Anthem BlueCross BlueShield

Working together to improve the health of our members.

April 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

CE0418
IN, KY, MO, OH, WI

Reimbursement

Specialty services: Behavioral Health

Medicaid Notifications

Health Care Reform (including Health Insurance Exchange)

Updates and Notifications

Please be sure to check the Health Care Reform Updates and Notifications and Health Insurance Exchange sections of our website regularly for new updates on health care reform and Health Insurance Exchanges, at www.anthem.com,>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

Look for new alpha-numeric member ID prefixes

The Blue Cross and Blue Shield Association (BCBSA) assigns member ID prefixes for all Blue Cross and Blue Shield-branded Plans – Anthem Plans as well as non-Anthem Plans. Effective April 15, 2018, the BCBSA will begin assigning prefixes that contain a combination of letters and numbers, or alpha-numeric prefixes.

Please take the following actions immediately to avoid possible business disruption:

1. Check your EDI Software to ensure it's ready to accept alpha-numeric prefixes.
2. Ask your patients for their most recent identification (ID) card.
3. When submitting claims, enter the identification number exactly as it appears on the member's ID card.
4. Review any internal documents you may have and update any references of "alpha prefix" to "prefix".

Note: Current three-character, alpha-only prefixes will not be affected by this change. Current prefixes will still be valid once the new alpha-numeric prefixes are issued.

Updated BlueCard® Provider Manual is available online

If you want to learn more about the BlueCard Program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area, check out the updated BlueCard Provider manual by going to anthem.com, select Menu > Providers > Find Resources for Your State. Choose your state, then Communications > General Information > BlueCard Provider Manual.

Introducing Anthem Intermittent Workforce Program

Anthem has designed a program to serve the needs of national companies in industries such as staffing, hospitality, retail and health care whose workforces include large numbers of intermittently employed part-time, temporary, variable-hour, contingent and contract workers.

The Anthem Intermittent Workforce Program, which features Anthem FlexHour benefit plans, is now available to employers with at least 1,000 intermittently employed workers in the United States. This program comes as some studies estimate that more than 40 million people currently work intermittently and that by 2020, as much as half of the U.S. workforce may be employed on an intermittent basis.

Anthem's Intermittent Workforce Program offers a full range of medical plans, from fully-insured to self-funded minimum essential coverage plans. The program includes dental, vision, life and short-term disability specialty plans. Anthem is also making available a comprehensive suite of supplemental health plans through a new multi-year partnership with the IHC Group.

Member ID cards for these health plans will include the reference "MEC Plan" or "MVP Plan" on the left side, under the "Group" field. Coverage for these plans can be administered on a monthly basis, like traditional insurance, or if the employer chooses, it can be administered on a payroll-period basis, e.g. weekly or biweekly. Providers should continue to verify eligibility and benefits for all Anthem members prior to rendering services.

New feature on Availity: View member ID card

Have you noticed the new View Member ID Card feature, now available for many Anthem members on the Availity Portal? An image of both the front and back of the member's ID card can be printed and/or saved, so you can have the information you need before your patient arrives for an appointment.

View Member ID Card requires a successful eligibility and benefits transaction on Availity, so you will need the complete member ID number (including the three-character alpha or alpha-numeric prefix) and date of birth (DOB) to access the online copy of the card.

To locate View Member ID Card, go to www.Availity.com, log on, then select Patient Registration | Eligibility and Benefits and complete the required eligibility and benefits fields. View Member ID Card will be one of the available links along the top of the Eligibility and Benefits results page. Select this link to see the member's ID card.

**Note: View Member ID Card is currently unavailable for Blue Card, FEP and some health plans' Medicare Advantage and Medicaid members.*

Post-service verification for specialty drugs

Providers currently submit select specialty drug prior authorization (PA) requests for Anthem's Commercial members by calling AIM Specialty Health® (AIM), a separate company, or by using the AIM provider portal. Most PA requests for specialty drugs do not require medical records to be submitted at the time of the authorization, which helps make processing time more efficient for providers.

To help ensure claims are paid appropriately, Anthem may conduct post-service verification of the information provided at the time of the authorization. For clarification, post-service verification is not a review of the medical necessity. It is a review of medical records to verify that the information provided during the PA is supported by medical record documentation.

Providers may receive a request from Anthem for medical records or other specific information required to complete the post-service verification review. Providers should respond to requests for medical records within 60 days of the initial request. In cases where medical records do not support the information provided during the PA process, or if there is no response from the provider, recoupments may result. Note: a letter of medical necessity does not replace a request for medical records or other specific requested information.

Update: Specialty pharmacy and oncology claim processing

Anthem recently discovered that some specialty pharmacy and oncology services that require precertification through AIM Specialty Health (AIM), a separate company, are processing without the required precertification. Effective May 1, 2018, our claims systems will be updated to correct this issue. As a reminder, claims for specialty pharmacy and oncology drugs continue to require precertification through AIM. For a list of the codes that require precertification, visit the AIM provider portal.

Virtual Second Opinion now available for select National Accounts

The Virtual Second Opinion (VSO) program is now available for select Anthem National Accounts. This program, intended to be a resource to members who may be at a crossroads in their care, offers additional support, including access to physicians who can provide members with a virtual second opinion for certain diagnoses, procedures, or courses of treatment. Anthem will identify members who may benefit from the VSO and invite them to participate in the program. If the member agrees, a vendor selected by Anthem will work with the member and coordinate the second opinion.

Here are some examples of the conditions where a VSO may be offered:

Condition/Disease Categories	Example
Digestive system	• Hepatitis C • Crohn's Disease • Ulcerative Colitis
Musculoskeletal	• Advanced Hip and Knee Degenerative joint disease (DJD) • Advanced Lumbar/Cervical Disc Disease
Nervous system	• Multiple Sclerosis • Parkinson's Disease
Neoplasms and diseases of the blood and blood-forming organs	• Advanced Stage Malignancies Breast Cancer • Chronic Myeloid and Lymphocytic Leukemia • Lymphoma, • Acute Leukemia • Readmission risk
Critical care	• Sepsis • Motor vehicle accidents • Severe burns • Traumatic brain injury (TBI)
Endocrine, nutritional and metabolic	• Diabetes with Neurologic complications • Morbid obesity • Chronic Kidney Disease Neuroendocrine Tumors
Circulatory system	• Valvular Heart Disease • Coronary Artery Disease
Genitourinary system	• Renal Cell Carcinoma • Prostate Cancer
Commonly misdiagnosed conditions	• Rheumatoid Arthritis • Lupus • Lyme Disease
Respiratory	• Lung Transplant
Congenital malformation	• Malformation of the Circulatory System • Complex Pediatric Musculoskeletal
Injury, poisoning and other external causes	• Industrial exposure

Reminder: Include the member ID three digit prefix when filing a claim

When submitting a claim on your patient's behalf, it is critical that the complete member ID, including the three-digit alpha or alpha-numeric prefix, appear on the claim form. Omitting the prefix, or using an outdated one, may cause the claim to be delayed or denied, or otherwise processed incorrectly.

Please remind your office staff that things can change, so it's important to check each patient's member ID card at every visit. It's equally important that your billing office stay up to date on any changes to the patient's member ID. Taking these steps will help ensure timely and accurate processing of your patient's claim.

OH: Notice of change in provider hospital affiliation

Ohio Administrative Code Section 3901-8-16 (Required Provider Network Disclosures for Consumers), requires an insurer to notify an enrollee of a termination of a provider or facility from the issuer's network, or a change in a provider's hospital affiliation. Effective April 13, 2018, Anthem will begin sending a revised member letter when there is a change to their physician's hospital affiliation and/or hospital privilege status. The letter will be sent when Anthem is made aware of the change. The letter explains to members that a change in affiliation/status does not mean that the provider is no longer in Anthem's health plan network and it does not necessarily mean that the provider is no longer seeing patients at that hospital. However, Anthem is encouraging members to contact their provider's office and confirm current hospital affiliation if they anticipate needing services at a particular hospital.

OH: Change of claim notice for some Ohio claims

Starting in second quarter 2018, you may begin to see more claims denied for "Policyholder's premium not paid to date." Ohio law requires that insurers take action on a claim within 30 days of receipt of a claim and provide notice to members and providers of the status of the claim at that time. If a group or individual policyholder has not paid the premium at the time a claim is processed, the claim will not be paid. The following reason will appear on the provider remittance: Policyholder's premium not paid to date."

Health Care Management

Medical policy and clinical guideline updates

Anthem medical polices were reviewed on January 25, 2018 for Indiana, Kentucky, Missouri, Ohio and Wisconsin. The following medical policies were converted to clinical guidelines and will be effective on May 1, 2018.

New Clinical Guideline (CG)	Content Moved from CG and/or Medical Policy
CG-DME-42 Non-implantable Insulin Infusion and Blood Glucose Monitoring Devices	Content moved from CG-DME-01 External (Portable) Continuous Insulin Infusion Pumps, CG-DME-38 Continuous Interstitial Glucose Monitoring, and DME.00040 Automated Insulin Delivery Devices
CG-DME-43 High Frequency Chest Compression Devices for Airway Clearance	DME.00012 Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation
CG-SURG-70 Gastric Electrical Stimulation	Content moved from SURG.00046 Gastric Electrical Stimulation
CG-SURG-71 Reduction Mammaplasty	Content moved from SURG.00086 Reduction Mammaplasty
CG-SURG-72 Endothelial Keratoplasty	Content moved from SURG.00108 Endothelial Keratoplasty

The following medical policies were converted to clinical guidelines and will be effective on July 1, 2018.

New Clinical Guideline	Content Moved From Medical Policy
CG-THER-RAD-03 Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy	Content moved from THER-RAD.00005 Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy
CG-THER-RAD-04 Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors	Content moved from THER-RAD.00006 Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors

The following are revisions to current Medical Policies or Clinical Guidelines.

Policy Number	Policy Title and Description	Effective
MED.00123	Axicabtagene ciloleucel (Yescarta™) Added new HCPCS code Q2041 for Yescarta (will be active 04/01/18), and NOC C9399 for use prior to 04/01/18; added ICD-10-CM Z51.12 to pend	2/28/2018
MED.00124	Tisagenlecleucel (Kymriah™) Added ICD-10-CM Z51.12 to pend	7/1/2018
SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting HCPCS codes related to the following products will pend for appropriate diagnosis codes (they were investigational/not medically necessary (INV&NMN): Oasis (Q4102, Q4124), GraftJacket (Q4107), PriMatrix (Q4110), DermACELL (Q4122), Strattice (Q4130), EZ-Derm (Q4136), Biobrane & DermaMatrix (both NOC); removed Q4182 TransCyte (no longer addressed)	2/1/2018
SURG.00112	Occipital Nerve and Supraorbital Nerve Stimulation Added investigational and Not medically necessary (INV&NMN) statement for supraorbital nerve stimulation Added CPT code 64553 and ICD-10-PCS codes 00HE0MZ, 00HE3MZ, 00HE4MZ for cranial electrodes (not specific to supraorbital nerve)	7/1/2018

MPTAC approved the use of MCG 22nd edition of ORG: B-905-CI (BHG) – Crisis Intervention Behavioral Health Level of Care. The use of this guideline will be effective date July 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.

Vena Cava filters (CG-SURG-59)

Clinical guideline CG-SURG-59 addresses the indications for placement and removal of a Vena Cava Filter and is effective for dates of service on and after July 1, 2018. Only outpatient requests will be reviewed per this guideline. Prophylactic use of the filters is considered not medically necessary if criteria are not met. The criteria was based on peer review literature and evidence based practice guidelines.

AIM radiation, oncology clinical guidelines updates

Effective with dates of service on and after July 1, 2018, AIM Specialty Health (AIM), a separate company, will apply AIM's Radiation Oncology Clinical Appropriateness Guidelines to precertification requests for the services noted below.

- Brachytherapy
- Intensity modulated radiation therapy (IMRT)
- Stereotactic body radiation therapy (SBRT)
- Stereotactic radiosurgery (SRS)
- External beam radiation therapy (EBRT)
- Image-guided radiation therapy (IGRT)
- Special physics consult
- Special treatment procedure

For Anthem plans with radiation oncology services medically managed by AIM, AIM guidelines will replace certain Anthem radiation oncology medical policies and clinical guidelines. Note: Anthem will continue to review services for plans not managed by AIM.

As a result of this change, AIM will also manage requests for:

- Intraoperative radiation therapy (IORT) to include the following CPT codes:
    - 77424 – Intraoperative radiation treatment delivery, x-ray, single treatment session
    - 77425 – Intraoperative radiation treatment delivery, electrons, single treatment session
    - 77469 – Intraoperative radiation treatment management
    - 19294 – Preparation of tumor cavity
- SRS, SBRT, and EBRT, for CPT code77295 – 3-dimensional radiotherapy plan, including dose-volume histograms

Note: Proton beam radiation therapy requests will continue to be reviewed against Anthem's medical policy, THER-RAD.00002.

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

- Access AIM's *ProviderPortal*$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com.
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday–Friday, 8:30 am–7 pm ET.

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

Imaging level of care expands to include local self-funded plans

Effective with dates of service on and after July 1, 2018, Anthem will offer local self-funded benefit plans in Indiana, Kentucky, Missouri, Ohio and Wisconsin, the opportunity to add a medical necessity review of the requested level of care for non-emergent, outpatient, computed tomography (CT) imaging, magnetic resonance imaging (MRI), and magnetic resonance angiogram (MRA). The following clinical guideline will apply: Level of Care: Advanced Radiology Imaging, CG-MED-55. The clinical review will be administered by AIM Specialty Health (AIM), a separate company.

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

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

Please submit prior authorization requests to AIM in one of the following ways:

- Access AIM's *ProviderPortal*$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com.
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday–Friday, 8:30 am–7 pm ET.

Please note, this program already applies to local fully insured Anthem members in Indiana, Kentucky, Missouri, Ohio and Wisconsin with imaging services medically managed by AIM. It does not apply to BlueCard® or the Federal Employee Program® (FEP®).

For questions regarding level of care reviews, please contact the Provider Services number on the back of the member ID card.

Anthem expands Specialty Pharmacy prior authorization list

Effective for dates of service on and after July 1, 2018, the following specialty pharmacy codes from new or current medical policies or clinical UM guidelines will be included in our pre-service review process.

Anthem's pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health (AIM), a separate company.

Medical Policy or Clinical Guideline	Code	Drug	Comment
CG0-DRUG-78	J7199, J3590	Hemlibra	New drug to existing guideline
DRUG.00080	J3490, J3590	Fasenra	New drug to existing policy
DRUG.00116	J3490	Mepsevii	New drug guideline
CG-DRUG-77	A9606	Xofigo	Existing guideline
CG-THER-RAD-03	A9543	Zevalin	Existing policy
CG-MED-67	J9325	Imlygic	Existing guideline
CG-DRUG-85	J3490	Egrifta	Existing guideline

Anthem expands opioid analgesics UM clinical policies

Beginning with prescriptions filled on and after May 1, 2018, Anthem will expand its opioid utilization management clinical policies to help improve patient safety and reduce the misuse and abuse of opioid analgesics.

- Short-acting opioid analgesics: Members will be limited to six units per day, up to seven days per fill not to exceed 14 days per 30 days – greater quantities will require prior authorization.
- Long-acting opioid analgesics: Members will have a quantity limit for long-acting opioids based on dosing frequency (i.e., two per day for a q12h drug)

Current users of short-acting or long-acting opioid analgesics will only be impacted by these changes should they have a change in their prescription requesting an increase in dosage or quantity that exceeds the new limitations.

Members with a diagnosis of cancer-related pain or a diagnosis of a terminal condition, and receiving palliative care and needed short-acting or long-acting opioid analgesics, will automatically be approved through the prior authorization process.

Note: This update does not apply to Medicare plans.

Visit the pharmacy information page for details on prior authorization criteria, or any other requirements, restrictions or limitations that may apply.

For more information, please contact the Provider Services number on the back of the member ID card.

Medicare

UM decisions based on appropriateness of care, benefits

Utilization management (UM) decisions are based only on appropriateness of care and service and the member's coverage. Anthem does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits. Financial incentives for UM decision makers do not encourage decisions that result in underutilization, or create barriers to care and service for our members.

PA requirements for CAR-T therapy

(CAR) T-cell immunotherapy currently requires a prior authorization (PA). We will continue to require PA for CAR-T therapy regardless of the place of service in which it is given and regardless if it is billed with an unlisted code. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services (CMS) guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. Non-compliance with requirements may result in denied claims.

CAR-T therapy is currently represented by the following codes. However, CAR-T therapy in any form will continue to require a PA.

- Q2040 - Tisagenlecleucel, up to 250 million CAR-positive viable T cells, including leukapheresis and dose preparation procedures, per infusion. (Kymriah)
- Q2041 - Axicabtagene Ciloleucel, up to 200 million Autologous Anti-CD19 CAR T Cells, including leukapheresis and dose preparation procedures, per infusion. (New code, effective April 1, 2018.)

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at www.Availity.com. Contracted and non-contracted providers who are unable to access Availity may call Provider Services at the phone number on the back of the member's ID card for PA requirements.

Post-payment reviews of distinct procedural services modifiers

Anthem follows CMS guidelines regarding Modifiers for Distinct Procedural Services. To help ensure claims are paid accurately, Anthem conducts post-payment reviews of Medicare Advantage and Medicare Supplement professional claims billed with Modifiers for Distinct Procedural Services.

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

Visit Medicare Advantage Reimbursement Policies at anthem.com/medicareprovider to review specific policies.

On-formulary topical corticosteroids

Topical corticosteroids included on all Anthem formularies are listed below. This table does not represent all of the commercially available topical corticosteroids.

When prescribing medications, always select "substitution permissible by law" where applicable. This will help ensure your patients benefit from generic medications, when available.

Therapeutic Class	Formulary Product	Relative Cost per Rx*
Topical Corticosteroids-*Low potency*	hydrocortisone cream, hydrocortisone ointment	$
Topical Corticosteroids-*Medium potency*	triamcinolone cream, triamcinolone ointment	$
Topical Corticosteroids-*High potency*	fluocinonide E cream	$$
Topical Corticosteroids-*Very high potency*	clobetasol cream, clobetasol E cream, clobetasol gel, clobetasol ointment	$$$

*Relative cost per Rx is intended to be directional in nature. Costs may change based on market dynamics. The information provided is meant to be used as a guide, and should not take place of clinical decision making by a prescriber regarding the treatment of their patients.

Formulary status or drug availability may change. There may be additional qualifications needed for access to some drugs, such as a prior authorization or step therapy. This information does not guarantee benefit coverage for any medications as member coverage may vary.

OH: Anthem, Core Care Select in delegated arrangement

Effective Jan. 1, 2018, Anthem delegated responsibility for medical claims payment, prior authorizations, case management, provider credentialing and inpatient and outpatient utilization management to Core Care Select for individual Medicare Advantage HMO members in Franklin, Delaware, Fairfield, Union and Ross counties in central Ohio. These members have COPC Senior Care Advantage on their member ID card.

Additional information will be available at Important Medicare Advantage Updates at anthem.com/medicareprovider. You may also call Central Ohio Primary Care provider services at 614.259.0286

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:
Medicare risk adjustment and documentation training
Prior authorization requirements for part B drugs: Mylotarg and Mvasi
Prior authorizations required for new group-sponsored MA membership (updated with new members' alpha prefixes)
OH: Contracted provider responsibility and liability for issuance of NOMNC to a SNF (OH only)

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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

Anthem expands hospice policy

Beginning June 1, 2018, Anthem is further extending hospice benefits to allow disease modifying treatments to continue alongside hospice services. Additionally, we will expand access of hospice services to members with prognoses of up to 12 months (rather than 6 months). This change will apply to local Anthem fully insured members.

If you have a patient with an advanced illness and life expectancy of less than 12 months, now is the time to talk about hospice. Hospice is a powerful support resource for patients that can work in tandem with their treatment.

Patient benefits:

- More support, earlier: Relaxing the previous benefit maximum and treatment limitations will help patients with advanced illnesses access hospice services earlier. Talking to their doctor sooner means patients can better choose the care that fits their personal needs. Families will also get more support to ease the emotional burden.
- Coordinated team: Hospice support is an integrated part of the treatment plan. Patients will have a dedicated team that coordinates access to medication, medical supplies, and equipment. Patients can depend on hospice services for their care needs rather than emergency room and intensive care professionals who are unfamiliar with their histories, goals, and preferences.

- Improved quality of life: Research shows that there is considerable value in the concurrent delivery of palliative and disease-modifying care, particularly for patients with advanced illness. Patients receive help sooner, manage their pain and symptom relief better, and families are able to discuss planning of personal needs more effectively.

Provider benefits:

- Improved communication: Discussions about hospice can begin earlier and can help to normalize the idea. Patients are then empowered to express their goals, values, and preferences earlier in their disease. They can make better care decisions so they can enjoy the best quality of life in the time that remains.
- Centralized care: The treating provider remains at the center of the patient's overall treatment plan – supported by the entire hospice team. Patients get the benefit of expert medical care, pain management, and emotional and spiritual support all working together. With more support for pain and symptom management, patients can avoid unnecessary trips to emergency rooms and intensive care where the hospital clinicians may be unaware of the patient's history or wishes.
- Planning resource: Caregiver stress. Fears of the future. Bereavement planning. End-of-life discussions. All are important but never easy. Hospice professionals are a useful resource for doctors to help aid in these discussions with patients and families.

Note: This update does not apply to Commercial ASO, Federal Employee Program® (FEP®), Medicare and Medicaid. Providers should continue to verify eligibility and benefits for all members prior to rendering services or referring members for hospice care.

HEDIS 2018® Weight Assessment and Counseling

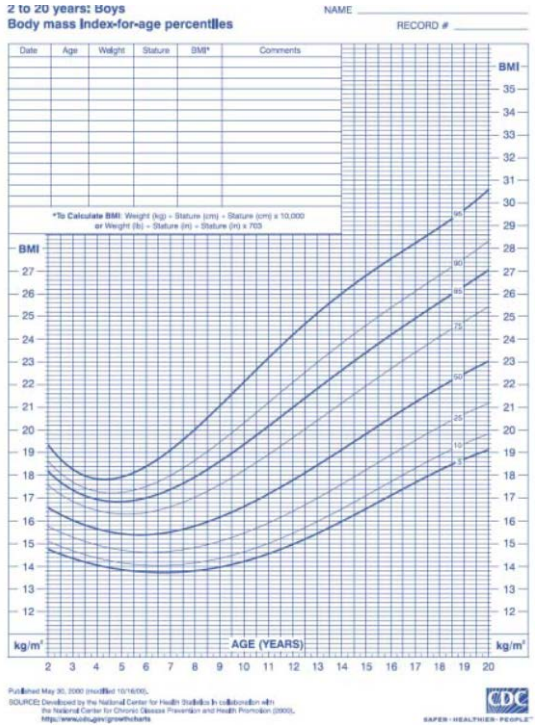
One of the measures for which records are collected includes Weight Assessment and Counseling for Nutrition and Physical Activity (WCC). In 2017, it measures the percentage of members 3 -17 years of age who had an outpatient visit with a PCP or OB/GYN and had evidence of the following:

- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

BMI percentile documentation

- Because BMI norms for youth vary with age and gender, the WCC measure evaluates if a BMI percentile was assessed rather than the actual BMI value.
- A distinct BMI percentile is required. (Ranges and thresholds do not meet for this measure).
- The height, weight and BMI percentile may be from different dates of service in 2017.
- The distinct BMI percentile must be documented in the medical record or plotted on a BMI for age-growth chart for a date of service in 2017 corresponding to the child's age at the time of that visit.
- NCQA will not allow health plans to calculate BMI%.

Body Mass Index (BMI) Graph-For -Age



Nutrition Counseling Documentation guidelines include:

- Documentation of current nutrition behaviors (eating habits or dietary behaviors).
- Use of a checklist indicating nutrition was addressed.
- Counseling or referral for nutrition education.
- Member received educational materials on nutrition during a face-to-face visit.
- Documentation of anticipatory guidance for nutrition.
- Weight or obesity counseling.

Documentation that does not count as compliant includes notation of “health education” or “anticipatory guidance” without specifically indicating nutrition is not compliant. Please provide copies of any nutrition handouts given to parent, if applicable.

Physical Activity Documentation guidelines include:

- Discussion of current physical activity behaviors (exercise routine, participation in sports activities, exam for sports participation).
- Checklist indicating physical activity was addressed.
- Counseling or referral for physical activity.
- Documentation that member received educational materials on physical activity during a face-to-face visit.
- Documentation of anticipatory guidance for the child’s physical activity.
- Weight or obesity counseling.

Documentation that does not count as compliant includes:

- Notation of “health education” or “anticipatory guidance” without specifically indicating physical activity.
- Notation of anticipatory guidance related solely to safety (i.e. wears helmet or water safety) without specific mention of physical activity recommendations.

- Notation solely related to screen time (computer or television) without mention of physical activity.

Please provide copies of any physical activity handouts given to parent, if applicable.

For more information on HEDIS, go to anthem.com > Menu > Providers> Find Resources for Your State. Select your state, then on the Provider home page, look on the blue toolbar for the Health and Wellness tab. Click it and then select the Quality Improvement and Standards link, then scroll down to "HEDIS Information." Thank you for your continued cooperation and 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

Update: E&M services and related modifiers 25 & 57

In the February 2018 edition of *Network Update*, Anthem shared information regarding changes to the professional reimbursement policy, Evaluation and Management Services and Related Modifiers 25 and 57. 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, and billed with Modifier 25, would be reduced by 25% beginning March 1, 2018. Please note, Anthem has made the decision not to implement this reduction. All other policy content will remain the same.

Post-payment reviews of distinct procedural services and modifiers

Post-payment reviews of distinct procedural services and modifiers
To help ensure claims are paid accurately, Anthem conducts post-payment reviews of professional claims billed with Modifiers for Distinct Procedural Services (59, XE, XP, XS, and XU).

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

Update: Claims requiring additional documentation (Facility)

Anthem continues to take steps to improve the payment accuracy of provider claims and reduce post-payment recoveries. To this end, beginning with dates of service on and after July 13, 2018, Anthem will update its facility policy, Claims requiring additional documentation, to include the following requirement: Inpatient stay claims

reimbursed at a percent of charge with billed charges above $40,000 require an itemized bill to be submitted with the claim.

- *Indiana, Kentucky, Missouri and Wisconsin*: Anthem has engaged Equian to administer the review of these claims
- *Ohio:* Anthem has engaged Ceris to administer the review of these claims.

Pharmaceutical Waste: New facility reimbursement policy

A new policy addressing pharmaceutical waste has been posted on anthem.com and will become effective for dates of service on and after July 1, 2018.

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, then Answers@Anthem> Reimbursement Policies – Professional or Reimbursement Policies -- Facility.

Specialty Services – Behavioral Health

Reminder: Access requirements for behavioral health services

Anthem conducts studies to assess how well practices meet appointment access requirements for behavioral healthcare (BH). Your office may receive a call from North American Testing Organization, a vendor working on Anthem's behalf. To be compliant, providers should make best efforts to meet access standards. Please click the link below to view the access standards for your state:
Indiana
Missouri
Kentucky, Ohio, Wisconsin

Medicaid Notifications

Indiana Medicaid

Unlisted, Unspecified or Miscellaneous Codes

(Policy 06-004, effective 07/01/2018)

As of July 1, 2018, Anthem requires unspecified diagnosis codes be used only when an established diagnosis code does not exist to describe the diagnosis. Reimbursement is based on review of the unspecified diagnosis code on an individual claim basis. If the claim must have an unspecified diagnosis code, and there is a corresponding left, right or bilateral diagnosis, then a description supporting the use of the unspecified diagnosis code must be provided.

For additional information, please review the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at www.anthem.com/inmedicaiddoc.

Medical policy update

On December 20, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies for 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. We made these *Medical Policies* publicly available on our website on the effective date listed below.

Visit 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.

Medical policy effective date	Medical policy number	Medical policy title	Revised or new?
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

Clinical UM guideline update

On December 20, 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 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	Revised or new?
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

Elotuzumab to require prior authorization

Effective May 1, 2018, Anthem will require prior authorization (PA) for elotuzumab for Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect members. Federal and state law as well as state contract language and CMS guidelines (including definitions and specific contract provisions/exclusions) take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following code: J9176 — injection, elotuzumab, 1 mg

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

- Web: www.availity.com
- Phone: Hoosier Healthwise: 866-408-6132; HIP: 844-533-1995; Hoosier Care Connect: 844-284-1798
- Fax: 866-406-2803

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at www.availity.com. Providers who are unable to access Availity can use the Precertification Lookup Tool on our website (www.anthem.com/inmedicaiddoc >Prior Authorization & Claims > Prior Authorization Lookup Tool) or call Provider Services for PA requirements: Hoosier Healthwise: 866-408-6132; HIP: 844-533-1995; Hoosier Care Connect: 844-284-1798

Asthma controller medication

Effective December 1, 2017, Anthem updated the formulary for asthma controller medications. See the table on the next page for details regarding the new requirements for your members.

Asthma Controller Medication	New status	Less than 6 years of age[1]	6 years of age and older	12 years of age and older
Inhaled corticosteroid (ICS) products		Prior authorization (PA) not required		
Arnuity® Ellipta®	Preferred			X
Budesonide Respules	Preferred	X		
Alvesco®	Nonpreferred			
Asmanex HFA	Nonpreferred			
Asmanex Twisthaler®	Nonpreferred — 6 years of age and older	X		
Flovent® Diskus®	Preferred – under age 12; Nonpreferred 12 years of age and older	X		
Flovent® HFA	Preferred – under age 12; Nonpreferred 12 years of age and older	X		
Pulmicort Flexhaler®	Nonpreferred			
Pulmicort Respules®	Nonpreferred			
Qvar[2]	Preferred – under age 12; Nonpreferred 12 years of age and older	X	X	
ICS/long-acting beta agonists products		PA not required		
Breo® Ellipta®	Preferred			X
Dulera®	Preferred			X
Advair Diskus®	Nonpreferred	X[3]	X[3]	
Advair® HFA	Nonpreferred			
Symbicort®	Nonpreferred			

1 FDA minimum age restriction still applies.
2 Can be utilized with external valve holding chamber.
3 If claims history shows that the member has tried one ICS agent within 180 days, the member doesn't need PA.

Kentucky

Unlisted, Unspecified or Miscellaneous Codes

(Policy 06-004, effective 07/01/2018)

As of July 1, 2018, Anthem Blue Cross and Blue Shield Medicaid requires unspecified diagnosis codes be used only when an established diagnosis code does not exist to describe the diagnosis. Reimbursement is based on review of the unspecified diagnosis code on an individual claim basis. If the claim must have an unspecified diagnosis code, and there is a corresponding left, right or bilateral diagnosis, then a description supporting the use of the unspecified diagnosis code must be provided.

For additional information, please review the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://mediproviders.anthem.com/ky/pages/reimbursementpolicies.aspx

Medical policy update

On November 28, 2017, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies for 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. 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.

Medical Policy effective date	Medical Policy number	Medical Policy title	Revised or new?
9/27/17	DRUG.00110	Inotuzumab ozogamicin (Besponsa®)	New
9/27/17	DRUG.00043	Tocilizumab (Actemra®)	Revised

Update to provider payment frequency

Beginning in 2018, most 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 program 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 855-661-2028.

Elotuzumab to require prior authorization

Effective May 1, 2018, Anthem requires prior authorization (PA) for elotuzumab for members. Federal and state law as well as state contract language and CMS guidelines (including definitions and specific contract provisions/exclusions) take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following code: J9176 — injection, elotuzumab, 1 mg

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

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

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at www.availity.com. Providers who are unable to access Availity can use the Precertification Lookup Tool on our website (https://mediproviders.anthem.com/ky>Precertification> Precertification Lookup Tool) or call Provider Services at 855-661-2028 for PA requirements.

New fax numbers for pharmacy PA requests

Anthem has streamlined its pharmacy intake and authorization process for its Kentucky Medicaid members. Please use the following fax numbers to submit all Anthem pharmacy prior authorization requests.

- Prescription drugs: 844-879-2961
- Medical injectables: 844-487-9289

Please update your records immediately and discontinue the use of all previous pharmacy prior authorization fax numbers. For more information, call Anthem Provider Services at 855-661-2028.

2018 Utilization Management Affirmative Statement concerning UM decisions

The following statements govern Anthem Blue Cross and Blue Shield Medicaid, as a corporation and as individuals, involved in utilization management (UM) decisions:

- UM decision making is based only on appropriateness of care and service and the existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

Wisconsin Medicaid

Unlisted, Unspecified or Miscellaneous Codes

(Policy 06-004, effective 07/01/2018)

As of July 1, 2018, Anthem requires unspecified diagnosis codes be used only when an established diagnosis code does not exist to describe the diagnosis. Reimbursement is based on review of the unspecified diagnosis code on an individual claim basis. If the claim must have an unspecified diagnosis code, and there is a corresponding left, right or bilateral diagnosis, then a description supporting the use of the unspecified diagnosis code must be provided.

For additional information, please review the Unlisted, Unspecified or Miscellaneous Codes reimbursement policy at https://mediproviders.anthem.com/wi.

Elotuzumab to require prior authorization

Effective May 1, 2018, Anthem Blue Cross and Blue Shield requires prior authorization (PA) for elotuzumab for BadgerCare Plus members. Federal and state law as well as state contract language and CMS guidelines (including definitions and specific contract provisions/exclusions) take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

PA requirements will be added to the following code: J9176 — injection, elotuzumab, 1 mg

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

- Web: www.availity.com
- Phone: 855-558-1443
- Fax: 800-964-3627

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the provider self-service tool at www.availity.com. Providers who are unable to access Availity can use the Precertification Lookup Tool on our website (https://mediproviders.anthem.com/wi > Precertification > Precertification Lookup Tool) or call Provider Services at 1-855-558-1443 for PA requirements.

Eight injectable drugs will require prior authorization update

Effective June 1, 2018, Anthem will require prior authorization (PA) for eight injectable drugs. Please refer to the *Precertification Lookup Tool* for detailed authorization requirements. Navigate to https://mediproviders.anthem.com/wi/ and select **Precertification** from the left-side menu. From the drop-down options, select **Precertification Lookup Tool**.

Noncompliance with the new requirements may result in denied claims. PA requirements will be added to the following codes:

- J0565 — Injection, bezlotoxumab, 10 mg
- J1428 — Injection, eteplirsen, 10 mg
- J2326 — Injection, nusinersen, 0.1 mg
- J2350 — Injection, ocrelizumab, 1 mg
- J9022 — Injection, atezolizumab, 10 mg

- J9023 — Injection, avelumab, 10 mg
- J9285 — Injection, olaratumab, 10 mg
- Q2040 — Tisagenlecleucel

Please use one of the following methods to request PA:

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

Federal and state law, as well as state contract language including definitions and specific contract provisions/exclusions, take precedence over these prior authorization 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.

Hyaluronan injection update

Effective December 27, 2017, the Medical Policy and Technology Assessment Committee approved the following revision of the *DRUG.00017 Hyaluronan Injections in Joints Other Than the Knee* policy: Position statement revised from Medically Necessary to **Investigational and Not Medically Necessary** for hyaluronan injections for the treatment of temporomandibular joint disorders. For questions regarding this update, please contact your Provider Relations representative.

2018 Utilization Management Affirmative Statement concerning UM decisions

The following statements govern Anthem, as a corporation and as individuals, involved in utilization management (UM) decisions:

- UM decision making is based only on appropriateness of care and service and the existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.