# Network Update

## October 2015

**Network Update**

A bi-monthly update for the health care professional community from Anthem Blue Cross and Blue Shield and its affiliate Healthkeepers, Inc. Unless otherwise noted, the information in this newsletter pertains to all the aforementioned entities.

### Provider Communications

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Richmond, VA 23230

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Announcements – ICD-10 update

Anthem implements ICD-10

The U.S. Department of Health and Human Services (HHS) mandated October 1, 2015, as the compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10.

Effective October 1, 2015, Anthem Blue Cross and Blue Shield in Virginia (Anthem) began accepting and processing ICD-10 diagnosis and inpatient procedure codes for claims with dates of service/discharge on or after the compliance date of October 1, 2015. Our systems, supporting business processes, policies and procedures are now compliant with ICD-10.

Anthem's ICD-10 Updates webpage contains reference materials and other information for your use:

- Coding guidelines for pre-authorization and claims submission reference chart
- Claims billing by service type reference chart that includes information on billing claims with span dates
- Link to electronic data interchange (EDI) edits for ICD-10
- Guidance on paper claims containing ICD-10 codes
- Our response to the Centers for Medicare & Medicaid Services (CMS)/American Medical Association (AMA) announcement on ICD-10 in July 2015
- FAQs with Anthem-specific information
- Our coverage guidelines and clinical utilization management (UM) guidelines have been updated to include ICD-10 coding.

Please note once ICD-10 goes live on October 1, 2015, and providers are ready, these preparation tools and resources will no longer be available on our webpage:

- TIBCO Validator claims file acceptance testing
- Coding Practice Tool for Professional Providers
- e-Cast on Preparing for ICD-10: A Provider’s Perspective
- Dedicated email box for ICD-10 inquiries and surveys

Effective October 1, 2015, all questions and claims inquiries regarding ICD-10 should be handled as any other questions and claims inquiries are handled today. Contact the PROVIDER SERVICES UNITS first. The Provider Services representatives can address questions on ICD-10 and resolve ICD-10 claims issues.
ICD-10: Guidance on interim claims for institutional/facility providers

Here is guidance for handling interim claims for inpatient stays that span the ICD-10 compliance date of October 1, 2015. Interim claims are a set of continuous claims filed at interim periods of time for prolonged inpatient stays.

Anthem will not accept claims for inpatient stays with both ICD-9 and ICD-10 codes, or mixed code claims.

When previous claims for services on or before September 30, 2015, are filed with ICD-9 codes prior to discharge, the next continuing claim will require ICD-10 codes because the service THROUGH date is on or after the ICD-10 compliance date of October 1, 2015. To that end, the entire inpatient stay must be coded in ICD-10.

To manage the payment of these claims, if the interim period begins on or before September 30 and continues on or after October 1, 2015, Anthem will require a single replacement claim coded in ICD-10 for the entire inpatient stay, from admission to discharge, including services previously filed on interim claims.

Here are two examples of how to bill the interim claims:

**Example 1: Admission Date August 24 – Discharge Date November 5**

<table>
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<tr>
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<th>Bill type 112</th>
<th>Date of service: From 8/24 through 9/24</th>
<th>Interim claim filed with ICD-9 codes and processed</th>
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<tr>
<td>Second Claim</td>
<td>Bill type 113</td>
<td>Date of service: From 9/25 through 10/24</td>
<td>Hold this claim until discharge</td>
</tr>
<tr>
<td>Third Claim (final claim)</td>
<td>Bill type 117</td>
<td>Date of service: From 8/24 through 11/5 (Entire inpatient stay)</td>
<td>File final claim coded with ICD-10 codes for the entire inpatient stay from admission to discharge, including services filed on the first claim</td>
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**Example 2: Admission Date August 29 – Discharge Date October 8**

<table>
<thead>
<tr>
<th>First Claim</th>
<th>Bill type 112</th>
<th>Date of service: From 8/29 through 9/28</th>
<th>Interim claim filed with ICD-9 codes and processed</th>
</tr>
</thead>
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<tr>
<td>Second Claim (final claim)</td>
<td>Bill type 117</td>
<td>Date of service: From 8/29 through 10/8 (Entire inpatient stay)</td>
<td>File final claim coded with ICD-10 codes for the entire inpatient stay from admission to discharge, including services filed on the first claim</td>
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AIM alerts

(Information regarding Anthem’s implementation of AIM Specialty Health® initiatives)

Anthem continues efforts to implement AIM initiatives in Virginia

Transitioning management of outpatient advanced diagnostic imaging services and sleep disorder services

Over the last several months, Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. have been working to transition the management of outpatient advanced diagnostic imaging services and sleep disorder services to AIM Specialty Health® (AIM) – a leading specialty benefits management company with more than 20 years of experience and a growing presence in the management of radiology, cardiology, oncology, sleep medicine, and specialty drugs.

See our May 2015 SPECIAL EDITION Network Update for details on the implementation in Virginia.

Anthem’s Cancer Care Quality Program gets under way in Virginia

In addition, we notified oncologists and hematologists regarding the implementation of our Cancer Care Quality Program that launched on September 1, 2015. This innovative quality initiative is an evidence-based cancer treatment program that enables these physicians to compare planned cancer treatment regimens against evidence-based clinical criteria. AIM is administering the program on behalf of Anthem in Virginia, and you can find further details about the cancer care initiative in our June 2015 Network Update and August 2015 Network Update.

Precertification requirement for certain outpatient radiation therapy services

Also effective September 1, Anthem and HealthKeepers, Inc. now require precertification of certain non-emergency, outpatient radiation therapy services through AIM Specialty Health. For treatment plans that are scheduled to begin on or after September 1, 2015, all providers must contact AIM for precertification for the following non-emergency, outpatient radiation therapy modalities:

- Intensity Modulated Radiation Therapy (IMRT)
- Proton Beam Radiation Therapy
- Stereotactic Radiosurgery (SRS) Stereotactic Body Radiotherapy (SBRT)
- Brachytherapy
If you are interested in reviewing the full details about this change, please see our June 2015 Network Update and August 2015 Network Update.

AIM highlights addressed in October 2015 Network Update

In this edition of the Network Update, we are including updates regarding our progress with rolling out these new initiatives in Virginia. As with any new process, there have been challenges. Please see the following three articles in this section of the newsletter that address ways we're working to help ease the transition to AIM.

AIM online registration via OptiNet® is required for professional and facility providers

In May 2015, we began collecting information about the imaging capabilities of all Anthem in Virginia contracted providers who provide the technical component of imaging services (Computed Tomography CT/CTA, Magnetic Resonance Imaging MRI/MRA, Nuclear Cardiology, and Positron Emission Tomography PET). The data you provide will become an important part of the information available to ordering physicians and members.

AIM’s online registration tool, OptiNet®, and provider registration is available online at www.aimspecialtyhealth.com/goweb. Simply select “Anthem BCBS VA” from the drop down menu. Only those providers who have completed the provider registration will be able to view their information online. Site information became available for review online starting March 15, 2015. All facilities need to complete their registration to have their site included in the online directory. If you have questions or need help completing the registration, please call AIM Customer Service toll free at 1-800-252-2021. In addition for more details about OptiNet registration, please see our May 2015 SPECIAL EDITION Network Update.

IMPORTANT UPDATE: Provider searches on the AIM Specialty Health® online portal

Anthem’s implementation to AIM Specialty Health’s for management of outpatient advanced diagnostic imaging services, sleep testing, and oncology services has created some challenges with the new business processes. There are issues with properly identifying the participation status of servicing providers for the AIM call center and also for our Anthem providers when using the AIM portal. We have been working with AIM to determine the best way to prevent participating provider groups from being identified as non-participating. Group names are typically not used for claims processing, so they are not being loaded into the AIM system. When AIM or an ordering provider tries to search for a group name, it will not be found.

If the actual servicing provider is known, we suggest that you search for that provider. If unknown, search for any individual provider within the servicing group. Any participating provider who is appropriate for the service being requested in the group will do.
Ordering providers can expedite the AIM authorization process by identifying an individual provider within the servicing practice who can be used for the authorization in advance of requesting the authorization. To get this information, the ordering provider can call the imaging location and ask for a list of participating providers; look up the imaging center online and identify individual providers; or call an Anthem network manager for assistance.

When providers try to use the AIM portal and cannot find the group they are looking for, providers should search for a specific provider at that location. Providers can then use that name/record to create the authorization. When searching for providers who are located in Virginia, it is best not to use the expanded search option.

AIM most frequently asked questions – Revisited

Here are some additional questions we’ve received from providers over the last several months regarding our AIM initiatives.

Does AIM handle retrospective reviews?

Retrospective reviews (service already rendered without precertification) more than two business days will not be accepted. Retrospective reviews greater than two business days will be reviewed by Anthem or HealthKeepers, Inc. after you submit your claim. All contract provisions for authorization requirements will apply for Anthem HealthKeepers members.

How do I handle radiology precertification in emergency room and observation settings?

Services performed in a true emergency room setting do not require a precertification review (pre-authorization). Services for Virginia members performed in observation will require review. In some cases, AIM does not perform review on services performed in observation for other health plans. To ensure your review is completed in an observation setting, you will need to indicate that the service is being performed in the outpatient setting of the hospital and not refer to it as “observation.”

Can I have a peer-to-peer review for a denial?

Yes, you can request a peer-to-peer review for a service that may be denied with an AIM physician. The time frame in which to request that peer-to-peer review is within two business days. AIM will only leave the authorization request open for two business days. Once it is closed, the decision cannot be changed, and you will need to request the next level of review such as a reconsideration or appeal with Anthem or HealthKeepers, Inc.

Where to find other FAQs regarding AIM initiatives

To review other AIM FAQs, the May 2015 SPECIAL EDITION Network Update includes frequently asked questions about the new AIM rollout. Visit the Virginia provider section of anthem.com for our provider newsletters. If you prefer, please contact your network manager if you have questions about the new AIM process.
Changes to AIM Specialty Health’s Sleep Disorder Management Diagnostic and Treatment Guidelines

An important component of AIM Specialty Health’s (AIM) Sleep Disorder Management program focuses on the management of Obstructive Sleep Apnea (OSA) through the use of custom made oral appliances. These appliances include mandibular repositioning appliances that are billed using HCPCS E0486.*

Effective January 1, 2016, AIM will be revising this guideline to ensure that oral appliances used in the treatment of OSA meet the criteria established by the Centers for Medicare & Medicaid Services (CMS) for mandibular repositioning appliances. The CMS specifies that to be coded as E0486, custom fabricated mandibular advancement devices must:

- Have a fixed mechanical hinge at the sides, front or palate, and,
- Have a mechanism that allows the mandible to be advanced in increments of one millimeter or less, and,
- Be able to protrude the mandible beyond the front teeth at maximum protrusion, and,
- Be adjustable by the beneficiary in increments of one millimeter or less, and,
- Retain the adjustment setting when removed, and
- Maintain mouth position during SLEEP so as to prevent dislodging the device.

To this addition to the preamble section of the guideline, a question will be added to the pre-authorization request. The question will read:

**Does the mandibular repositioning device requested comply with CMS criteria?**

Cases in which the provider responds “No” or “I don’t know” will be routed for review.

*Prefabricated oral appliances (HCPCS code E0485) are not considered appropriate therapy for OSA in any clinical situation.*
Coverage and clinical guideline update

Specialty pharmacy site-of-service reviews – Effective November 1, 2015

In our August 2015 edition of the Network Update, Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. announced that the setting for specialty pharmacy infusions will be reviewed for appropriate clinical setting effective November 1, 2015. In this October edition, we are sharing additional details regarding this upcoming change.

Anthem and HealthKeepers, Inc. recognize that most patients prefer to receive their infusions in their physician’s office, infusion center or at home through home infusion therapy. This is more convenient for the member, results in lower member financial responsibility and, in many cases, is a clinically appropriate setting. For our members who require infusion therapy services, out-of-pocket expenses, the place of infusion service, safety, time and convenience are contributing factors that can impact health care quality, value and member satisfaction.

However, there may be other circumstances where a patient’s medical situation requires that he or she receive infusions in a hospital facility. Therefore, beginning November 1, the setting for specialty pharmacy infusions will be reviewed for appropriate clinical setting. Anthem and HealthKeepers, Inc. will review the drug appropriateness for clinical indications and the site of service using a new clinical guideline CG-DRUG-47. During the review process, the nurse reviewer will provide other options if a setting is considered not medically necessary. More information follows below about CG-DRUG-47.

Our members count on their physicians to provide comprehensive information so the members can make informed decisions about their health care choices. Members may have questions about alternate settings in which they can receive their intravenous infusions and costs associated with other aspects of their intravenous infusion therapy. We encourage you to discuss with our members the options available to get their intravenous infusions safely and conveniently, at a lower, out-of-pocket cost.

Level of Care: Specialty Pharmaceuticals (CG-DRUG-47)

This new clinical UM guideline provides clinical criteria for use of outpatient infusion therapy service in the hospital outpatient department or hospital outpatient clinical level of care for intravenous (IV) infusion therapy.

An outpatient infusion therapy service in the hospital outpatient department or hospital outpatient clinic level of care for the use of an infused pharmacologic or biologic agent is considered medically necessary when all of the following are present:

1. The inherent complexity or risk of the infusion required by an individual is such that it can be performed safely and effectively only by or under the general supervision of skilled nursing personnel; AND

2. The individual’s medical status or therapy is such that it requires enhanced monitoring beyond that which would routinely be needed for infusion therapy; AND

3. The potential changes in the individual’s clinical condition are such that immediate access to specific services of a medical center/hospital setting, having emergency resuscitation equipment and personnel, and inpatient admission
or intensive care is necessary, for example, the individual is at significant risk of sudden life-threatening changes in medical status based on clinical conditions including but not limited to:

a. Concerns regarding fluid overload status, or
b. History of anaphylaxis to prior infusion therapy with a related pharmacologic or biologic agent, or
c. Acute mental status changes.

All other uses of outpatient infusion therapy services in the hospital outpatient department or hospital outpatient clinic level of care for the infusion of pharmacologic and biologic agents are considered not medically necessary.

The services addressed in this coverage guideline will require authorization for all of our products offered by HealthKeepers, Inc. with the exception of Anthem HealthKeepers Plus (Medicaid). Other exceptions are Medicare Advantage, the Medicare-Medicaid Plan (Dual Integration product) and the Blue Cross Blue Shield Service Benefit Plan (also known as the Federal Employee Program or FEP) which will not be reviewed at this time with this guideline. A pre-determination can be requested for our Anthem PPO products.

**Important information about coverage for Digital Breast Tomosynthesis (DBT) or 3-D mammography**

In 2015, the U.S. Preventive Services Task Force (USPSTF) reviewed screening recommendations for breast cancer and concluded in a *draft recommendation statement* that Digital Breast Tomosynthesis (DBT) or three-dimensional (3-D) mammography does not meet evidence level A or B and should not be recommended in place of digital mammography for routine breast cancer screening. The draft statement also notes that DBT may expose women to approximately twice the radiation of two-dimensional (2-D) digital mammography.

Based on the USPSTF’s conclusion and Anthem Blue Cross and Blue Shield’s independent review of the available evidence, Anthem considers Digital Breast Tomosynthesis investigational and not medically necessary for all indications.

Please note that two imaging vendors currently have the U.S. Food and Drug Administration’s approval for DBT, and the vendors actively promote their services to academic centers and private hospitals or imaging centers. As marketing and adoption of DBT increases, we expect an increase in interest and use of this service, which is why it is important for providers to be aware that DBT is a non-covered service.

Anthem has extensively reviewed the available evidence addressing the use of Digital Breast Tomosynthesis and presented this data to the Medical Policy and Technology Assessment Committee (MPTAC) for discussion and evaluation. (MPTAC is a multiple disciplinary group including community physicians from various medical specialties, clinical practice environments and geographic areas as well as Anthem medical directors and other associates.) The MPTAC agrees with the USPSTF’s concerns and recommendations.

To read more about the USPSTF’s conclusion, please see the [USPSTF Breast Cancer Screening Draft Recommendation Statement](#). Providers can also review [Anthem’s coverage guideline for Digital Breast Tomosynthesis](#).
SPECIAL NOTE

The services addressed in ALL the coverage guidelines presented in this section (pages 11 through 13) will require authorization for all of our products offered by HealthKeepers, Inc. with the exception of Anthem HealthKeepers Plus (Medicaid). Other exceptions are Medicare Advantage and the Medicare-Medicaid Plan (Dual Integration product).

A pre-determination can be requested for our Anthem PPO products.

Coverage guidelines effective January 1, 2016

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage and clinical UM guidelines effective January 1, 2016. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage and the Medicare-Medicaid Plan (Dual Integration product).

Furthermore, the guidelines were among those recently approved at the quarterly Medical Policy and Technology Assessment Committee meeting held on August 6, 2015.

Guidelines addressed here are:

- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies (GENE.00021)
- Genetic Testing of an Individual’s Genome for Inherited Diseases (GENE.00043)
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation) (MED.00064)
- Panniculectomy and Abdominoplasty (SURG.00048)
- Doppler-Guided Transanal Hemorrhoidal Dearterialization (SURG.00141)
- Adaptive Behavioral Treatment for Autism Spectrum Disorder (CG-BEH-02)
- Gender Reassignment Surgery (CG-SURG-27)
- Cranial Remodeling Bands and Helmets (Cranial Orthotics) (CG-OR-PR-04)

Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies (GENE.00021)

This revised coverage guideline addresses chromosomal microarray analysis (CMA) as a diagnostic tool for congenital anomalies as well as for individuals with unexplained developmental delay (DD), autism spectrum disease (ASD) or intellectual disability (intellectual developmental delay).

CPT and HCPCS codes currently associated with this revised coverage guideline are 81228, 81229 and S3870. Effective January 1, 2016, CPT code 81405 will be subject to review based on the position statements in the coverage guideline.
Genetic Testing of an Individual’s Genome for Inherited Diseases (GENE.00043)

This coverage guideline was revised to consider the use of the Corus coronary artery disease (CAD) test to identify individuals who are unlikely to have obstructive CAD and who may avoid invasive diagnostic testing to be investigational.

Currently there is not a specific CPT or HCPCS code for the Corus CAD test. Codes 81479, unlisted molecular pathology procedure and 81599, unlisted multianalyte assay with algorithmic analysis are listed to represent this service.

Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation) (MED.00064)

This coverage guideline was revised to consider transcatheter radiofrequency ablation or cryoablation of arrhythmogenic foci in the pulmonary veins investigational for the treatment of atrial flutter.

The CPT codes associated with this revised coverage guideline are 93656 and 93657.

Panniculectomy and Abdominoplasty (SURG.00048)

This revised coverage guideline addresses the surgical procedures panniculectomy and abdominoplasty and when they are considered medically necessary, not medically necessary and cosmetic for those members that have a contractual benefit.

Abdominoplasty when done to remove excess skin or fat with or without tightening of the underlying muscles is considered cosmetic.

The CPT codes associated with this revised coverage guideline are 00802, 15830, 15847, 15877, 17999.

Doppler-Guided Transanal Hemorrhoidal Dearterialization (SURG.00141)

This new coverage guideline addresses transanal hemorrhoidal dearterialization (THD), a minimally invasive procedure utilizing Doppler guidance to interrupt the blood supply by ligation of the hemorrhoidal arteries in the lower rectum.

Transanal hemorrhoidal dearterialization is considered investigational.

The CPT code associated with this new coverage guideline is 0249T.

Adaptive Behavioral Treatment for Autism Spectrum Disorder (CG-BEH-02)

This revised clinical UM guideline addresses the use of Adaptive Behavioral Treatment (ABT), including but not limited to Applied Behavioral Analysis (ABA) or similar services that utilize intensive behavioral intervention when included in relevant state mandates, as treatment for Autism Spectrum Disorder (ASD) when a state mandate requires or benefit plan language explicitly provides coverage for ABT.
The CPT and HCPCS codes associated with this revised clinical UM guideline are 0359T, 0360T, 0361T, 0362T, 0363T, 0364T, 0365T, 0366T, 0367T, 0368T, 0369T, 0370T, 0371T, 0372T, 0373T, 034T, H0031, H032, H0046, H2012, H2014, H2019

**Gender Reassignment Surgery (CG-SURG-27)**

The medical necessity criteria was revised in this clinical UM guideline to require hormonal therapy unless there is a medical contraindication. Referral letters from two qualified mental health professionals must have been signed within 12 months of the request submission as well.

The CPT codes associated with this revised clinical UM guideline are 55970, 55980, 19325, 54125, 54520, 54660, 54690, 55180, 56625, 56800, 56805, 57110, 57291, 57295, 57296, 57426, 58150, 58552, 58554, 58571, and 58573

**Cranial Remodeling Bands and Helmets (Cranial Orthotics) (CG-OR-PR-04)**

This clinical UM guideline addresses the use of the adjustable band or helmet cranial orthosis as a treatment of craniosynostosis, non-synostotic plagiocephaly (asymmetrically shaped posterior head), scaphocephaly (abnormally shaped narrow head), and brachycephaly (abnormally shaped head; shortened in antero-posterior dimension without asymmetry) in infants.

The initial use of a cranial orthosis is considered medically necessary as an adjunct to surgical therapy for synostotic skull deformity or to treat non-synostotic skull deformity when medical necessity criteria are met.

A second application of a cranial orthosis is considered medically necessary for infants between 6 and 18 months of age when medical necessity criteria are met.

Initial application of a cranial orthosis for infants over the age of 12 months is considered not medically necessary. The continued use of a cranial orthosis after 18 months of age is also considered not medically necessary.

The use of a cranial orthosis is considered cosmetic for non-surgical treatment of synostotic skull deformities.

HCPCS codes associated with this clinical UM guideline are L0112, and S1040. Effective January 1, 2016, L0112 and S1040 will be subject to review based on the position statements in the clinical UM guideline.

All of these coverage and clinical UM guidelines are available for review on our website at [www.anthem.com](http://www.anthem.com) after October 6, 2015.
Business update

Telemedicine guidelines and filing claims to Anthem

Opportunities are on the rise for providers and patients to utilize telemedicine – the remote delivery of health care services and clinical information using telecommunications technology. Many of our providers have reached out to Anthem and our affiliate HealthKeepers, Inc. with questions about how best to incorporate telemedicine within their practices and whether services delivered by telemedicine are covered.

Telemedicine has been a covered service for our PPO and Anthem HealthKeepers plans since January 1, 2011. This includes health plans our members may have purchased on or off the Health Insurance Marketplace or commonly called “the exchange.” [There are some lines of our business that are excluded from telemedicine. These are Anthem HealthKeepers Plus (Medicaid/FAMIS), Medicare Advantage, the Medicare-Medicaid Plan (MMP), and the Blue Cross Blue Shield Service Benefit Plan commonly referred to as the Federal Employee Program or FEP.]

The Virginia Board of Medicine recently issued a guidance document regarding telemedicine available at this link: https://www.dhp.virginia.gov/medicine/guidelines/85-12_Telemedicine.doc

Telemedicine services

Telemedicine services include the use of interactive audio, video or other electronic media to provide diagnosis, consultation or treatment. The process is a real-time, two-way transfer of medical data and information. Equipment utilized for telemedicine must have a high enough level of audio quality and visual clarity to be the same as what members would experience in a face-to-face office visit with a health care provider.

Who can provide telemedicine services?

Currently, the following qualify as “originating” sites to provide telemedicine services if the locations possess the technology to provide these services:

- Office and physician office
- Office of practitioner, including physician assistant, nurse practitioner, clinical nurse specialist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian, or nutrition professional
- Rural health clinic
- Federal qualified health center
- Hospital (including critical access, general acute care and acute psychiatric hospitals)
- Hospital-based or critical access hospital-based renal dialysis center including satellites (independent renal dialysis facilities are not eligible originating sites)
Skilled nursing facility
Community mental health center

Examples of covered telemedicine services include:

- Telehealth Consultation (inpatient or outpatient)
- Telehealth Office Visit
- Telehealth Visit (inpatient or outpatient)

**Items not considered telemedicine services**

It’s important to note that telemedicine services do not include an audio-only phone call, home video conference sessions initiated through unsecured technology such as Skype, or electronic mail message (e-mail) or fax transmission – all of which will continue to be a non-covered service.

**Impact to members’ benefits/specialty care reviews**

Members’ payments for the services will be the same as if they had seen a specialist in person. As with any covered service, the members’ actual costs will be based on their specific plan benefits when receiving telemedicine services. A physician can advise whether telemedicine services are appropriate based on the members’ circumstances. In addition, physicians can help members find a location from which to receive the services remotely.

Please note that telemedicine services are considered as any other “visit.” As such, a specialty care review (referral) is required from the member’s primary care physician (PCP) for the specialist visit under most of our Anthem HealthKeepers plans. If the specialist calls in an additional provider for a consultation through telemedicine services, the regular procedures for obtaining a specialty care review (office) or precertification (facility) apply. Services that currently require precertification/prior approval will continue to do so (such as Advanced Diagnostic Imaging services) under our health plans.

In summary, providers seeking to provide and bill for telemedicine services should:

- Ensure that technical standards will provide a secure connection with your patient
- Bill the appropriate level evaluation and management (E/M) code
- Collect a cost share from the patient, if applicable
- Reflect the telemedicine visit in the patient’s medical record
- Bill with a “GT” modifier to indicate a telemedicine service
Introducing Anthem Togetherworks

At Anthem Blue Cross and Blue Shield, we look for ways to get results and achieve goals together. Every day, we bring our tools, information and expertise to the table in ways that benefit our members and providers. With this effort, we introduce Anthem Togetherworks – a new name for our provider collaboration strategy. Anthem Togetherworks refers to a broad spectrum of partnership options already in place at Anthem and includes programs like Enhanced Personal Health Care (EPHC) and the Quality-In-Sights®: Hospital Incentive Program (Q-HIP®). Anthem Togetherworks also includes tools we offer, such as our Web-based Provider Care Management Solutions and Care Delivery Transformation support. Through Anthem Togetherworks, we’ll continue to offer a wide range of provider collaboration programs and offerings based on your needs to help us work together to meet the challenges of a new era in health care.

HEDIS® 2016: Colorectal cancer screening

One of the HEDIS measures we are collecting for 2016 is colorectal cancer screening. This measure is collected to ensure that our members between the ages of 50 and 75 have been screened appropriately for colorectal cancer. The following items are needed from the member’s medical record:

1. **Documentation must indicate the date that the member had one of the following screenings:**
   - **Colonoscopy** – Completed within the last 10 years (January 1, 2006, through December 31, 2015).
   - **Flexible Sigmoidoscopy** – Completed within the last 5 years (January 1, 2011, through December 31, 2015).
   - **Fecal Occult Blood Test (FOBT)** – **ALL** tests that were completed in 2015. There are two types of FOBT tests: guaiac (gFOBT stool card with 3 samples) and immunochromatographic (iFOBT- sometimes referred to as FIT-1 sample). Depending on the type of FOBT test, a certain number of samples are required, so please send all tests.

   A result is **NOT** required if the documentation is clearly part of the “Medical History” section of the record. If this is not clear, the result or finding must also be present to ensure that the screening was performed and not merely ordered. Hemoccult tests taken during a routine rectal exam do not count towards this screening measure.

2. **Documentation of a history of one of the following at any time through December 31, 2015:**
   - Colorectal cancer
   - Total colectomy

We have found that evidence of colorectal cancer screening is not always found in the same part of every medical record. We encourage your staff to check the History and Physical, Consultation Reports, Procedure List, Progress
Notes and Lab Sections of the chart for the required documentation before indicating that a screening was not completed. Please submit any documentation that is found to serve as evidence of screening.

Our goal is to make the record retrieval process as easy as possible for your office. We also want you to know that we are available to answer any questions you have about HEDIS or any of the measures.

We look forward to working with you during the 2016 HEDIS season, and thank you in advance for your continued cooperation and support of HEDIS.

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

Help us keep your information up-to-date

At Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc., we are working to ensure you receive prompt payments for the claims you submit to us. We work hard to avoid any unnecessary delays and returned claims. You can help in this effort by ensuring that you notify Anthem of any changes in your status or address information so that our internal records for you are accurate and up-to-date. As indicated in network agreements with us, providers are required to notify Anthem with 30 days prior written notice of:

- A change in providers who are part of the group, if applicable. Any new providers must meet Anthem’s credentialing standards prior to being designated as a network/participating provider; or
- Any new physical location, tax identification number, mailing address or similar demographic information

When notifying us of any address changes, please ensure to include any suite numbers, where appropriate along with your financial address and physical street/mailing address. If you've given us a suite number along with the National Provider Identifier (NPI) number you registered with us, you will need to bill the suite number on the claim to ensure accurate claims payments. A financial address is needed to ensure that all checks and explanations of payments are mailed to the correct address where you receive payments.

A physical street address is necessary so we can publish adequate information in our online provider directory that includes mapping capabilities. Without correct physical street addresses, we cannot give adequate information to our members about providers' office locations.

With the year drawing to a close soon, please take a few moments to ensure we have your current address information and update any changes, including your financial and physical street address. If your mailing address is different from your physical street address, please let us know the correct mailing address as well. Please contact your Anthem network manager with any demographic changes. A contact list is available on the Virginia provider section of anthem.com or just select this [Provider Representatives](https://www.anthem.com) link.
Misrouted protected health information (PHI)

As a reminder, providers and facilities are required to review all member information received from Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. to help ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or e-mail. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Anthem’s provider services area to report receipt of misrouted PHI.

Clinical practice and preventive health guidelines available on the Web

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 to providers 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 the “Provider” home page at www.anthem.com. From there, select “Provider” and Virginia> then Health & Wellness> Practice Guidelines.

Or, for Anthem HealthKeepers Plus (Medicaid/FAMIS), select the following link:

http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/va/f2/s2/t0/pw_a035223.htm&state=va&rootLevel=1&label=Practice%20Guidelines
Behavioral health update

Behavioral health outpatient coding

In 2013, updated behavioral health outpatient current procedural terminology (CPT) codes and new coding guidelines were issued. The new guidelines included:

- CPT code 90834   45 to 53 minutes face-to-face with the patient
- CPT code 90837   53 to 60 minutes with the patient

Prior to 2013, the psychotherapy “hour” was billed using a code for 45 to 50 minutes of time with the patient. With the release of the new CPT codes, Anthem’s records indicate that more than half of the billing for this type of psychotherapy is now being filed with CPT code 90837, indicating 53 to 60 minutes spent face-to-face with the patient at each session.

As a reminder, please adhere to the specific guidelines as outlined in the American Medical Association’s CPT codebook for commonly billed codes:

If you use an evaluation and management (E/M) code:

- The type and level of an E/M service is selected based on key components of history, examination and medical decision-making. Therefore, time may not be used as the basis of E/M code selection.
- Time associated with activities used to meet criteria for the E/M service is not included in the time used for reporting the psychotherapy add-on service.

If you use a psychotherapy code which is defined by time:

- Documentation should include the time spent face-to-face with the patient and give specific details to what was done in the session.
- The American Psychological Association 2013 guidelines state:

  “When billing a private insurer that does not require authorization for 90837 and has not indicated that this code should be used infrequently, you should bill this code if your session time falls into the 53-minute or more time frame that pertains to 90837. We recommend, however, that you record your exact session start and stop times in your clinical note (for example, 1:02 to 1:57) when billing the new codes, as Medicare providers must do. At any point, a company can ask you for appropriate documentation or explanations. Also be mindful that if you have historically billed a company primarily the 45 to 50-minute code and switch to primarily using the new 60-minute code, that company may ask you to explain this change.”

As always, Anthem retains the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to help ensure coding guidelines have been followed. Please refer to the AMA’s CPT codebook for further code definitions and details.
Central nervous system (CNS) assessments

An education and audit program for central nervous system (CNS) assessments begins later this fall. The purpose of this program will ensure proper documentation for the services billed.

Central nervous system (CNS) assessments and/or tests involve the testing of cognitive processes, visual motor responses and abstractive abilities and are accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate useful information for treating and caring for the patient. This includes psychological and aphasia assessments; neuropsychological and developmental testing; and a neurobehavioral status exam.

Neuropsychological testing uses standard techniques to objectively evaluate behavioral and cognitive abilities of patients by comparing the patient's results to established normal results. Neuropsychological testing generally involves the use of paper/pencil and mechanical procedures and carries little, if any, risk to the patient. A complete neuropsychological evaluation includes:

a. Review of information from the referral
b. Face-to-face evaluation with the patient and/or the family, at which time some screening tests may be done
c. Administration of various neuropsychological tests tailored to the patient's condition
d. Test scoring and interpretation, which is reviewed with the referring clinician and/or the patient, for example Halstead-Reitan, LURIA, and WAIS-R testing

Anthem requires that the medical record documentation for CNS assessments/tests be legible, signed, dated, and contain, at a minimum, the following elements:

a. Relevant medical and personal history
b. Results of initial evaluation determining the need for testing
c. Suspected mental illness and/or neuropsychological abnormality/dysfunction
d. Types of testing indicated
e. Previous testing (if conducted) by same or different provider and efforts to obtain those results
f. Tests administered, scoring, and interpretation
g. Time involved for each test performed;
   - When the testing is done over several days, the testing time should be reported all on the last date of service
h. Treatment report and recommendations
The time spent in interpreting and preparing the report and any explanation of the report to the patient and family are to be billed with the applicable code used to perform the test.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96101</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96102</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face</td>
</tr>
<tr>
<td>96103</td>
<td>Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), administered by a computer, with qualified health care professional interpretation and report</td>
</tr>
<tr>
<td>96105</td>
<td>Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report</td>
</tr>
<tr>
<td>96111</td>
<td>Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report</td>
</tr>
<tr>
<td>96116 (See also our frequency editing policy)</td>
<td>Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report</td>
</tr>
<tr>
<td>96118</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96119</td>
<td>Neuropsychological testing (e.g., Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
<tr>
<td>96120</td>
<td>Neuropsychological testing (e.g., Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report</td>
</tr>
<tr>
<td>96125</td>
<td>Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report</td>
</tr>
</tbody>
</table>
As always, Anthem appreciates the care provided to our members. And as a reminder, Anthem retains the right, based on a provider’s agreement, to conduct reviews and audits of services rendered to our members to ensure coding guidelines have been followed. Please refer to the American Medical Association’s CPT codebook and Anthem documentation policies to ensure your practice is in compliance with these documentation requirements.

**Health care reform (including health insurance exchange)**

Refer to anthem.com for information about health care reform and the exchange

We continue to post information on our dedicated Web pages regarding health care reform and the health plans HealthKeepers, Inc. is offering on and off the exchange. Click either of these Web pages Health Care Reform or Health Insurance Exchange for more information, and refer back to these pages often.

**eBusiness**

Invalid use of authorization notes in Point of Care; use Availity’s secure messaging feature

With Anthem’s transition to the Web-based provider tool Availity, the use of the authorization notes feature in Point of Care to request an adjustment via an electronic 151 form is no longer allowed and considered invalid. If you need to follow up on a claim that Anthem has denied for precertification or we’ve requested additional information in order to complete the precertification process, use the secure provider messaging feature on the Availity Web Portal to request a claim adjustment.

Please do NOT use authorization notes within Point of Care to request a claim adjustment. Those requests using Point of Care will no longer be forwarded to our internal claims area.

With secure provider messaging, you can easily find the claim and then submit a detailed message that is electronically delivered to Anthem. This process allows you to ask a question and quickly track the status of the inquiry. Please note that the 151 form is still available and can be downloaded from our website at anthem.com to request claim adjustments via a paper format if desired. If you have any questions, please contact the number on the back of the member’s ID card.

Availity, an independent company, provides claims management services for Anthem Blue Cross and Blue Shield.
Receive e-mail notifications via our Network eUPDATE

Our provider newsletter, Network Update, is our primary source for providing important information to health care providers and professionals. Network Update is published bi-monthly and is posted to our website on the Virginia provider section of anthem.com for easy 24/7 access.

Note that in addition to this newsletter and our website, we also use our e-mail 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 we will be sending about the Health Insurance Marketplace or commonly called exchanges and other pertinent topics.

Reminder notifications sent via e-mail

When you sign up, you'll not only receive an e-mail reminder for each newsletter posted online, you'll also be notified of other late breaking news and important information you'll need when providing services and filing claims for our members. It's easy to sign up – just select Virginia and access the provider home page. There, you'll find a link to register for our Network eUPDATE.

Medicaid information

(Anthem HealthKeepers Plus offered by HealthKeepers, Inc.)

Remember to check the formulary regularly

HealthKeepers, Inc. uses a formulary to define drugs covered for the Anthem HealthKeepers Plus member pharmacy benefit. The formulary, or preferred drug list (PDL), is an expanded list of prescriptions and over-the-counter (OTC) drugs recommended by the health plan. Use this link to access a complete list of preferred OTC medications, current formulary and information about prior authorization for drugs not found on the PDL.
Provider self-service tools make it easy to do business

The provider self-service Web portal offers 24/7 access to simple to use tools - making it easier than ever to get information. Read more for benefits and access.

Important update regarding behavioral health psychological testing codes

Effective November 1, 2015, HealthKeepers, Inc. is changing the psychological testing requirements for Anthem HealthKeepers Plus members. The new psychological testing requirements will allow the provider to bill up to four units without precertification. Psychological and neuropsychological testing for medical diagnoses will also require authorization. Use this link for additional information about these preauthorization changes.

Synagis guidelines for Respiratory Syncytial Virus season

Respiratory syncytial virus (RSV) season begins as early as September with occurrences through April. Synagis (palivizumab) is a monoclonal antibody indicated for the prevention of RSV. All requests for Synagis require prior authorization to ensure Anthem HealthKeepers Plus members meet medical necessity criteria based on the American Academy of Pediatrics recommended guidelines. Read more about dosage, preferred specialty pharmacy and prior authorization.

Antipsychotic medication coverage in pediatrics

There has been an increase in the over utilization of antipsychotics in pediatric populations, children up to 17 years of age. To optimize the therapeutic outcomes and to ensure appropriate use of these medications, there have been adjustments to the clinical criteria for prior authorization for these drugs prescribed to Anthem HealthKeepers Plus members. Use this link to access these changes.

ICD-10 documentation and diagnosis coding tips

This handy reference sheet puts ICD-10 formatting, structure, official outpatient services guidelines, documentation concepts and more, right at your fingertips. Get the coding tips reference sheet here.
CDC predicts another moderately severe flu season predominated by influenza A (H3N2)

HealthKeepers, Inc. is launching an annual member outreach campaign to encourage high-risk Anthem HealthKeepers Plus members to visit their providers for a flu vaccine. Outreach includes automated outbound telephone calls, text messages and newsletter articles. Providers may experience an increase in phone calls and early appointments for the flu vaccine as a result of this outreach campaign. Read more about the impacts of flu season on your practice.

Coverage guidelines and clinical utilization management guidelines update

The Medical Policy and Technology Assessment Committee (MPTAC) approved Anthem Blue Cross and Blue Shield Medicaid coverage guidelines (medical policies) and clinical utilization management (UM) guidelines, developed or revised to support clinical coding edits for Medicaid members. These approved medical policies and clinical UM guidelines are publicly available on the provider website.

Reimbursement policy update – Allergy Treatment: Immunotherapy

Allergy Treatment: Immunotherapy
(Policy 06-110, effective October 2, 2015)

Reimbursement is allowed for allergy immunotherapy. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate for the injection, antigen dosage/preparation when meeting certain criteria.

Read the full reimbursement policy by using this link.

Improving pregnancy outcomes

In our continuing efforts to improve pregnancy outcomes and prevent preterm birth, HealthKeepers, Inc. announces our endorsement of the American College of Obstetricians and Gynecologists and Society for Maternal Fetal Medicine guidelines on cervical length screening and progesterone treatment for our Anthem HealthKeepers Plus members. Use this link to read the Medical Director’s letter.

For questions about these communications, contact Anthem HealthKeepers Plus Provider Services at 1-800-901-0020.
Medicare-Medicaid Plan update

This section of the newsletter addresses information about the Anthem HealthKeepers Medicare-Medicaid Plan or MMP. Members are enrolled in both Medicare and Medicaid under the Commonwealth Coordinated Care Plan, also known as the Duals Demonstration ("Demonstration") Program.

New for PCPs – Reimbursement for interdisciplinary care team participation

Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, will now provide reimbursement to primary care physicians (PCPs) for participation in interdisciplinary care team (ICT) meetings for our members. Read more about eligibility and reimbursement amounts.

New patient payment process effective October 1, 2015

Effective for dates of service on or after October 1, 2015, providers of long-term care services will not have to submit patient pay on claims. Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, will automatically reduce the final claims payment. The amount of patient pay, using the patient pay amounts the Department of Medical Assistance Services (DMAS) directly reports to us, will be made on a first in (date of claims adjudication) first out basis until fully deducted. Read more about the impacts of this change.

For questions about MMP articles, contact Customer Care at 1-855-817-5788.

Medicare information

(Anthem’s Medicare Advantage and Medicare Supplement plans)

Keep up with Medicare Advantage news at Important Medicare Advantage Updates

Please continue to check Important Medicare Advantage Updates on your provider portal for the latest Medicare Advantage information.
Imaging site scores for outpatient diagnostic imaging could impact reimbursement

Anthem is dedicated to meeting the evolving needs of our members and ensuring that they receive the most appropriate care possible. We are pleased to introduce a new program for imaging services administered by AIM Specialty Health® (AIM).

What Does This Mean to You?

Effective November 1, 2015, Anthem Medicare Advantage plans will begin collecting information about the imaging capabilities of all Anthem Medicare Advantage contracted providers who provide the technical component of the following outpatient diagnostic imaging services for our individual Medicare Advantage members:

- Computed Tomography (CT)
- Magnetic Resonance (MR)
- Positron Emission Tomography (PET)
- Nuclear Medicine (NUC)
- Ultrasound
- X-Ray
- Echocardiograph

Emergency room outpatient diagnostic imaging services are excluded.

AIM’s online registration tool, OptiNet®, will continue to collect modality-specific data from providers who render imaging services in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment, and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC). That data will continue to be used to calculate site scores for providers who render imaging services to our individual Medicare Advantage members. Each modality or piece of equipment will receive its own score. Providers with an imaging site score of 76 or higher will see no change in reimbursement.

- Effective March 1, 2016, for providers who have not completed the online registration: Claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

- Effective March 1, 2016, for providers with an imaging site score below 76 for the applicable modality for any of the outpatient diagnostic imaging services listed above: Claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the claim, including the
professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

**Members cannot be balance billed if a line-item denial occurs.**

Please note that any decision to deny reimbursement and/or approval of an imaging service is separate and apart from the determination of the medical necessity of the same service.

Please note that the line-item denial for a site score below 76 for the applicable modality applies only to individual Medicare Advantage claims at this time.

Please see [Important Medicare Advantage Updates](#) for additional information.

Consistent with the above information, the following new provisions are added to the “Other Reimbursement Information” section of the Plan Compensation Schedule Attachment to your Anthem Blue Cross and Blue Shield Provider Agreement effective March 1, 2016:

With respect to Covered Individuals enrolled under non-group Medicare Advantage products (“Non-Group MA Members”), Provider understands and agrees as follows:

- Plan or its designee will collect information about Provider’s technical component imaging capabilities in connection with the following outpatient diagnostic imaging services:
  - Computed Tomography (CT)
  - Magnetic Resonance (MR)
  - Positron Emission Tomography (PET)
  - Nuclear Medicine (NUC)
  - Ultrasound
  - X-Ray
  - Echocardiograph

- The online registration tool, OptiNet® ([www.aimspecialtyhealth.com/goweb](http://www.aimspecialtyhealth.com/goweb)) must be used to allow Plan or its designee to collect modality-specific data in areas such as: facility qualifications, technician and physician qualifications, accreditation, equipment, and technical registration. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

- This data will be used to calculate imaging site scores for Provider. Each modality or piece of Provider’s equipment will receive its own score.
If Provider has not completed the OptiNet online registration by March 1, 2016, Claims with dates of service on or after that date, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the Claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

Effective March 1, 2016, if Provider’s imaging site score is below 76 for the applicable modality for any of the outpatient diagnostic imaging services listed above, Claims with dates of service on or after March 1, 2016, for any of the outpatient diagnostic imaging services listed above will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. Other services on the Claim, including the professional component of the outpatient diagnostic imaging service, will be processed as usual as long as required authorizations are in place.

The Provider will make no charge and render no bill to any Plan, the Covered Individual, or the Covered Individual's guarantor for any services denied under the above provisions.

Routine physical exams are covered in 2016

Anthem Medicare Advantage (MA) plans will continue to offer coverage for routine physicals in 2016 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay as applicable by the member’s plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider.

Additional details can be found at Important Medicare Advantage Updates at www.anthem.com/medicareprovider.

Administrative denials may be appealed

For the member to receive maximum benefits, the health plan must authorize or precertify the covered services prior to being rendered. As previously communicated, please notify Anthem as soon as possible for planned or unplanned inpatient admissions, but no later than within one business day of admission.

If you do not notify us within the required timeframe, you may file an appeal. As part of the appeal, providers must demonstrate that they did notify Anthem or attempted to notify Anthem AND that the service is medically necessary. Anthem
also reminds all providers – network physicians and facilities -- that they cannot bill the member if the services are denied for the failure to obtain a required precertification.

Please refer to your provider agreement, the Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at www.anthem.com for further information on existing precertification requirements and provider appeals.

HRM program designed to reduce risk for Medicare Advantage members

Anthem is working to decrease the amount of high risk medications (HRMs) prescribed by primary care providers. When used in the Medicare Advantage population, age 65 years and older, high risk medications can cause an increased risk of side effects. Additionally, there are known alternatives to these HRMs which are safer with a lesser side effect profile that could be just as beneficial to the member. Examples of commonly prescribed HRMs include zolpidem (Ambien®), zaleplon (Sonata®) and eszopiclone (Lunesta®). This class of drugs is known to increase the risk of falls and fractures due to their sedating properties.

In an effort to prevent such negative outcomes, Anthem identifies providers who have prescribed HRMs and will contact the prescriber’s office to validate the prescriber/patient relationship. Anthem then will schedule an appointment for an Anthem pharmacist to speak with the provider about HRMs. (Revised October 5, 2015)

Precertification requirements updated for 2016

Please refer to your provider agreement, Medicare Advantage HMO & PPO Provider Guidebook and the Medicare Advantage Precertification Guidelines found at the Medical Policy, UM Guidelines and Precertification Requirements link on the Anthem provider home page at www.anthem.com for further information on existing precertification requirements and new precertification requirements for 2016. Non-contracted providers should contact the Health Plan.

For providers who treat members in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, please see related information in your provider manual. To access your provider manual, log on to the provider portal at mediproviders.anthem.com/va and click on Manuals under the Provider Education section.
Pharmacy update

Pharmacy information available on anthem.com

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit:


The commercial drug list is reviewed and updates are posted to the website quarterly (the first of the month for January, April, July and October). For Anthem HealthKeepers Plus (Medicaid), visit SSB Pharmacy Information.

To locate the “Marketplace Select Formulary” and pharmacy information for health plans offered on the Health Insurance Marketplace (also called the exchange), go to Customer Support, select your state, Download Forms and choose “Select Drug List.”

New state law includes provisions governing the prior authorization process for prescription drugs

Impacts all health care professionals who prescribe prescription drugs and make prior authorization drug requests

Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. are working to comply with a Virginia law (House Bill 1942) that requires our company to include provisions in our provider contracts governing the prior authorization process when we or Express Scripts (Anthem’s drug benefit manager) require prior authorization for a drug benefit. As part of our compliance with the new law, we must honor response times regarding prior authorization requests for certain pharmacy benefit plans.

The bill requires that insurance companies like Anthem and HealthKeepers, Inc. accept prior authorization drug requests from physicians and other health care drug prescribers over the phone, electronically or via fax. For urgent requests, Express Scripts – on Anthem’s behalf – is required to respond within 24 hours indicating that the drug request is approved, denied or requires further documentation. By Virginia law, for non-urgent requests, Express Scripts is required to notify drug prescribers within two business days of submission of a fully completed prior authorization drug request that the request is approved, denied or requires further documentation. When a member changes health insurance carriers, the new insurer must honor any prior authorized medications for the first 30 days.
The new law is effective **January 1, 2016**, and the change impacts prescription drug benefit coverage under certain Anthem and HealthKeepers, Inc. health plans. Members enrolled in our PPO and Anthem HealthKeepers health plans are impacted. This includes health plans that members have purchased on or off the Health Insurance Marketplace (also called the exchange).

Several lines of our business are excluded*, and these are:

- Anthem HealthKeepers Plus (Medicaid/FAMIS)
- Medicare Advantage and Medicare Supplement
- Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP)
- National accounts (large group accounts that may have locations in multiple regions of Virginia, multiple states or nationwide/worldwide)
- Self-funded groups
- Commonwealth of Virginia health benefits program

Watch for our December *Network Update* for additional information and any action required when submitting prior authorization drug requests to us in support of the law’s new requirements.

*As always, health care professionals can check eligibility and benefits for patients who have Anthem and HealthKeepers, Inc. health care plans using Availity, our Web-based provider tool.

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**Bulletin board**

**Last Anthem webinar for the year scheduled for November 18 – Register today**

Please take time to register today for the webinar coming near the end of the year on November 18. Don’t miss an opportunity to attend this online session. For your convenience, we offer these informative, hourly sessions online to eliminate travel time and help minimize disruptions to your office or practice.
Due to subject matter content, these webinars will be made available only to "professional providers," defined as Anthem network-participating providers and their staffs who submit claims using the 837P or CMS-1500 format, and who have the following medical credentials: MD, DO, DC, DPM, LCSW, LCP, LPC, LFMT, CNS, CNM, plus DDS, DMD & OD (non-routine medical services only).

WEBINAR ATTENDEES MUST HAVE INTERNET AND SIMULTANEOUS TELEPHONE ACCESS. THE BELOW INFORMATION IS REQUIRED IN ORDER TO RECEIVE OUR WEBINAR CONNECTIVITY INFORMATION:

**PROVIDER REQUEST FOR ANTHEM WEBINAR INVITATION**

Provider/Practice Name: ____________________________________________________________

Medical Specialty: ____________________________________     Your Provider Type(s) (circle):

MD, DO, DC, DPM, LCSW, LCP, LPC, LFMT, CNS, CNM, DDS, OD, or OTHER: __________

Location of main office in Virginia: _____________________________________________________

NPI #: ________________________________   Tax ID #: _____________ _____________________

* Attendee Name: _________________________________________________________________

* E-mail Address: __________________________________________________________________

Phone #: _______________________________________ Fax #: ____________________________

IMPORTANT NOTE: If multiple attendees will be viewing the webinar and listening together as a group via a single computer and phone line, we only need one e-mail address. However, if multiple attendees will each be viewing and listening from their own work stations, we must have SEPARATE registration forms with each individual's e-mail address.

Please mark which **2015** WEBINAR(s) you wish to attend:

- [ ] Wednesday, November 18 (10:30 a.m.-11:30 a.m.) – Fourth Quarter Anthem Updates

**PLEASE COMPLETE FORM AND FAX IT TO (804) 354-2979**