**Anthem webinars on April 6 – Register today**

**Anthem webinar on April 6**

**Important phone numbers**

1-877-952-7667

**Provider Communications**

2221 Edward Holland Drive

Richmond, VA 23230

**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 required practice guidelines.**

**Anthem** and its affiliates and subsidiaries are not responsible for the accuracy of the information contained herein.

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- Introducing Patient360 – Get quick and easy access to your Anthem patients’ records
- Receive email notifications via our Network eUPDATE

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Bulletin board
- Anthem hosts first 2017 provider education webinar on April 6 – Register today
- Anthem webinar and registration form
REMINDER: Important changes to Anthem’s National Drug List (formulary) effective April 1

Effective April 1, 2017, medications listed at the link below will be removed from the Anthem Blue Cross and Blue Shield National Drug List.

These changes will apply to all members enrolled in our Anthem PAR/PPO and Anthem HealthKeepers health plans (non-government plans) that have the Anthem National Drug List.

To help ensure a smooth transition and to avoid disruption in care, please take time to switch your patients currently on the non-preferred drugs to an appropriate preferred drug. Thank you for your cooperation with this formulary change.

For a complete list of the medications removed from the National Drug List and their preferred alternatives, please select:

http://materials.anthem.com/64774VAEENBVA.pdf

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

Change to name of Anthem’s drug list for small group ACA plans effective April 1

Please note that Anthem has changed the name of the drug list (formulary) our small groups use for members enrolled in plans that comply with the Affordable Care Act (ACA or health care reform law). Effective April 1, 2017, the new name is the Traditional Open Drug List. The medications included on the drug list for members enrolled in small group plans have NOT changed.

Anthem webinar on April 6 – Register today

Anthem’s first 2017 provider education webinar takes place on April 6. Designed for our network-participating providers, the webinar addresses Anthem business updates and billing guidelines that impact your business interactions with us.

For your convenience, we offer these informative, hourly sessions online to eliminate travel time and help minimize disruptions to your office or practice. The dates for the 2017 webinars are:

- Thursday, April 6, 2017, from 10:30 to 11:30 a.m.
- Thursday, October 19, 2017, from 10:30 to 11:30 a.m.

Please take time to register today for a webinar using the registration form in this edition of the Network Update.
Coverage guidelines effective July 1, 2017

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective **July 1, 2017**. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage and 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 February 2, 2017.

Services related to specialty pharmacy drugs (non-cancer related) require a Medical Necessity review, which includes site of service criteria, as outlined in the applicable coverage or clinical UM guideline listed below.

Guidelines addressed in this edition of the *Network Update* are:

- Serological Antibody Testing for Helicobacter Pylori (LAB.00034)
- Treatments for Urinary Incontinence (SURG.00010)
- Extracorporeal Carbon Dioxide Removal (SURG.00146)
- Synthetic Cartilage Implant for Metatarsophalangeal Joint Disorders (SURG.00147)
- Substance-Related and Addictive Disorder Treatment (CG-BEH-04)
- Eating and Feeding Disorder Treatment (CG-BEH-05)

**SPECIAL NOTE**

The services addressed in ALL the coverage guidelines presented in this section (pages 4 through 6) 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 and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP).

A pre-determination can be requested for our Anthem PPO products.
Serological Antibody Testing for Helicobacter Pylori (LAB.00034)

This new coverage guideline addresses the use of serological antibody testing Helicobacter pylori, a causative agent for peptic ulcers, gastritis, dyspepsia and stomach cancer.

The use of serological antibody testing for Helicobacter pylori is considered investigational and not medically necessary for all indications.

Effective July 1, 2017, CPT code 86677 will be subject to review of this new coverage guideline.

Treatments for Urinary Incontinence (SURG.00010)

This coverage guideline addresses treatments for urinary incontinence including vaginal weight training, injection of periurethral bulking agents, transvaginal radiofrequency bladder neck suspension, transurethral radiofrequency energy collagen micro-remodeling, and artificial urinary sphincter devices. It has been revised to consider inFlow™ intraurethral valve-pump implantation investigational and not medically necessary.

The CPT and HCPCS codes associated with this revised coverage guideline are 51715, 53445, 53446, 53447, 53448, 53449, 53860, A4335, and C1815.

Extracorporeal Carbon Dioxide Removal (SURG.00146)

This new coverage guideline addresses the use of extracorporeal carbon dioxide removal (ECCO²R), a minimally invasive, low-flow veno-venous or venous-arterial procedure used to treat acute hypercapnic respiratory failure or as an alternative to standard extracorporeal membrane oxygenation (ECMO).

Extracorporeal carbon dioxide removal is considered investigational and not medically necessary for all conditions, including but not limited to acute hypercapnic respiratory failure.

Currently, there is not a specific CPT code for extracorporeal carbon dioxide removal. Code 37799, unlisted procedure, vascular surgery is listed to represent this service.

Synthetic Cartilage Implant for Metatarsophalangeal Joint Disorders (SURG.00147)

This new coverage guideline addresses the use of a metatarsophalangeal synthetic cartilage implant.

Use of a metatarsophalangeal synthetic cartilage implant (consisting of biocompatible, molded cylindrical hydrogel) is considered investigational and not medically necessary as a treatment for metatarsophalangeal joint disorders including but not limited to hallux limitus or hallux rigidus.

Currently, there is not a specific CPT or HCPCS code for metatarsophalangeal synthetic cartilage implant. Code 28899, unlisted procedure, foot or toes is listed to represent the implantation of a synthetic cartilage implant into the metatarsophalangeal joint. Code L8699, prosthetic implant, not otherwise specified is listed to represent a synthetic cartilage implant (SCI) for use in the metatarsophalangeal joint.
Substance-Related and Addictive Disorder Treatment (CG-BEH-04)

This revised clinical UM guideline provides medical necessity criteria for levels of care relating to substance and addictive disorders.

The clinical indications have been revised to take into consideration a member's medical needs.

Eating and Feeding Disorder Treatment (CG-BEH-05)

This revised clinical UM guideline provides medical necessity criteria for levels of care relating to eating and feeding disorder treatment.

The clinical indications have been revised to take into consideration a member's medical needs.

Clinically equivalent agents

As we previously notified you in the February edition of the Network Update, Anthem Blue Cross and Blue Shield has selected Remicade (infliximab) to be the infliximab of choice and the clinically equivalent agent over Inflectra (Infliximab-dyyb). Synvisc, Synvisc One, Orthovisc, and Monovisc have been selected as the clinically equivalent Hyaluronic Acid agents of choice.

Please note: Some benefit plans require the use of clinically equivalent agents. Therefore, when prescribing a product in these categories, please consider using these agents.

Below are Clinical Guidelines and Coverage Guidelines that have been updated to include the requirement of a clinically equivalent treatment effective July 1, 2017, (previously communicated effective May 1, 2017).

For more information on Anthem Coverage Guidelines and Clinical UM guidelines and dosing guidelines, refer to the complete list of our Coverage Guidelines and Clinical UM Guidelines that can be accessed on Anthem’s provider website at www.anthem.com.

<table>
<thead>
<tr>
<th>Coverage Guideline</th>
<th>Impacted Products</th>
<th>Clinically Equivalent/Cost Effective Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>FDA-Approved Biosimilar Products; CG.DRUG.64</td>
<td>Inflectra®</td>
<td>Remicade®</td>
</tr>
<tr>
<td>*CG.Drug.29</td>
<td>Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®</td>
<td>Monovisc®, Orthovisc®, Synvisc®, Synvisc One®</td>
</tr>
</tbody>
</table>

*CG.DRUG.29 is for clinically equivalent agents only.
Below are clinical guidelines and coverage guidelines that have been updated to include the requirement of a clinically equivalent treatment effective July 1, 2017.

For more information on Anthem coverage guidelines and clinical UM guidelines and dosing guidelines, refer to the complete list of our coverage guidelines and clinical UM guidelines that can be accessed on Anthem’s provider website at www.anthem.com.

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</thead>
<tbody>
<tr>
<td>DRUG.00017 Hyaluronan injections for indications in joints other than the knee</td>
<td>Euflexxa®, Gel-One®, GelSyn®, Genvisc 850®, Hyalgan®, Hymovis®, Supartz®</td>
<td>Monovisc®, Orthovisc®, Synvisc®, Synvisc One®</td>
</tr>
</tbody>
</table>

Clinical guideline informational notices

Archived Clinical Guideline number effective December 28, 2016

(The following guideline number has been archived.)

CG-DRUG-15 – Gonadotropin Releasing Hormone Analogs [NOTE: Content of CG-DRUG-15 transferred to new clinical UM guidelines CG-DRUG-60 Gonadotropin Releasing Hormone Analogs for the Treatment of Oncologic Indications and CG-DRUG-61 Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications. Only CG-DRUG-61 has been adopted at this time].

Archived Clinical Guidelines effective February 17, 2017

The following guidelines have been archived (no longer require review):

CG-DME-30 Prothrombin Time Self-Monitoring Devices
CG-DRUG-14 Dihydroergotamine Mesylate (DHE) Injection for the Treatment of Migraine or Cluster Headaches in Adults
CG-DRUG-34 Docetaxel (Taxotere®)
CG-DRUG-41 Zoledronic Acid
CG-MED-28 Iontophoresis for Medical Indications
CG-MED-32 Ancillary Services for Pregnancy Complications
CG-MED-38 Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer

Updated biosimilar product information

Biosimilar products are now addressed in CG-DRUG-64 (effective November 17, 2016). The clinical indications have not changed.
Beginning with dates of service on and after **July 1, 2017**, Anthem Blue Cross and Blue Shield will implement a new clinical guideline, **Drug Dosage, Frequency, and Route of Administration CG-DRUG-53**. This will apply to the review process for specialty pharmacy Virginia administers for non-oncology indications.

**What’s new beginning with dates of service on and after July 1, 2017?**

- **Description:** CG-DRUG-53 contains clinical criteria for review of the medical necessity of dosage and frequency.

  As part of the authorization process, the following will be required:

  1. Weight, Height, Age, Gender
  2. Dose per treatment and Directions per treatment (frequency), and duration (length of therapy)

**To ensure accurate and timely payment, it is important that you provide the above requested information effective July 1, 2017.**

**Providers may continue to request authorization for specialty drugs in one of several ways:**

**Call Anthem in Virginia for authorizations:**

- **Telephone:** 800-533-1120 (Toll free)
- **Hours available:** 8 a.m. – 5 p.m., Monday- Friday (ET)

**Use Provider Portal to create authorization request:**

- **Web:** Point of Care Web portal via [www.availity.com](http://www.availity.com)
- **Hours available:** Standard (Exceptions will be posted)
  - 6 a.m. – 12 a.m. Monday-Saturday (ET)
  - 6 a.m. – 1 p.m. & 8 p.m. -12 a.m. (ET)

For more information on Anthem Coverage Guidelines and dosing guidelines, refer to the complete list of our Coverage Guidelines and Clinical UM Guidelines that are accessed on Anthem’s provider website at [www.anthem.com](http://www.anthem.com).

**Reminder – Drug wastage should be reported with modifier “JW”**

Providers may be reimbursed for single dose vial drug wastage beyond the approved dosage that is authorized per the Utilization Review process outlined above. The Provider is expected to utilize the most economical combination of vial sizes for the drug administered and must report the drug wastage as a separate line item on the claim form with modifier “JW” appended. Anthem’s reimbursement limits will apply and will take into consideration applicable wastage based on the most economical combination of vial sizes.
REMINDER: U.S. Food and Drug Administration approval

As a reminder, Anthem Blue Cross and Blue Shield in Virginia and our affiliate HealthKeepers, Inc. require that any supply or device used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. This requirement applies to our PAR, PPO, Anthem HealthKeepers products (non-government), and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP).

Business update

Billing anesthesia and surgical services when provided by the same physician or an employed/subcontracted CRNA

Anthem Blue Cross and Blue Shield (Anthem) has received questions regarding anesthesia reimbursement to physicians who provide both surgical and anesthesia services for the procedures they perform and bill using CPT coding. This clarification of our reimbursement policy applies to Anthem’s following lines of business:

- Anthem PAR/PPO (including BlueCard)
- Anthem HealthKeepers (not including Medicaid)*
- Blue Cross and Blue Shield Service Benefit Plan (also known as the Federal Employee Program or FEP)

Physicians performing surgical services and administering anesthesia

If a physician, (such as a surgeon, oral surgeon, gastroenterologist, or any specialty other than an anesthesiologist), performs a surgical service and at the same time administers the anesthesia him or herself, **there will be NO separate reimbursement for the anesthesia.** Physicians, in this situation, should append modifier 47 to their surgical CPT code, and they should NOT report an anesthesia CPT code (00100-01999).

Physicians using certified registered nurse anesthetists (CRNAs)

If a physician (other than an anesthesiologist) is performing a surgical service and has a practice employed/subcontracted CRNA providing the anesthesia, the physician should bill for both the surgery and the anesthesia. The anesthesia claim line should be billed using the appropriate anesthesia CPT code and one of the anesthesia modifiers below, as we do require an anesthesia modifier in order to process the claim.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Reimbursement Percentage of Maximum Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>QX</td>
<td>CRNA with medical direction by a physician</td>
<td>50%</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA without medical direction by a physician</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Note: Anthem HealthKeepers does not cover Medicaid patients.*
Additional information

Please refer to the reimbursement policies section of the Plan Compensation Schedule Attachment in your provider contract to see the complete policy on anesthesia services and other reimbursement policies. If you have questions regarding your provider contract, please contact your Anthem network manager.

*To review reimbursement policies specifically applicable to Anthem HealthKeepers Plus (Medicaid) and the Anthem HealthKeepers Medicare-Medicaid Plan (a Commonwealth Coordinated Plan also known as the Duals Demonstration Program), please use the following link:

https://mediproviders.anthem.com/va/pages/claims.aspx

To review reimbursement policies applicable to Anthem Medicare Advantage, use the following link:


REMINDER: Billing code 96401

There has been some confusion as to the number of units to bill for 96401—chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic. Code 96401 should only be billed once for each different drug that is given—not the number of injections sites needed to administer the total dose of the same drug.

One example of this situation is billing 96401 for administration of the drug Xolair. Due to the drug’s viscosity, only 150 mg can be given in one site. In some cases up to four injections sites may be needed to give the complete dose. So in this situation, only one unit of 96401 should be billed since it is for the same drug.

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.
Anthem announces change regarding in-network labs for BRCA testing and other genetic testing services

Effective **July 1, 2017**, Myriad Genetic Laboratories will no longer be an in-network laboratory for Anthem Blue Cross and Blue Shield in Virginia. Other laboratories that continue to be in-network for BRCA testing and other genetic testing services include:

- Ambry Genetics
- Counsyl, Inc.
- Invitae
- LabCorp
- Medical Diagnostic Laboratories (MDL)
- GeneDx
- Quest Diagnostics

Please begin to use one of these in-network labs for Anthem members requiring this testing. As a reminder, your Anthem agreement requires referrals to in-network providers. By using in-network laboratories, you help your patients maximize their laboratory benefits and minimize their out-of-pocket expenses.

If you have specific questions regarding BRCA testing or other genetic testing performed by the following in-network labs, please contact them directly:

- **Ambry Genetics**: 866-262-7943 or [http://www.ambrygen.com/contact-us](http://www.ambrygen.com/contact-us)
- **Counsyl, Inc**: 888-268-6795 or [https://www.counsyl.com/contact/](https://www.counsyl.com/contact/)
- **Invitae**: 800-436-3037 or [https://www.invitae.com/en/contact](https://www.invitae.com/en/contact)
- **LabCorp**: 888-LABCORP (888-522-2677) or [www.LabCorp.com](http://www.LabCorp.com)
- **Medical Diagnostic Laboratories (MDL)**: 877-269-0090 or [https://mdlab.com/company/contact/](https://mdlab.com/company/contact/)
- **GeneDx**: 888-729-1206 or [http://www.genedx.com/about-genedx/contact-us/](http://www.genedx.com/about-genedx/contact-us/)

*A complete listing of laboratories can be found using our online Provider Finder at [www.anthem.com](http://www.anthem.com)*

**IMPORTANT NOTE:**

Providers should continue to use LabCorp for all laboratory services for members enrolled in Anthem HealthKeepers, Anthem HealthKeepers Plus (Medicaid), and Health Insurance Marketplace (exchange) health plans.
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. In addition, the guidelines 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 anthem.com. Click “Menu” at the top of the screen to display options and select “Providers.” Next, select “Virginia” from the dropdown listing of states and press “Enter.” On the Provider home page, select the “Health & Wellness” tab and then the “Practice Guidelines” link.

Health care reform (including health insurance exchange)

Anthem provides new or additional evidence considered during an appeal

The U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury published final Affordable Care Act (ACA) Market Reform regulations. Under the rule, issuers must automatically provide impacted members (free of charge) a copy of any new or additional evidence considered in conjunction with the appeal of a claim. This information must be provided in advance of a final adverse benefit determination.

Please be advised, in accordance with the regulation, Anthem Blue Cross and Blue Shield in Virginia will send new or additional evidence to impacted members. This includes any information providers submit that is used in decision making for a grievance or appeal request.

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

Visit anthem.com for updates, 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.
Incentive opportunity for physicians treating patients with Anthem plans purchased on or off the exchange; ePASS webinars scheduled

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 for our health care exchange business. Anthem and HealthKeepers, Inc. are working with Inovalon to help ensure that our members, who have purchased health care plans on and off the exchange, get their diagnoses confirmed, corrected, and updated every year, as well as have potential preventive care gaps addressed.

To accomplish this goal, Anthem network providers – usually primary care physicians – may receive letters from Inovalon, asking you to perform patient outreach and assessments, followed by submission of a SOAP Note (also called Encounter Facilitation Form). SOAP Note stands for Subjective, Objective, Assessment, and Plan which is the standardized document format of a medical record.

If you receive a request from Inovalon, we understand that completing these SOAP Note requests may take time. We offer contracted exchange providers the opportunity to increase reimbursement. As a reminder, you are eligible to receive $100 in addition to your office visit fee for each properly submitted electronic SOAP Note submitted through Inovalon’s ePASS tool.

You may also elect to submit your patient assessment data for the members we request using the paper SOAP Note option via Inovalon’s secure fax line at 1-866-682-6680. For each paper SOAP Note properly submitted for patient assessments performed, you are eligible to receive $50 in addition to your office visit fee.

Submitting a SOAP Note

- **Electronically**: You may use ePASS (Electronic Patient Assessment Solution Suite), an electronic tool that retrieves information about your Anthem patients, including potential preventive care gaps, and drops this data into the SOAP Note to document your patients’ conditions. The ePASS® tool may be used for members Inovalon identifies, and the members have purchased individual and small group health plans on and off the exchange. To utilize ePASS®, please sign up online at the following Web address: [https://ePASS.inovalon.com](https://ePASS.inovalon.com)

- **Paper**: You have the option to fax in a completed paper SOAP Note to Inovalon at 1-866-682-6680. To ensure that the paper SOAP Note is fully processed, all required fields must be completed and signed by the member’s physician.

**Overview of the ePASS® tool – Attend a webinar**

If you receive a request from Inovalon to complete a SOAP note and you're interested in an overview of the ePASS® tool, please see below for various webinar dates. This webinar provides a practical overview of how ePASS can be used by eligible providers to access a supplemental clinical profile and complete a compliant medical SOAP note for patients Anthem identifies. The webinar typically takes 30 minutes followed by time for questions.

**Registration**

We encourage you to register in advance by sending an email to [ePASSProviderRelations@inovalon.com](mailto:ePASSProviderRelations@inovalon.com) with your name, organization, contact information and the date of the webinar you wish to attend.
Webinar dates for second quarter 2017

All webinars take place on Wednesdays from 3 p.m. to 4 p.m. Eastern time.

**April 2017:** April 5, April 12, April 19 and April 26  
**May 2017:** May 3, May 10, May 17, May 24 and May 31  
**June 2017:** June 7, June 14, June 21 and June 28

Joining webinars

The following information can be used to join all webinars scheduled in April, May and June 2017:

- Teleconference: Dial 1-415-655-0002 (US Toll) and enter access code: 736 436 872
- WebEx: Visit [https://inovalonmeet.webex.com](https://inovalonmeet.webex.com) and enter meeting number: 736 436 872
- Once you join the call, live support is available at any time by dialing *0

If you have questions about the Inovalon effort, incentives and this ongoing outreach effort, we’ve compiled a list of questions and responses – [FAQs](#) – for your reference on our website.

Facility footnotes

**Outpatient Hospital Allowance Schedule (OHAS) drug billing effective May 1**

Revenue codes used for billing drugs (250-259 and 630-636) for outpatient services require code level details. Contractually, all facilities have been required to report the HCPCS/CPT code level for these revenue codes. However, Anthem allowed a grace period so that facilities’ billing processes could be changed to accommodate the requirement.

Effective [May 1, 2017](#), all drug codes billed with revenue codes listed above will now require a valid HCPCS/CPT code for all OHAS fee schedules. Failure to provide the information on the claim will result in an invalid revenue/CPT code combination, and the line will deny on the claim.

**REMINDER: Observation billing guidelines for facilities**

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. are sharing the following reminder about billing observation services on claims for members enrolled in Anthem’s PAR, PPO and Anthem HealthKeepers health plans (non-government).
“Outpatient observation services” are generally defined as active, short-term medical and/or nursing services performed by facilities. These type services include the use of a bed and monitoring by the facility’s nursing or other staff who are required to observe a member’s condition to determine if the member requires an inpatient admission to the facility. Outpatient observation services shall not exceed 24 hours in duration and include services provided to a member designated as being in “observation status.”

Observation services should be billed with:

- Revenue Code 762 and
- CPT/HCPCS codes: 99234, 99235, 99236, G0378 or G0379

Currently, observation claims are being audited after Anthem has processed the claims to determine if the claim billed exceeds 24 hours of observation. Effective May 1, 2017, if a facility bills more than 24 hours of observation on a claim, Anthem will use a front-end claims processing edit to determine the number of hours billed and limit the payment to 24 hours of observation on that claim as appropriate.

**Drug/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 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](http://www.fepblue.org) > Benefit Plans > Brochures and Forms > Medical Policies.
Check out Anthem’s streamlined remittance inquiry search option

Anthem Blue Cross and Blue Shield in Virginia has changed the check/electronic funds transfer (EFT) search option to make it easier for you to find your remittances. You have three search options:

- Search by check/EFT which now only requires a Tax ID and does NOT require an NPI
- Search using a date range which does require both a Tax ID and NPI
- Search by Notification Summary

Here’s how to access your remittances from the Availity Web Portal:

From the Availity Web Portal home page, select Payer Spaces, next choose Anthem BlueCross BlueShield from the list of payer options, and then select Remittance Inquiry.

Need an imaged copy of the remittance for your records?

Select the View Remittance link associated with each remittance to access the imaged copy of the paper remittance. You will have the option to print or save.

Don’t see this valuable tool when you log in to the Availity Web Portal?

Contact your Availity Administrator to request Claims Status access which includes Remittance Inquiry. If you do not know who the administrators are for your organization, log in to Availity, go to your account and select: Who controls my access?

We encourage you to try the Remittance Inquiry application today and see for yourself how easy it is to retrieve your remittances. It’s just one more way Anthem is working to improve our internal business processes to make it easier for you to do business with us and to access the information you need quickly.

Introducing Patient360 – Get quick and easy access to your Anthem patients’ records

In mid-April 2017, Patient360 will be offered on the Availity Web Portal. This online application lets you quickly retrieve detailed records about your Anthem patients.

Patient360 will be replacing Patient Care Summary that you have been accessing through Eligibility and Benefits on the Availity Web Portal. It will also replace Member Medical History Plus (MMH Plus).
What is Patient360?

Patient360 is real-time dashboard that gives you a robust picture of a patient’s health and treatment history and will help you facilitate care coordination. You can drill down to specific items in a patient’s medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information and care management related activities.

This level of detail at your fingertips can help you:

- Spot utilization and pharmacy patterns
- Avoid service duplication
- Identify care gaps and trends
- Coordinate care more effectively
- Reduce the number of communications needed between PCPs and case managers

Access to Patient360 on the Availity Web Portal

To access Patient360 on the Availity Web Portal, users need to be assigned to the Patient360 role which Availity administrators can locate within the clinical roles options. If a user already has the Patient Care Summary role, he or she will automatically be re-assigned to the Patient360 role. You may choose one of the two options listed below to navigate to Patient360:

**Option 1**

- Select Patient Registration from Availity's top menu bar
- Choose Eligibility and Benefits
- Complete the required fields on the Eligibility and Benefits screen
- Select the Patient360 link on the member’s benefit screen
- Enter the member information in the required fields

**Option 2**

- Select Payer Spaces from Availity’s top menu bar
- Choose the “Anthem Blue Cross Blue Shield” tile
- Select Patient360 located on the Applications page
- Enter the member information in the required fields

Not registered on the Availity Web Portal?

- Go to [www.Availity.com](http://www.Availity.com)
- Select Register
- Select Get Started
- Complete the online registration form
Need assistance?

If you have questions about Patient360, please contact your Anthem local network manager. If you have questions regarding Availity Web Portal registration, contact Availity Client Services at 1-800-282-4548.

Receive email 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 email service – Network eUPDATE – to communicate urgent and time sensitive information. If you are not yet signed up to receive Network eUPDATES, we encourage you to enroll now.

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.

FEP update

Gender Reassignment Surgery: New benefit for the Federal Employee Program®

On January 1, 2017, the Gender Reassignment Surgery (GRS) benefit was added to provide surgical benefits for the treatment of gender dysphoria for members age 18 or older enrolled in the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP). A brochure, available on fepblue.org, outlines all criteria and requirements to utilize the GRS benefit.

The GRS benefit requirements include but are not limited to the following:

- A diagnosis of Gender Dysphoria by a qualified health professional
- A prior approval for surgeries requested
- A treatment plan with all surgeries listed and the proposed plan of care
- Inclusion of two referral letters from qualified mental health professionals
Provider toolkit

A provider toolkit for the GRS benefit is available that lists all prior approval requirements and includes form fields to enter name(s) and contact number(s). A list of covered procedures is included with the toolkit. To request this provider toolkit, call our Utilization Management area toll free at 1-800-860-2156 to speak to a representative. To assist with the prior authorization of the services requested, a completed provider toolkit and the required documentation must be provided to the Plan.

For prior approval requests, it’s important to identify the care coordinator and/or the referring provider who would be the single point of contact for all care for the member’s gender reassignment. Providing this contact name will assist in the prior approval process. If you do not have the care coordinator or referring provider contact information, please ask the member to call the Utilization Management area at 1-800-860-2156 to provide the name of his/her care coordinator to a UM nurse or intake representative.

Medicaid information

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

Notification process reminder

Effective **April 1, 2017**, failure to obtain precertification for Anthem HealthKeepers Plus members and failure to notify HealthKeepers, Inc. of a member’s admission or transfer within established time frames (as outlined below) may result in your claims being administratively denied, and you will not receive payment for the service(s). For participating providers, this is a contractual obligation per the Provider Manual effective April 1, 2017, or as stipulated in your contract. As a reminder, providers cannot balance-bill Anthem HealthKeepers Plus members for services that were administratively denied. Members who are retroactively enrolled into the Medicaid Plan by the state are deemed out-of-scope.

If your claim is administratively denied, you may file an appeal as outlined in the Agreement and the Provider Manual. As part of your appeal, you must demonstrate you notified, or attempted to notify, HealthKeepers, Inc. and the services were medically necessary.

HealthKeepers, Inc. must be notified of all admissions or transfers within one business day of admission. Ideally, notification should occur the day of admission; however, you have one business day to notify without penalty. A business day is considered Monday through Friday, excluding weekends and federal holidays.

Notification for all admissions, including transfers, should occur within one business day of admission. The following clinical scenarios are deemed an emergency and, therefore, excluded from the one-business-day requirement for administrative denial. These services will be reviewed for clinical and medical necessity criteria upon receipt of notification:

- Admission to a Neonatal Intensive Care Unit
- Admission to an Intensive Care Unit (ICU)
- Direct admission to an operating room (OR)/recovery room
- Direct admission to a telemetry floor
- Involuntary behavioral health admission

An admission to a general ward (i.e., medical/surgical) is considered in scope for our standard notification requirement of one business day. Failure to notify us within one business day of transfer from an emergency level of care (see above list) to a lower level of care is considered failure to notify, and administrative denial applies.

Notification of OB antepartum/postpartum admissions that do not result in a delivery should occur within one business day.

To obtain precertification or to verify member eligibility, benefits or account information, follow instructions outlined within the Provider Website, Provider Quick Reference Guide, Provider Manual, IVR or via the Availity® website, where applicable.

For additional information and/or detailed precertification requirements, refer to the provider website https://mediproviders.anthem.com/va/pages/manuals-directories-training.aspx and choose precertification from the home page.

If you have questions about this communication, please contact your local Anthem HealthKeepers Plus Provider Relations representative or Provider Services at 1-800-901-0020.

**Reminders for Private Duty Nursing (PDN) providers**

Please note that all requests for Private Duty Nursing (PDN) must include the following requirements:

1. A current and signed EPSDT Medical Needs Assessment (DMAS-62) dated within six months or upon hospital discharge
   - Assessments must be reviewed and signed by a Physician, Physician’s Assistant or Nurse Practitioner

2. A Home Health Certification and Plan of Care (CMS-485) signed by a Physician, Physician’s Assistant or Nurse Practitioner that covers the requested time period
   - Include cover sheet noting total hours required, excluding school hours

3. Two most recent weeks of nursing notes

As a reminder, if members receive PDN services during school hours, those hours are not covered by HealthKeepers, Inc. Please ensure requests for school PDN services are sent to DMAS or the associated service authorization provider for DMAS. If HealthKeepers, Inc. is incorrectly billed for PDN hours provided in a school setting, the claim will be denied, and you will be instructed to re-submit the claim to DMAS or the associated service authorization provider for DMAS.
In order to save time, please use HealthKeepers, Inc. provider portal at https://mediproviders.anthem.com/va to check authorization status. If you do not have access to the provider portal, please contact your Provider Relations representative for assistance.

For questions regarding PDN or the billing process, please call 1-800-901-0020.

**Genetic Testing services to require prior authorization**

Effective **May 1, 2017**, HealthKeepers, Inc. will require prior authorization (PA) for Epidermal Growth Factor Receptor (EGFR) Testing, Prothrombin (Factor II) Mutation Testing, Methylene tetrahydrofolate Reductase Mutation Testing and Cell-Free Fetal DNA Based Prenatal Testing. This notice impacts claims for members enrolled in Anthem HealthKeepers Plus.

All requests must be reviewed for PA dates of service beginning on or after **May 1, 2017**. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, and including definitions and specific contract provisions/exclusions, take precedence over these prior authorization rules and must be considered first when determining coverage.

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

- 81235, 81291, 81420, 81507 and 0009M

Please use one of the following methods to request PA:

- Call Provider Services: 1-800-901-0020
- Fax: 1-800-964-3627
- Visit the web: https://mediproviders.anthem.com/va

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

**Reimbursement policies**

The following section addresses two reimbursement policy updates:

1. **Modifier 63: Procedure Performed on Infants Less Than 4 kg**
2. **Vaccines for Children Program**
Policy Update: Modifier 63 – Procedure Performed on Infants Less Than 4 kg
(Policy 06-015, effective 09/15/2017)

Currently, HealthKeepers, Inc., for its Anthem HealthKeepers Plus members, allows reimbursement of 120% for surgery on neonates and infants up to a present body weight of 4 kg. Effective September 15, 2017, HealthKeepers, Inc. will allow reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 at 100% of the applicable fee schedule or contracted/negotiated rate. Please note the neonate weight should be documented clearly in the report for the service.

Assistant surgeon and/or multiple procedure rules and fee reductions apply when:

- An assistant surgeon is used
- Multiple procedures are performed on neonates or infants less than 4 kg in the same operative session

**Key definition**

**Modifier 63**: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding Modifier 63 to the procedure.

In applicable circumstances, HealthKeepers, Inc. does not allow reimbursement for Modifier 63. To view these circumstances, please refer to the Modifier 63: Procedure Performed on Infants Less Than 4 kg Reimbursement Policy at https://mediproviders.anthem.com/va.

Policy Update: Vaccines for Children Program
(Policy 05-022, effective 09/15/16)

HealthKeepers, Inc. allows reimbursement for vaccinations provided by the Vaccines for Children (VFC) Program for eligible Anthem HealthKeepers Plus members under the age of 19. Medicaid providers who participate in the VFC Program and immunize children shall comply with all of the reporting requirements and procedures. HealthKeepers, Inc. does not reimburse providers for the vaccine serum, as it is provided free-of-charge through the VFC Program.

Although you may only be reimbursed for the administration of the vaccine, serum code(s) must be included on the claim to meet regulatory and HEDIS®* reporting requirements that members are receiving the proper immunization(s).

What’s New?

The eligible age was under the age of 21. Reimbursement is now allowed for vaccinations for eligible members under the age of 19.

For additional information, refer to the Vaccines for Children (VFC) Program Reimbursement Policy at https://mediproviders.anthem.com/va.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).*
On November 3, 2016, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following coverage guidelines applicable to Anthem HealthKeepers Plus members. These guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the below listing.

The coverage guidelines were made publicly available on the HealthKeepers, Inc. website on the effective date listed as follows. Visit https://mediproviders.anthem.com/va/Pages/medical.aspx to search for specific guidelines.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Coverage guideline number</th>
<th>Coverage guideline title</th>
<th>New or revised</th>
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</thead>
<tbody>
<tr>
<td>12/28/2016</td>
<td>DME.00040</td>
<td>Automated Insulin Delivery Devices</td>
<td>New</td>
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<tr>
<td>12/28/2016</td>
<td>DRUG.00090</td>
<td>Bezlotoxumab (ZINPLAVA™)</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00097</td>
<td>Olaratumab (Lartruvo™)</td>
<td>New</td>
</tr>
<tr>
<td>12/28/2016</td>
<td>DRUG.00102</td>
<td>Cabazitaxel (Jevtana®)</td>
<td>New</td>
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<tr>
<td>12/28/2016</td>
<td>LAB.00033</td>
<td>Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer</td>
<td>New</td>
</tr>
<tr>
<td>11/17/2016</td>
<td>DRUG.00036</td>
<td>Ultraviolet Light Therapy Delivery Devices for Home Use</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00038</td>
<td>Bevacizumab (Avastin®) for Non-Ophthalmologic Indications</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00041</td>
<td>Rituximab (Rituxan®) for Non-Oncologic Indications</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00042</td>
<td>Ustekinumab (Stelara®) (HAE)</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00048</td>
<td>Eribulin mesylate (Halaven®)</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00057</td>
<td>Canakinumab (Ilaris®)</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00068</td>
<td>Vedolizumab (Entyvio®)</td>
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<tr>
<td>12/28/2016</td>
<td>DRUG.00066</td>
<td>Antihemophilic Factors and Clotting Factors</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00071</td>
<td>Pembrolizumab (Keytruda®)</td>
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<td>11/17/2016</td>
<td>DRUG.00075</td>
<td>Nivolumab (Opdivo®)</td>
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<td>11/17/2016</td>
<td>DRUG.00082</td>
<td>Daratumumab (DARZALEX™)</td>
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<tr>
<td>11/17/2016</td>
<td>DRUG.00085</td>
<td>Ixabepilone (Ixempra®)</td>
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</tbody>
</table>
Clinical utilization management guidelines update

On November 3, 2016, the MPTAC approved the following clinical utilization management (UM) guidelines applicable to Anthem HealthKeepers Plus members. These clinical guidelines were developed or revised to support clinical coding edits. Several guidelines were revised to provide clarification only and are not included in the following listing. This list represents the Clinical UM Guidelines adopted by the Medical Operations Committee for the Government Business Division on December 6, 2016.

On November 3, 2016, the clinical guidelines were made publicly available on the HealthKeepers, Inc. coverage guidelines and clinical UM guidelines subsidiary website. To search for specific guidelines, visit: https://mediproviders.anthem.com/va/Pages/medical.aspx.

Existing precertification requirements have not changed. Please share this notice with other members of your practice and office staff.

<table>
<thead>
<tr>
<th>Effective date</th>
<th>Clinical UM guideline number</th>
<th>Clinical UM guideline title</th>
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<tbody>
<tr>
<td>11/17/2016</td>
<td>DRUG.00088</td>
<td>Atezolizumab (Tecentriq™)</td>
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<tr>
<td>12/28/2016</td>
<td>GENE.00002</td>
<td>Preimplantation Genetic Diagnosis Testing</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>GENE.00019</td>
<td>BRAF Mutation Analysis</td>
<td>Revised</td>
</tr>
<tr>
<td>11/17/2016</td>
<td>GENE.00035</td>
<td>Genetic Testing for TP53 Mutations</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>MED.00064</td>
<td>Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)</td>
<td>Revised</td>
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<td>11/17/2016</td>
<td>MED.00083</td>
<td>Melanoma Vaccines</td>
<td>Revised</td>
</tr>
<tr>
<td>11/17/2016</td>
<td>SURG.00055</td>
<td>Cervical Total Disc Arthroplasty</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>SURG.00121</td>
<td>Transcatheter Heart Valve Procedures</td>
<td>Revised</td>
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<tr>
<td>11/17/2016</td>
<td>CG-DRUG-64</td>
<td>FDA-Approved Biosimilar Products</td>
<td>New</td>
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<tr>
<td>12/28/2016</td>
<td>CG-DRUG-54</td>
<td>Agalsidase beta (Fabrazyme®)</td>
<td>New</td>
</tr>
<tr>
<td>12/28/2016</td>
<td>CG-DRUG-55</td>
<td>Elosulfase alfa (Vimizim®)</td>
<td>New</td>
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<tr>
<td>12/28/2016</td>
<td>CG-DRUG-56</td>
<td>Galsulfase (Naglazyme®)</td>
<td>New</td>
</tr>
<tr>
<td>12/28/2016</td>
<td>CG-DRUG-57</td>
<td>Idurasufase (Elaprase®)</td>
<td>New</td>
</tr>
</tbody>
</table>
Additional information on ClaimCheck® upgrade to ClaimsXten™

HealthKeepers, Inc. previously announced plans to upgrade from ClaimCheck to the ClaimsXten auditing system in the second quarter of 2017 for Anthem HealthKeepers Plus member claims.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider Explanation of Payment (EOP) or Clear Claim Connection explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the EOP when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your EOP, please call Provider Services at 1-800-901-0020.

Addiction and Recovery Treatment Services program

In response to growing opioid addiction concerns within Virginia, HealthKeepers, Inc. is covering several substance abuse services for Anthem HealthKeepers Plus members effective April 1, 2017. Addiction and Recovery Treatment Services (ARTS) is an expansion of substance abuse (SA)-covered services traditionally managed by Magellan. Through the ARTS program, HealthKeepers, Inc. will provide a number of community-based addiction and recovery treatment services. Not only
will the traditional SA services be covered, but several new services have been added for Anthem HealthKeepers Plus members, including inpatient/residential SA detoxification services and SA residential services.

As it is a widely used and comprehensive set of guidelines to determine placement, continued stay, and transfer/discharge for patients with addiction and co-occurring conditions, the American Society of Addiction Medicine criteria will be used for clinical review of services. Authorizations will be required for most services under this program.

HealthKeepers, Inc. continues to develop the ARTS provider network. If your organization is interested in participating or obtaining more information about the program, contact the provider network manager for your service area or Provider Services at 1-800-901-0020. Up-to-date ARTS information can also be found on the Virginia Department of Medical Assistance Services website at [http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx](http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx).

### Addiction and Recovery Treatment Services program — Facility billing information

In order to determine the level of service Anthem HealthKeepers Plus members receive, the Virginia Department of Medical Assistance Services requires the use of modifiers on all claims submitted to HealthKeepers, Inc. for American Society of Addiction Medicine (ASAM) levels 3.3, 3.5 and 3.7.

Required modifiers for each type of service are as follows:

<table>
<thead>
<tr>
<th>ASAM level of care</th>
<th>Revenue code</th>
<th>HCPCS code</th>
<th>Required modifier</th>
<th>Type of service</th>
</tr>
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<tbody>
<tr>
<td>3.3</td>
<td>1002</td>
<td>H0010</td>
<td>TG</td>
<td>Clinically-managed and population-specific high-intensity residential services for those with cognitive impairments</td>
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<td>3.5</td>
<td>1002</td>
<td>H0010</td>
<td>HA</td>
<td>Clinically-managed and population-specific high-intensity residential services (24-hour care) — adolescents</td>
</tr>
<tr>
<td>3.5</td>
<td>1002</td>
<td>H0010</td>
<td>HB</td>
<td>Clinically-managed and population-specific high-intensity residential services (24-hour care) — adults</td>
</tr>
<tr>
<td>3.7</td>
<td>1002</td>
<td>H2036</td>
<td>HA</td>
<td>Medically-monitored, intensive inpatient services (24-hour nursing care with physician availability) — adolescents</td>
</tr>
<tr>
<td>3.7</td>
<td>1002</td>
<td>H2036</td>
<td>HB</td>
<td>Medically-monitored, intensive inpatient services (24-hour nursing care with physician availability) — adults</td>
</tr>
</tbody>
</table>

### Amendment to the Virginia Health Maintenance Organization Medicaid Participation Attachment to the Blue Cross and Blue Shield Provider Agreement

Beginning **April 1, 2017**, changes to your *Virginia Health Maintenance Organization (HMO) Medicaid Participation Attachment to the Blue Cross and Blue Shield Provider Agreement* take effect. These changes are required by the Virginia
Department of Medical Assistance Services (DMAS) in support of the new Commonwealth Coordinated Care Plus (CCC Plus) program being implemented later this year for Managed Long-Term Services and Supports.

Article I: definitions

“CCC Plus” means the Commonwealth Coordinated Care Plus statewide Medicaid managed long term services and supports program. References to Medicaid and Medicaid Members herein also refer to CCC Plus and Medicaid Members receiving covered benefits from CCC Plus.

“Confinement” means any number of consecutive days that a Medicaid Member is confined to the Facility including leave days, if any.

“Medicaid Member” means a Member enrolled under any contract HMO may have with DMAS during the term of the Agreement. Medicaid Members include Members enrolled through Virginia’s Medallion 3.0 program, Family Access to Medical Insurance Security (“FAMIS”) plan, or FAMIS MOMS program or their successor programs as well as Members enrolled under any new programs for which HMO may contract with DMAS such as the Virginia Acute and Managed Long-Term Services and Supports Program, including CCC Plus.

“Medicaid Provider Manual” means the document or set of documents that sets forth certain operational and administrative rules, policies, programs and procedures established and implemented by HealthKeepers. HealthKeepers will make the Provider Manual(s) available through a commonly available web site https://mediproviders.anthem.com/va/pages/manuals-directories-training.aspx or upon request

Article II: Services/obligations

2.12 Provider shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act and the Deficit Reduction Act of 2005 (DRA).

2.13 Consistent with Federal managed care regulations at 42 C.F.R. 438.3(u), the Facility shall maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten (10) years. In following with 12VAC30-120-1730, for Members who are children under age 21 and enrolled in the Tech program, the Facility shall retain records for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age.

2.14 Provider shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. The provider shall be required to immediately report to HMO any exclusion information discovered. The provider shall be informed by the HMO that civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to CCC Plus members.
2.15 Provider shall comply with Federal contracting requirements described in 42 CFR Part 438, including identification of non-payment of provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.

2.16 Provider shall comply with the CMS HCBS Settings Rule detailed in 42 C.F.R § 441.301(c)(4)-(5).

2.17 Provider shall comply with corrective action plans initiated by HMO Contractor.

2.18 Provider shall comply with the Affordable Care Act Contractor policies and procedures, including but not limited to, reporting overpayments pursuant to state or federal law.

2.19 Provider shall have a National Provider Identifier (“NPI”) number

2.20 Provider shall accept HMO payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid member for Medicaid covered medically necessary services provided during the member’s period of HMO enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a CCC Plus recipient for any Medicaid covered service provided is expressly prohibited. Should an audit by the HMO or an authorized state or federal official result in disallowance of amounts previously paid to the provider, the provider will reimburse the HMO upon demand.

Article III: Compensation and audit

3.1.1 Provider agrees to provide to HMO, unless otherwise instructed, at no cost to HMO or the Medicaid Member, all information necessary for HMO to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Medicaid Covered Services. Once HMO determines it has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member’s Health Benefit Plan, the PCS, Regulatory Requirements, and the provider manual(s). Notwithstanding the foregoing, HMO shall make best efforts to pay Provider within thirty (30) days of the receipt of a Clean Claim for Medicaid Covered Services rendered to a Medicaid Member. Claims for LTSS Services (including when LTSS services are covered under ESPDT), community behavior health and early intervention services will be processed within fourteen (14) days of receipt of the clean claim for Members enrolled in CCC Plus. If HMO does not reimburse Provider within this thirty (30) day period, HMO will pay interest to Provider pursuant to Code of Virginia § 38.2-4306.1.

Article VII: General provisions

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, or the Provider Manual, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect. Notwithstanding the foregoing, any conflict in the interpretation of HMO’s policies and this Agreement shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and provider manuals.

These changes are made in accordance with Paragraph 7.1 — Regulatory Amendment of your Virginia HMO Medicaid Participation Attachment to the Blue Cross and Blue Shield Provider Agreement that states: “Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments.”
Note that no action is required by you. If you are currently participating in the Anthem HealthKeepers Plus network, your Medicaid attachment is automatically being updated to include provisions for new CCC Plus members. If you are not participating in the Anthem HealthKeepers Plus network and would like to participate, please contact your network manager.

Screen for Lead: Every child, every time. Filter paper lead testing

The Centers for Disease Control and Prevention estimate that 500,000 children in the United States suffer from levels of lead above the reference level at which public action is recommended. Lead poisoning may affect children of all socioeconomic levels and may occur without obvious symptoms. Blood lead screening may help detect lead poisoning.

Go to our website for additional information or select the following link for the lead screening flier: https://mediproviders.anthem.com/Documents/VAVA_CAID_PU_LeadTesting.pdf

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.

CORRECTION: Prior authorization required for Epidermal Growth Factor Receptor (EGFR) Testing

In the February 2017 edition of the Network Update, the effective date was stated in error. The correct effective date is May 1, 2017, for the prior authorization requirement regarding Epidermal Growth Factor Receptor Testing. For easy reference, we are including the article again in its entirety in this edition. We apologize for any inconvenience this situation may have caused.

Effective May 1, 2017, prior authorization (PA) will be required for Epidermal Growth Factor Receptor (EGFR) Testing for members enrolled in Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan.

Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines and including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage.

Non-compliance with the new requirement may result in denied claims. PA requirement will be added to the following code:

- 81235 – EGFR (epidermal growth factor receptor) (e.g., non-small cell lung cancer) gene analysis, common variants (e.g. exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)
To request PA, please access the tool under the PA tab on the provider self-service website at https://mediproviders.anthem.com/va.

Providers may also call the Anthem HealthKeepers MMP Customer Care team at 1-855-817-5788, Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

If you have questions about this communication or need assistance with any other item, contact Provider Services at 1-855-817-5788.

Prior authorization requirements for Part B drug – Exondys 51 (eteplirsen)

Effective June 1, 2017, HealthKeepers, Inc. will change prior authorization (PA) requirements for Part B injectable/infusible drugs covered for members enrolled in Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan. The drug is Exondys 51 (eteplirsen).

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

Non-compliance with new requirements may result in denied claims. PA requirements will be added to the following code, which is a drug billed with not otherwise classified (NOC) HCPCS J code J3590:

- **Exondys 51 (eteplirsen)**: An alkylating drug indicated for: 1) Use as a high-dose conditioning treatment prior to hematopoietic progenitor (stem) cell transplantation in patients with multiple myeloma. 2) The palliative treatment of patients with multiple myeloma for whom oral therapy is not appropriate. J3590

Please note, this drug is currently billed under the NOC J-code J3590. Since this code includes drugs that are NOC, if the authorization is denied for medical necessity, the plan’s denial will be for the drug and not the HCPCS.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at www.Availity.com at https://mediproviders.anthem.com/va > Login. Contracted and non-contracted providers unable to access Availity may call our Provider Services at 1-855-817-5788 for PA requirements.

Prior authorization requirements for Part B drug – Evomela® (melphalan for injection)

Effective June 1, 2017, HealthKeepers, Inc. prior authorization (PA) requirements will change for the Part B injectable/infusible drug covered for members enrolled in Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan.

This drug includes Evomela (melphalan for injection). Federal and state law as well as state contract language and CMS guidelines (including definitions and specific contract provisions/exclusions) take precedence over these precertification rules and must be considered first when determining coverage.
Noncompliance with new requirements may result in denied claims. PA requirements will be added to the code billed with not otherwise classified (NOC) HCPCS J-code J9999:

- **Evomela (melphalan for injection)**: for high-dose conditioning treatment for multiple myeloma patients undergoing autologous stem cell transplantation and palliative treatment of multiple myeloma patients who cannot take oral therapy (J9999)

Please note: This drug is currently billed under the NOC J-code J9999. Since this code includes drugs that are NOC, if the authorization is denied for medical necessity, the plan’s denial will be for the drug and not the HCPCS code.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool by logging in at [https://mediproviders.anthem.com/va](https://mediproviders.anthem.com/va). Contracted and non-contracted providers who are unable to access the Provider Self-Service Tool may call the MMP Customer Care line at **1-855-817-5788** for PA requirements.

### Prior authorization for outpatient radiation therapy services

HealthKeepers, Inc. requires prior authorization (PA) for outpatient radiation therapy services for members enrolled in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan.

Providers should continue to request PA for the radiation therapy modalities and services listed below:

- Intensity-modulated radiation therapy
- 3-D conformal/external beam radiation therapy
- Brachytherapy
- Proton beam therapy
- Stereotactic body radiation therapy and stereotactic radiosurgery

The type of review needed will determine the PA steps that should be taken:

- Planning: PA is administered by contacting HealthKeepers, Inc. via the Availity Web Portal.
- Planning and delivery: PA is administered by AIM Specialty Health® (AIM).
- Delivery: PA is administered by AIM.

If you are only requesting PA for planning codes, and you are not yet ready to request PA for delivery codes or the radiation therapy is being performed as part of an inpatient admission, you may request approval by contacting HealthKeepers, Inc. at **1-855-817-5788** or through the provider website, [https://mediproviders.anthem.com/va](https://mediproviders.anthem.com/va).
AIM reviews PAs for planning and delivery services under the umbrella of radiation therapy modalities. They evaluate certain treatment plans against clinical appropriateness criteria to ensure the care aligns with established medical best practices and Medicare/Medicaid guidelines as appropriate.

If you are ready to deliver any of the services listed above, please contact AIM. To submit your request, go to the AIM ProviderPortal℠ at www.aimspecialtyhealth.com. For additional assistance, contact AIM toll free at 1-800-714-0040 Monday through Friday from 8 a.m. to 8 p.m. ET.

**FX modifier and tetanus vaccine**

**Payment reduction for X-rays taken using film**

Effective for dates of service on or after January 1, 2017, HealthKeepers, Inc. follows the CMS requirement in which providers must use the FX bill modifier when billing X-rays using film for members enrolled in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan. A payment reduction of 20% will apply to the technical component (and the technical component of the global fee) for X-ray services provided using film for which payment is made under the Medicare Physician Fee Schedule.

**Claims for tetanus vaccinations**

Effective January 1, 2016, tetanus vaccine 90703 is no longer accepted by Medicare. Effective for dates of service on and after January 1, 2016, providers administering a tetanus vaccine for an open wound or laceration should bill using 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to a 90471 and/or 90472 administration code and the appropriate diagnosis code to indicate an open wound or laceration. Claims should be submitted to Anthem HealthKeepers MMP.

If a tetanus vaccine is administered for a reason other than a puncture wound or laceration and the member has pharmacy benefits, bill the member’s Medicare Part D plan. This applies to the vaccine and the administration charges.

To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse via their website (www.transactrx.com) or call Customer Service at 1-866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no cost to providers who use electronic funds deposit to receive payment; however, there is a service fee of $2.50 for check payments on claims.

**Launch of the Retrospective Medical Record Review Program**

Risk adjustment is the method used by CMS to adjust the capitated payment made to HealthKeepers, Inc. based on demographic characteristics and health status (represented by diagnosis data and disease interactions) of each member enrolled in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan. Risk adjustment relies on the timely and accurate collection and submission of member diagnosis data each year. All diagnosis data must be supported by the member’s medical record documentation. Federal regulations require HealthKeepers, Inc. to review and validate medical records to avoid underpayments and overpayments.
Program details

Our retrospective medical record review initiative is a risk adjustment program intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations.

HealthKeepers, Inc. contracts with Verscend Health (formerly Verisk) to conduct outreach to providers as well as collect, review and code medical records with dates of service for the 2017 target year through present day.

What you need to know

The Retrospective Risk Program Lead, Jaime Marcotte, is managing this initiative. For more information on this program, please contact Jaime at jaime.marcotte@anthem.com or 1-314-925-6094.

FAQs — Retrospective Medical Record Review Program

Q. What is the Retrospective Medical Record Review Program?
A. The program is intended to identify and capture previously undocumented data and/or new diagnosis information that may have been missed due to coding and/or technical limitations. We exclusively contract with Verscend Health (formerly Verisk) for this initiative.

Q. What services is Verscend performing on behalf of HealthKeepers, Inc.?
A. Verscend is contracted to retrieve the medical records of targeted members as well as review these records and code them based on ICD-10-CM coding guidelines and requirements. Additionally, Verscend sends a data extract including the coded conditions to us.

Q. Is the retrospective medical record review an audit?
A. This is not a retrospective claims validation audit.

Q. What dates of service are included for the 2017 initiative?
A. The scope for this initiative includes 2016 dates of service through present day.

Q. Are all Anthem HealthKeepers MMP members targeted?
A. No, HealthKeepers, Inc. conducts a complex effort synthesizing claims and pharmacy data with enrollment data. Due to the high probability of identifying undocumented data and/or new diagnosis information, persistent members are targeted for this initiative.

Q. What is the provider notification process?
A. Beginning in early May, Verscend will initiate the record retrieval process. The process begins with phone/fax outreach to the provider that is followed by a written request. The written request includes:

- Role of Verscend
- Purpose of the medical record retrieval request
- Action being requested (for example, submission of the entire medical record)
- Name of the member
- Date(s) of service being requested
Q. When do I need to submit the requested medical records?
A. You should supply the medical records within two weeks of receipt of the request. If the volume is large, Verscend will work with you throughout 2017 to obtain the requested records.

Q. What should I do if I did not actually see the member during the requested date(s) of service?
A. You should return the request to Verscend and include an explanation stating you do not have information relative to the request in the patient’s medical record.

Q. How do I submit a medical record? Are there different submission options?
A. Medical records should be returned to Verscend using one of the following methods:

- Mail with prepaid postage
- Electronic medical record (EMR) integration (Verscend requires remote access to the provider’s EMR system.)
- Secure file transfer protocol
- Secure Provider Upload Portal (Contact Jaime Marcotte for details regarding this option.)
- On-site scanning (reserved for providers with large record requests)

Q. I received a request for a large number of medical records; can special arrangements be made?
A. Verscend offers on-site scanning services for providers who receive a request for a large number of medical records.

Q. Am I required to comply with the request for medical records?
A. In accordance with the language in the Terms and Conditions of Payment section of your Provider Agreement, you are required to comply with requests from HealthKeepers, Inc. for medical records.

Q. Do I need HIPAA (Health Insurance Portability and Accountability Act) authorization or a release from the patient in order to supply his or her medical records?
A. No, the collection of risk adjustment data as well as the request for medical records to validate payment made to Medicare-Medicaid Plan organizations is considered a health care operation and, as such, does not violate the privacy provisions of HIPAA (CFR 164.502).

Q. Who can I contact if I have questions?
A. Verscend Retrospective Program Manager, Jaime Marcotte, is managing this initiative. She can be reached by phone at 1-314-925-6094 or by email at jaime.marcotte@anthem.com.
Hospital observation service limits

This is a correction to the previous HealthKeepers, Inc. hospital observation service limits communication published in October 2016. Observation services with less than eight hours will be considered a bundled service. Observation services billed over 72 hours will be considered as exceeding limits. This pertains to both contracted and non-contracted providers.

For those enrolled in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan, a member’s time in observation (and hospital billing) begins with the member’s admission to an observation bed. Time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including follow-up care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient. The billed units of service should equal the number of hours the patient receives observation services.

Hospitals should use HCPCS codes G0378 and G0379 to report observation services and direct admission for observation care. Hospitals are reminded not to report CPT codes 99217-99226 for observation services.

Additional information and discussion regarding hospital observation services can be found in the Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, 290.2.2.

Additional information on ClaimCheck® upgrade to ClaimsXten™ impacts MMP

HealthKeepers, Inc. previously announced plans to upgrade from ClaimCheck® to the ClaimsXten™ auditing system in the second quarter of 2017 regarding claims for members enrolled in the Anthem HealthKeepers Medicare-Medicaid Plan (MMP), a Commonwealth Coordinated Care plan.

This upgrade will continue to ensure claims auditing remains consistent with accepted industry coding standards. However, claim results may present differently than those processed in the earlier software even though the end result is the same.

The new software uses a set of explanation codes that differ from those currently in use. Along with the new explanation codes, any updated associated descriptive text will display on the provider Explanation of Payment (EOP) or Clear Claim Connection explaining the edits applied to the submitted claim, just like today.

You may notice another difference on the EOP when ClaimsXten applies an edit based on the number of units billed. Currently, claims receiving an audit due to units that exceed the maximum allowed are displayed on two separate lines. The new software will still show separate lines for claims with less than 100 units, but claims with units billed greater than 100 will be displayed on a single line showing the reimbursement amount and the number of allowed units.

If you have questions regarding ClaimsXten edits you receive on your EOP, please call MMP Customer Care at 1-855-817-5788.
Medicare information

(Anthem’s Medicare Advantage and Medicare Supplement plans)

Coding patient services reminders

To help ensure your patients and our members receive their medical care in a timely fashion, we would like to remind you of important things to keep in mind when submitting CPT codes for requested services:

1. Ensure the CPT code requested is the service that the physician/provider details in the medical record.

2. Review appropriate coding and Medicare guidelines to ensure service is a covered service and that the code is a valid code for that year.

3. If a code that is requested does not match the intended service, please be prepared to correct the error and resubmit the request.

4. Anthem relies on the information submitted from the medical record to make our determinations on your requests. It is important that all relevant information to the members requested service be submitted.

Providers requesting authorization for services based on incorrectly documented CPT/HCPCS codes may receive avoidable denial notices where the code/service is found not medically necessary or non-covered.

Preventive service procedure codes updated for 2017

Preventive service procedure codes have been updated. Please be sure to file claims with the new codes according to the dates of service applicable.

**Abdominal Aortic Aneurysms**

- Effective January 1, 2017, 76706 will replace **G0389** for Abdominal Aortic Aneurysms (AAA).

- **G0389** is used for services furnished prior to January 1, 2017.

**New flu vaccines – Medicare preventive benefit – Part B immunizations**

- 90674 Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use.
  - This new flu vaccine code can be used for dates of service on or after August 1, 2016.
90682 Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use.

- Currently, this new flu vaccine has not received FDA approval therefore this flu vaccine will be denied. Once approved by the FDA, this vaccine will be a covered Medicare Part B Immunization.

Smoking and tobacco cessation

- Effective October 1, 2016, G0436 and G0437 are no longer valid codes for smoking and tobacco cessation counseling services. Beginning with dates of service on or after October 1, 2016, CPT codes 99406 and 99407 should be used to report smoking and tobacco cessation counseling services.

CMS releases new coding guidelines for 3D mammography

When billing for mammography services, please use the following G codes for services on and after January 1, 2017: G0202, G0204, and G0206.

Additional information from CMS is available here:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Mammography-Services-Coding-Direct-Digital-Imaging.pdf

Comply with clinical information requests

Anthem requires that the treating physician, clinician or supplier 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.

The Centers for Medicare & Medicaid Services recently added an additional requirement for health plan peer reviewers to contact contracted and non-contracted providers to gather medical information needed to make a coverage determination (https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/HPMS-Guidance-on-Outreach-for-Information-to-Support-Coverage-Decisions-2016Oct18.pdf.) CMS expects plans “to make reasonable efforts to gather all of the information needed to make substantive and accurate decisions as early in the coverage process as possible.”

Anthem peer reviewers look forward to working with you to ensure that our members’ coverage determinations are made in a timely manner.
New G codes for home health agencies

For dates of service on and after January 1, 2017, a separate payment will be made to home health agencies (HHAs) who are reimbursed on a CMS PPS methodology and billing for disposable Negative Pressure Wound Therapy (NPWT) devices when furnished to a patient who receives home health services for which payment is made under the Medicare home health benefit. To receive separate payment for NPWT, in addition to billing a claim with type of bill 32X, HHAs must bill a claim with type of bill 34X, HCPCS 97607 or 97608 and the appropriate revenue code 042X, 043X or 0559.

Effective January 1, 2017, and thereafter, G0163 and G0164 will be retired and replaced with the following four new G-codes:

1. **G0493** – Skilled services of a registered nurse (RN) for the observation and assessment of the patient’s condition, each 15 minutes (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment in the home health or hospice setting).

2. **G0494** – Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient’s condition, each 15 minutes (the change in the patient’s condition requires skilled nursing personnel to identify and evaluate the patient’s need for possible modification of treatment in the home health or hospice setting).

3. **G0495** – Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

4. **G0496** – Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

New place of service code 02 for telehealth services

Effective January 1, 2017, Anthem is following CMS in implementing new place of service code 02. The new place of service code 02 is for use by physicians or practitioners furnishing telehealth services from a distant site. When billing telehealth services, distant site providers must bill with place of service code 02 and continue to bill modifier GT (via interactive audio and video telecommunication systems) or GQ (via asynchronous telecommunications system). Telehealth services not billed with the new place of service code 02 will be denied back to the provider.

See [https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html) for the list of Medicare Telehealth services.
Review high-risk medication reports

Anthem is required to monitor prescription activity for high-risk medications as defined by the Centers for Medicare & Medicaid Services (CMS) to improve patient safety.

To ensure providers are aware of any high-risk medications prescribed for our Medicare Advantage members, we fax a list of high-risk medication claims to providers each week.

Anthem also distributes a monthly report to prescribers detailing the number of members on high-risk medications and the number of high-risk medications prescribed year-to-date. We also contact members who have filled prescriptions for high-risk medications and suggest that they discuss the prescription with their physician and ask if there is a safer alternate drug.

If you receive a high-risk medication fax or report from Anthem, please review it and help us support safe medication choices. Alternatives to these high-risk medications are listed on www.anthem.com/maprovtoolkit

AccordantCare™ to provide support for Individual Medicare Advantage members with HIV

Anthem works with AccordantCare™ to provide targeted disease management services for our individual Medicare Advantage members with a number of rare medical conditions. Effective February 1, 2017, AccordantCare added Human Immunodeficiency Virus (HIV) management to the rare condition management program.

Members in your care who may benefit from additional outreach and information may receive letters, emails or phone calls from AccordantCare and Anthem. In the course of performing these activities, a nurse may contact you or your facility to obtain member information and/or AccordantCare may request medical information about Anthem members. AccordantCare and Anthem also will let you know of any health changes that may require your attention.

Members must give AccordantCare written consent that the company can communicate any medical health changes to you. If the consent is not given by the member, AccordantCare will not be able to disclose any information to you.

If you feel that an individual Medicare Advantage member would benefit from this program, please refer the member by contacting AccordantCare via phone (press #) or fax (press 6) at 1-866-247-1150.

Medicare Supplement – Please wait 30 days from Medicare remittance date before submitting another claim

All Blue Cross Blue Shield Association plans, including Anthem, are required to process Medicare crossover claims for services covered under Medigap and Medicare Supplement products through the Centers for Medicare & Medicaid Services (CMS). This eliminates the need for providers to submit an additional claim directly to Anthem.

When a Medicare claim has crossed over to Anthem for secondary payment, providers should wait 30 calendar days from the Medicare remittance date before submitting another claim to Anthem. Providers can identify if a claim has been crossed over for secondary payment by the following Medicare Remittance Advice remarks.
Medicare remittance advice remark codes MA18 or N89 indicate that Medicare crossover has been forwarded to the secondary carrier:

- **MA18 Alert**: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.

- **N89 Alert**: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.

If you use a claims clearing house to file Medicare Supplement claims, please ensure the clearing house waits 30 calendar days from the Medicare remittance date before submitting another claim to Anthem.

### Individual HMO MA members should use Hearing Care Solutions

As a reminder, members enrolled in our individual Medicare Advantage HMO plans that provide routine hearing exam and/or hearing aid benefits must use Hearing Care Solutions for their hearing benefits. When members contact Hearing Care Solutions to use hearing benefits, Hearing Care Solutions staff help the members find a provider in their area who will best meet their needs. Providers interested in joining the Hearing Care Solutions network should call 1-855-312-2545.

**Claims will be denied for HMO members who see a provider who is not contracted with Hearing Care Solutions.**

If you have questions, please call provider services on the number on the back of the member's ID card.

### Keep up with Medicare news

Please continue to check [Important Medicare Advantage Updates](https://anthem.com/medicareprovider) for the latest Medicare Advantage information, including:

- Risk Adjustment and Documentation Guidance Training Offered
- Retrospective medical record review program launches
- **HEDIS measure**: Ensure medication reconciliation is completed after discharge
- Home Health Services for Medicare Advantage Individual Members to Require Prior Authorization
- Prior Authorization Requirements for Part B Drugs: Exondys 51 (eteplirsen)
- Prior Authorization Requirements for Part B Drug – Evomela
- Claims for Tetanus Vaccinations
Additional Information on ClaimCheck Upgrade to ClaimsXten

Hospital Observation Service Limits

Providers Must Enroll with Medicare to be able to Prescribe Part D Beginning January 1, 2019

Tips for Improving Skilled Nursing Discharge Planning

Prior Authorization Requirements for Intracardiac Electrophysiological Studies and Catheter Ablation

CMS Emergency Preparedness Rule

Anthem hosts first 2017 provider education webinar on April 6 – Register today

Anthem's 2017 medical office provider education webinars begin this month – April 6, 2017. If you have not already done so, please consider registering today for the April 6 webinar so that you and your staff will receive the latest updates from Anthem that impact your business interactions with us. We’re also offering a second webinar on October 19. See the registration form on the next page to register.
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 2017 WEBINAR if you wish to attend:

☐ Thursday, April 6     (10:30 a.m.-11:30 a.m. ET) – Anthem Updates

☐ Thursday, October 19 (10:30 a.m.-11:30 a.m. ET) – Anthem Updates

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