February 2019 Anthem New Hampshire Provider Newsletter

Update to AIM Musculoskeletal Program Clinical Appropriateness Guidelines 1
Aware Recovery Care provides comprehensive drug and alcohol addiction rehab programs 2
Member satisfaction with behavioral health outpatient services 3
Clinical criteria updates for specialty pharmacy 4
Specialty pharmacy prior authorization list expanded 5
Specialty pharmacy medical step therapy drug list expanded 6
Sign up today for provider eUpdates 8
Claim edit enhancements for outpatient facility claims 8
Reminder: review ICD-10-CM coding guidelines: professional 9
Coverage change for contraceptives and contraceptive supplies effective January 1, 2019 9
Injectable Substances with Related Injection Services reimbursement policy update: professional 9
Body Mass Index reimbursement policy: facility 10
Significant Edits: professional 10
Clinical guideline updates are available on anthem.com 10
HEDIS® 2019 Federal Employee Program medical record request requirements ... 11
Reminder: Anthem follows Original Medicare policies 11
Use grouped CPT codes for AIM Specialty Health authorizations 11
Eye refraction and routine eye exam billing information 12
New specialty Medicare Part B device preferred product program 12
Keep up with Medicare news 12

Update to AIM Musculoskeletal Program Clinical Appropriateness Guidelines

Effective for dates of service on and after May 18, 2019, the following updates will apply to the AIM Specialty Health Musculoskeletal Program Clinical Appropriateness Guidelines.

Spine Surgery - Enhancements as indicated by section below:

- General requirements
  - Reporting of symptom severity: expanded to include IADLs as functional impairment
  - Tobacco cessation: removed nicotine-free documentation requirement
- Cervical decompression with or without fusion
  - Added exclusion of cervical/thoracic laminectomy if criteria not met
- Lumbar discectomy, foraminotomy, and laminotomy
  - Added criteria to define radicular pain for lumbar herniated intervertebral disc
- Lumbar fusion and treatment of spinal deformity (including scoliosis and kyphosis)
  - Added indication and criteria for flat back deformity
  - Added criteria for isthmic spondylolisthesis
  - Added indication and criteria for Scheuermann’s kyphosis
- Lumbar laminectomy
  - Exclusion of lumbar laminectomy if criteria not met
- Noninvasive electrical bone growth stimulation
  - Added risk factor criteria for cervical non-invasive bone growth stimulation

Interventional Pain Guidelines - Enhancements as indicated by section below:

- General requirements
  - Reporting of symptom severity: expanded to include IADLs as functional impairment
- Therapeutic epidural steroid injection
  - Updated time period of initial advanced imaging
  - Definition and frequency of repeat therapeutic epidural steroid injection
  - Updated maximum number of annual injections
  - Added criteria for subsequent injection after suboptimal

initial response

- Paravertebral facet injection/nerve block/neurolysis
  - Updated injection frequency limitations
- Diagnostic intraarticular sacroiliac joint injections
  - Updated pain reduction from initial injection
- Spinal cord stimulators
  - Added criteria for revision/removal of spinal cord stimulator
  - Separated criteria of trial stimulation and permanent stimulator implantation
  - Added exclusion of dorsal root ganglion stimulation

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

- Access AIM's ***Provider****Portall*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: 866-714-1107, Monday–Friday, 8:00 a.m.–5:00 p.m.

Please note, this program does not apply to FEP or National Accounts.

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.

Aware Recovery Care provides comprehensive drug and alcohol addiction rehab programs

Aware Recovery Care is pleased to announce that it has now opened an office in South Portland, Maine to serve Augusta and all parts south to the New Hampshire border. Aware Recovery Care is closely aligned with Anthem and is one of the most comprehensive drug and alcohol addiction rehab programs available in the country. This novel program works to provide a lasting solution for those suffering from the chronic disease of drug and alcohol addiction—in the comfort, privacy, and security of their home. Learn more at www.awarerecoverycare.com.

Member satisfaction with behavioral health outpatient services

We conduct an annual satisfaction survey of our member's behavioral health outpatient service experience. The random survey is conducted based on receipt of claims. We recently reviewed the 2018 survey experience results and wanted to share highlights with our network of behavioral health providers. The survey asks about the member's satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member's various providers), prescriptions/medication management process (if applicable), financial and billing process, and their perceived clinical improvement. We also asked members to give an overall rating of the experience. The 2018 overall practitioner rating was 90% in New Hampshire based on the survey results.

We were pleased to see overall improvement in the survey results, in particular, two areas of focus over the last year - - access and coordination of care. Members responding to the survey, indicated that obtaining an appointment was fairly easy and many respondents indicated that care was being coordinated among their providers, including medical. Care coordination and collaboration, particularly medical-behavioral integration, is a key focus at Anthem. We also encourage ongoing understanding of an individual's cultural, spiritual and religious beliefs while in treatment.

While we are pleased with our member's experience with our participating provider network and thank you for your network participation and the services you provide, we'd like to remind you of two key areas to maintain and improve satisfaction:

Member's access to behavioral health care

As a participating provider please be reminded of our expectation, based on NCQA definitions, of access to behavioral healthcare 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 a) assessing the availability of appointments via phone calls and surveys by our staff or designated vendor to the provider's office; b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members. We continue to look at gaps, barriers and alternative options to improve access to behavioral healthcare including telehealth services.

Members held harmless
As a participating provider in our behavioral health provider network, a participating provider shall look solely to us for compensation for covered services and under no circumstances shall render a bill or charge to any member except for applicable co-payments, deductibles and coinsurance and for services that are not medically necessary or are otherwise not covered, provided that the provider obtains the consent of the member before providing such service. We recommend that consent be in writing and dated, in order to protect our members and providers from disputes.

In addition, we also remind our participating providers that Anthem members must be advised of missed or cancelled appointment policies at the onset of treatment. We also recommend that the advisement be acknowledged by the member in writing, and that acknowledgement is dated.

Thank you again for the services that you provide to our members.

Clinical criteria updates for specialty pharmacy

The following clinical criteria will be effective May 1, 2019.

Erythropoiesis Stimulating Agents ING-CC-0001
Clinical criteria ING-CC-0001 addresses the use of recombinant erythropoietin products, also known as erythropoiesis stimulating agents (ESAs), for the treatment of severe anemia in chronic kidney disease (CKD), HIV, cancer, surgery, and other conditions.

Effective for dates of service on and after May 1, 2019, the use of Procrit®, Epogen®, and Retacrit™ for the treatment of severe anemia in hepatitis C, chronic inflammatory disease, and bone marrow transplant is considered not medically necessary.

H.P. Acthar Gel® (repository corticotropin injection) ING-CC-0004
Clinical criteria ING-CC-0004 addresses the use of repository corticotropin injection for the treatment of infantile spasms (West syndrome) and adults with a corticosteroid-responsive condition, including but not limited to acute exacerbations of multiple sclerosis.

Effective for dates of service on and after May 1, 2019, repository corticotropin injections for the treatment of conditions other than infantile spasms (West syndrome) are considered not medically necessary.

Selective Vascular Endothelial Growth Factor (VEGF) Antagonists ING-CC-0072
Clinical criteria ING-CC-0072 addresses the use of intravitreal vascular endothelial growth factor (VEGF) antagonists for the treatment of diabetic retinopathy and other retinal disorders associated with neovascularization.

Effective for dates of service on and after May 1, 2019, the use of Eylea® for the treatment of radiation retinopathy is considered not medically necessary.

To access the clinical criteria information please click here.

Specialty pharmacy prior authorization list expanded

Effective for dates of service on and after May 1, 2019, the following specialty pharmacy codes from new clinical criteria or current clinical guideline will be included in our prior authorization review process.

Please note, inclusion of NDC code on your claim will shorten the claim processing time of drugs billed with a Not Otherwise Classified (NOC) code.

Prior authorization review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Clinical Criteria/Guideline	HCPCS or CPT Code	NDC Code	Drug
CG-DRUG-63	J3490	68152-0112-01 68152-0114-01	Khapzory™
ING-CC-0002	Q5110	00069-0291-01 00069-0291-10 00069-0292-01 00069-0292-10	Nivestym™
ING-CC-0002	J3490	68152-0112-01 68152-0114-01	Udenyca™

ING-CC-0003	J1599	68982-0820-01 68982-0820-02 68982-0820-03 68982-0820-04 68982-0820-05 68982-0820-06 68982-0820-81 68982-0820-82 68982-0820-83 68982-0820-84 68982-0820-85 68982-0820-86	Panzyga®
ING-CC-0034	J3590	47783-0644-01	Takhzyro®
ING-CC-0062	J3590	61314-0871-02 61314-0871-06 61314-0876-02	Hyrimoz™
ING-CC-0062	Q5109	00069-0811-01	Ixifi™
ING-CC-0065	J7192	00026-3942-25 00026-3944-25 00026-3946-25 00026-3948-25 00026-4942-01 00026-4944-01 00026-4946-01 00026-4948-01	Jivi®
ING-CC-0074	J8655	69639-0102-01	Akynzeo®
ING-CC-0077	C9399 J3590	68135-0058-90 68135-0673-40 68135-0673-45 68135-0756-20	Palynziq™
ING-CC-0081	J0584	69794-0102-01 69794-0203-01 69794-0304-01	Crysvita®
ING-CC-0082	C9399 J3490	71336-1000-01	Onpattro™

To access the clinical criteria information please click here.

Specialty pharmacy medical step therapy drug list expanded

The following clinical criteria will be effective May 1, 2019.

Colony Stimulating Factor Agents ING-CC-0002

Effective for dates of service on and after May 1, 2019, the following specialty pharmacy codes from new or current criteria will be included in our existing specialty pharmacy medical step therapy review process. Zarxio® will be the preferred short-acting colony stimulating factor (CSF) agent over Neupogen®, Granix®, and Nivestym™®.

Prior authorization of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Additional information regarding biosimilar drugs can be found by viewing the attached PDF reference document, “Biosimilar Drugs – What are they?”.

To access the clinical criteria information please click here.

Clinical Criteria	Status	Drug	HCPCS or CPT Code	NDC Code
ING-CC-0002	Preferred Agent	Zarxio®	Q5101	61314-0304-01 61314-0304-10 61314-0312-01 61314-0312-10 61314-0318-01 61314-0318-10 61314-0326-01 61314-0326-10
ING-CC-0002	Non-Preferred Agent	Neupogen®	J1442	55513-0530-01 55513-0530-10 55513-0546-01 55513-0546-10 55513-0924-01 55513-0924-10 55513-0924-91 55513-0209-01 55513-0209-10 55513-0209-91
ING-CC-0002	Non-Preferred Agent	Granix®	J1447	63459-0910-11 63459-0910-12 63459-0910-15 63459-0910-17 63459-0910-36 63459-0912-11 63459-0912-12 63459-0912-15 63459-0912-17 63459-0912-36

ING-CC-0002	Non-Preferred Agent	Nivestym™	Q5110	00069-0291-10 00069-0291-01 00069-0292-01 00069-0292-10

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!

Claim edit enhancements for outpatient facility claims

Beginning in May 2019, we will enhance our 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 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, HCPCS, ICD-10, NUBC)

Reminder: review ICD-10-CM coding guidelines: professional

To help ensure the accurate processing of submitted claims, keep in mind ICD-10-CM coding guidelines when selecting the most appropriate diagnosis for patient encounters. Remember that ICD-10-CM has two different types of excludes notes and each type has a different definition. In particular, one of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes 1 Notes. An Excludes 1 Note is used to indicate when two conditions cannot occur together (Congenital form versus an acquired form of the same condition). An Excludes 1 Note indicates that the excluded code identified in the note should not be used at the same time as the code or code range listed above the Excludes 1 Note. These notes are located under the applicable section heading or specific ICD-10-CM code to which the note is applicable. When the note is located following a section heading, then the note applies to all codes in the section.

Coverage change for contraceptives and contraceptive supplies effective January 1, 2019

Coverage changes for contraceptives and related contraceptive supplies became effective January 1, 2019, due to recent mandates in Connecticut, Maine and New Hampshire.

The mandates in all three states require coverage of up to a 12-month supply of certain contraceptive drugs, devices or products with no out-of-pocket cost to the member. These include FDA-approved contraceptives, devices or products. In some cases, a prior authorization may be required if a member opts for a non-formulary drug that has a therapeutic equivalent on our drug lists.

The member can obtain the 12-month supply all at once or throughout the benefit year, at the prescribing physician’s discretion.

What’s the exception to these benefit requirements?
The only exception to these requirements is that a member will be charged for the cost of these drugs, devices or products, even if covered by the ACA, if they obtain them at an out-of-network pharmacy.

Injectable Substances with Related Injection Services reimbursement policy update: professional

Beginning with dates of service on or after May 1, 2019, we are updating our Injectable Substances with Related Injection Services reimbursement policy. The update will reflect that when a claim for an injection service is submitted without the applicable Healthcare Common

Procedure Coding System (HCPCS Level II) drug or injectable substance code for the injected drug or substance, the code for the injection service will not be eligible for reimbursement.

Additionally, when submitting a claim for an aspiration service, with or without an injection, be sure to submit code J3590 (*unclassified biologics*) with a zero charge to indicate the biologic contents of the syringe after aspiration, or the service will not be eligible for reimbursement.

For additional information, review our updated policy dated May 1, 2019 by visiting the by visiting the Reimbursement Policy page at anthem.com/provider.

Body Mass Index reimbursement policy: facility

Beginning with dates of service on or after May 1, 2019, we are updating our facility Body Mass Index (BMI) Reimbursement Policy. Reimbursement will be based on a review of all comorbidities, diagnosis codes reported, and the facility specific reimbursement methodology for body mass index (BMI) diagnosis codes reported as a secondary clinical condition along with other criteria set forth in our policy.

For additional information, please review our updated policy dated May 1, 2019 by visiting the Payment Policies page at anthem.com/provider.

Significant Edits: professional

We have updated our Significant Edits posting to reflect the 2018 analysis of claims data for significant edits. We define a significant edit as a code pair edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial of payment for a particular CPT code or HCPCS code submitted more than two-hundred and fifty (250) times per year in the Plan’s service area.

Clinical guideline updates are available on anthem.com

New and adopted clinical guidelines effective May 1, 2019
(The following guidelines were previously not adopted and have now been adopted. No significant changes were made.)

- CG-SURG-49 - Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities
- CG-SURG-59 - Vena Cava Filters

Un-adopted clinical guidelines effective February 1, 2019
(The following guidelines are no longer adopted.)

- CG-SURG-18-Septoplasty
- CG-SURG-30-Tonsillectomy for Children with or without Adenoidectomy
- CG-MED-46-Electroencephalography and Video Electroencephalographic Monitoring

HEDIS® 2019 Federal Employee Program medical record request requirements

Centauri Health Solutions is the contracted vendor to gather member medical records on behalf of the Blue Cross and Blue Shield Federal Employee Program (FEP). We value the relationship with our providers, and ask that you respond to the requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. Centauri Health will work with you to obtain records via fax, mail, remote electronic medical record (EMR) access, or onsite scanning/EMR download (as necessary). We ask that you please promptly comply within five (5) business days of the record requests. If you have any questions, please contact Catherine Carmichael with FEP at 202-942-1173 or Carol Oravec with Centauri at 440-793-7727.

Reminder: Anthem follows Original Medicare policies

We are required to follow all clinical and reimbursement policies established by Original Medicare in the processing of claims and determining benefits. We follow all Original Medicare local coverage determinations, national coverage determinations, Medicare rulings, code editing logic and the Social Security Act.

We may offer additional benefits that are not covered under Original Medicare. Certain benefits are only covered when provided by a vendor selected by Anthem. More information can be found at www.anthem.com/medicareprovider. You may also contact Provider Services at the phone number on the back of the member ID card.

Use grouped CPT codes for AIM Specialty Health authorizations

AIM Specialty Health® groups CPT codes on authorizations so they can be reviewed together to support a procedure or therapy. Grouped codes are used for radiology, cardiology, and sleep and radiation therapy programs. The groupings can be found at http://aimspecialtyhealth.com/ClinicalGuidelines.html by selecting the appropriate solution and then the exam or therapy being performed. Additional information is available at

www.anthem.com/medicareprovider under Important Medicare Advantage Updates.

Eye refraction and routine eye exam billing information

Refractions and routine eye exams are not covered under medical insurance for Anthem members. These benefits may be available through the member's supplemental insurance. These services must be billed to the supplemental vendor. Check the member's Anthem ID card for the name of the vendor.

Additional information, including billing modifiers and documentation requirements, will be available at www.anthem.com/medicareprovider under Important Medicare Advantage Updates.

New specialty Medicare Part B device preferred product program

Effective for dates of service beginning January 1, 2019, the following Medicare Part B devices will be preferred to support cost-effective benefits. During precertification initiation or renewal, providers requesting a nonpreferred device will be encouraged to switch to a preferred product. The preferred and nonpreferred products are listed below.

Preferred devices	Nonpreferred devices
Euflexxa® (J7323) Hyalgan®/Supartz®/Visco-3® (J7321) Durolane® (J7318)	Gel-One® (J7326) Gelsyn-3® (J7328) Genvisc 850® (J7320) Hymovis® (J7322) MonoviscTM (J7327) Orthovisc® (J7324) Synvisc® or Synvisc-One® (J7325) TriviscTM (J7329)

75557MUSENMUB 12/20/18

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 risk adjustment provider training
- New provider learning opportunity: Put the AIM ProviderPortal to work for you
- New provider service phone number beginning January 1, 2019

- Medicare Advantage reimbursement policy provider bulletin
- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective January 1, 2019