janus Kinase 2 (JAK2) V617F Gene Mutation Assay</td>
<td>GENE.00004 Janus Kinase 2 (JAK2) V617F Gene Mutation Assay</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-GENE-02 Analysis of KRAS Status</td>
<td>GENE.00014 Analysis of KRAS</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>(Added 81479 NOC code for extended RAS panel (e.g., Praxis test) The added code, 81479, will require review beginning 5/1/2018)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CG-GENE-03 BRAF Mutation Analysis</td>
<td>GENE.00019 BRAF Mutation Analysis</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-GENE-04 Molecular Marker Evaluation of Thyroid Nodules</td>
<td>GENE.00032 Molecular Marker Evaluation of Thyroid Nodules</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-MED-63 Treatment of Hyperhidrosis</td>
<td>MED.00032 Treatment of Hyperhidrosis</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)</td>
<td>MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-MED-65 Manipulation Under Anesthesia of the Spine and Joints other than the Knee</td>
<td>MED.00079 Manipulation Under Anesthesia of the Spine and Joints other than the Knee</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-MED-66 Cryopreservation of Oocytes or Ovarian Tissue</td>
<td>MED.00080 Cryopreservation of Oocytes or Ovarian Tissue</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-MED-67 Melanoma Vaccines</td>
<td>MED.00083 Melanoma Vaccines</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>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</td>
<td>MED.00113 Therapeutic Apheresis</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>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</td>
<td>SURG.00025 Cryosurgical Ablation of Solid Tumors Outside the Liver</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-62 Radiofrequency Ablation to Treat Tumors Outside the Liver</td>
<td>SURG.00050 Radiofrequency Ablation to Treat Tumors Outside the Liver</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>New Clinical Guideline</td>
<td>Content Moved From Medical Policy</td>
<td>Effective date</td>
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<tr>
<td>CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure</td>
<td>SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-65 Recombinant Human Bone Morphogenetic Protein</td>
<td>SURG.00059 Recombinant Human Bone Morphogenetic Protein</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-66 Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)</td>
<td>SURG.00060 Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-67 Treatment of Osteochondral Defects</td>
<td>SURG.00093 Treatment of Osteochondral Defects</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-68 Surgical Treatment of Femoracetabular Impingement Syndrome</td>
<td>SURG.00109 Surgical Treatment of Femoracetabular Impingement Syndrome</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-69 Meniscal Allograft Transplantation of the Knee</td>
<td>TRANS.00015 Meniscal Allograft Transplantation of the Knee</td>
<td>12/27/2017</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Title and Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MED.00123</td>
<td>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).</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Title and Description</th>
</tr>
</thead>
</table>
| 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 |
| 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) |
| 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) |
| 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 |

Effective date: 5/1/2018
<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Title and Description</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURG.00145</td>
<td>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</td>
<td>12/27/17</td>
</tr>
<tr>
<td>CG-ANC-04</td>
<td>Ambulance Services: Air and Water Added existing HCPCS code A0888 for excess mileage beyond closest facility as NMN</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>MED.00124</td>
<td>Tisagenleucel (Kymriah™) New HCPCS code Q2040 active 01/01/18 replacing NOC J3490, J3590 for Kymriah; added existing ICD-10-PCS codes XW033C3, XW043C3</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>GENE.00033</td>
<td>Genetic Testing for Inherited Peripheral Neuropathies New CPT code 81448 active 01/01/18 for panel test (INV&amp;NMN)</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>RAD.00002</td>
<td>Positron Emission Tomography (PET) and PET/CT Fusion New CPT code 0482T active 01/01/18 for PET quantitation of blood flow</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>SURG.00128</td>
<td>Implantable Left Atrial Hemodynamic Monitor Post edit - CPT Category III codes 0293T, 0294T deleted 12/31/17; replaced by NOC code 93799</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>SURG.00143</td>
<td>Perirectal Spacers for Use During Prostate Radiotherapy New CPT code 55874 active 01/01/18 replacing 0438T</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>GENE.00009</td>
<td>Gene-Based Tests for Screening, Detection and Management of Prostate Cancer New CPT codes 81541, 81551 for Prolaris and ConfirmMDx tests</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>GENE.00010</td>
<td>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</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>GENE.00012</td>
<td>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</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>GENE.00023</td>
<td>Gene Expression Profiling of Melanomas New genes LINCOO518, PRAME added to Tier 2 code 81401 for melanoma</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>GENE.00033</td>
<td>Genetic Testing for Inherited Peripheral Neuropathies New CPT code 81448 active 01/01/18 for panel test (INV&amp;NMN)</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>GENE.00036</td>
<td>Genetic Testing for Hereditary Pancreatitis New gene CTRC added to Tier 2 code 81405 for pancreatitis</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>GENE.00038</td>
<td>Genetic Testing for Statin-Induced Myopathy New Tier 1 81328 for SLCO1B1 replacing Tier 2 code</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>GENE.00043</td>
<td>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</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>MED.00081</td>
<td>Cognitive Rehabilitation New CPT code 97127 replacing 97532 for cognitive rehabilitation</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>MED.00111</td>
<td>Intracardiac Ischemia Monitoring CPT category III codes 0302T, 0303T, 0304T, 0305T, 0306T, 0307T deleted 12/31/17; replaced by NOC code 93799</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>SURG.00011</td>
<td>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</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>Policy Number</td>
<td>Policy Title and Description</td>
<td>Effective date</td>
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</tr>
<tr>
<td>SURG.00020</td>
<td>Bone-Anchored and Bone Conduction Hearing Aids New HCPCS code L8694 for replacement device</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>SURG.00037</td>
<td>Treatment of Varicose Veins (Lower Extremity) New CPT codes 36465, 36466 for microfoam sclerotherapy replacing NOC code</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>SURG.00054</td>
<td>Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transsection 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</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>SURG.00111</td>
<td>Axial Lumbar Interbody Fusion CPT category III code 0309T deleted 12/31/17, replaced by NOC code 22899</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>SURG.00121</td>
<td>Transcatheter Heart Valve Procedures New CPT category III codes 0483T, 0484T for mitral valve replacement</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>SURG.00137</td>
<td>Focused Microwave Thermotherapy for Breast Cancer CPT category III code 0301T deleted 12/31/17, replaced by NOC code 19499</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>THER-RAD.00004</td>
<td>External Beam Intraoperative Radiation Therapy New CPT code 19294 for placement IORT applicator for breast during mastectomy</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>TRANS.00009</td>
<td>Lung and Lobar Transplantation New CPT category III codes 0494T, 0495T, 0496T for preparation of cadaver donor lung</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>CG-MED-53</td>
<td>Cervical Cancer Screening and Human Papillomavirus Testing New CPT category III code 0500T for HPV testing; code 88154 deleted 12/31/17</td>
<td>5/1/2018</td>
</tr>
<tr>
<td>CG-REHAB-04</td>
<td>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.</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-REHAB-05</td>
<td>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.</td>
<td>12/27/2017</td>
</tr>
<tr>
<td>CG-SURG-24</td>
<td>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.</td>
<td>5/1/2018</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline</th>
<th>Code</th>
<th>Drug</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DRUG-78</td>
<td>J7195</td>
<td>Rebinyn</td>
<td>New Drug to Existing Policy</td>
</tr>
<tr>
<td>CG-DRUG-78</td>
<td>J7178</td>
<td>Fibryna</td>
<td>New Drug to Existing Policy</td>
</tr>
<tr>
<td>DRUG.00112</td>
<td>J9203</td>
<td>Mylotarg</td>
<td>New Drug Policy</td>
</tr>
<tr>
<td>DRUG.00118</td>
<td>J3590, J9999</td>
<td>Aliqopa</td>
<td>New Drug Policy</td>
</tr>
<tr>
<td>CG-DRUG-61</td>
<td>C9016, J3490</td>
<td>Triptodur</td>
<td>New Drug to Existing Policy</td>
</tr>
</tbody>
</table>

**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 ProviderPortalSM 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:
**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.

<table>
<thead>
<tr>
<th>Clinical Guideline</th>
<th>Impacted Agent</th>
<th>Clinically Equivalent Agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-DRUG-09  Immune Globulin (IG) Therapy</td>
<td>Bivigam®, Carimune NF®, Flebogamma®, Gammagard®, Gammagard S/D®, Gammaplex®, Privigen</td>
<td>Gamunex-C®, Octagam®</td>
</tr>
</tbody>
</table>

**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

70224MUPENMUB 12/22/2017
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](http://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.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Medical Policy number</th>
<th>Medical Policy title</th>
<th>New or revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/17/2017</td>
<td>DRUG.00111</td>
<td>Gusekumab (Tremfya™)</td>
<td>New</td>
</tr>
<tr>
<td>9/27/2017</td>
<td>LAB.00035</td>
<td>Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis</td>
<td>New</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>DRUG.00040</td>
<td>Abatacept (Orencia®)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>DRUG.00058</td>
<td>Pharmacotherapy for Hereditary Angioedema</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>DRUG.00071</td>
<td>Pembrolizumab (Keytruda®)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>DRUG.00082</td>
<td>Daratumumab (DARZALEX™)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>DRUG.00099</td>
<td>Cerliponase Alfa (Brineura™)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>DRUG.00107</td>
<td>Avelumab (Bavencio®)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>GENE.00011</td>
<td>Gene Expression Profiling for Managing Breast Cancer Treatment</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>MED.00051</td>
<td>Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>MED.00081</td>
<td>Cognitive Rehabilitation</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>RAD.00035</td>
<td>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)</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>RAD.00066</td>
<td>Multiparametric Magnetic Resonance Fusion Imaging Targeted Prostate Biopsy</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>SURG.00055</td>
<td>Cervical Total Disc Arthroplasty</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>SURG.00121</td>
<td>Transcatheter Heart Valve Procedures</td>
<td>Revised</td>
</tr>
</tbody>
</table>

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.

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.

```
<table>
<thead>
<tr>
<th>Effective date</th>
<th>Clinical UM Guideline number</th>
<th>Clinical UM Guideline title</th>
<th>New or revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/2017</td>
<td>CG-ADMIN-02</td>
<td>Clinically Equivalent Cost Effective Services – Targeted Immune Modulators</td>
<td>New</td>
</tr>
<tr>
<td>9/27/2017</td>
<td>CG-MED-57</td>
<td>Cardiac Stress Testing with Electrocardiogram (ECG)</td>
<td>New</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>CG-ANC-06</td>
<td>Ambulance Services: Ground; Non-Emergent</td>
<td>Revised</td>
</tr>
<tr>
<td>8/17/2017</td>
<td>CG-SURG-27</td>
<td>Sex Reassignment Surgery</td>
<td>Revised</td>
</tr>
</tbody>
</table>
```
**NOC drug codes and descriptions as of May 4, 2017:**

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

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:
  - Less than 22%: $1
  - 23% to 50%: $5
  - 51% to 75%: $10
  - 76% to 100%: $15
  - 101% to 138%: $20
  - 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:

- 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
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/inmedicaldoc > 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.

<table>
<thead>
<tr>
<th>Medical Policy number</th>
<th>Medical Policy title</th>
<th>Web location</th>
</tr>
</thead>
<tbody>
<tr>
<td>CG-MED-42</td>
<td>Maternity Ultrasound in the outpatient setting</td>
<td><a href="https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c159215.htm">https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c159215.htm</a></td>
</tr>
<tr>
<td>CG-MED-52</td>
<td>Allergy Immunotherapy (Subcutaneous)</td>
<td><a href="https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c183207.htm">https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c183207.htm</a></td>
</tr>
<tr>
<td>DRUG 00038</td>
<td>Bevacizumab (Avastin®) for Non-Ophthalmologic Indications (Cancer)</td>
<td><a href="https://www.anthem.com/medicalpolicies/policies/mp_pw_b078445.htm">https://www.anthem.com/medicalpolicies/policies/mp_pw_b078445.htm</a></td>
</tr>
<tr>
<td>RAD.00002</td>
<td>PET scans</td>
<td><a href="https://www.anthem.com/medicalpolicies/policies/mp_pw_a053258.htm">https://www.anthem.com/medicalpolicies/policies/mp_pw_a053258.htm</a></td>
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<tr>
<td>CG-MED-44</td>
<td>Ambulatory ECG Holter monitor</td>
<td><a href="https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160710.htm">https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160710.htm</a></td>
</tr>
<tr>
<td>CG-MED-46</td>
<td>Ambulatory and Inpatient Video Electroencephalography</td>
<td><a href="https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160712.htm">https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160712.htm</a></td>
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<tr>
<td>CG-MED-49</td>
<td>Auditory Brainstem Responses (ABRs) and Evoked Otoacoustic Emissions (OAEs) for Hearing</td>
<td><a href="https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160719.htm">https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c160719.htm</a></td>
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<tr>
<td>MED.00005</td>
<td>Hyperbaric Oxygen Therapy (Systemic/Topical)</td>
<td><a href="https://www.anthem.com/medicalpolicies/policies/mp_pw_a049925.htm">https://www.anthem.com/medicalpolicies/policies/mp_pw_a049925.htm</a></td>
</tr>
<tr>
<td>DRUG 000028</td>
<td>Intravitreal Treatment for Retinal Vascular Conditions</td>
<td><a href="https://www.anthem.com/medicalpolicies/policies/mp_pw_a050295.htm">https://www.anthem.com/medicalpolicies/policies/mp_pw_a050295.htm</a></td>
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<tr>
<td>CG-LAB-09</td>
<td>Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain</td>
<td><a href="https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c166612.htm">https://www.anthem.com/medicalpolicies/guidelines/gl_pw_c166612.htm</a></td>
</tr>
<tr>
<td>DRUG.00079</td>
<td>Bendamustine Hydrochloride</td>
<td><a href="https://www.anthem.com/medicalpolicies/policies/mp_pw_c184878.htm">https://www.anthem.com/medicalpolicies/policies/mp_pw_c184878.htm</a></td>
</tr>
</tbody>
</table>
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.

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

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 nonemergency 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 Nonemergency 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

<table>
<thead>
<tr>
<th>VFC supplied serum</th>
<th>Private stock serum (state supply shortages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier SL</td>
<td>No requirement</td>
</tr>
</tbody>
</table>

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](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](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](http://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.

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

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.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Medical Policy number</th>
<th>Medical Policy title</th>
<th>New or revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/17</td>
<td>DRUG.00110</td>
<td>Inotuzumab ozogamicin (Besponsa®)</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>MED.00124</td>
<td>Tisagenlecleucel (Kymriah™)</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>DRUG.00043</td>
<td>Tocilizumab (Actemra®)</td>
<td>Revised</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Clinical UM Guideline number</th>
<th>Clinical UM Guideline title</th>
<th>New or revised</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/17</td>
<td>CG-LAB-11</td>
<td>Screening for Vitamin D Deficiency in Average Risk Individuals</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>CG-MED-59</td>
<td>Upper Gastrointestinal Endoscopy for Diagnosis, Screening or Surveillance</td>
<td>New</td>
</tr>
<tr>
<td>9/27/17</td>
<td>CG-SURG-59</td>
<td>Vena Cava Filter</td>
<td>New</td>
</tr>
</tbody>
</table>

New PA requirements
Levoleucovorin calcium, elesulfase 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.