December 2018 Anthem New Hampshire Provider Newsletter

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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 ***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 www.availity.com.
- Call the AIM Contact Center toll-free number at 866-714-1107, Monday–Friday, 8:00 a.m.–5:00 p.m.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

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:

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- Access AIM via the Availity Web Portal at www.availity.com.
- Call the AIM Contact Center toll-free number at 866-714-1107, Monday–Friday, 8:00 a.m.–5:00 p.m.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

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 beginning January 1, 2019. To view the list of those CPT codes, you may access and download a copy of the current guidelines here.

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

- Access AIM's ***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 www.availity.com.
- Call the AIM Contact Center toll-free number at 866-714-1107, Monday–Friday, 8:00 a.m.–5:00 p.m.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Member's access to behavioral health care

As a participating provider please be reminded of your contractual obligation to help ensure our members have prompt access to behavioral health care:

- Non-life threatening emergency needs - must be seen, or have appropriate coverage directing the member, within 6 hours. When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.
- Urgent needs - must be seen, or have appropriate coverage directing the member, within 48 hours. Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.
- Routine office visit - must be within 10 business days. Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

We use several methods to monitor adherence to these standards. Monitoring is

accomplished by:

1. assessing the availability of appointments via phone calls by our staff or designated vendor to the provider's office;
2. analysis of member complaint data; and
3. analysis of member satisfaction.

Providers are expected to make best efforts to meet these access standards for all members.

Introducing new clinical criteria page for injectable, infused or implanted drugs

Beginning 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.

Electronic prior authorization requests for prescription medications accepted online

We accept 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.

Pharmacy information available on anthem.com

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions and other requirements, restrictions or limitations that apply to certain drugs, visit anthem.com/provider and select Pharmacy Information. The commercial and marketplace drug lists are reviewed and updates are posted to the website quarterly (the first of the month for January, April, July and October).

To locate the Marketplace Select Formulary and pharmacy information for health plans offered on the Exchange Marketplace, go to anthem.com > Customer Support > select state > Download forms > then choose 'Select Drug List'. This drug list is also reviewed and updated regularly as needed.

Federal Employee Program (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 FEP. You can view the Specialty Drug List online or call us at 888-346-3731 for more information.

Sign up today for provider eUpdates

Connecting with Anthem and staying informed is easy, fast and convenient with our provider eUpdates. eUpdates feature short topic summaries on late breaking news that impacts providers such as:

- Website updates
- System changes
- Policy updates
- Claims and billing updates
- And more.....

Registration is fast and easy. There is no limit to the number of subscribers who can register for our eUpdates, so your facility or practice can submit as many email addresses as you like. Sign up today!

Payment recovery process simplified for National Accounts membership

In our 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.

Availity to serve as EDI entry point for electronic submissions

We have 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, we continue 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 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, 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 (800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. Eastern Time.

Attention providers certified or licensed in acupuncture: Join Anthem's

new acupuncture provider network

We are pleased to announce that we are establishing a participating network of health care providers specializing in acupuncture services. The establishment of this network will enable our members to maximize their benefits when receiving services from certified or licensed acupuncturists who participate with us.

The projected effective date of our network of acupuncture providers will be January 1, 2019. If you are interested in becoming a participating provider, please contact your Provider Relations Representative or email us at nh_pec_demo-sm@anthem.com. Please be sure to include your name, location and contact information and the appropriate Provider Relations Representative will outreach to you directly.

Ensure the accuracy of your information in the provider directory

CMS requires that we ensure that the information in our provider directories is accurate; therefore, we conduct quarterly verifications of provider demographic and participation information. You may receive a fax, email or letter requesting that this information be confirmed. We appreciate your continued cooperation with this initiative.

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

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

- Provider
- Provider Specialty
- Street Address
- Phone number
- Accepting New Patients
- NPI
- Fax Number
- Email
- Handicap Accessibility

Misrouted protected health information (PHI)

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

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 anthem.com/provider > Find Resources for [state] > Health & Wellness (top blue bar) > Quality Improvement and Standards > HEDIS Information. You will find reference documents entitled “HEDIS 101 for Providers” and “HEDIS Physician Documentation Guidelines and Administrative Codes”.

Please click the attachment link to the right to view the 2018 HEDIS rates.

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 > scroll down and select 'Find Resources for [state]' > Health and Wellness > Practice Guidelines.

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.

We are available to offer assistance in these difficult moments with our Case Management (CM) Program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals who 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.

CM Email Address	CM Telephone Number	CM Business Hours
CMReferralSpecialistNE@anthem.com	800-231-8254	Monday – Friday, 8:00 a.m. – 7:00 p.m.
Federal Employee Program (FEP) No email	800-711-2225	Monday – Friday, 8:00 a.m. – 7:00 p.m.

ConditionCare Program benefits members and physicians

Our members have 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 members' 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 member's progress in the program.

Please visit our website to find more information about the program such as program guidelines, educational materials and other resources. Go to anthem.com/provider > scroll down and select 'Find Resources for [state]'. Also on our website is the Patient Referral Form, which you can use to refer other members you feel may benefit from our program.

If you have any questions or comments about the program, call 877-681-6694. Our nurses are available Monday-Friday, 8:00 a.m. - 9:00 p.m., and Saturday, 9:00 a.m. - 5:30 p.m.

For Federal Employee Program® members, call 844-730-0088. Nurses are available Monday – Friday, 9:00 a.m. - 8:00 p.m.

Coordination of care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. We 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. We urge all practitioners to obtain the appropriate permission from these members to coordinate care between behavioral health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

- Discuss with the patient the importance of communicating with other treating practitioners.
- Obtain a signed release from the patient and file a copy in the medical record.
- Document in the medical record if the patient refuses to sign a release.
- Document in the medical record if you request a consultation.
- If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
- 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, we have several tools available on our website including a coordination of care template and cover letters for both behavioral health and other healthcare practitioners.* 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 forms and cover letters are available at anthem.com/provider > scroll down and select 'Find Resources for [state]' > Answers@Anthem > Coordination of Care.

**Access to the Toolkit is available at anthem.com/provider > scroll down and select 'Find Resources for [state]' > Health and Wellness > Provider Toolkits.

Integrated Care Model for plans purchased on the Health Insurance Marketplace benefits members 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 an 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 who 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 by calling the number located in the grid below.

CM Telephone Number	CM Email Address	CM Business Hours
Phone: 800-231-8254 Fax: 800-947-4074	CMReferralSpecialistNE@anthem.com	Monday – Friday, 8:00 a.m. – 7:00 p.m.

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. Our medical policies are available on our 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/provider.

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 a.m. – 5:00 p.m. Monday - Friday (except holidays). More hours may be available in your area. Federal Employee Program hours are 8:00 a.m. – 7:00 p.m. 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 following phone lines are for physicians and their staff. Members should call the customer service number on their health plan ID card.

To Discuss UM Process and Authorizations	To Discuss Peer-to-Peer UM Denials w/Physicians	To Request UM Criteria	TDD/TTY
800-531-4450 Transplant: 800-255-0881 Behavioral Health: 800-228-5975 Autism: 844-269-0538 FEP Phone: 800-860-2156 Fax: 800-732-8318 (UM) Fax: 877-606-3807 (ABD)	800-437-7162 FEP 800-860-2156	800-437-7162 FEP Phone: 800-860-2156 Fax: 800-732-8318 (UM) Fax: 877-606-3807 (ABD)	711, or TTY/Voice: 800-735-2964

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.

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.

Members' Rights and Responsibilities

The delivery of quality health care requires cooperation between members, their providers and their health care benefit plans. One of the first steps is for members 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, we have adopted a Members' Rights and Responsibilities statement.

It can be found on our website at anthem.com/provider > scroll down and select 'Find Resources for [state]' > Health & Wellness > Quality > 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 anthem.com

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. When discussing treatment options with your patients, you may wish to use this tool as an aid in helping them make treatment decisions. This tool has been reviewed and certified by the Washington Health Care Authority (HCA) and is available on our website. To access the aid, visit anthem.com/provider > scroll down and select 'Find Resources for [state]' > Health and Wellness > Practice Guidelines > Shared Decision Making Aid.

Bundled Services and Supplies: professional

Beginning with dates of service on or after March 1, 2019, we 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, by visiting the Reimbursement Policy page at anthem.com/provider.

Reimbursement for convenience surgical supply kits: professional

We periodically review 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 our Global Surgery and/or Bundled Services and Supplies Reimbursement Policies located at the Reimbursement Policy page at anthem.com/provider for additional information.

Scope of License reimbursement policy update: 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, visit the Reimbursement Policy page at anthem.com/provider.

"Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services: professional

Please note that 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 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.

Medical policy updates are available on anthem.com

The following new and revised medical policies were endorsed at the September 13, 2018 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com/provider > scroll down and select 'Find Resources for [state]' > Medical Policies and Clinical UM Guidelines.

If you do not have access to the internet, you may request a hard copy of any updated policy by contacting the Provider Call Center.

Please note that the Federal Employee Program® Medical Policy Manual may be accessed at www.fepblue.org > Benefit Plans > Brochures and Forms > Medical Policies.

Revised medical policy effective September 20, 2018
(The following policy was revised to expand medical necessity indications or criteria.)

LAB. 00019 - Serum Markers for Liver Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease

Revised medical policies effective September 20, 2018
(The following policies may have word changes or coding updates, but had no significant changes to the policy position or criteria.)

DRUG.00078 - Proprotein Convertase Subtilisin Kexin 9 (PCSK9) Inhibitors
DRUG.00081 - Eteplirsen (Exondys 51™)
GENE.00010 - Genotype Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status
GENE.00016 - Gene Expression Profiling for Colorectal Cancer
GENE.00023 - Gene Expression Profiling for Uveal Melanoma
GENE.00041 - Short Tandem Repeat Analysis for Specimen Provenance Testing
LAB.00029 - Rupture of Membranes (ROM) Testing in Pregnancy
MED.00111 - Intracardiac Ischemia Monitoring
SURG.00098 - Mechanical Embolectomy for Treatment of Acute Stroke

Archived medical policy effective September 20, 2018
(This policy is now archived and should no longer be used.)

DRUG.00089 - Daclizumab (Zinbryta®)

Revised medical policies effective October 17, 2018
(The following policies were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.)

ADMIN.00006 - Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
DME.00011 - Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices
DME.00038 - Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices
GENE.00033 - Genetic Testing for Inherited Peripheral Neuropathies
GENE.00047 - Methylenetetrahydrofolate Reductase Mutation Testing
LAB.00028 - Serum Biomarkers for Multiple Sclerosis
MED.00057 - MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
MED.00082 - Quantitative Sensory Testing
MED.00089 - Quantitative Muscle Testing Devices
MED.00095 - Anterior Segment Optical Coherence Tomography
MED.00096 - Low-Frequency Ultrasound Therapy for Wound Management
MED.00099 - Electromagnetic Navigational Bronchoscopy
MED.00103 - Automated Evacuation of Meibomian Gland
OR-PR.00006 - Powered Robotic Lower Body Exoskeleton Devices
RAD.00004 - Peripheral Bone Mineral Density Measurement
RAD.00037 - Whole Body Computed Tomography Scanning
RAD.00057 - Near-Infrared Coronary Imaging and Near- Infrared Intravascular Ultrasound Coronary Imaging
RAD.00062 - Intravascular Optical Coherence Tomography (OCT)
RAD.00064 - Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)
SURG.00008 - Mechanized Spinal Distraction Therapy
SURG.00011 - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
SURG.00067 - Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
SURG.00082 - Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
SURG.00092 - Implanted Devices for Spinal Stenosis
SURG.00095 - Viscocnalosomy and Canaloplasty
SURG.00101 - Suprachoroidal Injection of Pharmacologic Agent
SURG.00103 - Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
SURG.00104 - Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
SURG.00114 - Facet Joint Allograft Implants for Facet Disease
SURG.00119 - Endobronchial Valve Devices
SURG.00127 - Sacroiliac Joint Fusion

SURG.00128 - Implantable Left Atrial Hemodynamic Monitor
SURG.00129 - Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
SURG.00131 - Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
SURG.00135 - Radiofrequency Ablation of the Renal Sympathetic Nerves
SURG.00144 - Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia
TRANS.00035 - Mesenchymal Stem Cell Therapy for Orthopedic Indications
TRANS.00036 - Stem Cell Therapy for Peripheral Vascular Disease

Archived medical policy effective November 5, 2018
(This policy is now an MCG Behavioral Health Clinical Guideline. This is a correction to the archive date from previous communications.)

BEH.00001 - Opioid Antagonists under Heavy Sedation or General Anesthesia as a Technique of Opioid Detoxification

Revised medical policies effective March 1, 2019
(The following policies listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

LAB.00030 - Measurement of Serum Concentrations of Monoclonal Antibody Drugs and Antibodies to Monoclonal Antibody Drugs
SURG.00011 - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting

New medical policy effective March 1, 2019
(The policy below is new and may result in services previously covered now being considered either not medically necessary and/or investigational)

MED.00125 - Biofeedback and Neurofeedback

Clinical guideline updates are available on anthem.com

The following new and revised medical policies were endorsed at the September 13, 2018 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com/provider > scroll down and select 'Find Resources for [state]' > Medical Policies and Clinical UM Guidelines.

If you do not have access to the internet, you may request a hard copy of any updated policy

by contacting the Provider Call Center.

Revised clinical guidelines effective September 20, 2018
(The following guidelines were revised to expand medical necessity indications or criteria.)

CG-DRUG-94 - Rituximab (Rituxan®) for Non-Oncologic Indications
CG-SURG-79 - Implantable Infusion Pumps

Revised clinical guidelines effective September 20, 2018
(The following guidelines were reviewed and had no significant changes to the position or criteria.)

CG-DRUG-16 - White Blood Cell Growth Factors
CG-DRUG-64 - FDA-Approved Biosimilar Products
CG-MED-38 - Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer
CG-SURG-03 - Blepharoplasty, Blepharoptosis Repair, and Brow Lift
CG-SURG-09 - Temporomandibular Disorders

Revised clinical guidelines effective October 17, 2018
(The following guidelines were revised to expand medical necessity indications or criteria.)

CG-DRUG-107 - Pharmacotherapy for Hereditary Angioedema
CG-MED-46 - Electroencephalography and Video Electroencephalographic Monitoring

Revised clinical guidelines effective October 17, 2018
(The following guidelines were reviewed and had no significant changes to the position or criteria.)

CG-DME-41 - Ultraviolet Light Therapy Delivery Devices for Home Use
CG-DME-42 - Non-implantable Insulin Infusion and Blood Glucose Monitoring Devices
CG-DRUG-03 - Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
CG-DRUG-08 - Enzyme Replacement Therapy for Gaucher Disease
CG-DRUG-09 - Immune Globulin (Ig) Therapy
CG-DRUG-55 - Elosulfase alfa (Vimizim®)
CG-DRUG-58 - Laronidase (Aldurazyme®)
CG-DRUG-61 - Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications
CG-DRUG-74 - Canakinumab (Ilaris®)
CG-MED-63 - Treatment of Hyperhidrosis
CG-MED-64 - Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)

CG-MED-66 - Cryopreservation of Oocytes or Ovarian Tissue
CG-REHAB-04 - Physical Therapy
CG-REHAB-05 - Occupational Therapy
CG-REHAB-08 - Private Duty Nursing in the Home Setting
CG-SURG-28 - Transcatheter Uterine Artery Embolization
CG-SURG-63 - Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure

Clinical guideline adopted effective November 1, 2018
(This guideline is now an AIM clinical guideline.)

CG-MED-59 - Upper Gastrointestinal Endoscopy in Adults

Archived clinical guidelines effective November 5, 2018
(These clinical guidelines are now MCG Behavioral Health Clinical Guidelines. This is a correction to the archive date from previous communications.)

CG-BEH-03 - Psychiatric Disorder Treatment
CG-BEH-04 - Substance-Related and Addictive Disorder Treatment
CG-BEH-05 - Eating and Feeding Disorder Treatment
CG-BEH-07 - Psychological Testing
CG-MED-23 - Home Health

New and adopted clinical guideline effective January 1, 2019
(This guideline is now an AIM clinical guideline.)

CG-REHAB-06 - Speech-Language Pathology Services

Update on clinical guideline communication in October 2018 provider newsletter

We'd like to make two corrections on information we provided in the October 2018 issue of our provider newsletter. In the article titled 'Clinical guideline updates are available on anthem.com', we incorrectly advised that the following guidelines previously unadopted would become effective January 1, 2019.

CG-DRUG-33 - Palonosetron
CG-DRUG-40 - Bortezomib (Velcade®)
CG-DRUG-52 - Temsirolimus (Torisel®)
CG-DRUG-60 - Gonadotropin Releasing Hormone Analogs for Oncologic Indications

Please be advised that these guidelines will remain unadopted at this time and will not become effective in January.

In addition, in the same article we announced that the guideline CG-DRUG-44 - Pegloticase (Krystexxa®) would also become effective on January 1, 2019. In fact, guideline CG-DRUG-44 became effective on September 1, 2018, as we communicated in the June 2018 issue of our provider newsletter.

We apologize for any inconvenience.

Benefit change for Infliximab for Federal Employee Program®

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 800-852-3316.

Coordination of benefits for a Federal Employee Program® (FEP®) member

We value the relationship we have with our providers, and always look for opportunities to help expedite the claim processing. When an FEP member visits the provider office, obtaining the most current medical insurance information will help to establish the primary carrier, and will help alleviate claim denials and support accurate billing. For questions please contact the Federal Employee Customer Service at 800-852-3316.

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. You'll 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 FEP members effective January 1, 2019. For questions please contact

FEP Customer Service at 800-852-3316.

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 help ensure you receive the most efficient service, please refrain from using the member services line and use only 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 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. We 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.

New MediBlue Select HMO Network effective January 1, 2019

We are pleased to announce the formation of our MediBlueSM Select HMO provider network, which, beginning January 1, 2019, will support a specific line of Medicare Advantage products and programs focused on quality metrics and improvements. This plan is available in Hillsborough and Rockingham counties only. MediBlue Select HMO members will have Anthem MediBlue Select (HMO) in the upper right corner of their member ID cards.

MediBlue participating primary care physicians (PCPs), specialists and hospitals who

participate in our Enhanced Personal Health Care Program will be designated as participating in this new provider network as will all other MediBlue participating ancillary providers and ancillary facilities. All questions may be directed to the Provider Call Center at 855 310-2473.

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State of New Hampshire offers Medicare Advantage option

Effective January 1, 2019, State of New Hampshire retirees who are eligible for Medicare Parts A and B will be enrolled in an Anthem Medicare Preferred (PPO) plan. The Anthem Medicare Preferred (PPO) plan will replace the current Anthem Medicomp plan. The plan includes the National Access Plus benefit.

With the National Access Plus benefit, retirees may receive services from any provider as long as the provider is eligible to receive payments from Medicare. In addition, State of New Hampshire retirees will pay the same cost share for both in-network and out-of-network services. The MA plan offers the same hospital and medical benefits that Medicare covers and also covers additional benefits that Medicare does not, such as an annual routine physical exam, LiveHealth Online and SilverSneakers®.

The prefix on State of New Hampshire ID cards will be XNS. The cards will also show the State of New Hampshire logo and National Access Plus icon.

Providers may submit claims electronically using the electronic payer ID for the Blue Cross Blue Shield plan in their state or submit a UB-04 or CMS-1500 form to the Blue Cross Blue Shield plan in their state. Claims should not be filed with Original Medicare. Contracted and non-contracted providers may call the number on the back of the member's ID card or Provider Services at 1-833-292-2603 for benefit eligibility, prior authorization requirements and any questions about State of New Hampshire member benefits or coverage.

Detailed prior authorization requirements also are available to contracted providers by accessing the Provider Self-Service Tool at Availity.com.

Keep up with Medicare news

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

- 2019 Provider Annual Notice of Change

- Prior authorization requirements for Colonoscopy and Upper Gastrointestinal Endoscopy
- 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 September 1

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