Network Update
GEORGIA

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Administration

Attention OB/GYN providers: prenatal/postpartum related HEDIS measure information

Recently, Anthem Federal Employee Program mailed out a Quick Reference Guide to our OB/GYN provider community, in an effort to help provide important information about prenatal and postpartum claim submission. The mailer included guidance for providers to submit the Category II CPT codes for Prenatal services: **0050F (Initial prenatal care visit)**, **0501F (Prenatal flow sheet documented in medical record by first prenatal visit)** and Postpartum services: **0503F (indicating a postpartum visit)** and ICD-10 code Z39.2 (routine postpartum follow-up). Submitting these codes helps alleviate the need for medical record submission and less time and disruption to your office by the health plan to review patient charts. We value the relationship we have with our BCBSGa providers, and appreciate any and all effort put forth on this request. If your office did not receive a Quick Reference Guide to post in your office billing department, please contact FEP Customer Service at 1-800-282-2473.

Network Update

December 2016

Georgia
Use the Interactive Care Reviewer (ICR) to submit and check the precert status for many of your BCBSGa patients today!

Use ICR today to initiate a request for precertification of inpatient and outpatient procedures. Now there are even more services where you may receive an immediate authorization decision. You can find additional ICR information including a complete list of services where an immediate decision is available on the Answers@BCBSGa page of our provider website.

Need to check the status of an authorization? No need to call or fax!
Also use ICR to inquire on a previously submitted case and find out right away what is the status of the precertification request. Ordering and servicing physicians and facilities can inquire to find information on a precert previously submitted via phone, fax, ICR or other online tool.

Don’t forget, you can find decision letters associated with your precertification requests on ICR. The letters are viewable and printable.

Attend one of our upcoming webinars and learn about the features that will help you to optimize your ICR experience! Register now by clicking here.

*Excludes: some Medicare Advantage, some Medicaid, Federal Employee Program® (FEP), BlueCard® and some National Account members
Requests involving transplant services, Services administered by AIM Specialty Health should follow the same precertification process that you use today.

Tips for billing CPT modifier 33

The modifier 33 was created to aid compliance with the Affordable Care Act (ACA) which prohibits member cost sharing for defined preventive services for non-grandfathered health plans. The appropriate use of modifier 33 reduces claim adjustments related to preventive services and your corresponding refunds to members.

Modifier 33 is applicable to CPT codes representing preventive care services. CPT codes not appended with modifier 33 will process under the member’s medical or preventive benefits, based on the diagnosis and CPT codes submitted.

Modifier 33 should be appended to codes represented for services described in the US Preventive Services Task Force (USPSTF) A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents, and women supported by the Health Resources and Services Administration (HRSA) Guidelines.

The CPT® 2016 Professional Edition manual shares the following information regarding the billing of modifier 33, “When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.”

You can find more Health Care Reform Updates and Notifications on our bcbsga.com provider website.
Make the transition to the Availity Web Portal now: ProviderAccess retirement coming in 2017

BCBSGa is targeting January 20, 2017 to retire ProviderAccess and continues to improve your web portal experience by transitioning all functionality to a single website, the Availity Web Portal. After this date, electronic access to Eligibility, Benefits, Claim Status Inquiry, Remittance Inquiry and important proprietary information will be available exclusively through Availity, our multi-payer portal solution.

Note: This change does not affect the anthem.com public website or electronic transactions submitted via our Enterprise EDI Gateway; you may continue to submit all X12 transactions through your current EDI transmission channels.

See something you can’t access, but you need it?
Contact your organization’s administrator to request the role you need. To determine who your organization’s administrator is, select “Who controls my access” from your account drop down box located in the upper right corner of the Availity Web Portal’s top menu bar.

Want quick and easy access to the tools you use most?
On the Availity Web Portal, you can save your frequently used tools by selecting the heart icon next to the tool. This action will save it to your personal favorites. Then the next time you log on to Availity select My Favorites from the top menu bar to quickly and easily access your favorites from the drop down options.

Do you have all of your tax IDs registered on the Availity Web Portal?
If not, now is the time to register. Your organization’s administrator can add additional tax ids by selecting Maintain Organization from the Admin Dashboard.

If your organization is not registered for Availity:
- Have your organization’s designated administrator go to availity.com and select Register.
- Complete the online registration wizard.
- The administrator will receive an e-mail from Availity with a temporary password and next steps.

Free Training
Once you log into the secure portal, you’ll have access to many resources to help jumpstart your learning, including free live training, on-demand training, frequently asked questions, and comprehensive help topics. To view the current training resources, access the Help menu on the Availity Web Portal.

Reminder about ICD-10 CM coding
As you are aware, the ICD-10 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, BCBSGa uses ICD-10 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:
• Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.

• Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider’s overall management or treatment of that patient in the remaining positions.

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

BCBSGa ePASS® weekly webinars

Overview
This webinar provides a practical overview of how eligible providers can use the Electronic Patient Assessment Solution Suite (ePASS®) to access a supplemental clinical profile and complete a compliant medical SOAP Note for patients identified by BCBSGa. (SOAP Note – or Subjective, Objective, Assessment, and Plan – is the standardized document format of a medical record.)

The webinar typically takes 30 minutes followed by time for questions.

Registration
We encourage you to register in advance by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

Webinar Dates
- Wednesday, December 7, 2016: 3:00 PM – 4:00 PM EST
- Wednesday, December 14, 2016: 3:00 PM – 4:00 PM EST
- Wednesday, December 21, 2016: 3:00 PM – 4:00 PM EST
- Wednesday, December 28, 2016: 3:00 PM – 4:00 PM EST

How to Join
The following information can be used to join all webinars scheduled in October, November and December 2016:
- Teleconference: Dial 1-888-850-4523 and enter access code: 108 607
- WebEx: Visit inovalon.webex.com and enter meeting number: 746 707 227
- Once you join the call, live support is available at any time by dialing *0

A new look is coming to provider communications
At BCBSGa, we are committed to continuously improve the way we do business with our contracted provider community. In that respect, we have listened to your feedback and are pleased to announce that over the next few months a new look and feel is coming to Network Update and the Communications page on the bcbsga.com provider website. The new design of Network Update will allow you to easily read and print individual articles that pertain to your practice.

While the Communications page may look a little different the next time you visit, we hope that the new design will allow you to more easily find the specific BCBSGa communications that are important to you and your practice.
Use the Provider Maintenance Form to update your practice information

We continually update our provider directories to help ensure that your current practice information is available to our members. At least 30 days prior to making any changes to your practice – updating address and/or phone number, adding or deleting a physician from your practice, etc. – please notify us by completing the BCBSGa Provider Maintenance Form located on the Provider Forms page of our provider website, bcbsga.com. Thank you for your help and continued efforts to keep our records up to date.

Clinical Practice and Preventive Health guidelines available on the web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, 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 the Health & Wellness page of our provider website.

Coordination of care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. BCBSGa 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. BCBSGa 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, BCBSGa 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. In addition,
there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.

Important information about utilization management

Our utilization management (UM) decisions are based on 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. BCBSGa’s medical policies are available on BCBSGa’s provider website.

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 toll-free at the 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 on our bcbsga.com provider website.

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 8:00 a.m.–5:00 p.m. Eastern. Monday through Friday (except on holidays).
- 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 staffs. Members should call the customer service number on their health plan ID card.

<table>
<thead>
<tr>
<th>To discuss UM Process and Authorizations</th>
<th>To Discuss Peer-to-Peer UM Denials w/Physicians</th>
<th>To Request UM Criteria</th>
<th>TDD/TTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health: 800-292-2879</td>
<td>Behavioral Health: 800-292-2879</td>
<td>Behavioral Health: 800-292-2879</td>
<td>Or</td>
</tr>
<tr>
<td>FEP Phone 800-860-2156 FAX 800 732-8318 (UM) FAX 877 606-3807 (ABD)</td>
<td>FEP Phone 800-860-2156</td>
<td>FEP Phone 800-860-2156 FAX 800 732-8318 (UM)</td>
<td>Voice: 800-255-0135</td>
</tr>
</tbody>
</table>
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.

We believe in continuous improvement

Commitment to our members' health and their satisfaction with the care and services they receive is the basis for the BCBSGa Quality Improvement Program. Annually, BCBSGa prepares a quality program description that outlines the plan’s clinical quality and service initiatives. We strive to support the patient-physician relationship, which ultimately drives all quality improvement. The goal is to maintain a well-integrated system that continuously identifies and acts upon opportunities for improved quality. An annual evaluation is also developed highlighting the outcomes of these initiatives. To see a summary of BCBSGa’s quality program and most current outcomes, visit our provider website.

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, BCBSGa has adopted a Members’ Rights and Responsibilities statement.

It can be found on the Quality Improvement and Standards page through the Health & Wellness page of our provider website. Practitioners may access the FEP member portal at fepblue.org/memberrights to view the FEPDO Member Rights Statement.

Improving your patients’ health care experience

BCBSGa is committed to working with our network physicians to make our members’ health care experience a positive one. Towards this end we wanted to share with you a document we discovered that was developed by the California Quality Cooperative. This resource outlines some helpful tips you can use to improve your relationship with your patients and provide better care at the same time.

The Improving Your Patient’s Care Experience document can be found on the Health & Wellness page of our BCBSGa provider website.

“This information is provided by the California Quality Collaborative. A healthcare improvement organization dedicated to advancing the quality and efficiency of outpatient care in California.”
HEDIS® spotlight: respiratory conditions

Asthma and Chronic Obstructive Pulmonary Disease (COPD) are major causes of morbidity, mortality, lower quality of life, and lost productivity including missed days from school or work. According to the Centers for Disease Control, 1 in 14 people have asthma or about 24 million Americans (roughly 7.4% of adults and 8.6% of children). Asthma causes almost 2 million emergency room visits each year; more than 14 million doctor visits; and 439,000 hospital stays. More than half of children and one-third of adults missed school or work due to their asthma. Each day, ten Americans die from asthma. Many of these deaths are avoidable with proper treatment and care.

Since medication is vital to controlling asthma exacerbations, the National Commission for Quality Assurance (NCQA) requires health plans to review claims for medication management among members with persistent asthma, and contributes to health plan Accreditation levels and the Quality Rating System (QRS) measurement weight for Marketplace plans.

Click here to read this article in its entirety.


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

Products and programs

New 2017 Individual Gatekeeper HMO products

BCBSGa has developed new Gatekeeper HMO products called Pathway X Guided Access HMO (on exchange) and Pathway Guided Access HMO (off exchange) that will be effective 1/1/2017 for individual Georgia members who reside in DeKalb, Fulton, Gwinnett, Henry, Clayton, Bibb, Houston, Richmond, Muscogee, and Chatham counties. Pathway X Guided Access HMO will be the only product offered for on-exchange business in the aforementioned counties in 2017. The Pathway network will support these products.

PCP assignment

Our Pathway Guided Access plans require members to have a primary care physician (PCP) assigned within the the Pathway Guided Access network to manage their care needs, including getting referrals to see other network doctors and specialist. The PCP will be printed on the member ID card. If a PCP is not selected, one will be automatically assigned to the member by BCBSGa. Members can change their PCP at any time but there may be a delay in processing the change. It is important for providers to verify the PCP of record for the member prior to providing service. PCP verification can be done through the Availity Web Portal. If the PCP is not the member’s selected PCP, they should not provide service to that member. If a claim is submitted for a PCP that is different from the one on the member’s electronic record, the claim will be denied.

HMO plans do not offer out-of-network benefits with the exception of medically necessary emergency and urgent care, or if a service is preapproved. If a member goes outside the network for any other reason they will be responsible for paying OUT OF POCKET, 100% of the billed cost of that service.
Referrals
The member’s PCP is contractually responsible for submitting the referral on behalf of the member and must confirm the specialist is in the Pathway Guided Access network. To obtain a referral to a specialty care provider, PCPs should follow the guidelines below when referring members to a BCBSGa contracted specialty care provider:

- Submit requests online via availity.com
- Submit request by telephone by calling 800-662-9023 or 800-722-6614
- Fax requests for HMO members to 404-467-2999

To ensure proper referral, the specialist should verify the referral has been obtained online at availity.com. If a referral cannot be confirmed, the specialists should inform the member that he or she may be responsible for all or part of the bill for the specialist’s services. The specialist may then contract the PCP, or direct the member to seek referral notification through the PCP and BCBSGa. The specialist must secure authorization from the member’s PCP for additional consultations or services beyond what was initially authorized for a specific condition. ONLY the member’s PCP can make a referral for that member. A specialist cannot refer a member to another specialist. Referrals are not required for OB/GYN, dermatologists, behavioral health providers, chiropractors, optometrists, or ophthalmologists.

You can find additional information on referral requirements in the BCBSGa provider manual.

Sample member ID card

If you have questions about this information, please contact your local network consultant or call provider services at 800-428-4446.

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2017 FEP Benefit information available online

The 2017 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP) can be found on the FEP website by selecting Benefit Plans at the top of the page, and then selecting Brochure & Forms. There you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2017. For questions please contact FEP Customer Service at 800-282-2473.

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Physician Quality Measurement (PQM) and Blue Physician Recognition (BPR) programs are ending

In partnership with the Blue Cross Blue Shield Association (BCBSA), BCBSGa implemented two physician quality transparency programs for primary care physicians – Physician Quality Measurement (PQM) and Blue Physician Recognition (BPR) in 2012.

Both programs have supported members in their health care decision-making through display of nationally-recognized physician performance measurements (PQM) and a logo (BPR) that identified physicians demonstrating a commitment to quality performance. Since their implementation, quality measurement and consumer transparency and engagement have evolved. Based on this and the analyses of these programs, BCBSA decided to sunset these programs and removed these displays from their National Doctor and Hospital Finder.

BCBSGa will remove this content from its website by April 23, 2017.

Additional information has been provided by BCBSA at:
- Sunset Blue Physician Quality Measurement Program
- Sunset Physician Quality Measurement Program

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.

BCBSGa 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.

How do you contact us?

<table>
<thead>
<tr>
<th>CM Telephone Number</th>
<th>CM Email Address</th>
<th>CM Business Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-800-353-0923</td>
<td><a href="mailto:GaLocalCaseManagement@bcbsga.com">GaLocalCaseManagement@bcbsga.com</a></td>
<td>Monday–Friday, 8:00am to 9:00pm EST</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Saturday, 9:00am to 5:30pm EST</td>
</tr>
<tr>
<td>National 1-866-202-8727</td>
<td><a href="mailto:CMNATIONALACT-ATL@anthem.com">CMNATIONALACT-ATL@anthem.com</a></td>
<td>Monday–Friday, 8:00am to 8:00pm</td>
</tr>
<tr>
<td>Federal Employee Program 800-711-2225</td>
<td>No email</td>
<td>Monday – Friday, 8:00am to 7:00pm EST</td>
</tr>
</tbody>
</table>
Important information about billing habilitative and rehabilitative services

In compliance with requirements of the Notice of Benefit and Payment Parameters for 2016 issued pursuant to the Affordable Care Act, BCBSGa will apply separate and distinct benefit limits for habilitative and rehabilitative services for all individual and small group On-Exchange and Off-Exchange health plans beginning with dates of service on and after January 1, 2017. This means these plans will no longer have a combined visit limit for habilitative and rehabilitative services. Habilitative services help a person keep, learn, or improve skills and functioning for daily living which have not (but normally would have) developed. Rehabilitative services help a person keep, restore, or improve skills and functioning for daily living which have been lost or impaired after an illness or injury, such as a car accident or stroke. Please note that this regulation does not apply to early intervention services.

Beginning with dates of service on and after January 1, 2017, the appropriate use of the modifier SZ is necessary when billing habilitative services to BCBSGa. The SZ modifier was effective in 2014 and distinguishes between habilitative and rehabilitative services. Appropriate use of the modifier will help reduce claims issues and adjustments related to habilitative services.

Please review your current coding practices as it relates to the use of modifier SZ and the billing of habilitative and rehabilitative services.

Enhanced Personal Health Care: Referral providers benefit by improving quality and controlling costs

A key goal of the Enhanced Personal Health Care Program is to improve quality while controlling health care costs. One of the ways this is done is by giving primary care physicians (“PCPs”) in the Program quality and cost information about the health care providers to which the PCPs refer their Attributed Members (the “Referral Providers”). If a Referral Provider is higher quality and/or lower cost, this component of the Program should result in their getting more referrals from PCPs. The converse should be true if Referral Providers are lower quality and/or higher cost. BCBSGa will share data on which it relied in making these evaluations upon request, and will discuss it with Referral Providers including any opportunities for improvement. Any such requests should be directed to your provider network representative.

Medical chart reviews for members with plans on or off the exchange

Each year, BCBSGa requests your assistance in our retrospective medical chart review programs. We continue to request members’ medical records to obtain information required by the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Centers for Medicare & Medicaid Services (CMS).

We will continue our chart review program for those members who have purchased our individual and small group health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the exchange). This particular effort is part of BCBSGa’s compliance with provisions of the Affordable Care Act (ACA) that require our company to collect and report diagnosis code data for our members who have purchased individual or small group health plans on or off the exchange. The members’ medical record documentation helps support this data requirement.

BCBSGa engages Inovalon to conduct medical chart reviews for our exchange members

To assist with our ongoing medical chart review program for members enrolled in our individual and small group exchange plans, BCBSGa is again collaborating with Inovalon – an independent company that provides secure, clinical documentation.
services – to contact providers on our behalf. Inovalon’s Web-based workflows help reduce time and improve efficiency and costs associated with record retrieval, coding and document management. BCBSGa is working with Inovalon in retrieving and reviewing our members’ medical records.

Inovalon is using the following methods of collecting medical record information:
- Scanned or faxed medical records that providers’ offices send to Inovalon
- Onsite medical record reviews by trained clinical personnel
- Automated medical record retrieval using electronic health records (EHR) system interoperability through the provider’s EHR system

More specifically, in cases where Inovalon sends a letter requesting fewer than six medical records for review, Inovalon follows up with a phone call to request that the providers’ offices fax or mail the medical chart information. We ask that provider offices fax or mail the medical record information to Inovalon within 30 days.

In cases where Inovalon is requesting more than six medical records to review, an Inovalon reviewer calls the provider’s office and arranges a time convenient to visit the office onsite to collect the appropriate information. Before the onsite visit, Inovalon mails or faxes the provider’s office a letter to confirm the upcoming visit. The Inovalon medical record review personnel coordinate all clinical facility communication, medical record data review scheduling, collection, and tracking – onsite or remotely.

To make it easier for providers, automated, medical record data retrieval occurs through the provider’s EHR system. Upon receiving the provider group’s one-time authorization, Inovalon’s systems automatically retrieve targeted medical record data for quality and risk score accuracy from a centrally maintained repository from each EHR partner. The goal of this partnership is to both improve the medical record data extraction experience for BCBSGa’s network-participating hospitals, clinics and physician offices. BCBSGa and Inovalon are working together to identify facilities and providers’ offices for engagement.

**Appropriate coding helps provide comprehensive picture of patients’ health and services provided**

As the physician of our members who have health plans on and off the exchange, you play a vital role in the success of this initiative and our compliance with ACA requirements. When members visit your practice or office, we encourage you to document **ALL** of the members’ health conditions, especially chronic diseases. As a result, there is ongoing documentation to indicate that these conditions are being assessed and managed.

By maintaining quality coding and documentation practices and by cooperating with our medical chart requests, you will help ensure your patients receive the proper care they need, and you will be instrumental in helping BCBSGa meet our ACA obligations. Together, we can help ensure risk adjustment payment integrity and accuracy.

**Survey says... Patients see room for improvement with physician care**

Every year BCBSGa sends out the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to our HMO/POS members. The survey provides BCBSGa members an opportunity to share their perceptions of the quality of care and services provided by our HMO/POS network physicians. The CAHPS survey is used by all HMO/POS plans that undergo accreditation review by the National Committee for Quality Assurance (NCQA).

The following tables compare our results from 2015 with those in 2016. Each column contains the score achieved for each measure along with the box color coded to reflect the NCQA Quality Compass National Percentile achieved by BCBSGa.
These Quality Compass percentiles are derived from the scores of all other HMO plans across the country that perform the CAHPS survey. Our goal is to achieve the 75th Percentile.

Click here to read this article in its entirety.

**HEDIS 2016 commercial results are in**

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) commercial data collection project for 2016. 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.

Click here to read this article in its entirety.

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**State Health Benefit Plan**

**Important SHBP updates**

- Along with the HRA and HMO plan offerings, in 2017 BCBSGa will also offer a Medicare Advantage Plan option to SHBP Medicare Eligible Retirees.
- Specialty RX List (Medical/Pharmacy Drug List) is updated monthly and posted to the SHBP page on our bcbsga.com provider website. Providers should ensure that they are reviewing the most current list when determining Rx coverage.
- ID Cards – All members will receive new ID cards for 2017. Please refer to the ID card with the January 1, 2017 date when verifying eligibility and benefits.
- Please review the updated SHBP precertification requirement list on the BCBSGa Provider website effective January 1, 2017.

State Health Benefit Plan information is posted as it becomes available on the State Health Benefit Plan information page of bcbsga.com.

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**Georgia State Health Benefit Plan Medicare Advantage contract awarded effective Jan. 1, 2017**

We are pleased to announce that BCBSGa will be a Medicare Advantage plan option for the State Health Benefit Plan (SHBP) effective Jan. 1, 2017. BCBSGa will be administering medical and pharmacy benefits for SHBP retirees through our Preferred Provider Organization (PPO) product. The 2017 plan is a passive PPO, meaning the cost share in-network and out-of-network is the same.

General precertification guidelines can be found at the Provider Forms section of the Blue Cross and Blue Shield of Georgia Medicare Advantage Public Provider Portal.
Cancer Care Quality Program will be available January 1, 2017 to State Health Benefit Plan members

Effective January 1, 2017, State Health Benefit Plan (SHBP) will participate in the Cancer Care Quality Program. The Program will be administered by AIM Specialty Health® (AIM). Providers should request precertification for services through the AIM Provider Portal, available 24/7, or by calling AIM directly at 800-252-2021 for portal support. Additional information on the AIM programs can be accessed on the Answers@BCBSGa page, the Precertification page on our bcbsga.com provider website, by visiting AIM’s website at aimspecialtyhealth.com.

The cost of new cancer therapies continues to rise. And there are 180 medical journals that publish new studies on cancer monthly and quarterly. The Cancer Care Quality Program can help. We are collaborating with providers to increase quality, improve patient outcomes and reduce costs for cancer care by using one of our cancer treatment pathways. This powerful initiative gives you the tools you need to be successful in the new value-based healthcare environment.

Improve quality
Evidence-based and patient centered, our cancer treatment pathways incorporate the latest national guidelines.

Enhanced reimbursements
Receive enhanced reimbursement for selecting one of our cancer treatment pathways, when appropriate.

Lower costs
Lower total cost of care for your patients while improving access to quality and affordable cancer care.

Registering your practice is easy.
If you haven’t already, visit the AIM oncology website and see why over 8,000 physicians already trust the program for their practice. AIM Specialty Health’s online portal is available twenty-four hours a day, seven days a week.

Reminder: State Health Benefit Plan
BCBSGa would like to remind you State Health Benefit Plan participates in the following AIM Specialty Health (AIM) Programs:
- Diagnostic Imaging Program
- Imaging Cost and Quality Program
- Outpatient Radiation Therapy Program
- Sleep Management Program
- AIM Enhanced Cardiology Program

SHBP Specialty Pharmacy
SHBP has contracted directly with ExpressScripts, Inc. (ESI) as its pharmacy vendor; however, some of the pharmaceuticals may be covered under the member’s medical benefit. Please refer to the SHBP page of our bcbsga.com provider website for a list of specialty meds that will determine if they are covered under the Medical or Pharmacy benefit.
Pharmacy

BCBSGa preferred products

Immunoglobulin preferred products
BCBSGa has reviewed the immunoglobulin products through the P&T process and has selected two preferred drugs: Gamunex-C® and Octagam®. When prescribing these products, please consider the preferred drugs for initial therapy.

<table>
<thead>
<tr>
<th>Preferred Product</th>
<th>Non Preferred Product</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gamunex C®</td>
<td>Gammagard®</td>
</tr>
<tr>
<td>Octagam®</td>
<td>Privigen®</td>
</tr>
</tbody>
</table>

Botulinum toxin agents preferred products
BCBSGa has reviewed the botulinum toxin agents and has selected Xeomin® as the preferred agent. When prescribing a botulinum toxin, please consider Xeomin® for initial therapy.

<table>
<thead>
<tr>
<th>Product</th>
<th>BCBSGa Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xeomin®*</td>
<td>Preferred</td>
</tr>
<tr>
<td>Botox®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Myobloc®</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Dysport®</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

*Preferred product for the following medical indications: upper limb spasticity, cervical dystonia and blepharospasm.

Hyaluronic acid preferred products
BCBSGa has reviewed the hyaluronic acid agents through the P&T process and has selected four preferred drugs: Synvisc-One®, Synvisc®, Monovisc® and Orthovisc®. Beginning September 1, 2016, an edit is in place requiring one of the preferred drugs below to be tried before a non-preferred drug. When prescribing these products, please consider the preferred agents below for patients needing hyaluronic acid therapy.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Weekly Injections</th>
<th>BCBSGa Formulary Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synvisc-One®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Synvisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Monovisc®</td>
<td>1</td>
<td>Preferred</td>
</tr>
<tr>
<td>Orthovisc®</td>
<td>3</td>
<td>Preferred</td>
</tr>
<tr>
<td>Euflexxa®</td>
<td>3</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Gel-One®</td>
<td>1</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Hyalgan®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
<tr>
<td>Supartz®</td>
<td>5</td>
<td>Non-preferred</td>
</tr>
</tbody>
</table>

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BCBSGa will be expanding the Specialty Pharmacy prior authorization list

Listed below are specialty pharmacy codes from new or current Clinical UM Guidelines that will be added to our existing pre-service review process effective March 1, 2017.
Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company administering the program on behalf of BCBSGa.

<table>
<thead>
<tr>
<th>Medical Policy or Clinical Guideline number</th>
<th>DRUG code</th>
<th>Drug Names</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>J3590</td>
<td>Erelzi (etanercept-szzs)</td>
<td>New drug to existing Medical Policy</td>
</tr>
<tr>
<td>DRUG.00081</td>
<td>J3490, J3590</td>
<td>Exondys 51</td>
<td>New Medical Policy</td>
</tr>
</tbody>
</table>

BCBSGa will be expanding the Specialty Pharmacy level of care medication list

Listed below are the specialty pharmacy codes from our new or current Medical Policies and Clinical UM Guidelines that will be added to our existing Level of Care review process using CG-DRUG-47 effective April 24, 2017.

Level of care pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health, (AIM), a separate company administering the program on behalf of BCBSGa. A [Level of Care medication list and FAQ's](#) are located on the AIM website.

<table>
<thead>
<tr>
<th>Medical Policy</th>
<th>Drug Name(s)</th>
<th>Drug Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRUG.00002</td>
<td>Inflectra</td>
<td>Q5102</td>
</tr>
<tr>
<td>DRUG.00084</td>
<td>Actimmune</td>
<td>J9216</td>
</tr>
<tr>
<td>DRUG.00086</td>
<td>Increlex</td>
<td>J2170</td>
</tr>
<tr>
<td>CG-DRUG-43</td>
<td>Tysabri</td>
<td>J2323</td>
</tr>
</tbody>
</table>

Important update: Delay of the transition of NOC oncology and biologic drugs to pre-service clinical review

BCBSGa in partnership with AIM Specialty Health (AIM) planned an expansion of Pre-service Review to the medical necessity of coverage requests for all not otherwise classified “NOC” oncology and biologic drugs starting November 1,
BCBSGa is delaying this transition to pre-service review by AIM until further notice. Any medical necessity review of NOC oncolytic and biologic drugs will continue to be reviewed by BCBSGa as they are today.

**Report HCPCS code C9257 for Avastin intravitreal injection**

BCBSGa will now accept HCPCS code C9257 for physician reporting of Avastin for intravitreal injection. Physicians should no longer report codes J3490, J3590, J9035, or J9999 for Avastin used in intravitreal injections.

BCBSGa has established a reimbursement allowance for code C9257, and will allow a maximum of 5 units per injection. Use of code C9257 will ensure that the appropriate reimbursement for this specific treatment is made.

This reporting and reimbursement change impacts commercial BCBSGa members only.

Pharmacy information available on anthem.com

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit [anthem.com/pharmacyinformation](http://anthem.com/pharmacyinformation). The commercial drug list is reviewed and updates 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.” Click the following links for the Federal Employee Program formulary Basic Option and Standard Options. These drug lists are also reviewed and updated regularly as needed.

Policy updates

**Do you have the DSM 5? There have been many changes.**

In an effort to keep our provider community abreast of changes occurring in the behavioral health community, we wanted to share a couple of new changes from the DSM 5.

When transitioning from the DSM IV-TR to the DSM-5, the provider community moved from using a multiaxial system to the current use of a non-axial system upon diagnosis. However, the information included in the diagnosis remains much the same. In fact, the axes from the DSM IV are still included in our diagnosis in the DSM-5 as appropriate. See the following table below:

(continued on next page)
The DSM-V Diagnosis

Unlike the DSM-IV-TR, DSM-5 combines Axes I-III into one list that contains all mental disorders, including personality disorders and intellectual disability (once Axis II; DSM-IV), as well as other medical diagnoses (once Axis III: DSM-IV). Other conditions that are a focus of the current visit of help to explain the need for a treatment or test may also be coded; usually, as ICD-10-CM V codes or Z codes. A list of these other conditions can be found on pages 715-727 of the DSM 5. As it pertains, what was once Axis 5: The World Health Organization Disability Assessment Schedule (WHODAS 2.0) was judged by the DSM-5 Disability Study Group to be the best current measure of disability for routine clinical use. The WHODAS 2.0 is based on the International Classification of Functioning, Disability, and Health (ICF) and is applicable to patients with any health condition. The scale, as well as scoring information is included in Section III of DSM-5.

We understand that our providers depend upon diagnoses for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research. Clinical training and experience are needed to use the DSM 5 for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations that require clinical expertise to differentiate from normal life variation and transient responses to stress.

You might notice that some commonly used codes have changes. See some examples below:

<table>
<thead>
<tr>
<th>DSM-IV Multiaxial System</th>
<th>DSM-5 Non-axial System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis I: Clinical d/o and other conditions that are focus of treatment</td>
<td>Combined attention to clinical disorders, including personality disorders and intellectual disability; other conditions that are the focus of treatment; and medical conditions.</td>
</tr>
<tr>
<td>Axis II: Personality d/o and mental retardation</td>
<td>Reason for visit, psychosocial, and contextual factors via expanded list of V Codes and Z Codes.</td>
</tr>
<tr>
<td>Axis III: General medical conditions</td>
<td>Disability included in notation. World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0) included as option.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>DSM-IV Multiaxial System</th>
<th>DSM-5 Non-axial System</th>
</tr>
</thead>
<tbody>
<tr>
<td>296.20 Major depressive affective disorder, single episode, unspecified</td>
<td>F32.9 Major depressive disorder, single episode, unspecified</td>
</tr>
<tr>
<td>296.21 Major depressive affective disorder, mild</td>
<td>F32.0 Major depressive disorder, single episode, mild</td>
</tr>
<tr>
<td>296.23 Major depressive affective disorder, single episode severe, without mention of psychotic behavior</td>
<td>F32.2 Major depressive disorder, single episode, severe without psychotic features</td>
</tr>
<tr>
<td>296.24 Major depressive affective disorder, single episode severe, specified as with psychotic behavior</td>
<td>F32.3 Major depressive disorder, single episode, severe with psychotic features</td>
</tr>
<tr>
<td>296.25 Major depressive affective disorder, single episode, in partial or unspecified remission</td>
<td>F32.4 Major depressive disorder, single episode, in partial remission</td>
</tr>
<tr>
<td>296.26 Major depressive affective disorder, single episode, in full remission</td>
<td>F32.5 Major depressive disorder, single episode, in full remission</td>
</tr>
<tr>
<td>311 Depressive Disorder NEC</td>
<td>F32.9 Major depressive disorder, single episode, unspecified</td>
</tr>
</tbody>
</table>
309.81 Posttraumatic Stress Disorder  
F43.10 Posttraumatic Stress Disorder, unspecified  
F43.12 Posttraumatic Stress Disorder, chronic

Some resources that may best help you include:
- American Medical Association, 2016 Professional Edition CPT (current procedural terminology)

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Update to claims processing edits and professional reimbursement policies

On December 1, 2016, we will be updating our website with the following new and/or revised reimbursement policies.

Bundled services and supplies and modifiers 59, XE, XP, XS, and XU

Beginning with dates of service on or after March 1, 2017, we will be implementing the following code pair edits and have documented these edits in our future Bundled Services and Supplies and Modifiers 59, XE, XP, XS, and XU reimbursement policies:
- Current Procedural Terminology (CPT®) code 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lumbar) will not be eligible for separate reimbursement when reported with CPT code 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.
- CPT code 22614 (arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (list separately in addition to code for primary procedure)) will not be eligible for separate reimbursement when reported with CPT codes 22600 (arthrodesis, posterior or posterolateral technique, single level; cervical below c2 segment), 22610 (arthrodesis, posterior or posterolateral technique, single level; thoracic (with lateral transverse technique, when performed)), 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)), 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar), and 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Modifiers will not override this edit.
- CPT codes 63081, 63082, 63085, 63086, 68087, and 63088 (vertebral corpectomies) will not be eligible for separate reimbursement when reported with CPT code 22558 (arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar). Modifiers will not override this edit.
- CPT code 82542 (column chromatography, includes mass spectrometry, if performed, non-drug analyte(s) not elsewhere specified, qualitative or quantitative, each specimen) will not be eligible for separate reimbursement when reported with CPT code 91065 (breath hydrogen or methane test). Modifiers will not override this edit.
- Taking guidance from the February 2016 CPT Assistant which states that train-of-four monitoring is bundled with the intraoperative neuromonitoring and should not be separately reported, we are adding an edit that CPT code 95937 (neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any 1 method) will not be eligible for separate reimbursement when reported with CPT codes 95940 (continuous intraoperative neuropsychology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes), 95941...
(continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour), and G0453 (continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes). Modifiers will not override these edits.

- Our current edit denies 76942 (ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental when reported with 76882 (ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific).

Based on our interpretation of CPT guidelines that state "Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized. Use of ultrasound, without thorough evaluation of organ(s), or anatomic region, image documentation, and final, written report, is not separately reportable" we are updating our edit and will deny 76882 when reported with 76942; modifiers will not override the edit.

The following article refers to an edit that was planned to be implemented on January 1, 2017, but has changed due to code changes/deletions in CPT.

Claims requiring additional documentation
There may be times when we conduct claim reviews or audits either on a prepayment or post payment basis and we, or our designee, may request documentation, most commonly in the form of patient medical records. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the patient’s plan of treatment or to confirm that charges were accurately reported in compliance with our policies and procedures as well as general industry standard guidelines and regulations.

Effective for claims with dates of service on or after March 1, 2017, we will have a new professional reimbursement policy titled Claims Requiring Additional Documentation. This policy documents our guidelines for claims requiring additional documentation and the professional provider’s compliance for the provision of requested documentation. Please refer to the policy for further details.

Durable medical equipment
For claims processed on or after November 21, 2016, we updated our policy to reflect that we will allow rental of two units per month for durable medical equipment (DME) that requires a back-up unit. These include items such as E0465 (home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)) and E0466 (home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)).

Frequency editing
Based on changes in vial size available for J9047 (injection, Carfilzomib, 1 mg (Kypolis)), we have updated our maximum dosage amount to 150 units. This update will apply to claims with dates of service on or after July 15, 2016.

We currently apply a frequency limit of one unit per date of service to CPT code 91065 (hydrogen or methane breath test). We consider this one test per challenge regardless of the number of samples collected; therefore, beginning with claims processed on or after November 21, 2016, modifiers will not override the frequency limit for CPT code 91065.

We consider that only one unit is applicable to HCPCS codes S9140 (diabetic management program follow–up visit non-MD provider) and S9141 (diabetic management program follow–up visit MD provider); therefore, beginning with dates of service
on or after January 1, 2017, we will be applying a frequency limit of one per date of service; modifiers will not override this frequency limit.

Beginning with dates of service on or after March 1, 2017, we will be implementing the following frequency limits:

- We consider HCPCS code(s) H0020 (alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)) and H0022 (alcohol and/or drug intervention service (planned facilitation)) to be “per day” services. Therefore, we will apply a frequency limit of one per date of service to HCPCS codes H0020 and H0022; modifiers will not override the frequency limit.
- We will apply a frequency limit of one per date of service to CPT code 49185 (sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed). This limit is based on our interpretation of CPT parenthetical instruction and the March 2016 CPT® Assistant Q&A which state “49185 may only be reported once per day for the treatment of multiple interconnected lesions via single access.” Modifiers will not override the frequency limit.
- Based on Center for Disease Control and Prevention (CDC) recommendation, we will apply a frequency limit of three per date of service to CPT codes 87491 (Chlamydia trachomatis, amplified probe technique) and 87591 (Neisseria gonorrhoeae, amplified probe technique).

**Global surgery and modifier rules**

Taking guidance from the Centers for Medicare & Medicaid Services, beginning with claims processed on or after November 21, 2016 for dates of service on or after October 1, 2016, when modifier 55 (postoperative management only) is appended to a surgical procedure with zero post-operative days, the procedure will not be eligible for reimbursement.

**Moderate (conscious) sedation, bundled services and supplies, and modifiers 59, XE, XP, XS, and XU**

For dates of service on or after January 1, 2017, we will continue with the concept that moderate (conscious) sedation, identified by new CPT codes 99151-99153 and 99155-99157, is included with the reimbursement for certain health plan designated surgical, diagnostic, or therapeutic procedures, and such sedation is not eligible for separate reimbursement when reported by the physician or other qualified health care professional performing one of the designated procedures. These designated procedures were previously listed in the deleted CPT Appendix G and are now identified in our “Codes that Include Moderate (Conscious) Sedation” list. Modifiers will not override the edits.

**Modifiers 59, XE, XP, XS, and XU**

Beginning with dates of service on or after March 1, 2017, modifiers will no longer override the following edits:

- Our current edit denies 22612 (arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)) when reported with 22633 (arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar). Based on CPT instruction that states to not report 22633 with 22612, modifiers will no longer override the edit.
- Our current edit denies 63048 (laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure) when reported with 22630 (arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar). We consider this correct coding; therefore, modifiers will not override the denial.
Our current edit denies CPT code 76942 (ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation) as incidental to 76881 (ultrasound, extremity, nonvascular, real-time with image documentation; complete). We consider this to be correct coding; therefore, modifiers will not override the denial.

We have a current edit that denies CPT code 42950 (pharyngoplasty (plastic or reconstructive operation on pharynx) as mutually exclusive to CPT code 15757 (free skin flap with microvascular anastomosis), when a free flap is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy). We consider this to be correct coding; therefore, modifiers will not override the edit.

Our edit denies CPT code 27275 (manipulation, hip joint, requiring general anesthesia) as incidental to procedures 27093 (injection procedure for hip arthrography; without anesthesia) and 27095 (injection procedure for hip arthrography; with anesthesia). We consider this correct coding; therefore, modifiers will not override the edit.

Multiple diagnostic cardiovascular procedures
We are adding information to section B of our policy that our multiple diagnostic cardiovascular reimbursement rules are not applicable to procedures for which there are no RVUs assigned to the technical component of a code.

Prolonged services
We have updated our Prolonged Services Diagnosis Coding list dated October 1, 2016, to include additional ICD-10-CM diagnosis codes that were effective October 1, 2016, and for which prolonged services are allowed—E083211-E083213, E083219, E083311-E083313, E083319, E083411-E083413, E083419, I16, I160, I161, I169, O115, O165. In addition, we have removed the ICD-9-CM diagnosis codes which are no longer valid for dates of service on or after October 1, 2015.

Sleep studies and related services & supplies and frequency editing
In our June 2016 issue of Network Update, we advised we would be implementing a one (1) per 60 days frequency limit to attended sleep studies represented by CPT codes 95807, 95808, 95810, 95811, 95782, and/or 95783 for dates of service on or after September 1, 2016. Upon further review, we have reconsidered our position and have removed this edit for dates of service on or after September 1, 2016.

Unit Frequency Maximums for Drugs and Biologic Substances
We are adding information to our policy to document that modifiers do not override our unit frequency maximums for drugs and biologic substances.

Review of reimbursement policies
The following professional reimbursement policies received an annual review and may have word changes or clarifications however they do not have significant changes to the policy position or criteria:

- Co-Surgeon/Team Surgeon Services
- Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder
- Documentation Guidelines for Central Nervous System Assessments and Tests
- Documentation and Reporting Guidelines for Consultations
- Duplicate Reporting of Diagnostic Services Injectable Substances with Related Injection Services
- Multiple Diagnostic Imaging Procedures
- Once per Lifetime Procedures
- Physical and Manipulative Maintenance Services
- “Rule of Eight” Reporting Guidelines for Physical Medicine and Rehabilitation Services
- Three Dimensional Rendering of Imaging Studies
**Significant edits**
We have updated our Significant Edits posting to reflect the 2016 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.

**Coding tip: 2017 presumptive drug tests**
Effective January 1, 2017, CPT has deleted presumptive drug class screening codes 80300 – 80304 and has added replacement codes 80305 – 80307. The new codes 80305 – 80307 have the same description as G0477 – G0479 and HCPCS Coding Standards: Levels of Use state "... When both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used." Providers are encouraged to follow HCPCS coding guidance and report the 80305 – 80307 CPT codes for presumptive drug screening services. Do not report both 80305 – 80307 and G0477 – G0479 for same date(s) of service as this would represent a duplication of services.

**Coding tip: 2017 Modifier 95 for telehealth services**
Effective January 1, 2017, CPT is adding modifier 95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). Based CPT instruction, modifier 95 is to be used only with the services listed in Appendix P of the CPT codebook when those services are rendered via real-time (synchronous) interactive telecommunication.

**System updates for 2017**
As a reminder, our ClaimsXten (or other proprietary) editing software package will be updated quarterly in February, May, August and November of 2017. These updates will:
- reflect the addition of new and revised CPT/HCPCS codes 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, preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

Notice of reimbursement policy modifications due to these updates will continue to be published in the BCBSGa Network Update and on BCBSGa Online Provider Services.

View BCBSGa Professional Reimbursement policies on our bcbsga.com provider website.

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**Facility reimbursement policy updates**
The implementation of the Place of Service and Evaluation & Management facility reimbursement policy that was communicated in the October 2016 edition of Network Update has been delayed until further notice.

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Medical policy and clinical guideline updates

The Medical Policy and Technology Assessment Committee adopted the following new and/or revised Medical Policies and Clinical Guidelines. Some may have expanded rationales, medical necessity indications or criteria and some may involve changes to policy position statements that might result in services that previously were covered being found to be either not medically necessary or investigational/not medically necessary. Clinical Guidelines adopted by BCBSGa and all the Medical Policies are available on our bcbsga.com provider website. Please note that our medical policies now include NOC (Not Otherwise Classified) codes to expedite the process of determining services that may require medical review. If you do not have access to the internet, you may request a hard copy of a specific Medical or Behavioral Health Policy or Clinical UM Guideline by calling Provider Services at (800) 241-7475 Monday through Friday from 8:00 a.m. to 7:00 p.m. or send written requests (specifying the medical policy or guideline of interest, your name and address to where the information should be sent) to:

Blue Cross and Blue Shield of Georgia and Blue Cross Blue Shield Healthcare Plan of Georgia
Attention: Prior Approval, Mail Code GAG009-0002
3350 Peachtree Road NE
Atlanta, GA 30326

NOTE: Any Clinical Guideline included in this standard MPTAC notification is only effective for Georgia if included on the GA Standard Adopted Clinical Guideline List unless there is a Group-specific review requirement in which case it will be considered ‘Adopted’ for that group only and for the specific type of review required. Additionally, as part of the Pre-Payment Review Program for commercial or Federal Employee Health Benefits Program (FEHBP) plans, Clinical Guidelines approved by Medical Policy and Technology Assessment Committee (MPTAC) but not included in the GA Standard Adopted Clinical Guideline List may be used to review a provider’s claims when a provider’s billing practices are not consistent with other providers in terms of frequency or in some other manner or for provider education and are “Adopted” for those purposes.

AIM Specialty Health® (AIM) – AIM is a nationally recognized leader in specialty benefits management. To submit your request for any of the services below, contact AIM online via AIM’s ProviderPortal at aimspecialtyhealth.com/goweb. From the drop down menu, select BCBSGa. You may also call AIM toll free at 866-714-1103, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

Cardiology Program – New precertification requirements for certain cardiovascular services began March 1, 2016. BCBSGa expanded its cardiovascular program to require preapproval for arterial ultrasound and percutaneous coronary intervention (PCI) effective March 1, 2016. The program is managed by AIM, a separate company administering the program on behalf of BCBSGa. The specific CPT codes requiring preapproval under the expanded cardiovascular program can be found on the Precertification page of our provider website, bcbsga.com. The clinical guidelines that will be adopted by BCBSGa to review arterial ultrasound and PCI for medical necessity are also available on bcbsga.com.

As a reminder, BCBSGa adopted a clinical guideline to review cardiac catheterization and began requiring preapproval for cardiac catheterization in July 2015. Effective March 1, 2016, preapproval review of cardiac catheterization is be handled by AIM instead of BCBSGa. Providers who call BCBSGa for preapproval of cardiac catheterization will be redirected to AIM for clinical appropriateness review. Please note that all BCBSGa local members who currently require preapproval for high-tech imaging and echocardiograms are included in the expanded cardiovascular program. However, these preapproval requirements do not apply to the following plans: Federal Employee Program® (FEP®), Medicaid, Medicare Advantage, and Medicare Supplemental plans.

Procedures performed in an inpatient setting or on an emergent basis are not included in the program. Determine if preapproval is needed for a BCBSGa member by clicking the “Medical Policy, Clinical UM Guidelines, and Pre-Cert
Requirements” link on our bcbsga.com provider website, or by calling the preapproval phone number printed on the back of the member’s ID card. Effective February 22, 2016, ordering physicians may submit a preapproval request for the additional program requirements to AIM through the AIM ProviderPortal, (available 24/7 to process orders in real-time), through the Availity Web Portal at availity.com, or by calling the AIM call center at 866-714-1103, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

BCBSGa recognizes that the necessity for arterial duplex imaging of the extremities may not be identified by providers until their patients have undergone physiologic testing. Similarly, the need for percutaneous coronary intervention (PCI) is predicated upon the results of cardiac catheterization. In these cases, we ask that you contact AIM no later than 10 business days after you perform arterial duplex imaging or PCI, but before you submit the claim, to request preapproval/clinical appropriateness review. If you have further questions, please contact your local Network Relations consultant or call Provider Customer Service at 800-428-4446.

Diagnostic Imaging Management – Diagnostic imaging management services are provided by AIM for certain health plan members. Diagnostic imaging services may be reviewed against AIM’s Diagnostic Imaging Utilization Management Clinical Guidelines. AIM’s clinical guidelines are available at aimspecialtyhealth.com/marketing/guidelines/185/index.html. If you have any questions about which guidelines are applicable, please call the customer service number on the back of the member’s ID card.

Radiation Therapy Services – New precertification requirements began March 1, 2016. Review of BCBSGa outpatient radiation therapy services are done by AIM. Providers must contact AIM for preapproval for the following non-emergency outpatient services: Intensity Modulated Radiation Therapy (IMRT), Proton Beam Radiation Therapy, Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiotherapy (SBRT) and Brachytherapy. Radiation therapy performed as part of an inpatient admission will continue to be reviewed through the BCBSGa’s inpatient preapproval process. Preapproval is required through AIM for all BCBSGa members, with the exception of members with Medicare supplemental policies, Medicare Advantage plans, BCBSGa as secondary coverage and the FEP.

Important: Revised date of pre-service clinical review of non-small cell lung cancer fractions for EBRT and IMRT
You were previously notified in the June 2016 edition of Network Update that BCBSGa is expanding the Radiation Therapy Program CG-THER-01 precertification requirements for Fractions (also referred to as units) to now include non-small cell lung cancer for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT) beginning on September 1, 2106. However, this transition was ultimately delayed. Please be advised that the precertification requirements for clinical review of non-small cell lung cancer for covered individuals getting EBRT or IMRT will now begin with AIM, effective October 31, 2016.

On March 1, 2016, BCBSGa expanded its Radiation Therapy Program to require preapproval of:
- Image Guided Radiation Therapy (IGRT).
- Fractions (also referred to as units) for breast and bone metastases for covered individuals getting External Beam Radiation Therapy (EBRT) or Intensity Modulated Radiation Therapy (IMRT).
- Special treatment procedure and special physics consult (CPT® codes 77470 and 77370) (e.g., total body irradiation, hemi-body radiation, or endocavitary irradiation and special medical radiation physics consultation).

A complete list of CPT codes requiring preapproval under the Radiation Therapy Program can be found on the Precertification Requirements and Forms page on our provider website, bcbsga.com. All BCBSGa local members who currently require preapproval for non-emergency outpatient radiation therapy are included in this program. These preapproval requirements do not apply to the following plans: Medicare Advantage, Medicare Supplement, Medicaid, FEP, members with BCBSGa as secondary coverage, and National Accounts. Determine if preapproval is needed for a BCBSGa member by
clicking the Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements link on our bcbsga.com provider website or by calling the preapproval phone number printed on the back of the member’s ID card.

Effective February 22, 2016, ordering physicians may submit a preapproval request for these additional requirements to AIM through the AIM ProviderPortal (available 24/7 to process orders in real-time), through the Availity Web Portal or by calling the AIM call center at 866-714-1103, Monday–Friday, 8:00 a.m.–6:00 p.m. ET.

Note: Retrospective requests received more than 2 business days after the date of service will not be considered by AIM for preapproval review. Any post-service clinical review would be handled by BCBSGa according to the terms of the applicable health benefit plan and/or provider agreement. Radiation therapy performed as part of an inpatient admission will continue to be reviewed through BCBSGa’s inpatient preapproval process. Members currently undergoing treatment on March 1, 2016 will not be impacted by the new enhancements to this program. However, members starting treatment on or after March 1, 2016 must follow the enhanced Radiation Therapy Program preapproval requirements noted above.

Outpatient Sleep Testing and Therapy Services – The specialty benefit management program for outpatient sleep testing and therapy services for obstructive sleep apnea is administered by AIM and includes the following:
- Home sleep test (HST)
- In-lab sleep study (PSG)
- Titration study
- Initial treatment order (APAP, CPAP, BPAP, oral devices, appliances and related supplies)
- Ongoing treatment order (APAP, CPAP, BPAP, oral devices, appliances, and related supplies)

BCBSGa uses sleep diagnostic and treatment guidelines developed by AIM. AIM’s Obstructive Sleep Apnea Diagnostic & Treatment Management Guidelines are available at aimspecialtyhealth.com/gowebsleep. The preapproval requirement applies to BCBSGa members who participate in BCBSGa local and individual health plans as well as members covered by Medicare Advantage. The requirement does not apply to those in the FEP and those for whom BCBSGa is secondary coverage including those whose primary insurance carrier is Medicare.

By clicking on the links above, you will be linked to sites created and/or maintained by another, separate entity (“External Site”). Upon linking you are subject to the terms of use, privacy, copyright and security policies of the External Sites. We provide these links solely for your information and convenience. We encourage you to review the privacy practices of the External Sites. The information contained on the External Sites should not be interpreted as medical advice or treatment provided by us.

The following policy is new and is effective on 11/17/2016.
DRUG.00097 Olaratumab (Lartruvo™)

The following policy and guidelines are new and will be effective on 12/28/2016.
DRUG.00090 Bezlotoxumab (ZINPLAVA™)
CG-DRUG-60 Gonadotropin Releasing Hormone Analogs for Treatment of Oncologic Indications
CG-DRUG-61 Gonadotropin Releasing Hormone Analogs for Non-Oncologic Treatment Indications

The following policies and guidelines are new and will be effective on 03/01/2017.
DME.00040 Automated Insulin Delivery Devices
DRUG.00102 Cabazitaxel (Jevtana®)
LAB.00033 Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer
CG-DRUG-54 Agalsidase beta (Fabrazyme®)
CG-DRUG-55 Elosulfase alfa (Vimizim®)
CG-DRUG-56 Galsulfase (Naglazyme®)
The following policies and guidelines were revised and are effective on 11/17/2016.

**DME.00036** Ultraviolet Light Therapy Delivery Devices for Home Use

**DRUG.00002** Tumor Necrosis Factor Antagonists

**DRUG.00038** Bevacizumab (Avastin®) for Non-Ophthalmologic Indications

**DRUG.00041** Rituximab (Rituxan®) for Non-Oncologic Indications

**DRUG.00048** Eribulin mesylate (Halaven®)

**DRUG.00057** Canakinumab (Ilaris®)

**DRUG.00068** Vedolizumab (Entyvio®)

**DRUG.00071** Pembrolizumab (Keytruda®)

**DRUG.00075** Nivolumab (Opdivo®)

**DRUG.00082** Daratumumab (DARZALEX™)

**DRUG.00085** Ixabepilone (Ixempra®)

**DRUG.00088** Atezolizumab (Tecentriq™)

**GENE.00019** BRAF Mutation Analysis

**GENE.00035** Genetic Testing for TP53 Mutations

**MED.00064** Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)

**MED.00083** Melanoma Vaccines

**SURG.00055** Cervical Total Disc Arthroplasty

**SURG.00121** Transcatheter Heart Valve Procedures

**CG-DRUG-38** Pemetrexed Disodium (Alimta®)

**CG-SURG-15** Endometrial Ablation

**CG-SURG-45** Bone Graft Substitutes

**CG-SURG-58** Radioactive Seed Localization of Nonpalpable Breast Lesions

The following policies and guidelines were revised and are effective on 12/28/2016.

**DRUG.00043** Tocilizumab (Actemra®)

**DRUG.00046** Ipilimumab (Yervoy®)

**DRUG.00050** Eculizumab (Soliris®)

**DRUG.00055** Denosumab (Prolia®, Xgeva®)

**GENE.00011** Gene Expression Profiling for Managing Breast Cancer Treatment

**GENE.00027** Combined PALB2 and BRCA2 Mutation Testing for Oncologic Indications

**MED.00032** Treatment of Hyperhidrosis

**MED.00080** Cryopreservation of Oocytes or Ovarian Tissue

**RAD.00004** Peripheral Bone Mineral Density Measurement

**SURG.00028** Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions

**SURG.00143** Perirectal Spacers for Use During Prostate Radiotherapy

**TRANS.00013** Small Bowel, Small Bowel/Liver, and Multivisceral Transplantation

**TRANS.00023** Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell
Dyscrasias

CG-DME-16  | Pressure Reducing Support Surfaces - Groups 1, 2 & 3
CG-DME-37  | Air Conduction Hearing Aids
CG-DRUG-29  | Hyaluronan Injections in the Knee
CG-DRUG-33  | Palonosetron
CG-DRUG-45  | Octreotide acetate (Sandostatin®; Sandostatin® LAR Depot)
CG-DRUG-52  | Temsirolimus (Torisel®)
CG-MED-39  | Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry
CG-MED-55  | Level of Care: Advanced Radiologic Imaging
CG-SURG-43  | Knee Arthroscopy
CG-SURG-49  | Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of Lower Extremities
CG-SURG-57  | Diagnostic Nasal Endoscopy

The following policies and guidelines were revised and are effective on 03/01/2017.

DRUG.00042  | Ustekinumab (Stelara®)
DRUG.00051  | Ziv-aflibercept (Zaltrap®)
DRUG.00066  | Antihemophilic Factors and Clotting Factors
GENE.00002  | Preimplantation Genetic Diagnosis Testing
GENE.00025  | Molecular Profiling and Proteogenomic Testing for the Evaluation of Malignant Tumors
MED.00057  | MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
SURG.00129  | Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
THER-RAD.00010  | Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
CG-MED-08  | Home Enteral Nutrition

The following policies and guidelines were reviewed and there was no change to current effective dates.

DRUG.00081  | Eteplirsen (Exondys 51™)
SURG.00026  | Deep Brain, Cortical, and Cerebellar Stimulation
CG-DRUG-59  | Testosterone Injectable

The following policies were reviewed and are effective on 11/17/2016.

LAB.00032  | Zika Virus Testing
TRANS.00035  | Mesenchymal Stem Cell Therapy For Orthopedic Indications

The following policies and guidelines were reviewed and are effective on 12/28/2016.

DRUG.00061  | Radium Ra 223 Dichloride (Xofigo®)
DRUG.00063  | Ofatumumab (Arzerra®)
DRUG.00089  | Daclizumab (Zinbryta™)
GENE.00047  | Methylene tetrahydrofolate Reductase Mutation Testing
OR-PR.00003  | Microprocessor Controlled Lower Limb Prosthesis
RAD.00035  | Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI)
RAD.00060  | Digital Breast Tomosynthesis
SURG.00092  | Implanted Devices for Spinal Stenosis
SURG.00128  Implantable Left Atrial Hemodynamic Monitor
SURG.00131  Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
SURG.00145  Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
THER-RAD.00006  Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors
CG-DRUG-49  Doxorubicin Hydrochloride Liposome Injection
CG-MED-53  Cervical Cancer Screening for Women Under 21 Years of Age
CG-SURG-48  Elective Percutaneous Coronary Interventions (PCI)
CG-SURG-53  Elective Total Hip Arthroplasty

The following policies and guideline were reviewed and are effective on 03/01/2017.
DRUG.00006  Botulinum Toxin
LAB.00011  Analysis of Proteomic Patterns
RAD.00002  Positron Emission Tomography (PET) and PET/CT Fusion
SURG.00144  Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia
CG-DRUG-09  Immune Globulin (Ig) Therapy

The following policy was archived effective 11/17/2016.
11/17/2016  DRUG.00039  Trastuzumab (Herceptin®)

The following guidelines will be archived effective 12/28/2016.
12/28/2016  CG-DRUG-15  Gonadotropin Releasing Hormone Analog
12/28/2016  CG-DRUG-30  Oprelvekin (Neumega®)

The following policies and guidelines were annual reviews and are effective 12/28/2016.
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.00034  Standing Frames
DME.00038  Static Progressive Stretch (SPS) and Patient-Actuated Serial Stretch (PASS) Devices
DRUG.00034  Insulin Potentiation Therapy
DRUG.00035  Panitumumab (Vectibix™)
DRUG.00060  Plerixafor Injection (Mozobil™)
DRUG.00070  Siltuximab (Sylvant®)
GENE.00001  Genetic Testing for Cancer Susceptibility
GENE.00004  Janus Kinase 2 (JAK2) V617F Gene Mutation Assay
GENE.00009  Gene-Based Tests for Screening, Detection and Management of Prostate Cancer
GENE.00014  Analysis of KRAS Status
GENE.00018  Gene Expression Profiling for Cancers of Unknown Primary Site
GENE.00020  Gene Expression Profile Tests for Multiple Myeloma
GENE.00022  In Vitro Companion Diagnostic Devices
GENE.00028  Genetic Testing for Colorectal Cancer Susceptibility
GENE.00029  Genetic Testing for Breast and/or Ovarian Cancer Syndrome
GENE.00030  Genetic Testing for Endocrine Gland Cancer Susceptibility
GENE.00033  Genetic Testing for Inherited Peripheral Neuropathies
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Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump during the Post-Operative Period
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Lower Limb Prosthesis
Home Oxygen Therapy
Orthopedic Footwear
Ankle-Foot & Knee-Ankle-Foot Orthotics (Braces)
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Seat Lift Mechanisms
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Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
Recombinant Erythropoietin Products
Nesiritide (Natrecor®)
Progesterone Therapy as a Technique to Prevent Preterm Delivery in High-Risk Women
Oncology Drug Treatment Regimens for Adults
Bortezomib (Velcade®)
Asparagine Specific Enzymes (Asparaginase)
Esophageal pH Monitoring
Three-Dimensional (3-D) Rendering of Imaging Studies
Outpatient Cardiac Rehabilitation
Temporomandibular Disorders
Ambulatory or Outpatient Surgery Center Procedures
Transcatheter Uterine Artery Embolization
Destruction of Pre-Malignant Skin Lesions
Special Radiation Physics Consult and Treatment Procedure
Kidney Transplantation

The following policies are annual reviews and are effective 03/01/2017.
Genetic Testing for Diagnosis and Management of Hereditary Cardiomyopathies (including ARVD/C)
Intravascular Optical Coherence Tomography (OCT)
Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
Suprachoroidal Injection of a Pharmacologic Agent
Medicare plans

Medicare Supplement members should be using new ID cards

BCBSGa Medicare Supplement individual members recently received new member ID cards. Please obtain a copy of the new member ID cards to file claims for dates of service December 1, 2016 and beyond. Additional information, including alpha prefixes, is available at the Answers@BCBSGa tab at the top of the BCBSGa provider home page.

Attend December webinar to learn how to complete OptiNet assessments

All participating Medicare Advantage providers who provide imaging services must complete registration for AIM’s online registration tool, OptiNet. OptiNet will collect modality-specific data from providers who render X-ray, ultrasound (abdominal/retroperitoneum, gynecological and obstetrical services only at this time), Magnetic Resonance (MR), Computed Tomography (CT), nuclear medicine (NUC), positron emission tomography (PET) and echocardiography imaging services. Areas of assessment include facility specifications, technologist and physician qualifications, accreditation, equipment and technical registration.

These data will be used to calculate scores for providers who render imaging services for our individual Medicare Advantage members.

All participating providers who provide imaging services, including x-rays and ultrasounds as noted above, must complete the registration. Providers who do not register, who score less than 76 or who do not complete the survey by Jan. 1, 2017 will receive a line-item denial for the technical component of the outpatient diagnostic imaging service only. This includes providers who have delegated risk arrangements and who may see BCBSGa members outside of those risk arrangements.

Participating providers who have already completed the survey but scored less than 76 can use the online registration at any time to update their information and improve their score. All providers, including those who score less than 76, will receive individualized information they can use to improve their score.

Act now to avoid line-item claims denials

Providers are strongly encouraged to register and improve their scores as needed before the line-item denials for claims submitted for dates of service on or after Jan. 1, 2017 begins. Facilities billing on a UB-04 claim form will be excluded from line item denials at this time.

The provider registration is available online at aimspecialtyhealth.com/goweb.

- Select BCBSGa MA from the drop down menu
- Only those providers who have completed the provider registration will be able to view their information online
- If you have questions or need help completing the registration, please call AIM Customer Service at 800-252-2021

To learn how to complete your survey, attend a webinar and find out how to:

- Access the OptiNet Assessment.
- Copy previously completed OptiNet Assessments to your BCBSGa Medicare Advantage account.
- Complete a new AIM OptiNet registration.
Interpret and improve your site score.

Please contact ronald.younger@anthem.com to have an invitation for the webinar delivered directly to your calendar.

Dec. 7, 2016, 4-5 p.m. ET
Dial: 866-308-0254
Pass code: 804 205 7402#
Smart Phone 1-Click Dial: 866-308-0254,,8042057402#

Additional information will be available at bcbsha.com/medicareprovider under Important Medicare Advantage Updates.

Cardioverter Defibrillators – confirm if authorization required for implants
When obtaining an authorization for a surgery that involves an implant, you must check the associated implant codes to determine if an authorization is also needed for the implant.

2017 Medicare Advantage individual benefits and formularies available
Summary of benefits, evidence of coverage and formularies for 2017 Individual Medicare Advantage plans as well as an overview of notable 2017 benefit changes will be available at bcbsha.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at bcbsha.com/medicareprovider for the latest Medicare Advantage information.

Application of Copayments
When member cost share is a copayment amount, members will be responsible for a copayment for each type of service rendered. If a member receives more than one type of service, the applicable copayment for each service will apply. Only one copayment will apply for each type of service rendered.

As an example, if a member receives three X-rays in a Specialist Office on the same date of service, the member would be responsible for the one X-Ray copayment and one Specialist Office copayment.

Please note: Certain places of service; including but not limited to, Inpatient Hospital, Outpatient Hospital, Emergency Room and Urgent care will only assess one member copayment for each visit.

No copay benefit for diabetes retinal exam and HbA1c testing effective 1/1/2017
Effective Jan. 1, 2017, no copay will be required for HbA1c testing for individual and group-sponsored Medicare Advantage members diagnosed with diabetes. Individual Medicare Advantage members diagnosed with diabetes also can receive an annual retinal exam at no out-of-pocket cost.

Routine physical exams are covered in 2017
The majority of BCBSGa Medicare Advantage (MA) plans will continue to supplement Medicare covered preventive services and offer coverage for routine physicals in 2017 for individual and group-sponsored Medicare Advantage members. A routine physical exam will help aid in appropriately assessing and diagnosing member conditions that may not have otherwise been
captured, which supports health plan ratings, Healthcare Effectiveness Data and Information Set (HEDIS), and hierarchical condition category (HCC) coding.

When the routine physical is completed by an in-network provider in an HMO and/or PPO plan, there are no out-of-pocket costs for the member. Physicals completed by out-of-network providers for members in PPO plans will be subject to member co-pay or coinsurance as applicable by the member’s plan. For the HMO plans, there will be no out-of-network coverage for routine physical as they must be rendered by an in-network provider. Please call the number of the back of the member’s ID card for specific coverage information.

Please see Important Medicare Advantage Updates at bcbsga.com/medicareprovider for additional information.

Dual Eligible Special Needs Plans – provider training required

In 2017, BCBSGa is offering Dual Eligible Special Needs Plans (D-SNPs) to people who are eligible for both Medicare and Medicaid benefits or who are qualified Medicare beneficiaries (QMBs). D-SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These plans are $0 premium plans. Some include a combination of supplemental benefits such as hearing, dental, vision as well as transportation to doctors’ appointments. Some D-SNP plans may also include a card or catalog for purchasing over-the-counter items. Centers for Medicare & Medicaid Services regulations protect D-SNP members from balance billing.

Providers who are contracted for D-SNP plans are required to take annual training to keep up-to-date on plan benefits and requirements, including coordination of care and Model of Care elements. Providers contracted for our D-SNP plans will receive notices in Q4 2016 that contain information for online training. Every provider contracted for our D-SNP plans is required to complete this annual training and click the attestation within the training site stating that they have completed the training. These attestations can be completed by individual providers or at the group level with one signature.

Additional information will be available at bcbsga.com/medicareprovider under Important Medicare Advantage Updates.

Claim adjustments may change member cost share

BCBSGa reminds providers to please check the explanation of payments on claims. There are situations in which a claim may be adjusted and this may change a member’s cost-share. If you receive a claim adjustment from BCBSGa, please ensure the member cost-share is still accurate. Basic member cost-share information is located on the front right-side of the member ID card but please note that not all cost shares are listed. If you have any questions about a member’s cost share, please call the number on the back of the member ID card.

Verify injectable, infusion billable units approved via AIM

Providers are to submit claims for medical injectable and infusion drugs in billable units for the Healthcare Common Procedure Coding System (HCPCS) code authorized. Providers can verify the amount of billable units approved for a case by using the member ID and authorization number provided. All claims submitted for more units than approved are subject to denial. To adjust the dose of an approved AIM authorization, please contact AIM for a new drug authorization request.
Claims are submitted in billable units per the HCPCS code. The billable units are calculated based on the HCPCS code administered and the dose associated with the code.

For example:
One (1) HCPCS unit of Rituxan represents 100mg of drug per HCPCS code J9310 (Rituxan) is administered at 1000mg for two doses
1000mg = 10 units (HCPCS code is 100mg)
Each dose of 1000mg is 10 billable units
Two doses = 20 billable units

AIM authorization details can be obtained via phone or the provider portal.
- AIM phone number: 1-800-714-0040
- AIM provider portal

For AIM Provider portal support please contact AIM by calling 1-800-252-202, option 2.

Note: An email address and the TIN for the facility/provider are needed to register for the site. Once registered, providers can view all AIM oncology drug approvals/denials by using the member information (name, ID#, Date of Birth).

For all other Part B injectable and infusion approvals/denials inquiries will be answered via:
- email at MASpecialtyPharm@BCBSGa.com
- phone at 1-866-797-9884 option 5

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**HCPCS codes required for Rural Health Clinic claims**

All claims from Rural Health Clinics (RHC) with dates of service 04/01/16 and after must contain an appropriate HCPCS code for each service line along with a revenue code on their Medicare Advantage claims. This pertains to contracted and non-contracted providers.

These billing instructions apply to all individual and group-sponsored Medicare Advantage plans, including Dual Special Needs Plans, and Medicare-Medicaid Plans.

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**Transitional Care Management Services eligibility**

A beneficiary is not eligible to receive TCM services until 30 days have passed since the beneficiary was discharged from an inpatient hospital setting. BCBSGa determines the date of discharge based on the date the beneficiary received their discharge evaluation and management (E&M) visit. TCM services will be denied by BCBSGa if the discharge E&M visit is not received before the TCM service.

These billing instructions apply to all individual Medicare Advantage plans, including Dual Special Needs Plans, and Medicare-Medicaid Plans.

For more information on TCM services can be found on the CMS website.
Avoid needless claims denials

Tips are available at bcbsga.com/medicareprovider under Important Medicare Advantage Updates for avoiding unnecessary claims denials, including:

- Services disallowed by utilization management
- Valid Clinical Laboratory Improvement Amendments number must be submitted
- Procedure not covered by diagnosis
- Inappropriate or missing modifier
- Duplicate claim.

Clarification – Requesting authorization for certain arterial duplex imaging procedures

As communicated in the April 2016 Network Update and Important Medicare Advantage Updates, BCBSGa is collaborating with AIM Specialty Health to conduct medical necessity reviews for Vascular ultrasound management for our individual Medicare Advantage members.

We understand the need for arterial duplex imaging procedures may not be identified until patients have undergone a physiologic study or cardiac catheterization. For these cases, please contact AIM to request clinical appropriateness review no later than 10 business days from the day the procedure is performed, and before you submit a claim.

Please note failure to contact AIM within the 10 day post service window for review will result in a denial of payment.

Impacted codes are as follows:

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<td>DUP-SCAN UXTR ART/ARTL BPGS UNI/LMTD STUDY</td>
</tr>
</tbody>
</table>

To submit your request, go to the AIM ProviderPortal. From the dropdown menu, select Anthem Medicare Advantage. For additional assistance you may also call AIM toll free at 800-714-0040, Monday through Friday, 8:00 a.m. to 8:00 p.m.

AIM clinical appropriateness guidelines for advanced imaging

Effective Feb. 18, 2017, the following changes to AIM Clinical Appropriateness Guidelines for Radiology and Cardiology will become effective:

**Oncologic imaging (CT, MRI and PET)**

- Enhanced criteria around surveillance following completion of therapy for colorectal cancer
- Updated criteria for appropriate use of imaging studies in the management of prostate cancer and breast cancer
- New guidelines for appropriate use of multiparametric MRI in the diagnosis of prostate cancer

**Breast MRI**

- Enhanced criteria for appropriateness of MRI in DCIS, atypical ductal hyperplasia, and follow up imaging of BIRADs 3 studies
Abdominal and pelvic imaging (CT and MRI)
- Updated criteria for appropriateness of imaging in inflammatory bowel disease
- Guidelines for follow up of incidental liver lesions utilizing advanced imaging
- Enhanced criteria for imaging in chronic abdominal pain and nephrolithiasis

Georgia State Health Benefit Plan Medicare Advantage contract awarded effective Jan. 1, 2017

We are pleased to announce that Blue Cross and Blue Shield of Georgia (BCBSGa) will be a Medicare Advantage plan option for the State Health Benefit Plan (SHBP) effective Jan. 1, 2017. BCBSGa will be administering medical and pharmacy benefits for SHBP retirees through our Preferred Provider Organization (PPO) product. The 2017 plan is a passive PPO, meaning the cost share in-network and out-of-network is the same.

General precertification guidelines can be found at the Provider Forms section of the Blue Cross and Blue Shield of Georgia Medicare Advantage Public Provider at bcbsga.com/medicareprovider.

Keep up with Medicare news
Please continue to check Important Medicare Advantage Updates at bcbsga.com/medicareprovider for the latest Medicare Advantage information, including:
- Prior authorization requirements for Cuvitru, Ocrevus, and Lutathera
- September reimbursement policy provider bulletin
- Medicare Advantage reimbursement policies
- Prior authorization requirements for continuous interstitial glucose monitoring
- Diabetic supply coverage for individual Medicare Advantage members
- Medicare notices and provider requirements
- Clinical Cumulative Morphine Equivalent Dosing Point of Sale Edit effective January 1, 2017
- Prior authorization requirement for Torisel
- Prior authorization changes to Interferon gamma-1b, Mecasermin, and Azacitidine
- Prior authorization requirements for Doxil and Sustol

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