December 2018 Anthem Kentucky Provider Newsletter

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Upcoming Changes for Automotive Accounts

Beginning on January 1, 2019, there will be two changes for General Motors, Fiat Chrysler Automobiles (FCA), Delphi, and Aptiv PPO members living in Indiana, Ohio, and Kentucky.

Claims processing changes

The claims processing system for these members will be changing. As part of this change the benefits for these members will be administered directly by Blue Cross Blue Shield of Michigan, rather than from Anthem. This means that the utilization review program will be administered through Blue Cross Blue Shield of Michigan, who uses the services of AIM Specialty Health. The submission process for utilization review requests will be the same, through the AIM Portal, but will follow the program design for Blue Cross Blue Shield of Michigan.

Prior authorization changes

Of particular note, Blue Cross Blue Shield of Michigan will require prior authorization for in-lab sleep testing by instate providers. Preapproval must be obtained for the following procedure codes:

- 95805
- 95807
- 95808
- 95810
- 95811

The procedure codes will require preauthorization for both office settings and hospital outpatient locations.

All authorized attended sleep study services should be performed at a laboratory or center accredited by the American Academy of Sleep Medicine or the Joint Commission.

All providers performing sleep study services for our members must be certified in sleep medicine by a board recognized by Anthem.

GM Precertification and Integrated Health Management (360 Health) changes for CY 2019

Anthem will no longer perform precertification requests for General Motors (GM) members as of **December 1, 2018** for:

- Acute Inpatient Medical Hospital
- Acute Inpatient Rehabilitation
- Skilled Nursing
- Long Term Acute Care
- Integrated Health Management (360 Health)

Anthem precertification approvals are valid for admission dates through November 30, 2018.

Anthem Integrated Health Management engagement is valid through DOS November 30, 2018.

To request precertification and engagement in Integrated Health Management (360 Health), facilities are encouraged to utilize the self-service tools available through the Availity portal or by using the available fax forms located on the BCBSM.com website.

For questions regarding the precertification or engagement process call 1-800-676-BLUE (2583).

Please contact your Anthem Network Management Representative with any questions.

Anthem Accepts Electronic Prior Authorization Requests for Prescription Medications Online

Anthem accepts electronic medication prior authorization (ePA) requests for commercial health plans through covermymeds.com. This feature reduces processing time and helps determine coverage quicker. Some prescriptions are even approved in real time so that your patients can fill a prescription without delay. For example, medications such as celecoxib (Celebrex®), ezetimibe (Zetia®), fluocinolone acetonide (Synalar®), Victoza®, and long acting opioids are automatically approved when a member meets step therapy and/or clinical criteria (as applicable).

Electronic ePA offers many benefits:

- More efficient review process
- Ability to identify if a prior authorization is required
- Able to see consolidated view of ePA submissions in real time
- Faster turnaround times
- A renewal program that allows for improved continuity of care for members with maintenance medications
- Prior authorizations are preloaded for the provider before the expiration date.

Providers can submit ePA requests by logging in at covermymeds.com. Creating an account is FREE. For questions, please contact the provider service number on the member ID card.

Introducing the New Clinical Criteria Page for Injectable, Infused or Implanted Drugs

Beginning in January 2019, providers will be able to visit the Clinical Criteria tab of the Pharmacy Information page to review clinical criteria for all injectable, infused or implanted prescription drugs.

Injectable oncology medical specialty drug clinical criteria will be located on the new site at a later date in 2019.

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 and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate "*Marketplace, select Formulary*" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List." This drug list is also reviewed and updated regularly as needed.

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

Anthem Streamlines Member ID Cards - Use Availity to Verify Members' Cost Shares and Benefits at Time of Service

In the June edition of our Network Update provider newsletter, Anthem Blue Cross and Blue Shield announced the introduction of a streamlined member identification (ID) card coming

July 1, 2018, to help reduce confusion about members' cost shares. The updated member ID cards maintain the current style, but **specific cost share information (such as copayments, deductibles and coinsurance) will be absent from cards.** In addition, there may be alpha-numeric prefix and other changes to members' ID cards, so please check members' ID cards carefully. The new simpler and easier to read ID cards are available to groups over time as they renew coverage with Anthem.

Use Availity and EDI to verify eligibility, members' cost shares and benefits at time of service. Since the cost share information will no longer display on many of our ID cards, we urge providers to access **Availity** (our secure Web-based provider tool) and the **EDI** (Electronic Data Interchange) to verify member benefits and eligibility to obtain the most up-to-date cost share information in order to collect the applicable deductibles and coinsurance amounts at the time of service as appropriate. If a member presents an older ID card with outdated benefits at the provider office, it can create confusion about the member's cost share.

As always, please request that a member enrolled in our health benefit plans present their most current ID cards at the time of service. When filing claims to Anthem, enter the member’s ID numbers exactly as the numbers appear on the card, including the alpha-numeric prefix, to help speed claims processing and reimbursement.

As the streamlined ID cards are adopted over time, it will help reduce misunderstandings around cost shares since real-time information is readily available via Availity about members' benefits and cost shares. Additionally, members will be encouraged to learn more about their benefits through Anthem's digital and online tools. Members can retain their cards for as long as they remain in the same product plan, regardless of changes to cost share information.

Electronic ID cards
As a reminder, members can now view, download, email, and fax an electronic version of their member ID cards using the Anthem Anywhere mobile app. And because our electronic ID cards look just like our physical ID cards, members can show either an electronic or physical ID card when obtaining services. Anthem member ID cards are also available through the Availity portal.

For questions, contact the provider service number on the back of members' ID cards.

Please note, this notice does NOT apply to National Accounts, the Federal Employee Program® (FEP), Medicaid or Medicare plans.

Availity to Serve as EDI Entry Point for Electronic Submissions

Anthem has designated Availity to operate and serve as your electronic data interchange (EDI) entry point or also called the EDI Gateway. The EDI Gateway is a **no-cost option** to our direct trading partners. With this change, Anthem continues our efforts to ensure consistency between your provider portal and the EDI Gateway.

As a mandatory requirement, all trading partners who currently submit directly to the Anthem EDI Gateway must transition to the Availity EDI Gateway. Availity is well known as a Web portal and claims clearinghouse. In addition, Availity functions as an EDI Gateway for multiple payers and is the single EDI connection for our company.

Your organization can submit and receive the following electronic transactions through Availity's EDI Gateway**:**

- 837- Institutional Claims
- 837- Professional Claims
- 837- Dental Claims
- 835 - Electronic Remittance Advice
- 276/277- Claim Status
- 270/271- Eligibility Request

If you wish to become a direct a trading partner with Availity, the setup is easy. Use the Availity Welcome Application to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions.

If you prefer to use your 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 you may have.

835 Electronic Remittance Advice (ERA)
Effective June 1, 2018, please 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.

Electronic Funds Transfer (EFT)
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 one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes. No other action is needed.

Contacting Availity
If you have any questions, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. ET.

Anthem to Enhance Claim Edits for Outpatient Facility Claims

Beginning in April 2019, Anthem will enhance its claims editing systems to include outpatient facility editing. These edits will:

- Help ensure correct coding and billing practices are being followed
- Help ensure compliance with industry standards such as Centers for Medicare & Medicaid Services (CMS), American Medical Association (AMA), National Uniform Billing Committee (NUBC), and national specialty and academy guidelines
- Reinforce compliance with standard code edits and rules (i.e., CPT, HCPC, ICD-10, NUBC)

Anthem Works to Simplify Payment Recovery Process for National Accounts Membership

In our company's ongoing efforts to streamline and simplify our payment recovery process, we continue to consolidate our internal systems and will begin transitioning our National Accounts membership to a central system in 2019. While this is not a new process, we are transitioning the National Accounts membership to align with the payment recovery process across our other lines of business.

Currently, our recovery process for National Accounts membership is reflected in the EDI PLB segment on the electronic remittance advice (835). This segment will show the negative balance associated with the member account number. Monetary amounts are displayed at the time of the recovery adjustment.

As National Accounts membership transitions to the new system and claims are adjusted for recovery, the negative balances due to recovery are held for 49 days to allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remits ***only*** within the "Deferred

Negative Balance" sections.

After 49 days, the negative balances due are reflected within the 835 as a corrected and reversed claim in PLB segments.

If you have any questions or concerns, please contact the E-Solutions Service Desk toll free at (800) 470-9630.

HEDIS® 2018 Commercial Results Are In

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS®) commercial data collection project for 2018. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS® scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS® results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS® project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate the HEDIS® process improvement by:

- Responding to our requests for medical records within five days, if possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient's medical record

Further information regarding documentation guidelines and administrative codes can be found on the HEDIS® page of our Provider Portal.

In addition, more information on HEDIS® can be found by visiting the provider portal at: www.anthem.com *> Provider > Choose State > Find Resources for your state > Health & Wellness (top menu) > Quality Improvement and Standards > HEDIS Information*. You will find reference documents entitled "HEDIS 101 for Providers" and "HEDIS Physician Documentation Guidelines and Administrative Codes".

To view the **HEDIS 2018 COMMERCIAL HMO and PPO Report**, click here.

Now is the time to review your patient's records to ensure that they have received their preventative care and/or immunizations before the end of the year.

Again, we thank you and your staff for demonstrating teamwork as we work together to improve the health of our members and your patients. We look forward to working with you again next HEDIS season.

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

Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem is available to offer assistance in these difficult moments with our **Case Management Program**. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

To contact Case Management:

Commercial
Email: centregcmref@anthem.com
Phone: 1-888-662-0939 / 800-944-0339
Business Hours: Monday - Friday, 8:00 am - 7:00 pm ET

Federal Employee Program (FEP)
Phone: 1-800-711-2225
Business Hours: Monday - Friday, 8:00 am - 7:00 pm ET

ConditionCare Program Benefits Patients and Physicians

Anthem members have additional resources available to help them better manage chronic conditions.

The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of registered nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition.

Engagement methods vary by the individual's risk level but can include:

- **Education** about their condition through mailings, email newsletters, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Care Managers and other health professionals.

Physician benefits:

- **Save time** by answering patients' general health questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient's progress in the program.

Please visit ***anthem.com/provider*** *> select Kentucky > Find Resources for Kentucky > Health & Wellness*, and select ***Condition Care*** to find more information about the program such as program guidelines, educational materials and other resources.

Also available is the Care Management Program Referral Form to be used to refer other patients you feel may benefit from our program.

If you have any questions or comments about the program, call **1-877-681-6694**.
Our nurses are available Monday through Friday, 8:00 am to 9:00 pm, and Saturday, 9:00 am to 5:30 pm. ET.

Integrated Care Model for Plans Purchased on the Health Insurance Marketplace Benefits Patients and Physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the Exchange) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Members or caregivers can refer themselves or family members using the information below.

To contact Case Management:
Email: centregcmref@anthem.com
Phone: 1-888-662-0939 / 800-944-0339
Business Hours: Monday - Friday, 8:00 am - 7:00 pm ET

Coordination of Care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from

these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:
1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
    - Diagnosis
    - Treatment plan
    - Referrals
    - Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available on the Provider website including a Coordination of Care template and cover letters for both Behavioral Health and other Healthcare Practitioners. Access to the forms and cover letters are available at *anthem.com/providers* > select *your state* > *Find Resources for your state* > then select *Answers@Anthem*.

In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information. Access to the Toolkit is available at *anthem.com/providers* > select *your state* > *Find Resources for your state* > then select *Health and Wellness.*

Important Information about Utilization Management

Our utilization management (UM) decisions are based on written criteria, the appropriateness of care and service needed, as well as the member’s coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem’s medical policies are available on Anthem’s website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by

calling us at the toll-free numbers listed below. UM criteria are also available on the web. Just select “Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements” from the Provider home page at anthem.com.

We work with providers to answer questions about the utilization management process and the authorization of care. Here’s how the process works:

- Call us toll free from 8:30 am - 5:00 pm, Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 am - 7:00 pm ET.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The phone numbers below are for physicians and their staffs. Members should call the member service number on their health plan ID card.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

	To discuss UM Process and Authorizations	**To Discuss Peer-to-Peer UM Denials w/Physicians**	**To Request UM Criteria**
IN	1-800-345-4348, 1-877-814-4803 *Behavioral Health:* 1-866-582-2293 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-888 870 9342	1-877-814-4803
KY	1-800-568-0075 *KEHP:* 1-844-402-5347 *Behavioral Health:* 1-866-582-2293 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-877-814-4803	1-877-814-4803
MO	1-800-992-5498, 1-866-398-1922 *Behavioral Health:* 1-866-302-1015 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-800-992-5498, 1-866-398-1922 *CDHP/Lumenos:* 1-866-398-1922	1-800-992-5498, 1-866-398-1922

OH	1-800-752-1182 *Behavioral Health:* 1-866-582-2293 *Transplant:* 1-800-824-0581 *Autism:* 844-269-0538	1-877-814-4803	1-877-814-4803
WI	1-800-242-1527, 1-800-472-6909, 1-800-472-8909, 1-866-643-7087 *Transplant:* 1-800-824-0581 *Autism:* 1-844-269-0538	1-800-242-1527, 1-800-472-6909, 1-866-643-7087	1-800-242-1527, 1-800-472-6909
FEP/ Nat'l	*FEP:* 1-800-860-2156 *Fax:* 1-800 732-8318 (UM) *Fax:* 1-877 606-3807 (ABD)	*FEP:* 1-800-860-2156 *Nat'l:* 1-800-821-1453	*FEP:* 1-800-860-2156 *Fax:* 1-800 732-8318 (UM) *Fax:* 1-877 606-3807 (ABD)

TTY Information

		TTY	Voice
IN	711 or	1-800-743-3333 (V/T)	1-800-743-3333 (V/T)
KY	711 or	1-800-648-6056 (T/ASCII)	1-800-648-6057 (V)
MO	711 or	1-800-735-2966 (TTY/ASCII)	1-866-735-2460 (V)
OH	711 or	1-800-750-0750 (V/T)	1-800-750-0750 (V/T)
WI	711 or	1-800-947-3529 (T)	1-800-947-6644 (V)

For language assistance, members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.

Members' Rights and Responsibilities

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, Anthem Blue Cross and Blue Shield has adopted a Members' Rights and Responsibilities statement. It can be found on our website. To access, go to the "Provider" home page at *anthem.com* > *Provider* > select your state > *Find Resources for* your state > then *Health & Wellness* > *Quality Improvement Standards* > *Member Rights & Responsibilities*.

Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

Vaginal Birth after Cesarean (VBAC) Certified Shared Decision Making Aid Available on the Web

As part of our commitment to provide you with the latest clinical information, we have posted a VBAC shared decision making aid to our provider portal. This is a tool for you to discuss with your patients to aid in making a decision regarding their treatment options. This has been reviewed and certified by the Washington Health Care Authority (HCA) and is available on our website. To access the aid, go to anthem.com and select *Provider* >select *your state* > choose *Find Resources in your state* > then select *Health & Wellness* > *Practice Guidelines* > then **Shared Decision Making Aid**.

Restructure of AIM Advanced Imaging Clinical Appropriateness Guidelines

AIM advanced imaging clinical appropriateness guidelines have been restructured to improve usability and to further link clinical criteria with supporting evidence. These structural enhancements resulted in no changes to existing clinical criteria or content.

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's *ProviderPortal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday - Friday, 8:30 am - 7:00 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, visit the AIM Specialty Health website to access and download a copy of the current guidelines.

Update to AIM Clinical Appropriateness Guidelines

Effective for dates of service on and after March 9, 2019, the following updates will apply to all of AIM's Clinical Appropriateness Guidelines, including Advanced Imaging, Cardiac, Sleep, Radiation Oncology and Musculoskeletal guidelines.

Clinical Appropriateness Framework

Replacing pretest requirements, this section will more accurately describe the guideline’s purpose, which is to provide a summary of the fundamental components of a decision to pursue diagnostic testing. In order to support the full spectrum of AIM solutions, the terms “imaging request” or “diagnostic imaging” are replaced with “diagnostic or therapeutic intervention”.

Ordering of Multiple Diagnostic or Therapeutic Interventions
Replacing ordering of multiple studies, this section expands its applicability to AIM solutions outside of diagnostic imaging. Terminology specific to imaging studies is replaced with the term “diagnostic or therapeutic intervention” to reflect a broader application of the principles included here.

Repeat Diagnostic Testing and Repeat Therapeutic Intervention
Replacing repeated imaging, these sections establish conditions in which duplication of the initial test or intervention may be warranted, and where such requests will require peer-to-peer discussion.

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM’s *ProviderPortal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday - Friday, 8:30 am - 7:00 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, visit the AIM Specialty Health website to access and download a copy of the current guidelines.

Updates to AIM Musculoskeletal Surgery Clinical Appropriateness Guidelines

Beginning with dates of review on and after January 1, 2019, the following updates will apply to AIM **Musculoskeletal Spine Surgery** Clinical Appropriateness Guidelines as indicated by section below:

- Cervical Decompression with or without Fusion
    - Added criteria for the appropriate use of laminectomy for cordotomy and biopsy, excision, or evacuation

        - Added indications for non-traumatic atlantoaxial instability

- Lumbar Laminectomy
    - Added criteria for the appropriate use of laminectomy for biopsy, excision, or evacuation
    - Added indication of Dorsal Rhizotomy

Beginning with dates of review on and after January 1, 2019, the following updates will apply to AIM **Musculoskeletal Interventional Pain Management** Clinical Appropriateness Guidelines as indicated by section below:

- Paravertebral Facet Injection/Nerve Block/Neurolysis
    - Exclusions: Radiofrequency neurolysis for sacroiliac (SI) joint pain is considered not medically necessary

These services or procedures were previously reviewed by Anthem, but will now be reviewed by AIM as part of the Musculoskeletal program. Visit the AIM Specialty Health website to view the CPT codes and access and download a copy of the current guidelines.

Ordering and servicing providers may submit prior authorization requests to AIM in one of the following ways:

- Access AIM ***Provider****Portal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 1-800-554-0580, Monday - Friday, 8:30 am - 7:00 pm ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com.

Interactive Care Reviewer (ICR) New Features

Interactive Care Reviewer (ICR), Anthem's online authorization tool, is adding a new feature to further increase the efficiency of your authorization process. In mid-December, you can begin using ICR to request a clinical appeal for denied authorizations and check the status of a clinical appeal. This feature is available for authorization requests submitted through ICR,

phone or fax.

Requesting a clinical appeal is easy:
Log on to ICR from the Availity Portal and locate the case using one of the search options, or from your ICR dashboard.

- Select the **Request Tracking ID** link to open the case. If the case is eligible for an appeal you will see the **Request Appeal** menu option on the **Case Overview** screen.
- Select **Request Appeal** to open the **Appeal Details** screen and complete the required fields on the appeal template. (You also have the option of uploading attachments and images to support your request.)
- Select Submit

Take the steps below to check the status of a clinical appeal:
Logon to ICR from the Availity Portal

- Select **Check Appeal Status** from the ICR top menu bar
- Type the **Appeal Case ID** and **Member ID** in the allocated fields
- Select **Submit**

The appeal status and detail of the decision will open on the bottom of the screen.

Need more information on how to navigate the new ICR Appeals feature?
Download the *ICR Clinical Appeals Reference Guide* located on the Availity Portal. Select: *Payer Spaces* > *Applications* > *Education and Reference Center* > *Communication and Education*. Find the link to the reference guide below the ICR menu.

Additional Training:
If you are new to ICR or want to get a refresher please attend our monthly ICR webinar. The next event is taking place on December 6 at 1:00 pm ET. **Register Here**

Bundled Services and Supplies (Professional)

Beginning with dates of service on or after March 1, 2019, Anthem will apply our always bundled edit to HCPCS code G0453 (Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)). For more information, review Section 1 of the policy dated March 1, 2019, along with the Bundled

Services and Supplies Section 1 Coding list, on anthem.com/provider. To access the guidelines, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Reimbursement for Convenience Surgical Supply Kits: Professional

Anthem periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our members' benefit plans. Some providers are submitting claims for point-of-use convenience kits that are used in the administration of injectable medicines or other office procedures. These prepackaged kits contain not only the injectable medicine, but also non-drug components including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

Typically, the cost of a convenience kit exceeds the cost of its components when purchased individually. As a reminder, non-drug components included in the kits are inclusive of the practice expense for the procedure performed for which no additional compensation is available to the provider.

Please refer to Anthem's Global Surgery and/or Bundled Services and Supplies Reimbursement Policies located at anthem.com for additional information.

Clinical practice and preventive health guidelines available on anthem.com

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research.

All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website at anthem.com/provider. To access the guidelines, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Medical Polices and Clinical Guidelines Updates - December 2018

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were

reviewed on September 13, 2018 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Below is a new Medical Policy effective March 1, 2019:

New Medical Policy	Effective March 1, 2019
MED.00125 Biofeedback and Neurofeedback	• Outlines the MN and INV&NMN indications for biofeedback and neurofeedback. Existing CPT codes 90875, 90876, 90901, 90911 will be reviewed for MN (medical necessity) criteria; HCPCS device code E0746 considered INV&NMN (Investigational and Not Medically necessary)

The below current Clinical Guidelines and/or Medical policies were reviewed and updates were approved.

Below are Medical Policy updates effective March 1, 2019:
requires precertification

Medical Policy Updates	Effective March 1, 2019
CG-ADMIN-02 Clinically Equivalent Cost Effective Services – Targeted Immune Modulators	• Added cost effective agent language for Cimzia to the Clinically Equivalent Cost Effective Services (CECE) for Crohn's Disease or Ulcerative Colitis section • Added off-label indications for Remicade in immune checkpoint inhibitor-related toxicities to Table section • Added off-label indications for Actemra in chronic antibody mediated rejection (cAMR) in renal transplantation to Table section
*****CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring	Revised title • Revision to the ambulatory EEG MN statement to include with or without video monitoring • Revision to NMN statement of ambulatory EEG by adding "Antiepileptic drug treatment withdrawal or modification in individuals because the risk of seizure precipitation would require immediate medical intervention" • Revision to the MN statement for attended EEG video monitoring in a healthcare facility by adding "withdrawal"

LAB.00030 Measurement of Serum Concentrations of Monoclonal Antibody Drugs and Antibodies to Monoclonal Antibody Drugs	Revised title • Expanded scope of policy to address all monoclonal antibody drugs • Revised position statement to state: "The measurement of serum concentrations of either of the following is considered investigational and not medically necessary under all circumstances: A. Monoclonal antibody drugs, including but not limited to tumor necrosis factor antagonist drugs; or B. Antibodies to monoclonal antibody drugs, including but not limited to tumor necrosis factor antagonist drugs
SURG.00011 Allogeneic, Xenographic, Synthetic, and Composite Products for Wound Healing and Soft Tissue Grafting	• Added several products to the INV&NMN section. Added existing codes 65778, 65779, 65780, V2790 for ocular indications, considered INV&NMN (investigational and not medically necessary)
*SURG.00103 Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	• Added iStent inject Trabecular Micro-Bypass System as MN when criteria met • Revised INV&NMN to include iStent inject Trabecular Micro-Bypass System for all indications not listed as MN • Revised MN and INV&NMN statements as a result of manufacturer's voluntary removal of the CyPass System from the market CPT Category III code 0474T (CyPass) changed to INV&NMN

Below are Coding updates effective March 1, 2019:

Coding Updates	Effective March 1, 2019
GENE.00016 Gene Expression Profiling for Colorectal Cancer	Added CPT code 0069U expression profiling test considered INV&NMN
GENE.00010 Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	Added CPT codes 0070U-0076U for CYP2D6 testing replacing 0028U (MN criteria); added pain panel 0078U considered INV&NMN
LAB.00029 Rupture of Membranes (ROM) Testing in Pregnancy	Added CPT code 0066U considered INV&NMN
MED.00111 Added HCPCS code C9750 considered INV&NMN	Added HCPCS code C9750 considered INV&NMN

View reimbursement policies online at anthem.com

To find Anthem's professional and facility reimbursement policies online, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

Reimbursement Policy Updates - December 2018

"Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services – Professional

Please note: We have updated the title of our *"Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services* reimbursement policy to *Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation Services*.

System updates for 2019 – Professional

As a reminder, our claim editing software will be updated monthly throughout 2019 with the most common updates occurring in quarterly in February, May, August and November of 2019. These updates will:

- reflect the addition of new, and revised codes (e.g. CPT, HCPCS, ICD-10, modifiers) and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, frequency edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

Modifier 79 –Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period –Professional

This coding tip is based on recent findings for claims processed with modifier 79 during a postoperative period.   *Current Procedural Terminology* (CPT®) specifically states modifier 79 should be reported by the same individual when reporting unrelated procedures or services during the postoperative period. For example, this modifier is used when a patient presents with a problem that is unrelated to a previous surgery (yet within the postoperative period) and requires additional services by the **same provider/individual**. When modifier 79 is appended for a different provider (e.g. Nurse Practitioner or Physician Assistant) during the postoperative period the claim line will deny.

In addition to modifier 79, modifiers 58 and 78 are also based on **Same Physician or Other Qualified Health Care Professional** as documented below:

- 58 – Staged/Related Procedure/Service by the Same Physician/Other Qualified Health

Care Professional during the Postoperative Period.
- 78 – Unplanned Procedure/Service by Same Physician/Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure during the Postoperative Period.

Reimbursement Policy Update - Scope of License (Professional)

In the December 2017 edition of *Network Update,* we announced a new Scope of License Policy which states that we will not reimburse services performed by a provider that are outside their state license requirements. We are updating our editing systems to deny services deemed to be outside of a specific specialty's scope of license.

For more information about this policy, select your state to visit the Reimbursement Policy page: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

2019 FEP Benefit information available online

To view the 2019 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to *www.fepblue.org* > *select Benefit Plans* > *Brochure & Forms.*

Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2019, including information on the new PPO product, Blue Focus, being offered to federal employees effective January, 1, 2019. For questions please contact FEP Customer Service at the number below for your state:

IN – 1-800-382-5520
KY – 1-800-456-3967
MO – 1-800-392-8043
OH – 1-800-451-7602
WI – 1-800-242-9635

Coordination of Benefits for an FEP® member

Anthem Blue Cross and Blue Shield values the relationship we have with our providers, and always look for opportunities to help expedite the claim processing. When a Federal Employee visits the provider office, obtaining the most current medical insurance information will help to establish the primary carrier, and will alleviate claim denials and support accurate billing. For questions please contact the Federal Employee Customer Service at the number

below for your state:

IN – 1-800-382-5520
KY – 1-800-456-3967
MO – 1-800-392-8043
OH – 1-800-451-7602
WI – 1-800-242-9635

Benefit change for Infliximab for Federal Employee Program (FEP)

Beginning January 1, 2019, Blue Cross and Blue Shield Federal Employee Program® (FEP) benefit procedures will change for the autoimmune infusion drug infliximab (brand names Remicade, Inflectra, and Renflexis). Members currently receiving the drug may be covered under either pharmacy or medical benefits. However, members who receive a first infusion on or after January 1, 2019 can only receive the drug under medical benefits. Members who receive it under pharmacy benefits prior to January 1, 2019 will continue receiving it under pharmacy benefits. If you have any questions please contact FEP Customer Service at the number below for your state:

IN – 1-800-382-5520
KY – 1-800-456-3967
MO – 1-800-392-8043
OH – 1-800-451-7602
WI – 1-800-242-9635

New Medicare Advantage provider service phone number beginning January 1, 2019

Effective January 1, 2019, Medicare providers will have toll free phone numbers specifically designated for their service inquiries. These new provider numbers will be listed separately on the back of the member ID cards and should be used beginning January 1, 2019. The associates answering your provider service calls are trained to answer your questions and resolve your issues as quickly as possible. To ensure you receive the most efficient service, please refrain from using the member services line and use only 1-844-421-5662 or the provider services phone number listed on the back of the member ID card for individual Medicare Advantage calls beginning January 1, 2019.

2019 Medicare Advantage individual benefits and formularies

Summary of benefits, evidence of coverage and formularies for 2019 individual Medicare Advantage plans will be available at anthem.com/medicareprovider. An overview of notable 2019 benefit changes also is available at Important Medicare Advantage Updates at anthem.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information.

CMS Medicare Preclusion List effective April 1, 2019

The U.S. Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage and Part D organizations, including Anthem, will implement a new initiative, the Preclusion List, to protect the integrity of the Medicare Trust Funds. Beginning April 1, 2019, Medicare Advantage and Part D organizations will deny payment for items and services furnished by providers that CMS has placed on the Preclusion List. For more information, visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

When and how to initiate Medicare Advantage reopenings

When a claim must be corrected beyond the initial claim timely filing limit of one year from the **date of service**, a normal adjustment bill is not allowed. Providers must use the reopening process to correct the error. To learn when and how to initiate reopenings and adjustments, check Important Medicare Advantage Updates at anthem.com/medicareprovider

Individual Medicare plans move compound drugs off formulary beginning January 1, 2019

Beginning January 1, 2019, Individual Medicare Advantage plans will move compounded drugs to non-formulary with the exception of home infusion drugs. Group-sponsored Medicare Advantage members will continue to have compounded drug coverage; these drugs will require prior authorization. Compounded home infusion drugs will continue to be covered for both Individual Medicare and group-sponsored members without prior authorizations. Members and/or providers can request a non-formulary exception for compounded drugs.

Medicare Part B drugs may include Step Therapy beginning January 1,

2019

CMS updated its guidance to allow Medicare Advantage plans the option of implementing step therapy for Part B drugs as part of a patient-centered care coordination program beginning January 1, 2019. The goal is to lower drug prices while maintaining access to covered services and drugs for beneficiaries. Anthem will implement step therapy edits to promote clinically appropriate and cost effective drug options for our members. A patient-centered care coordination program will be created to ensure member access to necessary drugs, provide medication reviews and reconciliations, educate members regarding their medications, encourage medication adherence, and provide incentives to members who complete care coordination programs.

Keep up with Medicare news

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

- Medicare Advantage Reimbursement Policy October Provider Bulletin
- Prior authorization requirements for Part B drugs: Moxetumomab Pasudotox, Cemiplimab and Fulphila
- July Medicare Advantage reimbursement policy
- Submit PA medication requests electronically; new phone number for MA prescription PAs
- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective Jan. 1, 2019
- Inpatient Readmissions
- Submit PA medication requests electronically; new phone number for MA prescription prior authorizations effective Sept. 1

EDI Gateway migration

Anthem Blue Cross and Blue Shield has partnered with Availity to become our designated EDI Gateway, effective January 1, 2019.

What does this mean to you as a provider?
All EDI submissions currently received are now available on Availity. Please note, there is no impact to provider participation statuses and no impact on how claims adjudicate.

Next steps
Contact your clearinghouse to validate their transition dates to Availity. If your clearinghouse notifies you of changes regarding connectivity, workflow or the financial cost of EDI

transactions, there is a no-cost option available to you — you can submit claims directly through Availity!

Register with Availity
If you wish to submit directly through Availity for your 837 (claim), 835 (electronic remittance advice) and 27X (claim status and eligibility) transactions, please visit **https://www.availity.com** to register.

We look forward to delivering a smooth transition to the Availity EDI Gateway.

If you have any questions please contact Availity Client Services at **1-800-282-4548**, Monday to Friday, 8 a.m. to 7:30 p.m. Eastern time.

NCQA: Pharmacy Management Information

Need up-to-date pharmacy information?
Log in to our provider website (https://mediproviders.anthem.com/ky) to access our *Formulary*, *Prior Authorization* form, *Preferred Drug List* and process information.

Have questions about the *Formulary* or need a paper copy? Call Provider Services at **1-855-661-2028**.

Our Member Services representatives serve as advocates for our members. To reach Member Services, please call **1-855-690-7784 (TTY 711)**.

NCQA: Practitioners' Rights during Credentialing Process

The credentialing process must be completed before a practitioner begins seeing members and enters into a contractual relationship with a health care insurer. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application.
- Correct erroneous information regarding a credentialing application.
- Be notified of the status of credentialing or recredentialing applications.

The Council for Affordable Quality Healthcare (CAQH®) universal credentialing process is

used for all providers who contract with Anthem Blue Cross and Blue Shield (Anthem). To apply for credentialing with Anthem, go to the CAQH website at https://www.caqh.org and select **CAQH ProView™**. There is no application fee.

We encourage practitioners to begin the credentialing process as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members' claims.

Update: Drug Screen

Summary of change: As of August 1, 2018, Anthem Blue Cross and Blue Shield Medicaid drug screen and benefit details were updated to ensure alignment with state and company requirements.

What this means to me

As of August 1, 2018, the codes below were configured to ensure benefit guidelines are in place as listed below. Please share this information with office staff and other providers in your practice.

Code	Description	Category	State requirement
80320	Alcohols	Definitive	Covered one per week
80321	Alcohol biomarkers; 1 or 2	Definitive	Covered one per week
80322	Alcohol biomarkers; 3 or more	Definitive	Covered one per week
80323	Alkaloids, not otherwise specified	Definitive	Covered one per week
80324	Amphetamines; 1 or 2	Definitive	Covered one per week
80325	Amphetamines; 3 or 4	Definitive	Covered one per week
80326	Amphetamines; 5 or more	Definitive	Covered one per week
80327	Anabolic steroids; 1 or 2	Definitive	Covered one per week
80329	Analgesics, nonopioid; 1 or 2	Definitive	Covered one per week
80330	Analgesics, nonopioid; 3 to 5	Definitive	Covered one per week
80331	Analgesics, nonopioid; 6 or more	Definitive	Covered one per week

80332	Antidepressants, serotonergic class; 1 or 2	Definitive	Covered one per week
80333	Antidepressants, serotonergic class; 3 to 5	Definitive	Covered one per week
80334	Antidepressants, serotonergic class; 6 or more	Definitive	Covered one per week
80335	Antidepressants, tricyclic and other cyclicals; 1 or 2	Definitive	Covered one per week
80336	Antidepressants, tricyclic and other cyclicals; 3 to 5	Definitive	Covered one per week
80337	Antidepressants, tricyclic and other cyclicals; 6 or more	Definitive	Covered one per week
80338	Antidepressants, not otherwise specified	Definitive	Covered one per week
80339	Antiepileptics, not otherwise specified; 1 to 3	Definitive	Covered one per week
80340	Antiepileptics, not otherwise specified; 4 to 6	Definitive	Covered one per week
80341	Antiepileptics, not otherwise specified; 7 or more	Definitive	Covered one per week
80342	Antipsychotics, not otherwise specified; 1 to 3	Definitive	Covered one per week
80343	Antipsychotics, not otherwise specified; 4 to 6	Definitive	Covered one per week
80344	Antipsychotics, not otherwise specified; 7 or more	Definitive	Covered one per week
80345	Barbiturates	Definitive	Covered one per week
80346	Benzodiazepines; 1 to 12	Definitive	Covered one per week
80347	Benzodiazepines; 13 or more	Definitive	Covered one per week
80348	Buprenorphine	Definitive	Covered one per week
80349	Cannabinoids, natural	Definitive	Covered one per week
80350	Cannabinoids, synthetic; 1 to 3	Definitive	Covered one per week
80351	Cannabinoids, synthetic; 4 to 6	Definitive	Covered one per week
80352	Cannabinoids, synthetic; 7 or more	Definitive	Covered one per week
80353	Cocaine	Definitive	Covered one per week
80354	Fentanyl	Definitive	Covered one per week

80355	Gabapentin, nonblood	Definitive	Covered one per week
80356	Heroin metabolite	Definitive	Covered one per week
80357	Ketamine and norketamine	Definitive	Covered one per week
80358	Methadone	Definitive	Covered one per week
80359	Methylenedioxyamphetamines (MDA, MDEA, MDMA)	Definitive	Covered one per week
80360	Methylphenidate	Definitive	Covered one per week
80361	Opiates, 1 or more	Definitive	Covered one per week
80362	Opioids and opiate analogs; 1 or 2	Definitive	Covered one per week
80363	Opioids and opiate analogs; 3 or 4	Definitive	Covered one per week
80364	Opioids and opiate analogs; 5 or more	Definitive	Covered one per week
80365	Oxycodone	Definitive	Covered one per week
80366	Pregabalin	Definitive	Covered one per week
80367	Propoxyphene	Definitive	Covered one per week
80368	Sedative hypnotics (nonbenzodiazepines)	Definitive	Covered one per week
80369	Skeletal muscle relaxants; 1 or 2	Definitive	Covered one per week
80370	Skeletal muscle relaxants; 3 or more	Definitive	Covered one per week
80371	Stimulants, synthetic	Definitive	Covered one per week
80372	Tapentadol	Definitive	Covered one per week
80373	Tramadol	Definitive	Covered one per week
80374	Stereoisomer (enantiomer) analysis, single drug class	Definitive	Covered one per week
80375	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 1 to 3	Definitive	Covered one per week
80376	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 4 to 6	Definitive	Covered one per week

80377	Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified; 7 or more	Definitive	Covered one per week
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Covered one per week
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Covered one per week
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Covered one per week
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)	Definitive	Covered one per week
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem), excluding immunoassays (for example, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (for example, alcohol dehydrogenase), performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes	Definitive	Covered one per week

What if I need assistance?

If you have questions about this communication, contact your local Provider Relations representative or call Provider Services at **1-855-661-2028.**

What Matters Most: Improving the Patient Experience CME

Are you looking for innovative ways to improve your patients' experiences?
Numerous studies have shown that a patient's primary health care experience and, to some extent their health care outcomes, are largely dependent upon health care provider and patient interactions. Recently, Anthem Blue Cross and Blue Shield (Anthem) announced the launch of **a new online learning course** — *What Matters Most: Improving the Patient Experience* — to address gaps in and offer approaches to communication with patients. This curriculum is available at no cost to providers and their clinical staff nationwide.

Did you know?

- Substantial evidence points to a positive association between the patient experience and health outcomes.
- Patients with chronic conditions, such as Diabetes, demonstrate greater self-management skills and quality of life when they report positive interactions with their health care providers.
- Patients reporting the poorest-quality relationships with their physicians were three times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships.

How will this benefit you and your office staff?
Through the use of compelling real-life stories that convey practical strategies for implementing patient care, providers learn how to apply best practices.

You'll learn tips and techniques to:

- Improve communication skills.
- Build patient trust and commitment.
- Expand your knowledge of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

Get CME credits!
Providers may apply their completion of the course toward continuing medical education (CME) credit certification. The training has been reviewed and is acceptable for up to one (1) prescribed credit by the American Academy of Family Physicians.*

Like you, Anthem is committed to improving the patient experience in all interactions, and we are proud to work collaboratively with our provider network to provide support and tools to reach our goal.

Take the course today!

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Sources
What Is Patient Experience? Agency for Healthcare Research and Quality, Rockville, MD. (Content last reviewed March 2017.)
http://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html

CAHPS®: Assessing Health Care Quality From the Patient's Perspective Agency for Healthcare Research and Quality, Rockville, MD. (Content last reviewed March 2016.)
http://www.ahrq.gov/cahps/about-cahps/cahps-program/cahps_brief.html

Physician Communication and Patient Adherence to Treatment: A Meta-analysis Zolnierek, Kelly B. and DiMatteo, M. Robin (2009.)
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2728700/

* This Enduring Material activity, What Matters Most: Improving the Patient Experience, has been reviewed and is acceptable for up to 1.00 Elective credit(s) by the American Academy of Family Physicians. AAFP certification begins April 30, 2018. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Coding Spotlight: Substance Use Disorders and Smoking

Substance use disorders can affect a person’s brain and in turn their behavior. Substance use can start with the experimental use of a drug in a social situation or exposure to prescribed medications. Eventually it can lead to an inability to control the use of the legal or illegal drug or medication. When a patient is diagnosed with an alcohol- or drug- use disorder, the diagnosis is often more complex, as such conditions are susceptible to both psychological and physiological signs, symptoms, manifestations and comorbidities. This article will provide you with the information you need to provide high-quality care to patients struggling with substance use as well as how to code for the services provided to them.

Drug and substance addiction in the U.S.
The U.S. Department of Health and Human Services declared a public health emergency in 2017 due to an unprecedented opioid epidemic. Drug overdose deaths and opioid-involved deaths continue to increase in the U.S.[1]

Smoking is the leading preventable cause of death in the United States. According to the Centers for Disease Control (CDC), 15.5 % of all adults (37.8 million people) were current

cigarette smokers in 2016.[2]

Health risks of drug use and smoking
Drugs can have significant and damaging short-term and long-term effects, including psychotic behavior, seizures or death due to overdose. Dependence on drugs can create a number of dangerous and damaging complications, such as accidents, suicide, family/work/school problems and legal issues.

Smoking diminishes overall health and is a known cause of multiple cancers, heart disease, stroke, complications of pregnancy, chronic obstructive pulmonary disease (COPD) and many other diseases. There are also health dangers of involuntary exposure to (second-hand) tobacco smoke. Smoking increases risks for preterm delivery.[3]

Diagnosis and treatment
Diagnosing substance use disorders requires a thorough evaluation and includes an assessment by a psychiatrist or a psychologist or an independently licensed behavioral health practitioner that has met the state requirements to render a diagnosis. Blood, urine or other lab tests are used to assess drug use.

People with behavioral disorders are more likely to experience a substance use disorder and people with a substance use disorder are more likely to have behavioral health issues when compared to the general population. According to the National Survey of Substance Abuse Treatment Services, about 45% of Americans seeking treatment of substance use/abuse have also been diagnosed with behavioral health problems.[4]

When diagnosing a substance use disorder, most mental health professionals use criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association.

Treatment depends on the type of substance used and any related medical or behavioral health disorders that the patient may have. Some treatment options include:

- Chemical dependence treatment programs
- Detoxification
- Behavioral therapy
- Self-help groups

There are a lot of treatments to support tobacco cessation, including behavioral therapies and FDA-approved medications. Some treatment options to help ensure tobacco cessation include:

- Nicotine replacement therapy (NRT), as well as bupropion and varenicline
- Combination of behavioral treatment and cessation medications
- Mobile devices and social media help to boost tobacco cessation
- Tobacco cessations are not recommended for adolescents due to lacking high-quality studies
- Behavioral counseling can be provided either in person or by telephone and a variety of approaches are available such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), telephone support lines, text messaging, web-based services and social media.[5]

HEDIS® quality measures

Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment (IET) is a measure that assesses the percentage of plan members' ages 13 years and older with the new episode of alcohol or other drug (AOD) abuse or dependence who received the following: initiation of AOD and engagement of AOD.

Initiation of treatment is the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Engagement of treatment is the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days after the initiation visit.[6] This measure now includes medication-assisted treatment (MAT) as an appropriate treatment for people with alcohol and opioid dependence. This measure also adds telehealth to treatment options.

Use of Opioids at High Dosage (UOD) is a first year quality measure that assesses the number of members 18 years and older per 1,000 beneficiaries receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average morphine equivalent dose > 120 mg).[7]

Use of Opioids from Multiple Providers (UOP) is a first year quality measure that assesses the number of members 18 years and older per 1,000 receiving a prescription for opioids for ≥ 15 days during the measurement year who received opioids from multiple providers. Three rates are reported:

- *Multiple prescribers* – the rate per 1,000 members receiving prescriptions for opioids from four or more different prescribers during the measurement year
- *Multiple pharmacies* – the rate per 1,000 members receiving prescriptions for opioids from four or more different pharmacies during the measurement year
- *Multiple prescribers and multiple pharmacies* – the rate per 1,000 members receiving

prescriptions for opioids from four or more different prescribers *and* four or more different pharmacies during the measurement year.[7]

Unhealthy Alcohol Use Screening and Follow-Up (ASF) is a measure that assess the percentage of health plan members 18 years and older who were screened for unhealthy alcohol use using a standardized tool and, if screened positive, received appropriate follow-up care.

- *Unhealthy alcohol use screening* – the percentage of members who had a systematic screening for unhealthy alcohol use
- *Counseling or other follow-up* – the percentage of members who screened positive for unhealthy alcohol use and received brief counseling or other follow-up care within 2 months of a positive screening.

The intent of the measure: alcohol misuse is a leading cause of illness, lost productivity and preventable death in the U.S.[7]

Medical Assistance with Smoking and Tobacco Use Cessation (MSC) is a survey measure that assesses different facets of providing medical assistance with smoking and tobacco use cessation. There are three components of the survey:

- *Advising Smokers and Tobacco Users to Quit:* Adults 18 years of age and older who are current smokers or tobacco users and who received cessation advice during the measurement year
- *Discussing Cessation Medications:* Adults 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year
- *Discussing Cessation Strategies:* Adults 18 years of age and older who are current smokers or tobacco users who discussed or were provided cessation methods or strategies during the measurement year.

ICD-10-CM: general coding information

When a patient is diagnosed with an alcohol- or drug-related disorder, the diagnosis is often more complex, as such conditions are susceptible to both psychological and physiological signs, symptoms, manifestations, and comorbidities.

Details are required from the documentation to identify *use, abuse* or *dependence* of the substance.

Based on ICD-10-CM Coding Guidelines, when *use, abuse* or *dependence* of the same substance are documented in the medical record, only one code should be assigned based on the following hierarchy:

- If both *use* and *abuse* are documented, the code for *abuse* should be assigned
- If both *abuse* and *dependence* are documented, the code for *dependence* should be assigned
- If *use, abuse* and *dependence* are documented, the code for *dependence* should be assigned
- If both *use* and *dependence* are documented, the code for *dependence* should be assigned.[8]

Alcohol dependence and abuse

- Alcohol related disorders are classified to category **F10**-. An additional code for blood alcohol level **(Y90.-)** may be assigned, if applicable
- Alcohol *abuse* is classified under subcategory **F10.**-, Alcohol abuse
- Alcohol *dependence* is classified under subcategory **F10.2-**, Alcohol dependence
- Both categories *alcohol abuse* and *alcohol dependence***,** are further subdivided to specify the presence of *intoxication* or *intoxication delirium*. Additional characters are also provided to specify *alcohol-induced mood disorder*, *psychotic disorder*, and *other alcohol-induced disorders*
- Codes in sub classification **F10.23**-, Alcohol dependence with withdrawal, provide additional detail regarding withdrawal symptoms such as *delirium* and *perceptual disturbance*
- Selection of codes "in remission" for categories **F10-F19** requires the provider's clinical judgement. The appropriate codes for "in remission" are assigned only on the basis of provider documentation, unless otherwise instructed by the classification
- Toxic effect of alcohol is not classified to category F10 but to subcategory **T51.0**- instead.9

Drug dependence and abuse

ICD-10-CM classifies drug dependence and abuse in the following categories according to the class of the drug:

F12	Cannabis related disorders
F13	Sedative, hypnotic or anxiolytic related disorders
F14	Cocaine related disorders
F15	Other stimulant related disorders
F16	Hallucinogen related disorders
F17	Nicotine dependence
F18	Inhalant related disorders
F19	Other psychoactive substance related disorders

- In most cases, fourth characters indicate whether the disorder is *nondependent abuse* (1), *dependence* (2), or *unspecified use* (9).
- Additional characters also provided to specify *intoxication*, *intoxication delirium*, and *intoxication with perceptual disturbance*.
- Patients with substance abuse or dependence often have related physical complications or psychotic symptoms. These complications are classified to the specific drug abuse or dependence, with the fifth or sixth characters providing further specificity regarding any associated *drug-induced mood disorder*, *psychotic disorder*, *withdrawal*, and *other drug-induced disorders* (such as sleep disorder).

Tobacco use and dependence
Category F17. - (nicotine dependence) codes are located in chapter 5 of the ICD-10-CM book.

The Excludes 1 note reminds that this is not the same diagnosis as tobacco use **(Z72.0)** nor the history of tobacco dependence **(Z87.891).** Therefore, the documentation will need to specifically discern between tobacco use and nicotine dependence.

The Excludes 2 note reminds to code tobacco use (smoking) during pregnancy, childbirth and the puerperium **(O99.33-)** and toxic effect of nicotine **(T65.2-).**
If the patient has been in contact with, or in close proximity to, a source of tobacco smoke, then **Z77.22**, Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic), need to be reported.
Tobacco abuse counseling is reported using code **Z71.6** with the additional code for nicotine dependence **(F17.-).**

ICD-10-CM classifies nicotine dependence by substance:

- F17.20-, nicotine dependence, unspecified
- F17.21-, nicotine dependence, cigarettes
- F17.22-, nicotine dependence, chewing tobacco
- F17.29-, nicotine dependence, other tobacco product.[9]

Each category further breaks down the dependence using a sixth character to denote:

0	Uncomplicated
1	In remission
3	With withdrawal
8	With other nicotine-induced disorders

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References:

1. Opioid overdose. Overview of an epidemic. https://www.cdc.gov/drugoverdose/data/index.htm
2. Current cigarette smoking among adults – United States, 2016. https://www.cdc.gov/mmwr/volumes/67/wr/mm6702a1.htm?s_cid=mm6702a1_w%20
3. CDC. Health effects of cigarette smoking. Retrieved on 1/18/2018 from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm
4. Treatment for co-occurring mental and substance use disorders. https://www.samhsa.gov/treatment
5. What are treatments for tobacco dependence? Retrieved on 1/18/2018 from https://www.drugabuse.gov/publications/tobacco-nicotine-e-cigarettes/what-are-treatments-tobacco-dependence
6. HEDIS Benchmarks and Coding Guidelines for Quality Care. Amerigroup RealSolutions in healthcare. Retrieved from https://providers.amerigroup.com
7. NCQA updates quality measures for HEDIS 2018. http://www.ncqa.org/newsroom/details/ncqa-updates-quality-measures-for-hedisreg-2018?ArtMID=11280&ArticleID=85&tabid=2659
8. ICD-10-CM Expert for Physicians. The complete official code set (2017). Optum 360
9. Leon-Chisen N. (2017). ICD-10-CM and ICD-10-PCS Coding Handbook 2018. American Hospital Association, Chicago, IL.

These links lead to third-party sites. These organizations are solely responsible for the content on their sites.

Quarterly Pharmacy Formulary Change Notice

The formulary changes listed in the table below were reviewed and approved at the first quarter 2018 Pharmacy and Therapeutics Committee meeting. Effective August 1, 2018, the following formulary changes applied. This notice applies to Anthem Blue Cross and Blue Shield Medicaid (Anthem) benefits in Kentucky.

What action do I need to take?

Please review these changes and work with your Anthem patients to transition them to formulary alternatives. If you determine preferred formulary alternatives are not clinically appropriate for specific patients, you will need to obtain prior authorization to continue coverage beyond the applicable effective date.

What if I need assistance?

We recognize the unique aspects of patients' cases. If for medical reasons your Anthem patient cannot be converted to a formulary alternative, call our Pharmacy department at **1-855-661-2028** and follow the voice prompts for pharmacy prior authorization. You can find the *Preferred Drug List* on our provider website at

https://mediproviders.anthem.com/ky/pages/pharmacy.aspx.

If you need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-855-661-2028**.

Effective For All Patients On August 1, 2018			
2nd Notice - Additional Information Provided (Preferred NDCs Listed)			
Therapeutic Class	**Drug Name**	**Preferred Manufacturer**	**Preferred NDC**
OTC Prenatal Vitamins	Prenatal Tablet 28MG-0.8MG	21st Century HE	40985-0273-10
OTC Prenatal Vitamins	Daily Prenatal Combo Pack 28-800-440 Prenatal Vitamins Tablet 28MG-0.8MG	Amerisource Bergen	46122-0009-65 46122-0098-78
OTC Prenatal Vitamins	Prenatal Tablet 27MG-0.8MG	Cardinal Health	55154-1393-00
OTC Prenatal Vitamins	QC Prenatal Tablet 28MG-0.8MG	Chain Drug	35515-0947-74 63868-0001-01
OTC Prenatal Vitamins	CVS Prenatal Multi-DHA Softgel 27-0.8-250 CVS Prenatal Vitamin Tablet CVS Women's Prenatal + DHA 28-975-200	CVS	50428-0399-50 50428-2525-77 50428-4604-61
OTC Prenatal Vitamins	Prenatal 19 Tablet 29-1-25 MG Prenatal 19 Chewable Tablet 29 MG-1 MG	Cypress Pharm.	60258-0196-01 60258-0197-01
OTC Prenatal Vitamins	KPN Tablet Prenatal One Daily Tablet 27MG-0.8MG	Freeda Vitamins	10432-0033-01 58487-0031-31
OTC Prenatal Vitamins	Prenatal Tablet 27MG-0.8MG	Gendose Pharmacy	77333-0715-10 77333-0715-25
OTC Prenatal Vitamins	Prenatal Tablet 27MG-0.8MG	Geri-Care	57896-0575-01
OTC Prenatal Vitamins	GNP Daily Prenatal Combo Pack 28-800-440 GNP Prenatal Vitamins Tablet 28MG-0.8MG	Good Neighbor	87701-0405-76 87701-0407-99
OTC Prenatal Vitamins	HM Prenatal Tablet 28MG-0.8MG	Health Mart	52569-0134-33
OTC Prenatal Vitamins	Perry Prenatal Capsule 13.5-0.4MG	Kirkman Sales	11763-0522-01

OTC Prenatal Vitamins	Prenatal Tablet 28MG-0.8MG	Leader	96295-0128-31
OTC Prenatal Vitamins	Prenatal Tablet 27MG-0.8MG	Magno-Humphries	43292-0555-15 43292-0556-70
OTC Prenatal Vitamins	Prenatal Tablet 27MG-0.8MG	Major Pharmaceuticals	00904-5313-46 00904-5313-60
OTC Prenatal Vitamins	Prenatal Formula Tablet 28MG-0.8MG	NAT'L VIT. CO.	54629-0052-01 79854-0400-70
OTC Prenatal Vitamins	Prenatal Tablet 28MG-0.8MG	Plus Pharma;Inc	37864-0837-01 51645-0837-01
OTC Prenatal Vitamins	Prenatal Tablet 27MG-0.8MG	Prime Marketing	62107-0063-01
OTC Prenatal Vitamins	Prenatal Tablet 28MG-0.8MG	Richmond Pharm	54738-0050-01
OTC Prenatal Vitamins	RA Prenatal Tablet 28MG-0.8MG RA One Daily Prenatal DHA Pack 28-800-440	Rite Aid Corp.	11822-3089-10 11822-4898-00
OTC Prenatal Vitamins	Classic Prenatal Tablet 28MG-0.8MG Prenatal Vitamins Tablet 28MG-0.8MG	Rugby	00536-4063-01 00536-4085-01
OTC Prenatal Vitamins	Prenatal Vitamin Tablet 28MG-0.8MG	Safecor Health	48433-0112-01

Prior Authorization Requirements for Somatrem

Effective January 1, 2019, prior authorization (PA) requirements will change for injectable/infusible drug Somatrem to be covered by Anthem Blue Cross and Blue Shield Medicaid. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA 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 following:

- Somatrem — injection, 1 mg (J2940)

To request PA, you may use one of the following methods:

- **Web: https://www.availity.com**
- **Fax: 1-800-964-3627**
- **Phone: 1-855-661-2028**

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal (**https://www.availity.com**). Providers who are unable to access Availity may call us at **1-855-661-2028** for PA requirements.

Prior Authorization Requirements for Sublocade

Effective February 1, 2019, prior authorization (PA) requirements will change for the infusible/injectable drug Sublocade to be covered by Anthem Blue Cross and Blue Shield Medicaid. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA 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 following:

- Sublocade (Buprenorphine) — implant (J0570)
- Sublocade — injectable (Q9991, Q9992)

To request PA, you may use one of the following methods:

- **Web:** https://www.availity.com
- **Fax: 1-800-964-3627**
- **Phone: 1-855-661-2028**

Not all PA requirements are listed here. PA requirements are available to contracted providers through the Availity Portal (https://www.availity.com). Providers who are unable to access Availity may call us at **1-855-661-2028** for PA requirements.

Reimbursement Policy Update: Claims Requiring Additional Documentation

Policy 06-031, effective March 1, 2019

Professional providers and facilities are required to submit additional documentation for adjudication of applicable types of claims. If the required documentation is not submitted, the claim may be denied. Anthem Blue Cross and Blue Shield Medicaid may request additional documentation or notify the provider or facility of additional documentation required for claims, subject to contractual obligations.

Effective March 1, 2019, if an itemized bill is requested and/or required, then it must include the appropriate revenue code for each individual charge.

For additional information, please review the Claims Requiring Additional Documentation reimbursement policy at https://mediproviders.anthem.com/ky.