Nevada Provider News

July 2019 Anthem Provider News and Important Updates - Nevada

Medicare:

Medicaid:

Clinical criteria updates for specialty pharmacy

Published: Jul 1, 2019 - **Products & Programs** / Pharmacy

On December 1, 2018, Anthem Blue Cross and Blue Shield (Anthem) introduced the new clinical criteria page for injectable, infused or implanted drugs.

Effective for dates of service on and after August 1, 2019, the following new oncology clinical criteria will be included in our clinical criteria review process. The oncology drugs that require prior authorization will continue to require prior authorization notification with AIM.

Existing precertification requirements have not changed for the specific Clinical Criteria below. While there are no material changes, the document number and online location has changed. To access the clinical criteria information please access here. The table below will assist you in identifying the new document number for the clinical criteria that corresponds with the previous Clinical Guideline/Medical Policy.

Anthem's pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Clinical Guideline	Clinical Criteria Document Number	Clinical Criteria Name	Drug	HCPCS Code
CG-DRUG-76	ING-CC-0089	Mozobil (plerixafor)	Mozobil	J2562

URL: https://providernews.anthem.com/nevada/article/clinical-criteria-updates-for-specialty-pharmacy-24

Clinical Criteria coding updates for specialty pharmacy are available

Published: Jul 1, 2019 - **Products & Programs** / Pharmacy

As a result of coding updates in the claims system, the claim system edits for the clinical

criteria listed below will be revised. This will result in the review of claims for certain diagnoses before processing occurs to determine whether the service meets medical necessity criteria. As a result, these coding updates may result in a not medically necessary determination.

Effective May 1, 2019, we began be implementing coding updates in the claims system for the following clinical criteria listed below which may result in not medically necessary determinations for certain services.

- ING-CC-0073 – Alpha-1 Proteinase Inhibitor Therapy

To access the clinical criteria information please access here.

URL: https://providernews.anthem.com/nevada/article/clinical-criteria-coding-updates-for-specialty-pharmacy-are-available-3

Update to Provider/Facility UM reimbursement penalties and corresponding update to Provider/Facility Manual (MAC)

Published: Jul 1, 2019 - **Administrative**

Material Adverse Change (MAC)

Update to Provider/Facility UM reimbursement penalties and corresponding update to Provider/Facility Manual

URL: https://providernews.anthem.com/nevada/article/update-to-providerfacility-um-reimbursement-penalties-and-corresponding-update-to-providerfacility-manual-mac

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Changes coming this month with Anthem's Provider Newsletter and Important Updates

Published: Jun 28, 2019 - **Administrative**

Last August we announced that we had a new look and feel to our Provider newsletter. In an effort to help make communications from Anthem even more effective and concise, we are looking to change how we distribute our monthly newsletter and notices of material change to contract.

Historically, you have received two emails from Anthem on the first of each month which have been titled:

- **[Month] [Year] Anthem Provider Newsletter - Nevada**
  - This has been our publication which includes our monthly Provider Newsletter.

- **[Month] [Year] Anthem Important Updates - Nevada**
  - This has been our publication which includes our Notices of Material Change to Contract, or Material Adverse Changes (MAC), which are links to communications that are in a letter format vs a separate article within the publication.

Starting in July, you will receive one email on the first of the month instead of two as we combined this information into one publication. The new title of this combined publication will be as follows:

- **[Month] [Year] Anthem Provider News and Important Updates - Nevada**

Since we are combining these publications, we are also adding some additional identifiers to help you easily identify the MAC notifications which we have previously sent under the "Anthem Important Updates" publication. Starting in July you will now see the MAC articles with the following indicators:

- "**(MAC)**" at the end of the article title
- "**Material Adverse Change (MAC)**" under the article title

These new enhancements will improve the functionality and search features that are part of our electronic Provider News tool, as well as tracking and reporting of this tool. Along with these enhancements, we will also be referring to these publications as "Provider News" going forward rather than "Provider Newsletter".

Thanks for your attention to this important update, and for being a valued provider within our network!

URL: https://providernews.anthem.com/nevada/article/changes-coming-this-month-with-anthems-provider-newsletter-and-important-updates

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Working with Anthem Webinars - July 2019 schedule: Networks Overview

Published: Jul 1, 2019 - **Administrative**

We are continuing our series of “Working with Anthem” webinars for 2019. These webinars are focused on one topic each session, and designed to help our providers and their staff learn how to use the tools currently available to improve operational efficiency when working with Anthem Blue Cross and Blue Shield (Anthem).

2019 Subject Specific Webinars - July schedule

Topic:	**Networks Overview**
Date/Time:	**July 9 12pm PT**
Description:	Learn about ALL networks offered in Nevada, how to identify members accessing these networks, including membership ID card samples. Networks included in this overview: • Participating (PAR) • PPO • HMO Nevada • Pathway PPO • Pathway HMO • Pathway X – PPO • Pathway X – HMO • Anthem Choice PPO (Tier 1 – Pathway PPO, Tiers 2 – PPO)

• Medicare Advantage PPO	
Registration link:	https://antheminc.webex.com/antheminc/onstage/g.php?PRID=4dd9e774f237f0ecd17223a71abe7559

Webinars are offered using Cisco WebEx. There is no cost to attend. Access to the internet, an email address and telephone is all that's needed. **Attendance is limited, so please register today.**

Watch for additional topics and dates in future issues of our monthly provider newsletter throughout the year. We also will continue to offer our Fall Provider Seminars which will continue to cover a variety of topics in face-to-face and webinar options.

Recorded sessions:

Most sessions are recorded and playback versions are available on our Registration Page. The top portion of the page will show *"**Upcoming Events**"* and the bottom portion will show *"**Event Recordings**".*

URL: https://providernews.anthem.com/nevada/article/working-with-anthem-webinars-july-2019-schedule-networks-overview-1

Drug fee schedule update

Published: Jul 1, 2019 - **Administrative**

CMS average sales price (ASP) third quarter fee schedule with an effective date of July 1, 2019 will go into effect with Anthem Blue Cross and Blue Shield (Anthem) on August 1, 2019. To view the ASP fee schedule, please visit the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

URL: https://providernews.anthem.com/nevada/article/drug-fee-schedule-update-3

Make the move to the Availity EDI Gateway today

Published: Jul 1, 2019 - **Administrative**

If you currently submit claims directly to the Anthem EDI Gateway, now is the time to make the move. **It is mandatory that all trading partners must transition to the Availity EDI Gateway to avoid future disablement.**

Do you already have an Availity User ID and Login? You can use the same login for your Anthem EDI transactions.

- Log in to the Availity Portal at Availity.com, and select **Help & Training | Get Trained**.
- In the Availity Learning Center, search the Catalog by key word "**SONG**" for live and on-demand resources created especially for you.

If you wish to become a direct a trading partner with Availity, the setup is easy.

- Use the **Availity Welcome Application** to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions.

Do you use a clearinghouse today?

- We encourage you to contact your clearinghouse to ensure they have made the move.

Need Assistance?

The **Availity Quick Start Guide** will assist you with any EDI connection questions you may have.

If you need additional assistance, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. Eastern Time.

URL: https://providernews.anthem.com/nevada/article/clinical-criteria-updates-for-specialty-pharmacy-25

Anthem Commercial Risk Adjustment (CRA) Reporting Update: 2019 Program Year Progression - What's in it for you and your patients?

Published: Jul 1, 2019 - **Administrative**

Continuing our 2019 CRA reporting updates, Anthem Blue Cross and Blue Shield (Anthem) requests your assistance with respect to our CRA reporting processes.

As we reported in the May and June newsletters, we are completing our prospective and retrospective reviews for 2019. Prospectively, we intervene to encourage the participation of the members we have identified as appropriate for clinical assessments. Retrospectively, certified coders review medical charts to determine if there are diagnosis codes that have not been reported.

What's in it for you?

First, monthly you will receive lists of our members who are your patients to help you reach out to those who may have gaps in care, so they can come in for office visits earlier.

Second, we've heard resoundingly from providers that participation in these programs helps them better evaluate their patients (who are our members) and, as a result, perform more strongly in population health management and gain sharing programs. Many cite that they ask different questions today that allow them to better manage their patients end to end.

Finally, when you see Anthem members and submit assessments, **we pay incentives of $50 for a paper submission and $100 for an electronic submission**. For additional details on how to earn these incentives and the options available, please contact our CRA Network Education Representative listed below.

What's in it for your patients?

Anthem has completed monthly postcard campaigns to members with Affordable Care Act (ACA) compliant coverage when we suspect a high risk condition with messaging to encourage the member to call his or her Primary Care Provider (PCP) and schedule an annual checkup. The goal is to get the members in to see their PCPs, so the PCPs have an overall picture of their patients' health and schedule any screenings that may be needed.

We will continue these monthly postcard mailings throughout all of 2019 to continue to encourage the members to be seen in your office, which supplements any patient outreach

you may be doing as well.

If you have any questions regarding our reporting processes, please contact our CRA Network Education Representative: Socorro.Carrasco@anthem.com.

URL: https://providernews.anthem.com/nevada/article/ambulance-transportation-professional-reimbursement-policy-new-2

Anthem Works to Simplify Payment Recovery Process for National Accounts Membership

Published: Jul 1, 2019 - **Administrative**

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

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

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

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

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

URL: https://providernews.anthem.com/nevada/article/test-for-macs-option-2-article

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AIM Specialty Health Clinical Guidelines update - Advanced Imaging (MAC)

Published: Jul 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

Material Adverse Change (MAC)

AIM Specialty Health Clinical Guidelines update - Advanced Imaging

URL: https://providernews.anthem.com/nevada/article/aim-specialty-health-clinical-guidelines-update-advanced-imaging-mac

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Modifier 79 reminder: Professional

Published: Jul 1, 2019 - **Policy Updates** / Reimbursement Policies

A recent review of our claim trends has identified that many providers are not billing appropriately for modifier 79. According to Appendix A in the *CPT Professional Edition,* modifier 79 is used to indicate that a procedure or service is an "…*unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period*". If the current procedure or service does not fall within the postoperative period of a previously performed 0, (same day), 10 or 90 day postoperative period, by the same provider or a provider in the same group practice, please carefully consider the definition of modifier 79 when adding the modifier to a procedure or service.

URL: https://providernews.anthem.com/nevada/article/modifier-79-reminder-professional-3

Modifier 63 reminder: Professional

Published: Jul 1, 2019 - **Policy Updates** / Reimbursement Policies

According to Appendix A of the CPT Professional Edition codebook, modifier 63 is only used when an invasive procedure is performed on neonates or infants up to a present body weight of 4 kg to indicate significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. Unless otherwise designated, this modifier should only be appended to the procedures/services identified in the modifier description. Additionally, based on the modifier description, modifier 63 is not valid for use with evaluation and management, anesthesia, radiology, pathology/laboratory, or medicine codes. Furthermore, many procedures performed on infants for correction of congenital abnormalities include additional difficulty or complexity that are inherent to the procedure and are identified by the code nomenclature and the CPT parenthetical "do not use modifier 63

in conjunction with…" These codes are also identified in Appendix F of the CPT Professional Edition codebook. Please note, incorrect reporting of modifier 63 may result in claim denials.

URL: https://providernews.anthem.com/nevada/article/modifier-63-reminder-professional-3

ICD-10-CM Coding Guidelines and Laterality: Professional

Published: Jul 1, 2019 - **Policy Updates** / Reimbursement Policies

With the adoption of ICD-10-CM code set, we were introduced to diagnosis codes that now indicate the laterality of a condition. At present, diagnosis code descriptions indicate whether the condition is present on the left, right or exists bilaterally. A recent review of our claim denial trends has identified that many providers are not billing appropriately in regards to laterality. As a reminder, if a condition currently exists on both sides, please refer to the *ICD-10-CM Official Guidelines for Coding and Reporting FY 2019***,** specifically, the General Coding Guidelines Section and the Chapter Specific Sections; for specific guidance for reporting a diagnosis that designates a condition on the left and right versus a bilateral diagnosis. Please carefully consider the information contained in the ICD-10-CM Coding Guidelines when trying to decide between reporting a condition using left diagnosis and right diagnosis codes versus a bilateral diagnosis code.

URL: https://providernews.anthem.com/nevada/article/icd-10-cm-coding-guidelines-and-laterality-professional-3

Anthem Federal Employee Health Benefit Program® (FEP) PPO Members will now require prior approval for specific Specialty Drugs and Site of Care

Published: Jul 1, 2019 - **State & Federal** / Federal Employee Plan (FEP)

Effective July 1, 2019, Anthem Federal Employee PPO members, *(ID numbers beginning with an, **'R'**)*, aged 18 and older, and not Medicare Primary, will now need to have Prior Approval for the following medications:

List of medications by name and code

Code	Procedure Description
J0129	Abatacept injection (Orencia)

J0490	Belimumab injection (Benlysta)
J1459	Injection, immune globulin (Privigen)
J1555	Injection, immune globulin (Cuvitru)
J1556	Injection, immune globulin (Bivigam)
J1557	Injection, immune globulin (Gammaplex)
J1559	Injection, immune globulin (Hizentra)
J1561	Injection, immune globulin (Gamunex-c/Gammaked)
J1566	Injection, immune globulin (Carimune)
J1568	Injection, immune globulin (Octagam)
J1569	Injection, immune globulin, (Gammagard liquid)
J1572	Injection, immune globulin , (Flebogamma)
J1575	Injection, immune globulin/hyaluronidase (HyQvia)
J1599	Injection, immune globulin (Panzyga)
J1602	Golimumab IV (Simponi Aria)
J1745	Infliximab not biosimilar (Remicade)
J2323	Natalizumab injection (Tysabri)
J3380	Vedolizumab Injection (Entyvio)
Q5103	Infliximab dyyb biosimilar (Inflectra)
Q5104	Infliximab abda biosimilar (Renflexis)
Q5109	infliximab-qbtx, biosimilar (Ixifi)

In addition to acquiring Prior Approval for the medication, the Outpatient Hospital Site of Care must also be approved. The Prior Approval process will identify members who meet the appropriate Anthem site of care criteria and who can safely receive their medication in a location other than an outpatient hospital, including the home.

Effective January 1, 2020 failure to receive Prior Approval for these medications may result in non-coverage of the medication and facility services.

To acquire Prior Approval please contact the Anthem Federal Employee Program Utilization Management Department at (800-860-2156).

URL: https://providernews.anthem.com/nevada/article/anthem-federal-employee-health-benefit-program-fep-ppo-members-will-now-require-prior-approval-for-specific-specialty-drugs-and-site-of-care-2

Outpatient Rehabilitation Program transitioning to AIM

Published: Jul 1, 2019 - **State & Federal** / Medicare

Category: Medicare

Effective October 1, 2019, Anthem Blue Cross and Blue Shield (Anthem) will transition utilization management of our Outpatient Rehabilitation Program for Medicare Advantage from OrthoNet LLC to AIM Specialty Health® (AIM). AIM is a specialty health benefits company. The Outpatient Rehabilitation Program includes F services. Anthem has an existing relationship with AIM in the administration of other programs.

This transition enables Anthem to expand and optimize this program, further ensuring that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Anthem for medical necessity determination. For Medicare Advantage, Anthem makes coverage determinations based on guidance from CMS including national coverage determinations (NCDs), local coverage determinations (LCDs), other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Anthem clinical guidelines *GC.REHAB.04*, *CG.REHAB.05* and *CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed online at https://www.availity.com by selecting **Clinical Resources** in the *Education and Reference Center* under *Payer Spaces*.

Detailed prior authorization requirements are available online by accessing the Precertification Lookup Tool under *Payer Spaces* at https://www.availity.com. Contracted and non-contracted providers should call Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Prior authorization review requirements

For services scheduled to be rendered through September 30, 2019, providers must contact OrthoNet LLC to obtain prior authorizations for outpatient rehabilitation services. Any authorizations OrthoNet LLC makes prior to the transition date of October 1, 2019, will be honored and claims will process accordingly.

For services that are scheduled on or after October 1, 2019, providers must contact AIM to obtain prior authorization. Beginning September 15, 2019, providers will be able to contact

AIM for prior authorization on services to take place on or after October 1, 2019. Providers are strongly encouraged to verify that they have obtained prior authorization before scheduling and performing services.

How to place a review request

You may place a request online via the AIM ***Provider****PortalSM*. This service is available 24/7 to process requests in real time using clinical criteria. Go to www.providerportal.com to register. You can also call AIM at **1-800-714-0040**, Monday to Friday 7 a.m. to 7 p.m. Central time.

For more information

For resources to help your practice get started with the Outpatient Rehabilitation Program, go to www.aimproviders.com/rehabilitation. Our provider website helps you learn more and provides access to useful information and tools such as order entry checklists, clinical guidelines and FAQ.

ABSCRNU-0029-19 May
2019
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URL: https://providernews.anthem.com/nevada/article/outpatient-rehabilitation-program-transitioning-to-aim-3

Home health billing guidelines for contracted providers

Published: Jul 1, 2019 - **State & Federal** / Medicare

Category: Medicare

*This information is intended for home health agencies that **do not** submit their claims to MyNexus and are contracted with Anthem Blue Cross and Blue Shield (Anthem) to be compensated based on the original Medicare Home Health Prospective Payment System. This information is not intended for home health agencies that are contracted to be compensated based on per visit rates.*

Below are some billing guidelines we recommend home health providers use when billing a Request for Anticipated Payment (RAP) and final claim to Anthem Blue Cross and Blue Shield (Anthem). This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract.

- Anthem should receive the final bill within 120 days after the start date of the episode or 60 days after the paid date of the RAP claim -- whichever is greater. If the final bill is not received within this time frame, the RAP payment will be canceled/recouped -- This is a Medicare billing requirement.

- Bill the full Medicare allowed amount for the episode as the billed charges. Do not bill only the expected additional payment on the final claim as the billed charges. When this happens, the Lesser of Logic term in your contract affects the final payment made for the services. If the billed charges are less than the final allowed, the payment will be reduced to only pay up to the billed charges. The billed charges on the final claim should be for at least the full Medicare allowed amount for the services rendered. This will allow the claim to process correctly according to Medicare guidelines.

    - Example: RAP claim paid $500. The final claim is submitted with billed charges in the amount of $1,000. The Medicare allowed amount is $1,500. Since the billed charges on the final claim are only $1,000, Anthem would only pay an additional $500 for the final allowed according to the Lesser of Logic term in the contract. If the provider would have billed charges in the amount of at least $1,500, then an additional payment of $1,000 would have been paid.

Please contact your Provider Relations representative with any questions.

ABSCRNU-0023-19 May
2019
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URL: https://providernews.anthem.com/nevada/article/home-health-billing-guidelines-for-contracted-providers-4

Keep up with Medicare news

Published: Jul 1, 2019 - **State & Federal** / Medicare

Category: Medicare

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

- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus

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URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicare-news-70

Appointment availability and after-hours access requirements

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

To ensure members receive care in a timely manner, PCPs, primary care sites (PCS), specialty providers and behavioral health providers must maintain the following appointment availability and after-hours access standards.

Appointment availability requirements

PCPs:

Appointment type	Appointment standard
Medically necessary care	Same day

Urgent care	Within two calendar days	
	Routine care	Within two weeks
	After-hours access	Member must have access to communicate with provider after hours. See page two for specifics.

Specialists:

Appointment type	Appointment standard
Medically necessary care	Same day
Urgent care	Within three calendar days
Routine care	Within 30 days
Prenatal care, initial appointment · First trimester — within seven calendar days of the first request · Second trimester — within seven calendar days of the first request · Third trimester — within three calendar days of the first request · High risk — within three calendar days of the first request	Initial prenatal care appointment will be provided for enrolled members who are pregnant as follows:

Behavioral health providers:

Appointment type	Appointment standard
Care for nonlife-threatening emergency	Within six hours
Urgent care	Within 48 hours
Initial visit for routine appointment	Within 10 business days
Follow-up routine care	Within two weeks

After-hours access requirements

To ensure continuous 24-hour coverage, PCPs/PCS must maintain one of the following arrangements for members to contact them after normal business hours:

- Have the office telephone answered after hours by an answering service that can contact the PCP/PCS or another designated network medical practitioner. All calls answered by an answering service must be returned within 30 minutes.
- Have the office telephone answered after normal business hours by a recording in the language of each of the major population groups served by the PCP/PCS to direct the member to call another number to reach the PCP/PCS or another provider designated by the PCP/PCS. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.
- Have the office telephone transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP/PCS or a designated

Anthem Blue Cross and Blue Shield Healthcare Solutions network medical practitioner who can return the call within 30 minutes.

The following telephone answering procedures are **not** acceptable:

- The office telephone is only answered during office hours.
- The office telephone is answered after hours by a recording that tells members to leave a message.
- The office telephone is answered after hours by a recording that directs members to go to an emergency room for any services needed.
- After-hours calls are returned outside of 30 minutes.

What if I need assistance?

If you have questions, contact your local Provider Relations representative or call Provider Services at **1-844-396-2330**.

ANV-NU-0049-19 April 2019

Why do patients stop taking their prescribed medications and what can you do to help them?

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

You want what's best for your patients' health. When a patient doesn't follow your prescribed treatment plan, it can be a challenge. Approximately 50% of patients with chronic illness stop taking their medications within one year of being prescribed1. What can be done differently?

The missed opportunity may be that you're only seeing and hearing the *tip of the iceberg*, that is, the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline -- the giant, often invisible, patient self-talk that may not get discussed aloud -- can create a misalignment between patient and provider.

We've created an online learning experience to teach the skills and techniques that can help you navigate these uncharted patient waters. After completing the learning experience you'll know how to see the barriers, use each appointment as an opportunity to build trust and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence -- and you'll earn continuing medical education credit along the way.

Take the next step. Go to MyDiversePatients.com > *The Medication Adherence Iceberg: How to navigate what you can't see to enhance your skills*. The course is approximately one hour and accessible by smart phone, tablet or desktop at no cost.

1 Centers for Disease Control and Prevention. (2017, Feb 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from [https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm].

ANV-NU-0043-19 May 2019

URL: https://providernews.anthem.com/nevada/article/why-do-patients-stop-taking-their-prescribed-medications-and-what-can-you-do-to-help-them-18

Keep up with Medicaid news

Published: Jul 1, 2019 - **State & Federal** / Medicaid

Category: Medicaid

Please continue to check Medicaid Provider Communications & Updates at anthem.com/mediproviders for the latest Medicaid information, including:

- How to contact IngenioRx Specialty Pharmacy beginning May 1, 2019

URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicaid-news-2