# Network Update

## In this issue

### Announcements
- Anthem to mail professional contract amendment in September
- Anthem fall webinar scheduled for October 26
- Intranasal flu vaccine not covered for upcoming flu season

### Coverage and clinical guideline update
- Coverage guidelines effective November 1, 2016
- IMPORTANT DATE CHANGE: Expansion of precertification requirements for radiation therapy fractions now slated to begin October 31, 2016
- NOC oncology and biologic drugs, precertification required

### AIM alerts
- Enhancements to AIM Clinical Appropriateness Guidelines for advanced image effective November 1, 2016
- Reminder of the most recent updates to the Cancer Care Quality Program

### Business update
- HEDIS® 2016: Incentive winners announced for providers who serve members enrolled in Anthem HealthKeepers and PPO plans
- HEDIS® spotlight: Antibiotic use
- Register today for ePASS webinars in August and September
- Clinical practice and preventive health guidelines on the Web

### Facility footnotes
- REMINDER: Post-service reviews of MRIs in the emergency department expanded to include all MRIs

### Drug/pharmacy update
- Anthem implements opioid analgesics utilization management clinical policies
- Anthem updates SGLT2 Inhibitor Step Therapy Program
- Anthem works to help improve patient safety through Pharmacy Home program
- Pharmacy information available on anthem.com

---

**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
2221 Edward Holland Drive
Richmond, VA 23230

The information in this newsletter is for informational purposes only and should not be construed as treatment guidelines or expected practice guidelines. Delays, treatment recommendations, and the prospects of medical conditions for our members and beneficiaries are the responsibility of the providers and pharmacies.

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the City of Alexandria, and the independent City of Manassas Park Boro. Anthem Blue Cross and Blue Shield and its affiliate Healthkeepers, Inc. are managed administrative services of The Blue Cross and Blue Shield Association. ✓ ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

[anthem.com](http://anthem.com)

**Important phone numbers**
In this issue, continued

<table>
<thead>
<tr>
<th>Health care reform (including health insurance exchange)</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Refer to anthem.com for information about health care reform</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral health update</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Behavioral health appointment access</td>
<td>18</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FEP update</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ REMINDER: FEP upgrades to ClaimsXten™</td>
<td>20</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>eBusiness</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Check out the new Payer Spaces link on Availity</td>
<td>21</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicaid information</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Changes to ventilator codes</td>
<td>22</td>
</tr>
<tr>
<td>○ Updated clinical practice guidelines now available online</td>
<td>23</td>
</tr>
<tr>
<td>○ Hysterectomy and sterilization consent forms</td>
<td>23</td>
</tr>
<tr>
<td>○ AIM to manage clinical appropriateness reviews</td>
<td>23</td>
</tr>
<tr>
<td>○ New policy: Reimbursement for maximum units per day</td>
<td>26</td>
</tr>
<tr>
<td>○ Durable Medical Equipment (rent to purchase)</td>
<td>27</td>
</tr>
<tr>
<td>○ Policy reminder: DME modifiers for new, rented and used equipment</td>
<td>27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare-Medicaid plan update</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ New policy: Reimbursement for maximum units per day</td>
<td>28</td>
</tr>
<tr>
<td>○ Durable Medical Equipment (rent to purchase)</td>
<td>28</td>
</tr>
<tr>
<td>○ Policy reminder: DME modifiers for new, rented and used equipment</td>
<td>29</td>
</tr>
<tr>
<td>○ Vascular embolization or occlusion services to require precertification</td>
<td>29</td>
</tr>
<tr>
<td>○ Improve MMP members’ medication adherence with 90-day prescriptions</td>
<td>30</td>
</tr>
<tr>
<td>○ Rheumatoid Arthritis: Program helps members who may be missing important medications</td>
<td>30</td>
</tr>
<tr>
<td>○ Clinical cumulative morphine equivalent dosing point-of-sale edit effective January 1, 2017</td>
<td>30</td>
</tr>
<tr>
<td>○ Use Medicare billing guidelines when filing preventive service claims for Medicare-Medicaid Plan members</td>
<td>31</td>
</tr>
<tr>
<td>○ Please follow home health billing instructions</td>
<td>31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare information</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>○ Reach a nurse directly for prior authorizations that require clinical reviews, services that require Anthem authorization</td>
<td>32</td>
</tr>
<tr>
<td>○ Medicare Supplement members to receive new ID cards</td>
<td>33</td>
</tr>
<tr>
<td>○ Improve Medicare Advantage members’ medication adherence with 90-day prescriptions</td>
<td>33</td>
</tr>
<tr>
<td>○ Alendronate added to the $0 copay tier for 2016 for Medicare Advantage members</td>
<td>33</td>
</tr>
<tr>
<td>○ Part D drugs must be prescribed for FDA-supported indications, Medicare compendiums</td>
<td>34</td>
</tr>
<tr>
<td>○ Anthem offers in-home bone mineral density (BMD) testing</td>
<td>34</td>
</tr>
<tr>
<td>○ Program helps members who may be missing important medications to treat Rheumatoid Arthritis</td>
<td>34</td>
</tr>
<tr>
<td>○ Clinical cumulative morphine equivalent dosing point-of-sale edit effective January 1, 2017</td>
<td>34</td>
</tr>
<tr>
<td>○ Please check your contract prior to rendering supplemental benefits</td>
<td>35</td>
</tr>
<tr>
<td>○ Complying with medical record documentation requests</td>
<td>35</td>
</tr>
<tr>
<td>○ Ensure the accuracy of your information in the provider directory</td>
<td>36</td>
</tr>
</tbody>
</table>
Announcements

Anthem to mail professional provider contract amendment in September 2016

In late September, Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. will begin mailing compact discs (CDs) with information regarding changes to our existing provider agreements to network-participating professional providers. Along with changes to the provider agreements, we are updating our fee schedules and provider manual. These changes will be effective January 1, 2017.

Professional providers who currently contract with Anthem and/or HealthKeepers, Inc. should receive an amendment to their existing provider agreements. To continue network participation, no action will be required. Providers who expect to receive an amendment package and do not do so by October 3, 2016, should contact their Anthem network manager to obtain a copy.
Intranasal flu vaccine will not be covered for upcoming flu season

The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) has released interim recommendations that live attenuated influenza vaccine (given by intranasal spray nasal spray) should not be used for the upcoming 2016-2017 flu season. To help to ensure that members receive access to effective flu vaccines, Anthem Blue Cross and Blue Shield will not be providing benefit coverage for intranasal influenza vaccination in the upcoming 2016-2017 flu season. Anthem will continue to provide benefit coverage for all influenza immunizations recommended by ACIP.

Coverage and clinical guideline update

Coverage guidelines effective November 1, 2016

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective November 1, 2016. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage, the Medicare-Medicaid Plan (Dual Integration product), and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP). Furthermore, the guidelines were among those recently approved at the quarterly Medical Policy and Technology Assessment Committee meeting held on May 5, 2016.

The following guidelines are addressed in this edition of the Network Update:

- Treatment of Varicose Veins (Lower Extremity) (SURG.00037)
- Mechanical Embolectomy for Treatment of Acute Stroke (SURG.00098)
- SpaceOAR® System (SURG.00143)
- White Blood Cell Growth Factors (CG-DRUG-16)
**Treatment of Varicose Veins (Lower Extremity) (SURG.00037)**

This coverage guideline addresses various modalities for the treatment of valvular incompetence of the great saphenous vein or small saphenous vein and associated varicose tributaries as well as telangiectatic dermal veins.

This coverage guideline has been revised to include coil embolization. Coil embolization is considered investigational as a treatment of lower extremity veins.

CPT and HCPCS codes associated with this revised coverage guideline are 36468, 36470, 36471, 36475, 36476, 36478, 36479, 37241, 37799, 96999, and S2202.

**Mechanical Embolectomy for Treatment of Acute Stroke (SURG.00098)**

This coverage guideline addresses the use of intra-arterial mechanical embolectomy devices. This is also known as endovascular thrombectomy, for the treatment of acute thrombotic or embolic stroke.

The medically necessary criteria for intra-arterial mechanical embolectomy or thrombectomy in the treatment of acute ischemic stroke has been revised to require the procedure be performed with a stent retriever device.

The CPT code associated with this revised coverage guideline is 61645.

**SpaceOAR® System (SURG.00143)**

This new coverage guideline addresses the use of SpaceOAR, an injectable liquid hydrogel product intended to create distance and serve as a spacer between the prostate and the anterior rectal wall in individuals undergoing radiotherapy for prostate cancer.

Use of the SpaceOAR system or other similar injectable spacer product is considered investigational for all indications.

The CPT code associated with this new coverage guideline is 0438T.

**White Blood Cell Growth Factors (CG-DRUG-16)**

This clinical UM guideline addresses white blood cell growth factors administered to enhance recovery of blood related functions in neutropenia including febrile neutropenia.

The medically necessary criteria, addressing primary prophylaxis of developing febrile neutropenia (FN) of greater than or equal to 10% and less than 20% has been revised.

Filgrastin (Neupogen), Filgrastin-sndz (Zarxio), Pegfilgrastin (Neulasta), Sargramostim (GM-CSF, Leukine), or Tbo-Filgrastim (Granix) is considered *medically necessary* when used for:

**Primary prophylaxis** of developing FN is greater than or equal to 10% and less than 20% based on chemotherapy regimen and individuals have one or more of the following risk factors for FN:
1. Age greater than 65 years; or
2. Poor performance status (Eastern Cooperative Oncology Group [ECOG] 3 or 4; or
3. Previous episodes of FN; or
4. Bone marrow involvement by tumor producing cytopenias; or
5. Preexisting neutropenia (absolute neutrophil count [ANC] less than 1500mm3); or
6. Poor nutritional status (baseline albumin less than or equal to 3.5g/dL or body mass index [BMI] less than 20); or
7. Poor renal function (glomerular filtration rate [GFR] less than 60mL/min); or
8. Liver dysfunction (liver function tests at least 2X upper limit of normal); or
9. The presence of open wounds; or
10. Advanced cancer; or
11. Other serious comorbidities

Other revisions to this clinical UM guideline include the addition of pegfilgrastim (Neulasta) as medically necessary after accidental or intentional total body radiation of myelosuppressive doses (greater than 2 Grays (Gy).

Tbo-Filgrastim (Granix) is now also considered medically necessary:

After a hematopoietic progenitor stem cell transplant (HPCT/HSCT) for the following indications:

1. To promote myeloid reconstitution; or
2. When engraftment is delayed or has failed; or

To mobilize progenitor cells into peripheral blood for collection by leukapheresis, as an adjunct to peripheral blood/hematopoietic stem cell transplantation (PBSCT/PHSCT).

The HCPCS codes associated with this revised clinical UM guideline are J1442, J1447, J2505, J2820, Q5101, and S9537.

These coverage and clinical UM guidelines became available for review on our website at www.anthem.com after June 28, 2016.
IMPORTANT DATE CHANGE: Expansion of precertification requirements for radiation therapy fractions now slated to begin October 31, 2016

Impacts pre-service clinical review of non-small cell lung cancer fractions for EBRT and IMRT

As you may recall, we previously notified you in the June 2016 issue of the Network Update that our clinical UM guideline was expanded to include fractionation and radiation therapy for non-small cell lung cancer. However, this transition was ultimately delayed. Please be advised that the precertification requirements of fractionation and radiation therapy for non-small cell lung cancer for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT) will now begin with AIM Specialty Health® (AIM), effective October 31, 2016.

The Radiation Therapy Program is managed by AIM, a separate company administering the program on behalf of Anthem. Anthem local members who currently require precertification for non-emergency outpatient radiation therapy are included in this program. For Anthem in Virginia and HealthKeepers, Inc., these precertification requirements do NOT apply to the following:

- Blue Cross and Blue Shield Service Benefit Plan also known as the Federal Employee Program® (FEP)
- Medicare Advantage and Medicare Supplement plans
- Department of Corrections
- National Accounts
- Anthem HealthKeepers Plus/FAMIS plans (Medicaid)
- 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.]
- Members with Anthem as secondary coverage
- Unicare
- HealthLink

Determine if precertification is needed for an Anthem or HealthKeepers, Inc. member by clicking the “Coverage & Clinical UM Guidelines, and Pre-Cert Requirements” link on anthem.com or by calling the precertification phone number printed on the member’s ID card. A complete list of CPT codes requiring precertification is available on the Point of Care pre-authorization inquiry via the Availity Web Portal.

Ordering physicians may submit a precertification request for these additional requirements for services on or after October 31, 2016, to AIM through the AIM ProviderPortalSM (available 24/7 to process orders in real-time), through the Availity Web Portal or by calling the AIM call center at 1-866-789-0158 (weekdays, 8 a.m. to 5 p.m. ET).
Note: Retrospective requests received more than 2 business days after the date of service will not be accepted by AIM for precertification review. Any post-service clinical review would be handled by Anthem according to the terms of the applicable health benefit plan and/or provider agreement.

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

Thank you for your collaboration and ongoing support of the Radiation Therapy Program. If you have further questions, please call the provider customer service area at the phone number on the member’s ID card.

**NOC oncology and biologic drugs, precertification required**

As a reminder, Anthem Blue Cross and Blue Shield in Virginia has expanded our pre-service review to the medical necessity of coverage requests for not otherwise classified (NOC) oncology and biologic drugs. This pre-service review program applies to members enrolled in our PPO and Anthem HealthKeepers plans, local administrative services only (ASO) accounts, National Accounts and Medicare Advantage plans. This notice does NOT impact members enrolled in Anthem HealthKeepers Plus (Medicaid) or the Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program® or FEP).

**AIM alerts**

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

**Enhancements to AIM Clinical Appropriateness Guidelines for advanced imaging effective November 1, 2016**

On November 1, 2016, the following changes to the AIM Specialty Health’s® Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

**Radiology guidelines**

- New guidelines to address pretest requirements for advanced imaging and ordering of multiple exams
- Head and Neck imaging
  - Enhanced criteria for evaluation of cerebral aneurysm and imaging following head trauma
  - Restructure of hearing loss and acoustic neuroma guidelines with addition of threshold values

- Chest, abdomen and pelvis
  - Broadened exclusions for staging or surveillance of certain tumor types across all CT and MRI modalities
  - Updated appropriateness criteria for nephrolithiasis

- Spine imaging
  - Enhanced criteria for conservative management prior to imaging for neck pain and radiculopathy

**Cardiology guidelines - Echocardiography**

- Enhanced criteria to limit surveillance of asymptomatic patients with reduced LV function
- Allow for annual surveillance in asymptomatic complex congenital heart disease
- Clarify appropriate use of resting echo in evaluation of chest pain

If you have any questions or comments regarding these enhancements to the guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Click here to access and download a copy of the current guidelines.

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

**Attention Oncologists, Hematologists and Urologists:**

As a reminder, Anthem Blue Cross and Blue Shield’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 (“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 Pathway. The Program is administered by AIM Specialty Health® (AIM), a separate company.

**Effective August 1, 2016, Anthem added the following cancer treatment Pathways** for the Cancer Care Quality Program.
New Pathways added to the Program include:

- Classical Hodgkin Lymphoma
- Mantle Cell Lymphoma
- Colorectal Cancer
  - FOLFOXIRI plus bevacizumab will be added to 1st or 2nd line therapy
  - Trifluridine/tipiracil will be added to 3rd line therapy

The following Pathways are moving from “on” pathway to “off” pathway status:

- Colorectal Cancer
  - Regorafenib will be removed from 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 Pathways developed for this Program are intended to support quality cancer care. To access the full 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.

Business update

HEDIS® 2016: Incentive winners announced for providers who serve members enrolled in Anthem HealthKeepers and PPO plans

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. have completed the HEDIS data collection for 2016 for members who purchased our PPO and Anthem HealthKeepers products [excluding Anthem HealthKeepers Plus (Medicaid)]. We want to thank all of our provider offices and their staff members who assisted us. Your collaboration in this process allows us to achieve the best HEDIS results possible.

This is the fifth year for our incentive program to acknowledge some of our providers who either responded in a timely manner or went “Above and Beyond” to help make our HEDIS data collection efforts successful. Any practices that responded within five business days of our initial request or made extra efforts by taking additional steps to help us with data collection were entered in a drawing to receive a gift. In the event an office was not able to accept a tangible gift, a special written recognition was given. In this edition of the Network Update, we are pleased to announce our Virginia incentive winners:
Thanks again to all of our provider offices and their staffs for assisting us in collecting HEDIS data. Our HEDIS results reflect the excellent care you provide to our members. An overview of our HEDIS rates will be published in the Network Update in the fourth quarter. In addition, more information on HEDIS can be found by visiting the provider portal at: www.anthem.com > Provider > Virginia > Health & Wellness > Quality Improvement and Standards > HEDIS Information.

We look forward to working with you next HEDIS season.

**HEDIS® spotlight: Antibiotic use**

Antibiotic stewardship has been identified as a national priority. The first known superbug, or bacterial infection that is resistant to antibiotics of last resort, was recently discovered in the United States. The Centers for Disease Control and Prevention (CDC) estimates that drug resistant bacteria cause two million illnesses and 23,000 deaths annually. Studies indicate that up to 50 percent of antibiotic use is either unnecessary or inappropriate across all types of health care settings.¹

Misuse occurs for a variety of reasons including the use of antibiotics when they aren’t needed or clinically indicated; continuing treatment when it is no longer needed; the wrong dose of the antibiotic; the use of a broad-spectrum antibiotic to treat a susceptible agent; and, the use of the wrong antibiotic to treat the infection. In 2011, a national survey found that 60 percent of infectious disease physicians had seen a pan-resistant, untreatable infection in the last year.² Inappropriate antibiotic use adversely impacts patients and society and is leading to a pandemic of antimicrobial resistance.

To further underscore the focus on prescribing and using antibiotics appropriately, the National Committee for Quality Assurance (NCQA) has identified three Health Effectiveness Data and Information Set (HEDIS) measures around antibiotic use:

- **Children (2 to 18 years) who present with Pharyngitis who are first given a group A streptococcus (strep) test and then appropriately receive an antibiotic.**
- **Children (3 months to 18 years) with a diagnosis of Upper Respiratory Infection who are not given an antibiotic prescription.**
- **Adults with a diagnosis of Acute Bronchitis who are not given an antibiotic prescription.**

The ratings for each of these metrics are determined by claims data only. And, it only takes one time of an antibiotic being inappropriately prescribed (and filled) in the one year measurement period to lower the scores.
Things that might help you

In an effort to help slow the emergence of antibiotic resistant bacteria and prevent the spread of antibiotic resistant infections, please commit to:

- **Avoid prescribing antibiotics inappropriately**: Write a prescription for symptom relief instead of an antibiotic and educate patients on comfort measures that may work without antibiotics.

- **Communicate with patients**: Discuss realistic expectations for recovery time, explain that antibiotics do not significantly reduce the duration of symptoms, and that unnecessary use of antibiotics may cause adverse effects that lead to antibiotic resistance.

- **Test for bacterial infections**: If a child presents with a sore throat, do a strep test and prescribe accordingly. Don’t send a script home with the patient “just in case,” but rather offer to call it in if the test comes back positive.

- **Code claims correctly and accurately**: If your patient has comorbidities, bacterial infections, or competing diagnoses, the standard codes for adults with acute bronchitis (AAB) and upper respiratory infection (URI) may not be applicable. Ensure proper documentation is in the medical record and use correct diagnosis and procedure codes on claim/encounter.

Here are some Resources that might help you and your patients:

- Anthem one-minute video: [www.anthem.com/cold](http://www.anthem.com/cold)

- Choosing Wisely – [www.choosingwisely.org](http://www.choosingwisely.org): [5 Patient Questions to ask Before Taking Antibiotics](http://www.choosingwisely.org) and [Antibiotics: When you Need them and When you Don't in English](http://www.choosingwisely.org) and [Antibiotics: When you Need them and When you Don't in Spanish](http://www.choosingwisely.org)

- AWARE program materials – [Physician-Patient Resources in English and Spanish](http://www.aaware.org)

- CDC “Get Smart about Antibiotics” – [Patient and Provider Materials and References including Clinical Guidelines](http://www.cdc.gov/getsmart)

- [National Quality Forum Antibiotic Stewardship in Acute Care: A Practical Playbook](http://www.qualityforum.org)

- [CDC Core Elements of Hospital Antibiotic Stewardship Programs](http://www.cdc.gov)


**HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).**
Register today for ePASS webinars in August and September

Overview

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. continue to work with Inovalon – an independent company that provides secure, clinical documentation services – to conduct outreach efforts to members who have purchased our Affordable Care Act (ACA) health plans (plans purchased on or off the Health Insurance Marketplace or the exchange). As part of this effort, Anthem network providers – usually primary care physicians – may receive letters from Inovalon, requesting that physicians perform patient assessments, followed by submission of a Subjective, Objective, Assessment and Plan (also called SOAP Note or Encounter Facilitation Form which is a standardized document format of a medical record).

Inovalon conducts webinars on our behalf that share with eligible providers a practical overview of how the Electronic Patient Assessment Solution Suite (ePASS®) can be used to access a supplemental clinical profile and complete a compliant medical SOAP Note for patients Anthem identifies. The webinars typically take 30 minutes followed by time for questions.

Registration

We encourage you to register in advance for one of the Inovalon webinars by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

Webinar Dates for August and September

Webinars are held on Wednesdays from 3 p.m. to 4 p.m. ET.

How to join a webinar

The following information can be used to join all webinars scheduled in August and September 2016:

Teleconference: Dial 1-888-850-4523 and enter access code: 108 607

WebEx: Visit https://inovalon.webex.com and enter meeting number: 746 707 227

Once you join the call, live support is available at any time by dialing *0
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 that 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 anthem.com. From there, select “Provider” and Virginia> then Health & Wellness> Practice Guidelines.

Facility footnotes

REMINDER: Post-service reviews of MRIs in the emergency department expanded to include all MRIs

As previously communicated, Anthem Blue Cross and Blue Shield started performing post-service reviews of all claims with MRIs of the brain and lumbar spine performed on patients in the emergency department (ED) in June. Beginning September 1, 2016, Anthem will expand the post-service review of claims to include all MRI indications on patients in the ED for members enrolled in Anthem’s Virginia PPO and Anthem HealthKeepers group and individual policies (including policies our members purchase on or off the Health Insurance Marketplace or the exchange).

* All emergency room claims that include MRI services will pend for clinical review, and records will be requested if not submitted with the claim. Payment for those studies which do not meet the American Imaging Management’s (AIM) appropriateness criteria will be denied as not medically necessary. Furthermore, as specified in provider contracts, the member cannot be balanced billed in these situations and will be held harmless. There is no change to the review process for all other place of treatments. All requests are reviewed using the AIM Specialty Health Guideline for Radiology which is available in nine, convenient categories based on imaging exam type or body location. You may view this guideline at http://www.aimspecialtyhealth.com/marketing/guidelines.

Again, these post-service reviews will begin for additional MRI codes in September 1, 2016. Thank you for your cooperation, as we continue to work together to provide access to safe, quality care for our members – your patients – in all settings.

*Please note that the preceding notice does not impact our government lines of business including Anthem HealthKeepers Plus (Medicaid), Medicare Advantage, the Medicare-Medicaid Plan (also called MMP or the Duals Demonstration Program), or the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program® or FEP).
Drug/pharmacy update

Anthem implements opioid analgesics utilization management clinical policies

In September 2016, Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers Inc. will implement revised clinical policies for opioid analgesics to help improve patient safety through enhanced coordination and to reduce the misuse and abuse of opioid analgesics. The opioid analgesics utilization management clinical policies apply to all Anthem health plans.

The utilization management clinical policies include requirements for both the short-acting opioid analgesics and the long-acting opioid analgesics that are based on the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain: [http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm](http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm).

- **Short-acting opioid analgesics:** Members not currently using short-acting opioid analgesics on a regular basis will be limited to a seven days’ supply per fill and 14 days’ supply per 30 days before requiring a prior authorization. Members who are actively treating for cancer and those who are terminal and undergoing palliative care will be automatically approved. Requests for a days’ supply greater than the noted seven or 14 days’ supply will require additional review.

- **Long-acting opioid analgesics:** Members who are new starts and are not currently using a long-acting opioid analgesic will require prior authorization. Members currently using a long-acting opioid analgesic will not require prior authorization. Members who are newly prescribed a long-acting opioid and are actively treating for cancer or those who are terminal and undergoing palliative care will be automatically approved.

If you have any questions, please contact the Provider Service phone number on the back of the member ID card.

Anthem updates SGLT2 Inhibitor Step Therapy Program

On August 1, 2016, Anthem Blue Cross and Blue Shield is updating the Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitor Step Therapy Program. Farxiga, Invokana, Invokamet, and Xigduo XR will be part of the step therapy program. The SGLT2 Inhibitor Step Therapy Program applies to all Anthem health plans.

When a drug that is part of the step therapy program is prescribed, the member’s pharmacy will receive a message. This message will inform the pharmacy that the member must try a different, similar drug that’s covered by his or her plan as the “first step.” The member or the pharmacist will then have to call the prescriber’s office to get a prescription for that drug. Based on a cardiovascular outcomes study in over 7,000 members with Type 2 diabetes and established cardiovascular disease, Jardiance and Synjardy were superior to the placebo when added to the standard therapy for the primary
cardiovascular composite endpoint. Based on this data, we have selected Jardiance or Synjardy as our first step SGLT2 Inhibitor drugs.

Members currently taking Farxiga, Invokana, Invokamet, and Xigduo XR will be required to switch to Jardiance or Synjardy when their current prior authorization expires. These members will be mailed a letter advising them of the update to the SGLT2 Step Therapy Program. If one of your patients is currently taking Farxiga, Invokana, Invokamet, and Xigduo XR, you will receive a letter as well.

Drugs that are part of the step therapy program are proven to work well for most people, and they may cost less. However, you can ask for a review of the current drug for medical necessity if:

- The member has tried Jardiance or Synjardy before and the drug didn’t work well.
- The member tries Jardiance or Synjardy now and the drugs don’t work.
- You feel the member needs to stay on the current drug for any other reason.

The prescriber will just need to call the Provider Services number on the back of the member ID card to request that we cover the current drug.

If you have questions regarding the SGLT2 Inhibitor Step Therapy Program, please contact the Provider Service phone number on the back of the member ID card.


Anthem works to help improve patient safety through Pharmacy Home program

In April 2016, Anthem Blue Cross and Blue Shield in Virginia (Anthem) implemented the Pharmacy Home program to help improve patient safety through enhanced coordination and to reduce the misuse and abuse of prescription drugs, as set forth in the Certificate of Coverage. The Pharmacy Home program applies to Anthem’s fully insured group health plans. Members with an increased safety risk are identified for the Pharmacy Home program when a retrospective drug utilization review (DUR) indicates a member has one of the following claim scenarios within a 90 day period:

- Filled five or more controlled-substance prescriptions, or 20 or more prescriptions not limited to controlled substances
- Visited three or more health care providers for controlled substance prescriptions, or 10 or more providers not limited to controlled substances
- Filled controlled substances at three or more pharmacies, or 10 or more pharmacies not limited to controlled substances
Members will be mailed a letter advising them that they meet one of the above criteria. If the member’s claim activity does not change over the following 60 days, the member will be mailed an enrollment letter requesting them to select a single pharmacy location to fill all of their medications for a period of one year. The use of a single pharmacy will help improve the member’s coordination of care and reduce the potential risk for prescription abuse or misuse.

If one of your patients is identified for the Pharmacy Home program, you will receive a letter. This notification can help you assist with medication reconciliation. Medication reconciliation includes reviewing the medications your patient is taking to look for possible duplication of therapy to help ensure they are not at risk for negative drug interactions or possible prescription abuse or misuse.

If you have additional questions regarding the Pharmacy Home program, please feel free to contact us at rxhomeprogram@anthem.com, or fax: (855) 212-1249.

**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 anthem.com/pharmacy information.

The drug list for our PAR, PPO and Anthem HealthKeepers lines of business is reviewed, and updates are posted to the website quarterly (the first of the month for January, April, July and October). To locate “Marketplace Select Formulary” (for Affordable Care Act health plans our members purchase on or off the Health Insurance Marketplace or the exchange) and pharmacy information, go to Customer Support, select Virginia, Download Forms and choose “Select Drug List.”

For State-sponsored Business [Anthem HealthKeepers Plus (Medicaid/FAMIS)], visit SSB Pharmacy Information.

Website links for the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP) formulary Basic and Standard Options are:

- Basic Option: [https://www.caremark.com/portal/asset/z6500_drug_list807.pdf](https://www.caremark.com/portal/asset/z6500_drug_list807.pdf)
- Standard Option: [https://www.caremark.com/portal/asset/z6500_drug_list.pdf](https://www.caremark.com/portal/asset/z6500_drug_list.pdf)

This drug list is also reviewed and updated quarterly. FEP Pharmacy Policy updates have been added to the FEP Medical Policy Manual and may be accessed at [www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies](http://www.fepblue.org).
Health care reform (including health insurance exchange)

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

Visit anthem.com for updates about this topic, as 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.

Recently, we posted information regarding preventive care services covered with no member cost share HERE.

Behavioral health update

Behavioral health appointment access

Your contract with Anthem Blue Cross and Blue Shield and/or our affiliate HealthKeepers, Inc. requires that your practice provide timely access to care for our members. We will conduct daytime telephonic access studies to assess how well practices are meeting this provision, and your practice may receive a call from North American Testing Organization, a vendor in California working on Anthem’s behalf. To be compliant, please verify that your staff is familiar with Anthem’s timelines as outlined below.

Please note that the guidelines presented below apply to our PPO and Anthem HealthKeepers health plans. This includes health plans that our members purchase on or off the Health Insurance Marketplace or the exchange as well as the Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program® or FEP). The guidelines do NOT apply to Anthem HealthKeepers Plus (Medicaid), Medicare Advantage or the Medicare-Medicaid Plan (MMP or also known as the Duals Demonstration Program).
Anthem performs the annual assessment of Behavioral Health prescribers and non-prescribers.

<table>
<thead>
<tr>
<th>BH Appointment Type</th>
<th>Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td><strong>24/7 access</strong>&lt;br&gt;Immediate access at a facility, ER, 911 or Crisis Center, as appropriate.</td>
</tr>
<tr>
<td>Non-life threatening Emergent appointment – Members under acute distress, whose ability to conduct themselves for their own safety, or the safety of others, may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Situation has the potential to escalate into an emergency without clinical intervention.</td>
<td><strong>Within 6 hours</strong>&lt;br&gt;- Patient can be seen in the office by his or her BH Practitioner, another participating Practitioner in the practice or a covering Practitioner; or&lt;br&gt;- Patient directed to 911, ER or 24-hour crisis services, as appropriate.</td>
</tr>
<tr>
<td>Urgent Care appointment – Non-emergent care with significant psychological distress and symptoms. Calls are urgent when the severity or nature of presenting symptoms is intolerable but not life threatening to the member.</td>
<td><strong>Within 24 hours</strong>&lt;br&gt;- Patient can be seen in the office by his or her BH Practitioner, another participating Practitioner in the practice or a covering Practitioner; or&lt;br&gt;- Patient directed to 911, ER or 24-hour crisis services, as appropriate.</td>
</tr>
<tr>
<td>Routine initial appointment – New patient non-urgent appointment.</td>
<td><strong>Within 10 business days</strong>&lt;br&gt;New patient can be seen in the office by a BH Practitioner within the timeframe.&lt;br&gt;(After the intake assessment.)</td>
</tr>
<tr>
<td>Routine follow-up appointment – New or existing patient Evaluation of progress or members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.</td>
<td><strong>Within 30 calendar days</strong>&lt;br&gt;Patient can be seen in the office by his or her BH Practitioner, another participating Practitioner in the practice or a covering Practitioner within the timeframe.</td>
</tr>
<tr>
<td>After Hours Urgent Access – Contacting BH Practitioners for emergency and urgent instructions.</td>
<td><strong>24/7 phone access</strong>&lt;br&gt;- Recording or live person refers patient to ER/911/ 24-hour crisis services;&lt;br&gt;- Caller is directed to contact a BH professional (via cell, pager, beeper, transfer system) or get a call back for instructions or consultation.</td>
</tr>
</tbody>
</table>

Anthem uses several methods to monitor adherence to these standards, including a) assessing the availability of appointments via phone calls and surveys by our designated vendor to the provider’s office; b) analysis of member complaint data; and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members.
FEP update

REMINDER: FEP upgrades to ClaimsXten™

As a reminder, on June 17, 2016, Anthem Blue Cross and Blue Shield transitioned another line of our business to ClaimsXten™ – McKesson's next generation code auditing system. This change impacts claims for members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program® or FEP®). Other lines of our business are already being processed using ClaimsXten.

What is ClaimsXten?

ClaimsXten is an auditing software product from McKesson that in combination with claims processing systems:

- Reinforces compliance with standard code edits and rules
- Ensures correct coding and billing practices are being followed
- Determines the appropriate relationship between codes
- Processes those services according to industry standards

Why are we upgrading to ClaimsXten?

We periodically update our claims logic to:

- Conform to changes in coding standards
- Include new procedure and diagnosis codes

How does the upgrade to ClaimsXten affect you?

Professional providers will continue to see similar edits as before. ClaimsXten has enhanced logic which may result in some differences. Some of these differences are already noted in our Reimbursement Policies which are part of your Anthem Blue Cross and Blue Shield Provider Agreement. The following list is not all-inclusive:

- Rebundled or unbundled services
- Mutually exclusive services
- Incidental procedures
- Incorrect use of CPT codes
- Fragmented pre- and postoperative care
- Diagnosis to procedure mismatch
- Procedures with inappropriate modifiers
- Multiple Surgery

If you have additional questions on how a claim was processed, please contact FEP Customer Service toll free at 800-552-6989.

**eBusiness**

**Check out the new Payer Spaces link on Availity**

Anthem Blue Cross and Blue Shield introduced Payer Spaces along with the new Availity Web Portal home page design. This feature makes it easy for you to get the Anthem online tools and resources you need from one place. The link to Payer Spaces is located on the Availity Web Portal’s top menu bar in the upper right corner. Select the link, and then choose Anthem Blue Cross Blue Shield from the payer options.

**Here are some highlights of what is available to you now on the Payer Spaces page:**

- Remittance Inquiry: (Located below Applications)
- Research Procedure Code Edits: (Located below Resources)
- Online Provider Maintenance Form – Access only available to Administrators: (Located below Resources)

**Other helpful features currently available to Anthem providers on the Availity Web Portal are:**

- Eligibility
- Claims Inquiry
- Claims Submission
- Secure Messaging
Provider Online Reporting: (Select More from the Availity Web Portal’s top menu bar, located below My Payer Portals.)

Access to Point of Care: (Select More from the Availity Web Portal’s top menu bar, located below My Payer Portals.)

Having trouble accessing the information you need?

Contact your organization’s Availity administrator to request the role you need. To determine who your organization’s administrator is, select “Who controls my access” from your account drop down box located in the upper right corner of the Availity Web Portal’s top menu bar.

**Medicaid information**

*(Anthem HealthKeepers Plus offered by HealthKeepers, Inc.)*

**Changes to ventilator codes**

Effective January 1, 2016, the HCPCS codes E0463 and E0464 used by DME providers to bill for ventilators were discontinued by the Centers for Medicare & Medicaid Services (CMS). Likewise, HealthKeepers, Inc. no longer accepts these codes for DME for members enrolled in Anthem HealthKeepers Plus. There was a delay in our systems being updated to reflect these code changes. For providers who have unpaid claims for dates of service on or after January 1, 2016:

- Claims for E0463 and E0464 will deny with dates of service on or after January 1, 2016.
- If you have an approved prior authorization for E0463 and E0464 with dates of service including January 1, 2016, and thereafter, a new precertification will be issued using HCPCS codes E0465 or E0466.
- Previously submitted claims for E0463 and E0464 with dates of service on or after January 1, 2016, that denied need to be resubmitted with the new codes: either E0465 or E0466. This should be done after you have received the new precertification with the new code.

Please note: HealthKeepers, Inc. automatically reprocessed claims for codes E0465 and E0466 that were denied. Therefore, these claims should not be resubmitted.

If you have questions about this communication or need assistance with any other item, please call Provider Services at 1-800-901-0020.
Updated clinical practice guidelines now available online

Summary of change

Updated clinical practice guidelines (CPGs) are now available on the HealthKeepers, Inc. self-service website, https://mediproviders.anthem.com/va. These evidence-based guidelines were reviewed and approved by our Enterprise Clinical Quality Committee and Preventive Health Guidelines Work Group, a group of specialists and external practitioners. The guidelines include direct links to the source documents for reference.

What this means to you?

No action is necessary – this notice is for your information only. This is an annual update and notification to providers per National Committee for Quality Assurance (NCQA) guidelines.

What is the impact of this change?

The guidelines on the following page can be downloaded from our provider website at https://mediproviders.anthem.com/va. Under Medical, select Clinical Practice Guidelines. For a printed copy, please call Provider Services at 1-800-901-0020.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at 1-800-901-0020.

Hysterectomy and sterilization consent forms

To help ensure timely and accurate processing of claims, when applicable, please submit current hysterectomy and sterilization forms with necessary claims. The current hysterectomy consent form is MAP-3005. The current sterilization consent form is DMAS-3004 and DMAS-3004-S in Spanish. These current forms can be found on the Department of Medical Assistance Services provider website.

AIM to manage clinical appropriateness reviews

Effective September 1, 2016, clinical appropriateness review of radiation oncology, sleep medicine and cardiology services for Anthem HealthKeepers Plus members will be managed by AIM Specialty Health® (AIM). AIM works with leading insurers to improve health care quality and manage costs for today’s most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe and affordable.
Providers should contact AIM to request review of these services:

**Cardiology**

Providers should contact AIM to obtain an order number for the following cardiology services:

- Computed Tomography (CT/CTA), including cardiac
- Magnetic Resonance (MRI/MRA), including cardiac
- Positron Emission Tomography (PET) Scans, including cardiac
- Nuclear Cardiology
- Stress Echocardiography (SE)
- Resting Transthoracic Echocardiography (TTE)
- Transesophageal Echocardiography (TEE)
- Arterial ultrasound
- Cardiac catheterization
- Percutaneous coronary intervention (PCI)

We understand the need for arterial duplex imaging or PCI procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days after you perform these procedures and before you submit a claim. For all other cases, please contact AIM to obtain authorization before you perform the procedure.

**Learn more about submitting a cardiology request**


**Radiation oncology**

Providers should contact AIM to obtain pre-service review for the following nonemergency, outpatient radiation oncology modalities:

- Brachytherapy
- Intensity Modulated Radiation Therapy (IMRT)
- Proton Beam Radiation Therapy (PBRT)
- Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiotherapy (SBRT)
- 3D Conformal Therapy* (EBRT) for bone metastases and breast cancer
- Hypo fractionation for bone metastases and breast cancer when requesting EBRT and IMRT
- Special procedures and consultations associated with a treatment plan (CPT codes 77370 and 77470)
- Image Guided Radiation Therapy (IGRT)
- Radiation oncology performed as part of an inpatient admission is not part of the AIM program.

Radiation oncology providers are strongly encouraged to verify that an order number has been obtained before initiating scheduling and performing services. Review requests may also be initiated within two business days of the first treatment start date but before a claim is filed.

*Voluntary Notification for 3-D Conformal Radiation Therapy (EBRT). For EBRT, pre-service review is required only for procedures involving bone metastases and breast cancer. Additionally, HealthKeepers, Inc. is requesting that ordering providers contact AIM to review all other 3D-conformal therapy requests for Anthem HealthKeepers Plus members on a voluntary basis. Clinical review will be performed to confirm appropriateness and to ensure the ordering physician is aware of alternative treatments where applicable. Once the clinical review is completed, an order number will be issued. Claims will not be denied as a result of this voluntary process.

Learn more about submitting a radiation oncology request


Sleep medicine

Providers should contact AIM to obtain an order number before scheduling or performing any elective outpatient home-based (unattended) diagnostic study or a facility-based diagnostic or titration study (free-standing or hospital), as well as for sleep treatment equipment and related supplies. The following services are included in the program:

- Home sleep test (HST)
- In-lab sleep study (PSG, MSLT, MWT)
- Titration study
- Initial treatment order (APAP, CPAP, BPAP)
- Ongoing Treatment Order (APAP, CPAP, BPAP)
Oral Appliances (only for AIM guidelines adoption, non-HealthKeepers, Inc.)

Services performed in conjunction with emergency room services, inpatient hospitalization or urgent care facilities are excluded. Both ordering physicians (those referring the member for sleep testing) and servicing providers (those free-standing or hospital labs that perform sleep testing) may submit requests.

This program pertains to both new and existing sleep therapy patients.

New clinical guidelines

Effective September 1, 2016, the sleep management program for Anthem HealthKeepers Plus members will follow AIM Sleep Disorder Management Diagnosis and Treatment Guidelines. AIM’s clinical guidelines for sleep medicine are developed and revised through a rigorous review process that utilizes a comprehensive assessment of existing guidelines, evidence-based standards and literature, and feedback from the AIM External Physician Specialty Advisory Panel, which includes board-certified physicians from both community and academic practices. The clinical guidelines for sleep can be accessed on the AIM website at www.aimspecialtyhealth.com.

Learn more about submitting a sleep medicine request


ProviderPortalSM, the fastest, easiest way to contact AIM

An online application, ProviderPortalSM offers a convenient way to enter your order requests or check on the status of your previous orders. Go to www.providerportal.com to begin (registration required).

For questions regarding your online order, please contact the AIM ProviderPortalSM Support Team at 1-800-252-2021.

New policy: Reimbursement for maximum units per day

(Policy 15-003, effective January 1, 2017)

Anthem HealthKeepers Plus allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.
**Durable Medical Equipment (rent to purchase)**

(Policy 06-052, effective January 1, 2017)

Anthem HealthKeepers Plus allows reimbursement for Durable Medical Equipment (DME). Reimbursement is based on the rental price up to the maximum allowed of the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

**Components of rental DME**

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied.

**Circumstances affecting rental reimbursement**

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days
- If a member changes suppliers during the rental period, a new rental period will not start over

Anthem HealthKeepers Plus allows reimbursement for oxygen equipment for a maximum of 36 months; however, Anthem HealthKeepers Plus will continue to reimburse for oxygen contents.

**Policy reminder: DME modifiers for new, rented and used equipment**

(Policy 06-053, effective March 14, 2016)

Anthem HealthKeepers Plus allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For more information, about the reimbursement policies included here, visit [https://mediproviders.anthem.com/va](https://mediproviders.anthem.com/va).
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 policy: Reimbursement for maximum units per day

(Policy 15-003, effective January 1, 2017)

Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan allows reimbursement for a procedure or service that is billed for a single date of service by the same provider and/or provider group up to the maximum number of units allowed per day.

When the number of units assigned to a procedure or service exceeds the daily maximum allowed, our claims editing system will allow the number of units billed within the maximum limit; units billed in excess of the maximum per day limit will not be eligible for reimbursement.

Durable Medical Equipment (rent to purchase)

(Policy 06-052, effective January 1, 2017)

Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care allows reimbursement for Durable Medical Equipment (DME).

Reimbursement is based on the rental price up to the maximum allowed of the particular DME. The item is considered purchased once the purchase price has been met. There may be instances in which a particular item may be considered for direct purchase on a case-by-case basis.

Components of rental DME

Supplies and accessory components associated with rental DME are not separately reimbursed and considered all-inclusive in the rental reimbursement.

The reimbursement limit for rented DME is 10 months. Once the limit is met, claims submitted for the rental of the item will be denied.
Circumstances affecting rental reimbursement

- A new reimbursement period limit will begin for rental periods with a break in coverage of more than 60 days
- If a member changes suppliers during the rental period, a new rental period will not start over

Anthem HealthKeepers MMP allows reimbursement for oxygen equipment for a maximum of 36 months; however, Anthem HealthKeepers MMP will continue to reimburse for oxygen contents.

Policy reminder: DME modifiers for new, rented and used equipment

(Policy 06-053, effective March 14, 2016)

Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan allows reimbursement for new, rented or used equipment appended with the appropriate modifier. The listed modifiers must be billed in the primary or first modifier field to determine appropriate reimbursement:

- Modifier NU: new equipment
- Modifier RR: rented equipment
- Modifier UE: purchase of used equipment

These modifiers are appropriate for Durable Medical Equipment (DME), prosthetics and orthotics. These modifiers are inappropriate for supplies unless required under state or CMS guidelines. Claims for supplies appended with Modifier NU, RR or UE may be denied.

For more information, about the reimbursement policies included here, visit https://mediproviders.anthem.com/va.

Vascular embolization or occlusion services to require precertification

Effective September 1, 2016, precertification requirements will change for vascular embolization or occlusion services for members enrolled in Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan. This applies to the following procedure codes:

- 37243: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for tumors, organ ischemia or infarction
37244: Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the intervention; for arterial/venous hemorrhage or lymphatic extravasation

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

Noncompliance with new requirements may result in denied claims.

Not all precertification requirements are listed here. For more information, please refer to the Precertification Lookup Tool at https://mediproviders.anthem.com/va > Precertification > Precertification Lookup Tool. Providers may also call MMP Customer Care at 1-855-817-5788, Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

Improve MMP members' medication adherence with 90-day prescriptions

To help improve medication adherence among Medicare-Medicaid Plan members, Anthem will fax providers prescribing a 30-day supply of oral diabetic medications, RAS antagonists and statins to promote the use of 90-day prescriptions. Read the full article in the Medicare information section of this Network Update on page 33.

Rheumatoid Arthritis: Program helps members who may be missing important medications

Disease Modifying Anti-Rheumatic Drugs can help prevent long term disability and damage to persons with Rheumatoid Arthritis. Help ensure your RA patients have these important medications. Read the full article in the Medicare information section of this edition of the Network Update on page 34.

Clinical cumulative morphine equivalent dosing point-of-sale edit effective January 1, 2017

Beginning January 1, 2017, Medicare-Medicaid Plans will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale. Read the full article in the Medicare information section of this Network Update on page 34.
Use Medicare billing guidelines when filing preventive service claims for Anthem Medicare-Medicaid Plan members

Please use the same billing guidelines as set forth by Medicare for preventive service claims when filing claims for Anthem Medicare-Medicaid Plan members. Read the full article in the Medicare information section of this edition of the Network Update on page 37.

Please follow home health billing instructions

All claims from home health agencies (HHAs) must follow CMS billing instructions. These billing instructions pertain to providers contracted to Medicare pricing and non-contracted providers. These billing instructions apply to all individual and group-sponsored Medicare Advantage plans and Medicare-Medicaid Plans.

0322 – Interim First Claim

Statement Covers Period

Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the Request for Anticipated Payment (RAP) is a request for payment for future services, the ending date may not be known. The RAP contains the same date in both the “from” and “through” date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.).

Admission Date

Date the patient was admitted to home health care. On the first RAP in an admission, this date should match the statement covers period field (above) “from” date. On RAPs for subsequent episodes of continuous care, this date should remain constant, showing the actual date the beneficiary was admitted to home health care. The date on RAPs for subsequent episodes should, therefore, match the date submitted on the first RAP in the admission.

Service Date

For initial episodes, use the 0023 revenue code to report the date of the first covered visit provided during the episode. For subsequent episodes, the Home Health Agency should use the 0023 revenue code to report the date of the first visit provided during the episode, regardless of whether the visit was covered or non-covered.
0329 – Final Bill

Statement Covers Period

The beginning and ending dates of the period covered by this claim. The “from” date must match the date submitted on the RAP for the episode. For continuous care episodes, the “through” date must be 59 days after the “from” date.

Admission Date

The HHA enters the same date of admission that was submitted on the RAP for the episode.

Service Date

For initial episodes, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the episode. For subsequent episodes, the HHA reports on the 0023 revenue code the date of the first visit provided during the episode line, regardless of whether the visit was covered or non-covered.

Medicare information

*(Anthem’s Medicare Advantage and Medicare Supplement plans)*

Reach a nurse directly for prior authorizations that require clinical reviews, services that require Anthem authorization

Effective July 15, 2016, providers can speak to a nurse directly to request a prior authorization requiring clinical review for an individual Medicare Advantage member. Just call the number of the back of member ID card for prior authorization of services authorized by Anthem. The nurse may be able to make the clinical review immediately if the necessary clinical information is available. We hope this increased access to clinicians will streamline the prior authorization process for you and for our members.

Please use the phone numbers on the back of the member ID card and fax numbers published on our provider portal to reach us. Some fax numbers may be updated at a later date.
Medicare Supplement members to receive new ID cards

All Anthem Medicare Supplement Individual members will receive new member ID cards beginning November 1, 2016. Please obtain a copy of the new member ID cards to file claims for dates of service on or after November 1, 2016. Medicare will be notified of these changes for Anthem Medicare Crossover claim purposes. If you need to submit a claim that is not reflected as a Medicare Crossover claim, please use the correct member ID number beginning November 1, 2016. Please ask our members to present their most current ID cards each time they receive services – especially on or after November 1. This helps ensure appropriate claims routing and processing. Provider offices should carefully review member ID numbers when filing claims.

Payments will be processed daily. Remittances that may have been sent out only once a week will be received earlier.

All individual Medicare Supplement members will have a new group ID number and new member ID number on their new member ID cards.

Further information can be found in the spotlight section of the provider home page and at the “Answers @ Anthem tab at the top of the Anthem provider home page.

改善Medicare Advantage成员的服药依从性与90天药方

为了帮助改善Medicare Advantage成员的服药依从性，Anthem将向为30天药方处方的口服糖尿病药物、RAS拮抗剂和他汀类药物的提供者发送传真。90天药方有助于改善我们的Medicare Advantage成员的服药依从性，因为他们可以更少地去药店。当在医学上适宜时，我们要求您将成员的药方转为90天药方以改善患者依从性及结果，同时不损害护理质量。请注意，我们无意向药房转移这些药方。成员将在原来的药店获得90天药方药。

阿仑膦酸钠被添加到0元自付等级2016年Medicare Advantage成员

2016年，Medicare Advantage计划增加了阿仑膦酸钠用于骨质疏松症的0元自付等级，并继续为以下条件提供选择性药物：高血压、高胆固醇和糖尿病。2016年药方清单包括：阿仑膦酸钠，格列齐特，利司那洛肽，络拉汀，二甲双胍，西伐他汀，培哚普利，依那普利，依那普利-氢氯噻嗪，利司那洛肽-氢氯噻嗪，格列美脲，格列齐特 ER，络拉汀-氢氯噻嗪，二甲双胍 ER，阿托伐他汀，洛伐他汀和普拉伐他汀。

由赞助计划继续提供Select Generics福利，该福利为选择性非专利药提供0元自付。
Part D drugs must be prescribed for FDA-supported indications, Medicare compendiums

Anthem is responsible for ensuring that the Medicare Part D drugs that we cover are prescribed for medically accepted indications. Part D drugs must be prescribed for an indication supported by FDA-approved labeling and/or supported by at least one Medicare-approved compendium. If not, then by definition the drug is not considered a Part D drug. Please see Chapter six of the Medicare Prescription Drug Benefit Manual (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf) for additional information.

Anthem offers in-home bone mineral density (BMD) testing

Anthem is working with a vendor to conduct in-home bone mineral density (BMD) testing. Individual and group-sponsored female Medicare Advantage members age 67-85 who have claims that indicate a bone fracture and are not on an osteoporosis medication and/or have not had a BMD scan in the last 24 months receive a letter about osteoporosis. Through the letter and subsequent phone calls, these members are offered the opportunity to have an in-home screening. The screening takes about 10 minutes. The resulting T-Score is faxed to the attributed primary care provider (PCP). If the vendor cannot reach the member, a registered nurse may follow up with the PCP to request assistance with scheduling a BMD appointment for the member or inquire about medication therapy for the member.

Program helps members who may be missing important medications to treat Rheumatoid Arthritis

According to the American College of Rheumatology, Disease Modifying Anti-Rheumatic Drugs can help prevent long term disability and damage to persons with Rheumatoid Arthritis. If you see an Anthem individual or group-sponsored Medicare Advantage member who has been diagnosed with Rheumatoid Arthritis and that member has not received or filled a prescription for a DMARD, Anthem will send you a fax with that member’s contact information and a request to help ensure that the member has this important medication. A registered nurse also may follow up with the physician or the member to assist with appointments or prescriptions as needed.

Clinical cumulative morphine equivalent dosing point-of-sale edit effective January 1, 2017

Beginning January 1, 2017, most Medicare Advantage plans will implement a cumulative morphine equivalent (MEq) dosing edit at the point of sale. This MEq dosing edit will identify members taking a cumulative dose that exceeds the daily dose that Anthem sets. This is a patient safety edit intended reduce the risk from high dose opioid use. There is a higher risk for overdose when exceeding the set MEq dosing limit. The claim(s) will reject at the point of sale and require a prior

Network Update

August 2016
authorization review if the cumulative dosing is over the set daily limit. Certain members may be excluded from the edit, such as members with cancer. The edit supports the CMS guidance mandating that Medicare plans implement a cumulative dosing edit. Anthem anticipates that this edit will impact a fairly high number of claims.

Please check your contract prior to rendering supplemental benefits

Our Medicare Advantage HMO & PPO Plans may include supplemental benefits. Supplemental benefits are items or services that are not covered under Medicare Part A, Part B or Part D but are covered by the Plan in addition to what Medicare covers. Please refer to each plan’s benefit materials to locate any supplemental benefit coverage. Most supplemental benefits are required to be rendered by providers within the vendor network associated with that supplemental benefit or they are considered non-covered benefits.

Providers contracted with the vendor network associated with that supplemental benefit must bill that vendor directly.

Providers not contracted with the vendor network to render such a benefit, please note you will only reimbursed or able to bill a member if:

- For an HMO member, you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member’s MA plan. This will ensure that the member will receive a notice of denial of medical coverage and accompanying appeal rights. As per the Medicare Advantage HMO & PPO Provider Guidebook CMS has stated that the use of an Advanced Beneficiary Notice or a similar document is not sufficient in many instances with Medicare Advantage members. Therefore, you are required to seek a coverage determination prior to rendering such services.

- For a PPO member, you notify the member up front you are not contracted for the Supplemental Benefit. Therefore, an out-of-network cost share will apply.

Providers are encouraged to call the toll free customer service number on the back of the member ID card with any questions around services that may or may not be covered.

Complying with medical record documentation requests

As outlined in the Medicare Advantage HMO & PPO Provider Guidebook the facility, treating physician, clinician or supplier must comply with all requests for documentation from the Plan. Providers are responsible for providing any and all related medical records, answer questions from health plan representatives, or furnish any necessary information when requested. Information must be submitted in a timely manner, be complete and legible as well as identify the provider and date of service. Records can be requested by the Plan for reviews such as:

- Compliance with Medicare laws, audits and record retention requirements
Provider medical record audits/reviews

Precertification requests

Medicare appeals

Additional information can also be located in your provider contract. Please remember that your performance in submitting records impact you as well as our members in some situations. Provider compliance with requests will also be monitored.

Ensure the accuracy of your information in the provider directory

The Centers for Medicare & Medicaid Services (CMS) require that Anthem ensures that the information in our provider directories is accurate. Anthem conducts quarterly verifications of provider demographic and participation information. You may receive a fax, email or letter requesting that this information be confirmed. We appreciate your continued cooperation with this initiative.

Upon receipt of your verification form, please validate your demographic information for the specific location identified and indicate if changes are required. Fax back a revised form to the number indicated in your communication. If we need to verify information for your other locations or plans, we will contact you separately.

For reference, Anthem will ask you to submit any changes to the information listed below. Upon receipt, Anthem will include those changes in the provider directory within 30 days.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Specialty</th>
<th>Street Address</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting New Patients</td>
<td>NPI</td>
<td>Fax Number</td>
<td>Email</td>
</tr>
</tbody>
</table>

Medicare notices and provider requirements

The Centers for Medicare & Medicaid Services (CMS) require providers to notify every Medicare beneficiary of their discharge appeal rights using the Notice of Medicare Non-Coverage (NOMNC) for skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities, and the Important Message from Medicare About Your Rights (IM) for inpatient hospitals.

Download IM and NOMNC notices and instructions from the CMS website:


IMPORTANT REMINDER: Make sure the Medicare notices have the correct Beneficiary and Family Centered Care (BFCC) Quality Improvement Organization (QIO) contact information. Locate your QIO at http://www.qioprogram.org/contact.

For more information about CMS guidelines for delivery and retention of the NOMNC or IM, contact Carol Bossingham BSN, RN, CCM in the Clinical Compliance Department:

- Phone: 317-287-0196
- Fax: 877-261-2134 or
- Email: carol.bossingham@anthem.com.

Claim adjustments may change member cost share

Anthem reminds providers to please check the explanation of payments on claims. There are situations in which a claim may be adjusted and this may change a member cost share. If you receive a claim adjustment from Anthem, please ensure the member cost share is still accurate. Member cost share information is located on the front right-side of the member ID card. Please note that all cost shares are not listed. If you have any questions about a member’s cost share, please call the number on the back of the member ID card.

Please use Medicare billing guidelines when filing preventive service claims for Anthem Medicare Advantage members

Please use the same billing guidelines as set forth by Medicare for preventive service claims when filing claims for Anthem individual and group-sponsored Medicare Advantage members.

This applies to both professional and institutional billing.

- Professional claims should be filed on the CMS 1500 form with the appropriate Current Procedural Terminology (CPT) code and/or Health Care Procedural Code (HCPC) for the preventive service. The required primary and/or secondary diagnosis must also be listed with the appropriate CPT and/or HCPC.

- Institutional claims should be filed on the UB04 form with the appropriate revenue codes. The Medicare Preventive Services Chart does not list revenue codes. Please be sure to follow UB04 billing guidelines.

Examples:

Revenue Codes (except Rural Health Clinics and Federally Qualified Health Centers):

- 0636 – Vaccine (and CPT or HCPC)
- 0771 – Administration (and HCPC)

Rural Health Clinics and Federally Qualified Health Clinics – 052X revenue code series
Please refer to the Medicare Preventive Services Chart for specifics on billing found at https://www.cms.gov/Medicare/Prevention/PreventionGenInfo/Downloads/MPS-QuickReferenceChart-1TextOnly.pdf

Please follow home health billing instructions

All claims from home health agencies (HHAs) must follow CMS billing instructions. These billing instructions pertain to providers contracted to Medicare pricing and non-contracted providers.

Check Important Medicare Advantage Updates at www.anthem.com/medicareprovider additional information.

Keep up with Medicare Advantage news

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

June reimbursement policy provider bulletin
Medicare Advantage reimbursement policies
2016 Diabetic Supply Coverage for Individual Medicare Advantage Members
Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning Feb. 1, 2016
Contact Medicare Part B Specialty Pharmacy before Injections, Infusion Drug Prior Authorization Expire
Routine cervical cancer screening coverage guidelines

Enhancements to AIM Clinical Appropriateness Guidelines for Advanced Imaging Effective November 1, 2016

Informational notice: naviHealth coordinating prior authorizations for Highmark Medicare Advantage members

Anthem Blue Cross and Blue Shield in Virginia wants our PPO Medicare Advantage network providers to be aware of a recent mailing from Highmark, a Blue Cross and Blue Shield Association plan in Delaware, Pennsylvania and West Virginia. Highmark has initiated a partnership with naviHealth (www.navihealth.us), a national post-acute care management
company, to support its Medicare Advantage members. naviHealth began coordinating long-term acute care, inpatient rehabilitation and skilled nursing facility utilization and oversee proper care transitions to and from these facilities July 1, 2016.

As a courtesy to our participating providers, Anthem shares the following information from Highmark:

Anthem participating providers caring for Highmark Medicare Advantage members through the Blue Cross and Blue Shield PPO network sharing program must obtain prior authorization from naviHealth for admissions and concurrent stays to a Skilled Nursing Facility (SNF), Long Term Acute Care Hospital (LTAC) and Inpatient Rehabilitation Facility (IRF).

naviHealth will send additional information to providers when an authorization is requested. Anthem also will make additional information available at [www.anthem.com/medicareprovider](http://www.anthem.com/medicareprovider) under Important Medicare Advantage Updates.

---

**Bulletin board**

*Last Anthem provider education webinar for the year on October 26*

Fall will arrive soon and so will the date for our final provider education webinar. Please consider registering for this webinar today so that you and your staff will receive the latest updates from Anthem that impact your business interactions with us. See the registration form on the next page to register for the October webinar.
Registration Form

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 for 2016 WEBINAR if you wish to attend:

☐ Wednesday, October 26 (10:30 a.m.-11:30 a.m. ET) – Anthem Updates

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

August 2016