January 2019 Anthem Indiana Provider Newsletter

Benefits to be available for chronic care management and advance care planning services effective February 23, 2019

Anthem Blue Cross and Blue Shield (Anthem) is committed to investing in primary care, rewarding coordinated, patient-centered care, and promoting proactive chronic care management. In recognition of the time-intensive nature of this work, Anthem will reimburse chronic care management and advance care planning services for Commercial health plans effective for claims processed on or after February 23, 2019.

Chronic care management (CCM) is care rendered by a physician or non-physician health care provider and their clinical staff, once per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only one practitioner can bill a CCM service per service period (month). Three CCM codes are included in this payment policy change: 99490, 99487and 99489.

Advance care planning (ACP) is a face-to-face service between a physician or other qualified health care professional and a patient discussing advance directives with or without completing relevant legal forms. An advance directive is a document in which a patient appoints an agent and/or records the wishes of a patient pertaining to their medical treatment at a future time if they cannot decide for themselves at that time. No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary. Two ACP codes are included in the payment policy change: 99497 and 99498

Anthem requires patient consent prior to CCM or ACP service(s) being provided. Please refer to the current *Claims Requiring Additional Documentation* policy for more information. For more information, review our Bundled Services and Supplies policy dated February 23, 2019 by visiting the reimbursement policy page for your state, Indiana, Kentucky, Missouri, Ohio, Wisconsin, found on anthem.com.

HEDIS® 2019 starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax.

The fax will contain 1) a cover letter with contact information your office can use to contact us if there are any questions; 2) a member list, which includes the member and HEDIS measure(s) the member was selected for; and 3) an instruction sheet listing the details for each HEDIS measure. **As a reminder, under HIPAA, releasing PHI for HEDIS data**

collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c) (4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within **five business days**.

To return the medical record documentation back to us in the recommended 5-day turnaround time, simply choose one of these options:

1. Upload to our secure portal. This is quick and easy. Logon to www.submitrecords.com, enter the password included with your HEDIS Member List and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.

OR

2. Send a secure fax to **1-888-251-2985**

OR

3. Mail to us via the **US Postal Service** to:
   Anthem, Inc., 66 E. Wadsworth Park Drive, Suite 110H, Draper, UT 84020

Please contact your Provider Network Representative to let them know if you have a specific person in your organization that we should contact for HEDIS medical records.

Thank you in advance for your support of HEDIS.

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

Simplifying medication prior authorization processes

Anthem Blue Cross and Blue Shield (Anthem) is committed to offering efficient and streamlined solutions for submitting prior authorizations (PAs). This helps reduce the administrative burden while improving the member experience for their patients.

Anthem's *Proactive PA* process approves select drugs in real time, using an automated prior authorization (PA) process. *Proactive PA* uses integrated medical and pharmacy data to seamlessly approve medication prior authorization requests where diagnoses are required.

Anthem's prior authorization process helps to ensure clinically appropriate use of medications.

Providers can take advantage of the electronic prior authorization (ePA) submission process by logging in at covermymeds.com. Creating an account is FREE, and many prior authorizations are approved in real time. Read more about the ePA submission process in the article published in December 2018. To access this article, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin

Additionally, providers may be able to access real-time, patient-specific prescription drug benefits information through their electronic medical record (EMR) system. To learn more about this feature, refer to the article published in October 2018. To access this article, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin

Update regarding drugs not approved by the FDA

Anthem Blue Cross and Blue Shield (Anthem) continually monitors and updates the list of drugs not approved by the Food and Drug Administration (FDA), which are considered non-covered under prescription drug benefits. When drugs are added to this list, Anthem notifies impacted members that the drug is not FDA approved and will no longer be covered.

Effective December 1, 2018, these drugs were added to our list of drugs not approved by the FDA. For new members just beginning an Anthem plan or not yet having used one of these non-FDA-approved drugs, coverage for these drugs ended December 1, 2018.

Existing members who had been identified as already using at least one of the drugs added to the list received a letter to let them know their drug(s) will no longer be covered after December 31, 2018. However, if the patient had a prior authorization for a drug on this list, coverage for that drug continued until the prior authorization expired on December 31, 2018.

Eligible facilities to bill modifiers JG and TB on 340B drugs

On November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) issued its 2018 Outpatient Prospective Payment System "OPPS" Final Rule, CMS CY2018 OPPS Final Rule, which finalized the Medicare Part B payment for certain drugs acquired through the 340B Program.

As appropriate, the 340B Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly discounted prices.

As described in the Final Rule, CMS established two new modifiers to identify 340B drugs – the “JG” and “TB” modifiers. Beginning January 1, 2018, affected entities were required to report these modifiers on outpatient claims for certain separately payable drugs or biologicals that are acquired through the 340B program and administered or dispensed to patients.

Beginning **April 1, 2019**, for our Commercial lines of business, Anthem Blue Cross and Blue Shield will require that all facilities eligible for the 340B Program bill these modifiers on all outpatient claims impacted by these modifiers.

These facilities are *excluded* from this billing requirement:

- Sole community hospitals (“SCHs”)
- Children’s hospital
- PPO-exempt cancer hospitals
- Critical access hospitals (“CAHs”)
- Drugs administered/dispensed in non-excepted hospital off-campus outpatient departments (“HOPDs”)

Pharmacy information available at anthem.com

Visit anthem.com/pharmacyinformation 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.

The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October).

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the 2018 Specialty Drug List or call us at 888-346-3731 for more information.

Reminder: HCPCS code A0998 Ambulance response and treatment with no transport is active and available for use

In early 2018, Anthem Blue Cross and Blue Shield (Anthem) became one of the first major insurers to reimburse EMS providers for appropriate and medically necessary care billed under HCPCS code A0998 (Ambulance response and treatment, no transport). The code, which has been active since January 2018 for most standard Anthem benefit plans, allows EMS providers to receive reimbursement for treatment rendered in response to an emergency call to a member's home or scene, when transportation to the hospital emergency room (ER) was not provided. Previously, Anthem reimbursed EMS providers for treatment rendered only when a patient was transported to the ER.

Important reminders:

- The code is currently active and available for EMS use.
- If an EMS provider responds to an emergency call and provides appropriate treatment at-home or on-site without transporting to the ER, code A0998 can be used.
- The EMS provider must render treatment to the patient per EMS protocols which are approved by the medical director at the local or state level.
- Billing of A0998 when treatment is not rendered is not appropriate.
- Anthem will apply medical necessity review to A0998 using clinical guideline CG-ANC-06.
- HCPCS code A0998 applies to all of Anthem's commercial health plans, and reimbursement will be made in accordance with the member's benefits.

Questions?

- For contract questions, please reach out to your contract representative.
- For questions about using code A0998, please reach out to Jay Moore, Senior Clinical Director for Anthem, Inc.

Anthem offers risk adjustment and documentation training

Anthem Blue Cross and Blue Shield (Anthem) will offer general and condition-specific Medicare risk adjustment, documentation and coding training in 2019. Additional information will be available at Important Medicare Advantage Updates at anthem.com/medicareprovider.

Medicare Advantage member Explanation of Benefits redesigned

Anthem Blue Cross and Blue Shield (Anthem) recently introduced a redesigned monthly Explanation of Benefits (EOB) to Medicare Advantage members.

The new EOB includes:

- Personalized tips to help members save on health care expenses.
- A preventive care checklist — to point out opportunities for screenings or other care.
- Alerts when a claim needs immediate attention.

If you or your members have any questions about how to read the new EOB, please call the number on the back of the member ID card.

Keep up with Medicare news

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

- New provider service phone number beginning January 1, 2019
- Medicare Advantage Reimbursement Policy: October Provider Bulletin
- Prior authorization requirements for Part B drugs: Moxetumomab Pasudotox, Cemiplimab and Fulphila
- Submit prior authorization medication requests electronically; new phone number for Medicare Advantage prescription prior authorizations
- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective January 1, 2019
- Inpatient Readmissions

Electronic data interchange gateway update

Anthem Blue Cross and Blue Shield has designated Availity as a **no-cost option** to operate and service your electronic data interchange (EDI) entry point (or EDI gateway). This

designation will ensure greater consistency and efficiency in EDI submission.

Who is Availity?
Availity is well known as a web portal and claims clearinghouse, but they are much more. Availity also functions as an EDI gateway for multiple payers and serves as the single EDI connection.

Your organization can submit and receive the following transactions through Availity's EDI gateway:

- 837 — institutional claims
- 837 — professional claims
- 837 — dental claims
- 835 — electronic remittance advice (ERA)
- 276/277 — claim status
- 270/271 — eligibility request

Get started with Availity:

- If you wish to submit directly to Availity, setup is easy. Go to the Availity Welcome Application and begin the process of connecting to the Availity EDI Gateway for your EDI transmissions.
- If you wish to use a clearinghouse or billing company, please work with them to ensure connectivity.

Need assistance?
The *Availity Quick Start Guide* will assist you with any EDI connection questions.

Availity payer IDs
You can access the *Availity Payer List* here.

Electronic funds transfer (EFT) registration
To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™ enrollment tool, a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at a time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes.

ERA registration
Use Availity to register and manage account changes for ERA. If you were previously

registered to receive ERA, you must register using Availity to manage account changes. Manage your paper remittance vouchers suppression (turn off) here.

Contacting Availity
If you have any questions, call Availity Client Services at **1-800-AVAILITY (1-800-282-4548)** Monday through Friday from 8 a.m. to 7:30 p.m. Eastern time.

Long-acting reversible contraceptive office administration

Use the options outlined in this bulletin to receive the below long-acting reversible contraceptives for administration at your office. These drugs can only be obtained under the medical benefit using the following instructions. As always, you also have the buy and bill option under the member's medical benefit.

Therapeutic class	Drug
Long-acting reversible contraceptives	Kyleena® 19.5 mg system Mirena® system Liletta® 52 mg system Skyla® system Nexplanon® 68 mg implant Paragard® T 380-A IUD

Kyleena, Mirena, Liletta and Skyla: If you choose CVS/Caremark Specialty Pharmacy under the medical benefit, they are available to assist you Monday to Friday from 7:30 a.m. to 7:30 p.m. ET and can accept the prescription using a method convenient for you. The prescription can be given over the phone to a CVS Specialty pharmacist by calling **1-877-254-0015** and providing the patient's name and insurance information. The prescription or the completed manufacturer form can also be faxed to **1-866-336-8479**.

Nexplanon: You must follow the manufacturer's instructions by calling **1-844-NEX-4321 (1-844-639-4321)** Monday to Friday from 8 a.m. to 8 p.m. ET or visiting https://www.merckconnect.com/nexplanon/ordering-billing.html. After this, you have the option to use CVS/Caremark Specialty Pharmacy under the medical benefit.

Paragard: You must use the buy and bill option. Call Paragard Access Solutions at **1-877-PARAGARD (1-877-727-2427)** Monday to Friday from 8:30 a.m. to 8 p.m. ET or visit www.paragardaccesssolutions.com. Use the Paragard direct option for providers.

What if I need assistance?
If you need further assistance, contact your local Network Relations representative or call Provider Services at **1-866-408-6132** for Hoosier Healthwise, **1-844-533-1995** for Healthy Indiana Plan or **1-844-284-1798** for Hoosier Care Connect.

Medical Policies and Clinical Utilization Management Guidelines update: January 2019

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. For markets with carved-out pharmacy services, the applicable listings below are informational only.

Note:

- Effective November 1, 2018, AIM Specialty Health (AIM) *Musculoskeletal Level of Care Guidelines*, *Sleep Study Guidelines* and *Radiology Guidelines* will be used for clinical reviews.
- When requesting services for a patient (including medical procedures and medications), the Precertification Look-Up Tool may indicate that precertification is not required, but this does not guarantee payment for services rendered; a *Medical Policy* or *Clinical UM Guideline* may deem the service investigational or not medically necessary. In order to determine if services will qualify for payment, please ensure applicable clinical criteria is reviewed prior to rendering services.

Please share this notice with other members of your practice and office staff.

To search for specific policies or guidelines, visit Anthem Indiana Medicaid webpage.

Medical Policies
On July 26, 2018, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Anthem Blue Cross and Blue Shield (Anthem).

Publish date	***Medical Policy* number**	***Medical Policy* title**	**New or revised**
8/29/2018	DRUG.00096	Ibalizumab-uiyk (Trogarzo™)	New
8/29/2018	GENE.00049	Circulating Tumor DNA Testing for Cancer (Liquid Biopsy)	New
8/29/2018	ADMIN.00007	Immunizations	Revised

8/29/2018	DRUG.00046	Ipilimumab (Yervoy®)	Revised
8/29/2018	DRUG.00050	Eculizumab (Soliris®)	Revised
8/2/2018	DRUG.00067	Ramucirumab (Cyramza®)	Revised
8/2/2018	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
8/29/2018	DRUG.00075	Nivolumab (Opdivo®)	Revised
8/29/2018	DRUG.00088	Atezolizumab (Tecentriq®)	Revised
8/29/2018	DRUG.00098	Lutetium Lu 177 dotatate (Lutathera®)	Revised
8/29/2018	GENE.00006	Epidermal Growth Factor Receptor (EGFR) Testing	Revised
8/2/2018	GENE.00011	Gene Expression Profiling for Managing Breast Cancer Treatment	Revised
8/29/2018	GENE.00025	Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignant Tumors	Revised
8/29/2018	GENE.00029	Genetic Testing for Breast and/or Ovarian Cancer Syndrome	Revised
8/2/2018	MED.00124	Tisagenlecleucel (Kymriah®)	Revised
8/2/2018	SURG.00023	Breast Procedures including Reconstructive Surgery, Implants and Other Breast Procedures	Revised
8/2/2018	SURG.00032	Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention	Revised

Clinical UM Guidelines

On July 26, 2018, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. This list represents the guidelines adopted by the medical operations committee for the Government Business Division on August 31, 2018.

Publish date	***Clinical UM Guideline* number**	***Clinical UM Guideline* title**	**New or Revised**
9/20/2018	CG-DME-45	Ultrasound Bone Growth Stimulation	New
9/20/2018	CG-DRUG-103	Botulinum Toxin	New
9/20/2018	CG-DRUG-104	Omalizumab (Xolair®)	New
9/20/2018	CG-DRUG-105	Abatacept (Orencia®)	New
9/20/2018	CG-DRUG-106	Brentuximab Vedotin (Adcetris®)	New
9/20/2018	CG-DRUG-107	Pharmacotherapy for Hereditary Angioedema	New

9/20/2018	CG-DRUG-108	Enteral Carbidopa and Levodopa Intestinal Gel Suspension	New
9/20/2018	CG-DRUG-109	Asfotase Alfa (Strensiq™)	New
9/20/2018	CG-DRUG-110	Naltrexone Implantable Pellets	New
9/20/2018	CG-DRUG-111	Sebelipase alfa (KANUMA™)	New
9/20/2018	CG-DRUG-112	Abaloparatide (Tymlos™) Injection	New
9/20/2018	CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	New
9/20/2018	CG-MED-74	Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry	New
9/20/2018	CG-MED-75	Medical and Other Non-Behavioral Health-Related Treatments for Autism Spectrum Disorders and Rett Syndrome	New
9/20/2018	CG-MED-76	Magnetic Source Imaging and Magnetoencephalography	New
9/20/2018	CG-MED-77	SPECT/CT Fusion Imaging	New
9/20/2018	CG-REHAB-11	Cognitive Rehabilitation	New
9/20/2018	CG-SURG-81	Cochlear Implants and Auditory Brainstem Implants	New
9/20/2018	CG-SURG-82	Bone-Anchored and Bone Conduction Hearing Aids	New
10/31/2018	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	New
9/20/2018	CG-SURG-84	Mandibular/Maxillary (Orthognathic) Surgery	New
10/31/2018	CG-SURG-85	Hip Resurfacing	New
10/31/2018	CG-SURG-86	Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection	New
9/20/2018	CG-SURG-87	Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring *Previous title:* Nasal Surgery for the Treatment of Obstructive Sleep Apnea and Snoring	New
9/20/2018	CG-SURG-88	Mastectomy for Gynecomastia	New
9/20/2018	CG-SURG-89	Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia	New

8/29/2018	CG-ADMIN-02	Clinically Equivalent Cost Effective Services — Targeted Immune Modulators	Revised
8/29/2018	CG-DRUG-09	Immune Globulin (Ig) Therapy	Revised
8/29/2018	CG-DRUG-65	Tumor Necrosis Factor Antagonists	Revised
8/29/2018	CG-DRUG-68	Bevacizumab (Avastin®) for Non-Ophthalmologic Indications	Revised
8/29/2018	CG-DRUG-73	Denosumab (Prolia®, Xgeva®)	Revised
8/29/2018	CG-DRUG-81	Tocilizumab (Actemra®)	Revised
8/29/2018	CG-GENE-03	BRAF Mutation Analysis	Revised
8/29/2018	CG-MED-35	Retinal Telescreening Systems	Revised
8/29/2018	CG-MED-71	Wound Care in the Home Setting	Revised
8/2/2018	CG-SURG-24	Functional Endoscopic Sinus Surgery (FESS)	Revised
8/29/2018	CG-SURG-49	Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities	Revised
8/2/2018	CG-SURG-73	Balloon Sinus Ostial Dilation	Revised

Facility Take-Home Drugs Reimbursement Policy Update

CORRECTION - 1/14/2019: This policy will be effective February 15, 2019.

Effective January 15, 2019, Anthem Blue Cross and Blue Shield will not allow reimbursement of take-home drugs — those dispensed by a facility for take-home use under the inpatient or outpatient hospital benefit. Claims submitted by a facility for drugs with revenue codes denoting take-home use will be denied.