Drug fee schedule update

CMS average sales price (ASP) second quarter fee schedule with an effective date of April 1, 2016 will go into effect with Anthem Blue Cross and Blue Shield (Anthem) on May 1, 2016. To view the ASP fee schedule, please visit the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/.

Anthem Whole Health Connection SM

Anthem Whole Health Connection is a program that enhances clinical care with more data including dental, vision, disability and pharmacy, and creates a bigger picture of patient health1. It also consolidates data from primary care physicians, specialists, ancillary providers like eye doctors and dentists, pharmacies and labs. Sophisticated data analytics are applied to the data to deliver relevant, HIPAA compliant patient health profiles and actionable insights. The insights are then shared with physicians and care managers to allow for more informed treatment plans and better health outcomes.

How it Works

1. Data Collection – Anthem consolidates all claims and benefit information from all coverage lines (medical, dental, vision, disability, pharmacy and behavioral health) in a central repository.

2. Analytics – Data is analyzed to deliver condensed, relevant patient health profiles and actionable insights via care alerts and proactive care management referrals.

3. Connect, share and manage – Anthem connects physicians to this data via the Member Medical History Plus (MMH+) tool. Sharing of information allows for more informed treatment plans to manage a patient’s condition. The data is further shared with care managers, and ancillary providers such as vision providers.

Why is it important to connect dental, vision, disability and pharmacy data to population health?

It’s important because oral health, eye health and productivity contribute to overall health.

The value to your practice

- More efficient data collection. The MMH+ supplements the physician’s patient health records with the following information:
  - Medications and utilization (if not carved out)
  - Labs (LabCorp)
  - Medical Diagnoses (non-sensitive)
Opportunities for your practice

View the MMH+ to complement your electronic health record (EHR) and get a bigger picture of each Anthem patient’s health.

Interesting in learning more about the MMH+ advantages?

Access our Member Medical History Plus (MMH+) Training document online. Go to anthem.com, select the Provider link in top center of the page. Select Nevada from drop down list and enter. From the Provider Home tab, under the Self Service and Support heading, select the link titled Enhanced Personal Health Care Program. Next select Provider Toolkit, then Milestone 2: Risk Stratifying Populations, and lastly, Member Medical History Plus (MMH+) Training.

This self-guided presentation introduces Member Medical History Plus, or MMH+, our longitudinal patient record. In addition to basic logon information, this presentation shows the kinds of information available via MMH+, and includes hypothetical scenarios that demonstrate how using MMH+ can help improve patient care.

Already have access to MMH+?

Log in today and start using it: http://mmhehr.anthem.com/mmhplus

Need to request access to MMH+?

Please contact our NV Provider Relations team at NVproviderrelations@anthem.com or 866-767-9846 (shared phone).

1 Anthem Whole Health Connection applies to employer groups that have purchased an Anthem pharmacy, dental, vision or disability plan, in addition to their medical plan.

2 American Journal of Preventive Medicine’s Impact of Periodontal Therapy on General Health Study, June 2014

Reminder: Behavioral Health educational outreach

As a reminder, Anthem’s vendor partner, EquiClaim, will be reaching out to behavioral health providers using complex office or psychotherapy codes. The intent of the outreach is to help ensure billed services are supported by proper documentation. If you have any questions about Anthem’s documentation guidelines, please reference our Documentation Guidelines for Psychotherapy Services reimbursement policy.

Reimbursement Policies are available on our secure provider portal, ProviderAccess

All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com, and select the Provider link in the top center of the page. Select Nevada from the drop down list, and enter. From the Provider Home page, go to
the ProviderAccess Login tou (blue box on the left side of the page), and select Medical from the drop down list and click on the login button.

Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Professional Reimb & Admin Policies”. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select Continue. Select link titled “Anthem’s Professional Reimbursement & Administrative Policies – By Type”, then select the Reimbursement link, and next the policy titled Documentation Guidelines for Psychotherapy Services.

**Required Behavioral Health Follow-ups**

Every year, the National Committee for Quality Assurance (NCQA) requires health plans to collect Healthcare Effectiveness Data and Information Set (HEDIS®) quality outcome measures and report the rates. These rates can then be used by individuals and employer groups to make health plan membership decisions. Within the behavioral health area, there are three measures that are evaluated based on claims/encounter documentation that providers submit to the health plan.

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>Why is the Measure Important</th>
<th>Follow-up Time Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up Care for Children Prescribed ADHD Medication (ADD):</td>
<td>The percentage of children newly prescribed attention deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.</td>
<td>Initiation Phase: Within 30 days of receiving medication</td>
</tr>
<tr>
<td></td>
<td>Patients need to be monitored regularly in face to face visits to make sure that they are receiving the right treatment and that the child’s condition is being managed.</td>
<td>Continuation and Maintenance: At least 2 visits between 30 day initiation and 270 days (9 months) after initiation</td>
</tr>
<tr>
<td>Antidepressant Medication Management (AMM):</td>
<td>The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment.</td>
<td>Those who remained on antidepressant medication:</td>
</tr>
<tr>
<td></td>
<td>Patients may show improvement within two weeks of initiating antidepressants, but they may need longer to demonstrate full response. The likelihood of response to treatment increases if there is follow-up contact within three months of diagnosis or initiation of treatment. Most people who are treated for an initial depression episode may need to stay on medications for at least six to twelve months.</td>
<td>• For at least 84 days (12 weeks)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For at least 180 days (6 months)</td>
</tr>
<tr>
<td>Follow-up After Hospitalization for Mental Illness (FUH):</td>
<td>The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.</td>
<td>Access to follow-up care with a mental health provider within 7 days of hospital discharge for mental illness is a strong predictor of a reduction in hospital readmission. The facility might help stabilize the patient with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend the improvement outside of the hospital. Ensuring that there is continued care outside of the hospital and compliance with outpatient follow-up care can help detect post-hospital problems early and can provide continued support that helps to improve the treatment outcomes and reduces health care costs.</td>
</tr>
</tbody>
</table>
Anthem is helping

- The Pharmacy team sends educational materials on depression and ADHD treatment to members who have recently initiated medication therapy.
- The Pharmacy team provides refill reminder notifications for depression medications.
- The Behavioral Health Care Management team can assist with any appointment scheduling or modifications, remind patients of their scheduled appointment, and support any ongoing case management needs.

How you can help

- Ensure that a claim or encounter is submitted for all monitoring and follow-up appointments and services and the dates of service are clearly indicated.
- Educate your patients on the importance of follow-up visits and the importance of continuing the prescribed medication(s) even if they are feeling better, as well as the importance of notifying you of any side effects.
- If a patient needs assistance finding a behavioral health provider, they can call Anthem or look on www.anthem.com, “Find a Doctor” tool. Your patients may also request case management assistance.
- For individuals who have been admitted to the hospital, connect with them and start the discharging planning early including making sure that a follow-up appointment with a behavioral health provider has been scheduled prior to discharge.
- Coordinate with the patient’s support system including family members.
- Routinely use depression assessment tools, such as the PHQ-9 (Patient Health Questionnaire), as a tool to support follow-up discussions, which can include screening for medication side effects and reinforcing treatment expectations.
- Use the Vanderbilt Assessment Scales, developed through the Attention Deficit Hyperactivity Disorder (ADHD) Collaborative as a tool to drive ADHD discussion and follow-up. The Vanderbilt Assessment scales are available and can be downloaded from the National Institute for Children’s Health Quality (NICHQ) website: [http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales](http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales). An ADHD resource tool kit is also available: [http://www.nichq.org/childrens-health/adhd/resources/adhd-toolkit](http://www.nichq.org/childrens-health/adhd/resources/adhd-toolkit).

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

New Residential Treatment Center benefit for FEP®

Blue Cross Blue Shield Service Benefit Plan® also known as Federal Employee Program, has a new Residential Treatment Center (RTC) benefit effective January 1, 2016. The new benefit provides RTC services with the following requirements:

- FEP members **must be enrolled and participating in case management** prior to RTC admission and remain in case management through post discharge
- Facility must provide a preliminary treatment plan and a discharge plan prior to admission.
- Care must be medically necessary for treatment of a mental health, substance abuse or medical condition
- Precertification must be obtained prior to admission or the entire admission is denied as non-covered
- The Residential Treatment Center must be licensed and accredited.

**Note:** If the above requirements are not met prior to the admission, the entire Residential stay will not be covered.
Additional information can be found in the Service Benefit Plan Brochure located at [www.fepblue.org](http://www.fepblue.org) or call FEP Customer Service at: 800-727-4060.

**New: Find valuable Anthem information under Payer Spaces on the Availity Web Portal**

The new Payer Spaces page is where you can now find the Resources link for Anthem forms and other information. To navigate to the Payer Spaces page, select the Payer Spaces link located on the right side of the top menu bar on the Availity Web Portal. Choose Anthem Blue Cross and Blue Shield from the payer options. Next, select Resources from the menu located on the Payer Spaces page. Payer Spaces and Resources will replace the existing Payer Resources link on the Availity Web Portal's top menu bar as the destination where you will find Anthem forms and information. For now, you can navigate to Resources using either the Payer Spaces or the Payer Resources links. Later this summer, the Payer Resources link will be retired and no longer available. At that time, Anthem forms and information will be available exclusively under Payer Spaces going forward.

**Process update for Compound Drug claims**

A change in claims processing for compound drug claims that aligns with members’ benefit plans is being implemented for individual and group plans upon their renewal on or after January 1, 2016. A compound drug is a customized medication prepared by a pharmacist for a specific person.

Once implemented, in order for a compound drug to be a covered benefit, all its ingredients must be approved by the Food and Drug Administration (FDA), with some exception for delivery adjuvants (products that are utilized to deliver an active ingredient). A prescription is also required for the drug. These control measures are in place to ensure compound drugs are safe and effective.

As a result, claims for certain compound drugs currently being paid will no longer be paid for products containing:

- Compounded bulk powders (not FDA-approved)
- Single Source, Proprietary Pharmaceutical Adjuvants (compounding vehicles, not FDA-approved)

Members utilizing compounds whose ingredients are not all FDA-approved may have to pay for the cost of the drug the next time they fill their prescription. We will continue to cover compound drugs whose ingredients are FDA-approved and not otherwise excluded, as defined under the member’s benefit plan.

**HEDIS® 2016: Comprehensive Diabetes Care – Eye Exam**

One of the measures we collect during the Healthcare Effectiveness Data and Information Set (HEDIS) collection season is the Comprehensive Diabetes Care measure. This measure focuses on ensuring that our diabetic members (type 1 and type 2) who are between the ages of 18 to 75 are receiving appropriate testing and care. One of the indicators for this measure is ensuring that our diabetic members are receiving annual eye exams:

- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in 2015 –OR–
- A negative retinal or dilated exam (negative for retinopathy) by an eye care professional in 2014

Documentation in the member’s medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional, the date when the procedure was performed and the results.
- A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional reviewed the results.
Documentation of a negative retinal or dilated exam by an eye care professional in 2014, where results indicated retinopathy was not present.

We have found that documentation from the Eye Care Provider is sometimes missing in the PCP record. This may be because the member has gone to an Out-of-Network Eye Care Provider, or may not have been referred for an annual eye exam. Our 2014 results show that on average, less than 50% of our diabetic members are getting annual eye exams, particularly in our west states. We encourage you to refer our diabetic members for annual eye exams and request the records from the Eye Care Provider.

For more information on HEDIS is available online at anthem.com. Click on the Provider link at the top of the landing page (under the “Other Anthem Websites” section). Select Nevada and click enter. Click on the Health and Wellness tab (on the blue toolbar), and 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).

Precision Medicine: Cancer Care Quality Program expansion supports NCI-MATCH

The Cancer Care Quality Program is expanding to include enhanced reimbursement for treatment planning and care coordination services provided by network providers for those eligible members who enroll in NCI-Molecular Analysis for Therapy Choice (NCI-MATCH), a National Cancer Institute clinical trial. NCI-MATCH seeks to determine whether treating cancers according to their molecular abnormalities will show evidence of effectiveness.

The Cancer Care Quality Program Precision Medicine expansion provides a unique opportunity to support the White House’s Precision Medicine Initiative through the National Cancer Institute to accelerate knowledge and learn as rapidly as possible which genes and therapies are clinically effective. It also supports your practice with enhanced reimbursement for treatment planning and care coordination services provided to those eligible members who enroll in NCI-MATCH.

Learn more

Visit our special website, www.CancerCareQualityProgram.com/PrecisionMedicine, to learn more about the program:

- How to participate
- Member eligibility
- Enhanced reimbursement
- Frequently asked questions

Reminder of the most recent updates to the Cancer Care Quality Program

Attention Oncologists, Hematologists and Urologists

As a reminder, Anthem’s Cancer Care Quality Program (“Program”), a quality initiative, provides participating physicians with evidence-based cancer treatment information that allows them to compare planned cancer treatment regimens against evidence-based clinical criteria. The Program also identifies certain evidence-based Cancer Treatment Pathways. Participating physicians who are in-network for the member’s benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on a designated Cancer Treatment Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.
Effective May 1, 2016, Anthem will make the following changes to the Cancer Treatment Pathways for the Cancer Care Quality Program:

**New Cancer Treatment Pathways added to the Program include:**

- **Kidney (renal) cancer treatment pathways**
- **Non-small Cell Lung Cancer**
  - Osimertinib will be added to 2nd line therapy for patients with EGFR T790M positive mutation
  - Nivolumab will be added to 2nd line therapy for non-squamous histology
- **Multiple Myeloma**
  - Bortezomib, lenalidomide, plus dexamethasone will be added to 1st line therapy
  - Elotuzumab, lenalidomide, plus dexamethasone will be added to 3rd and subsequent lines of therapy
  - Daratumumab will be added to 3rd and subsequent lines of therapy
- **Breast Cancer: Endocrine therapy**
  - Letrozole plus palbociclib will be added to 1st line therapy for post-menopausal, ER+ or PR+
  - Fulvestrant plus palbociclib will be added to 2nd line therapy for post-menopausal, ER+ or PR+
  - Fulvestrant, palbociclib plus ovarian suppression therapy will be added to 1st line therapy for pre-menopausal, ER+ or PR+

**Cancer Treatment Pathways removed* from the Program include:**

- **Multiple Myeloma**
  - Melphalan, prednisone, plus bortezomib (MPB) will be removed for 1st line/primary therapy in non-transplant candidates
  - Bortezomib monotherapy will be removed for 2nd line therapy
  - Bortezomib plus dexamethasone will be removed for 2nd line therapy
  - Carfilzomib will be removed for 3rd line therapy

* This means that providers will not be eligible for an enhanced reimbursement when these regimens are prescribed. This does not restrict the use of these regimens for members when clinically appropriate, and claims will be adjudicated in accordance with the members’ benefit plans.

The Cancer Treatment Pathways developed for this Program are intended to support quality cancer care. To access the full Cancer Treatment Pathways document, go online to CancerCareQualityProgram.com, our dedicated provider website.

**Note:** Participating physicians who are in-network for the member's benefit plan are eligible to participate in the Program and for enhanced reimbursement if an appropriate treatment regimen is ordered that is on Pathway.

**Update on precertification of cardiovascular services**

Anthem recently expanded its cardiovascular program to require precertification for arterial ultrasound, cardiac catheterization, and percutaneous coronary intervention (PCI). An additional note about the program: arterial duplex imaging of the extremities (codes 93925,
Updates to Blue Physician Recognition Program

Anthem is committed to providing members with the tools they need to effectively partner with their doctors and make more informed health care choices. As part of that effort, Anthem is pleased to participate in the Blue Cross and Blue Shield Association’s consumer engagement initiative.

The Blue Physician Recognition (BPR) Program is designed to reinforce Blue Plans’ commitment to quality by providing more meaningful and consistent information on physician quality improvement and recognition on the Blue National Doctor & Hospital Finder site and on Anthem’s online provider directories. A BPR indicator is used to identify physicians, groups and/or practices who have demonstrated their commitment to delivering quality and patient-centered care by participating in local, national, and/or regional quality improvement programs as determined by the local Blue Plan.

Anthem recognizes primary care physicians practicing in the specialties of Family Practice, Internal Medicine and General Practice with a BPR designation if they have achieved recognition from either the National Committee for Quality Assurance (NCQA) or Bridges to Excellence (BTE) based on their successful completion of a care recognition program. Information regarding these recognition programs can be found at [http://www.ncqa.org](http://www.ncqa.org) or [http://www.hc3.org](http://www.hc3.org).

At a minimum, we will update these recognitions annually to reflect the current status as identified by the Blue Cross and Blue Shield Association’s Quality Recognition Extract.

If you have questions regarding the update, please contact your Provider Solutions contracting representative.

Important reminders about providing services to out-of-state BCBS Medicaid members

The February 2016 edition of the Network Update indicated that Anthem will begin mailing letters to providers when additional information is needed in order to process out-of-state Medicaid claims that are administered by a Blue Cross and Blue Shield (BCBS) health plan. Additional information may require the provider to enroll in the out-of-state member’s state Medicaid program, or provide missing Medicaid encounter data. Mailed letters will begin April 18, 2016.
The following frequently asked questions provide additional detail about Medicaid provider enrollment and the billing and reimbursement of claims for out-of-state BCBS Medicaid members:

**Why are providers required to enroll in some out-of-state Medicaid plans?**

At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Medicaid is a state-run program, and requirements vary for each state, and thus each BCBS Plan. Some states require providers to enroll in their state Medicaid program in order to be reimbursed for claims for the out-of-state Medicaid member.

If you are required to enroll in another state’s Medicaid program in order to be reimbursed, you should receive notification of this requirement when verifying eligibility and benefits for the member. Providers should enroll in the state’s Medicaid program before submitting a claim for an out-of-state BCBS Medicaid member to avoid delays in processing.

To view provider enrollment requirements for each state, visit [Medicaid.gov](http://medicaid.gov).

**Which states currently require provider enrollment?**

Currently, the following states require provider enrollment: Illinois, Indiana, Kentucky, New Mexico, Pennsylvania, South Carolina, Tennessee, Texas and Virginia. Please note this list is subject to change, so it is important to always confirm if provider enrollment is required when verifying eligibility and benefits for Medicaid members.

**What happens if a provider submits a claim for a Medicaid plan that requires provider enrollment, and the provider is not enrolled in the member’s state Medicaid program?**

If a provider submits a claim for an out-of-state BCBS Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. Beginning April 18, 2016, Anthem will send the provider a letter with information about how to enroll in the member’s state Medicaid program online. If the provider does not enroll in the member’s state Medicaid plan, the state law may require the member be held harmless.

**How can providers identify an out-of-state BCBS Medicaid member?**

Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. BCBS Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most BCBS ID cards, but will contain disclaimer language on the back of the ID card indicating benefit limitations. For example, a card may read, “This member has limited benefits outside of the members State”. Providers should always verify eligibility and benefits for these members.

**How should providers submit a claim for an out-of-state BCBS Medicaid member?**

Claims should be submitted to Anthem in the same way you would submit a claim for other BCBS members.

**What data elements should be included on the claim for a BCBS Medicaid member?**

Providers can check the Medicaid website of the state where the member resides for specific information on Medicaid billing requirements, however, the following data elements should be submitted, when applicable.
Medicaid claims submitted without these data elements will be denied:

- National Drug Code (situational)
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

Medicaid claims submitted without these data elements may be pended or denied until the required information is received:

- Billing Provider (Second) Address Line
- Billing Provider Middle Name or Initial
- (Billing) Provider Taxonomy Code
- (Rendering) Provider Taxonomy Code
- (Service) Laboratory or Facility Postal Zone or Zip Code
- (Ambulance) Transport Distance
- (Service) Laboratory Facility Name
- (Service) Laboratory or Facility State or Province Code
- Value Code Amount
- Value Code
- Condition Code
- Occurrence Codes and Date
- Occurrence Span Codes and Dates
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT))
- Service Facility Name and Location Information
- Ambulance Transport Information
- Patient Weight
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

How will providers be paid for services rendered to an out-of-state BCBS Medicaid member?

Providers receive payment on their Anthem remittance. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member’s home state, which may or may not be equal to what you are accustomed to receiving for the same service in your state. Billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (42 CFR 447.15).

You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member’s plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the member’s state Medicaid fee schedule for that service.

Which states have Medicaid programs administered by a Blue Cross and Blue Shield Plan?

Blue Cross and Blue Shield (BCBS) Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New Mexico, New York, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Virginia and Wisconsin as a Managed Care Organization (MCO).
DHS shares information on opioid abuse

Anthem would like to share some information from the U.S. Department of Health & Human Services that recently published an overview of the opioid abuse epidemic, including information on abuse prevention, treatment for addiction, and responding to an overdose. Additional information on this topic can be found in this recent White House memorandum.

Update to Claims Processing Edits and Professional Reimbursement Policies

We have updated our secure Provider Portal, ProviderAccess, with the following new and/or revised reimbursement policies. The updates below identify if the article pertains to professional or facility provider billing.

Bundled Services and Supplies – professional

We are updating Section 2 of our policy to reflect our current edit that denies CPT code 69209 (removal impacted cerumen using irrigation/lavage, unilateral) and 69210 (removal impacted cerumen requiring instrumentation, unilateral) when reported with evaluation and management services on the same date of service. We consider the removal of impacted cerumen to be included in the Evaluation and Management services when the appropriate level of E&M service is selected.

We are updating Section 2 of our policy to reflect our current edit that denies supply HCPCS codes A4206-A4209, A4212, A4213, A4215-A4217, A4221-A4223, A4244-A4248, A4550, A4649, A4657, and A4930 when reported with home infusion/specialty drug administration codes 99601 and/or 99602.

Drug Screen Testing – professional

We have reviewed and updated our policy effective April 1, 2016 to reflect coding changes for 2016. As previously identified in our Bundled Services and Supplies policy dated March 15, 2016, presumptive and definitive drug screen testing are now to be reported with HCPCS codes G0477-G0483 that were effective January 1, 2016. We consider CPT codes 80300-80304, 80320-80377, and 83992 for presumptive and definitive drug screen testing to be always bundled services that are not eligible for reimbursement.

Prolonged Services – professional

We have reviewed and updated our policy to add new CPT codes 99415 and 99416 (prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision...(list separately in addition to code for outpatient evaluation and management service)) as not eligible for reimbursement. These codes were effective January 1, 2016 and were identified in our Bundled Services and Supplies policy dated January 1, 2016 as always bundled services. We consider these services to be part of the overall care of the patient and not eligible for reimbursement.

Review of reimbursement policies – professional

The following policies have been reviewed and may include language revisions that do not change the policy position or criteria.

- Cancer Treatment Planning
- “Incident To” Services
- Modifier 22
- Urgent Care
Notice of reimbursement policy modifications due to these updates will continue to be published in the Anthem Network Update and on our secure provider portal, ProviderAccess.

Reimbursement Policies and Clear Claim Connection are available on our secure provider portal, ProviderAccess

Please review the full policy for any changes referenced above for further information. All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com, and select the Provider link in the top center of the page. Select Nevada from the drop down list, and enter. From the Provider Home page, go to the ProviderAccess Login tout (blue box on the left side of the page), and select Medical from the drop down list and click on the login button.

Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Professional Reim & Admin Policies”. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select Continue. Select link titled “Anthem’s Professional Reimbursement & Administrative Policies – By Type”, then select the Reimbursement link, and next the Policy you would like to view.

Clear Claim Connection™ is our web-based editing tool from McKesson and includes an interface that will allow you to view the clinical rationale for ClaimsXten edits when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Follow the directions listed above to log into ProviderAccess. Once logged in, from the Claims tab, select the Clear Claim Connection link.

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ClaimsXten® is a registered trademark of McKesson Information Solutions LLC

Medicare Advantage Updates

AIM to conduct medical necessity reviews for radiology, cardiology, sleep services

Anthem is collaborating with AIM Specialty Health® (AIM) to conduct medical necessity reviews for radiology services, cardiology services and sleep studies and sleep study related equipment and supplies for our individual Medicare Advantage members.

Effective April 25, 2016, AIM will accept prior authorization requests for dates of service May 1, 2016 and thereafter. To submit your request, go to the AIM ProviderPortals at www.aimspecialtyhealth.com/goweb. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 7 a.m. to 7 p.m. CT.

Detailed prior authorization requirements are available to the contracted provider by accessing the Provider Self-Service Tool withinAvaility. Contracted and non-contracted providers should contact Anthem if they are not able to access Availity.

9027COPENABS 03/07/2016

Additional radiation oncology prior authorizations should be directed to AIM effective July 1, 2016

Prior authorization of outpatient radiation therapy services for Anthem individual Medicare Advantage members is administered by AIM Specialty Health® (AIM).

AIM reviews certain treatment plans against clinical appropriateness criteria to help ensure that care aligns with established medical best practices. Effective July 1, 2016, providers should contact AIM to request prior authorization for the radiation therapy modalities and services listed below:
Network Update is produced monthly by Anthem Blue Cross and Blue Shield.

Editor: Jackie Ferguson, 700 Broadway, Denver, CO 80273, E-mail: Jackie.Ferguson@anthem.com.

The content of this update is for informational purposes only and should not be construed as treatment protocols or required practice guidelines, nor should anything herein be construed as legal advice. Readers are strongly advised to consult their own legal counsel as necessary. Diagnoses, treatment recommendations and the provision of health care services for Anthem Blue Cross and Blue Shield members are the responsibility of physicians and providers.

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- Fractions (number of treatments) for patients with breast cancer or bone metastases
- Image Guided Radiation Therapy (IGRT)
- Special consults and procedures associated with radiation therapy

Providers should continue to contact AIM to request prior authorization for the radiation therapy modalities and services listed below:

- Intensity Modulated Radiation Therapy (IMRT)
- 3D Conformal/ External Beam Radiation Therapy (EBRT)
- Brachytherapy
- Proton Beam Therapy
- Stereotactic body radiation therapy (SBRT) and Stereotactic radiosurgery (SRS)

Radiation therapy performed as part of an inpatient admission will continue to be reviewed through Anthem inpatient precertification process.

To submit your request, go to the AIM ProviderPortal at www.aimspecialtyhealth.com/goweb. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 7 a.m. to 7 p.m. Central Time.

Coverage of services will continue to be subject to all of the terms and conditions of the member’s health benefit plan and applicable law. For questions regarding these changes, please contact AIM at 800-714-0040.

For more information: Go to www.aimprovider.com/radoncology.

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AIM to review oncology and oncology supportive specialty drugs for medical necessity

Effective May 1, 2016 all oncology and oncology supportive specialty drugs that require prior authorization for Anthem individual Medicare Advantage members will be reviewed for medical necessity through AIM’s ProviderPortal -- www.providerportal.com -- or by contacting AIM at 1-800-554-0580.

Prior authorization requirements also can be reviewed online at Availity.com. Providers may be familiar with and participating in the Cancer Care Quality Program administered by AIM. Effective May 1, 2016, CCQP reviews and prior authorizations will be performed by the same review team. The Medicare Advantage Specialty Pharmacy will no longer review oncology and oncology supportive drugs for medical necessity for individual Medicare Advantage members effective May 1, 2016.

The Medicare Advantage specialty pharmacy team will continue to conduct oncology and oncology supportive drug prior authorization reviews for Medicare Advantage group-sponsored members. Anthem Medicare Advantage member ID cards contain a CMS identifier in the lower right corner of the card. The member is in a group-sponsored plan when the CMS identifier contains eight characters and the last three digits start with an eight (BXX).
Dual Eligible Special Needs Plans training required

In 2016, Anthem is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors’ appointments. Some D-SNP plans also may include a card or catalog for purchasing over-the-counter items.

D-SNPs are a kind of Medicare Advantage plan that are approved by Medicare and also contract with the state Medicaid agency. Providers who see Anthem Medicare Advantage members in Colorado are “in network” and available to see Anthem D-SNP members effective January 1, 2016, unless they have opted out of participating with the D-SNP plan.

Providers should understand that D-SNP members are protected from all balance billing. Anthem D-SNPs are “zero cost share” plans, meaning we only enroll dual-eligible beneficiaries (people eligible for both Medicare and Medicaid) who have Medicare cost sharing protection under their Medicaid benefits. The provider may not seek payments for cost sharing from dual-eligible members for health care services. Providers cannot bill D-SNP members for services not reimbursed by Medicaid or Anthem’s D-SNP plan, nor can providers balance bill for the difference between what has been paid and the billed charges.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans received notices in January that contained information for online training, either through scheduled WebEx sessions or through self-paced training on our provider portal. Every provider contracted for our D-SNP plans is required to complete an attestation stating that they have completed the annual training. These attestations are located at the end of the self-paced training document and can be completed by individual providers or at the group level with one signature along with a roster of providers that participate within the group.

To take the self-paced training and read related FAQs, please go to the Provider Training and FAQs link at www.anthem.com/medicareprovider.

Quality programs support patient safety, health improvement

Anthem has a number of programs in place to help measure and improve the health of our Medicare Advantage members. Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for additional information.

Keep up with Medicare news

Medicare Supplement providers – Medicare Supplement Individual members will receive new member ID cards for use with medical services beginning June 1, 2016. Please obtain a copy of the new member ID cards to file for dates of service June 1, 2016 and beyond. Additional information is available in the spotlight section of the provider home page.

Please continue to check Important Medicare Advantage Updates at www.anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Medicare Advantage reimbursement policies
- Medicare Physician Fee Schedule Update
- Federally Qualified Health Center Billing Guidelines in Effect for Original Medicare
- Medicare Notices and Provider Requirements
Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance marketplace / affordable care act information may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance marketplace / affordable care act, and all achieved articles, you can access them all online. Go to anthem.com, select the Provider link in the top center of the page. Select Nevada from the drop down list, and click Enter. From the Provider Home page, select the link titled Health Care Reform Updates and Notifications or Health Insurance Marketplace / Affordable Care Act information.