January 2019 Anthem Ohio Provider Newsletter

Benefits to be available for chronic care management and advance care planning services effective February 23, 2019

Anthem Blue Cross and Blue Shield (Anthem) is committed to investing in primary care, rewarding coordinated, patient-centered care, and promoting proactive chronic care management. In recognition of the time-intensive nature of this work, Anthem will reimburse chronic care management and advance care planning services for Commercial health plans effective for claims processed on or after February 23, 2019.

Chronic care management (CCM) is care rendered by a physician or non-physician health care provider and their clinical staff, once per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only one practitioner can bill a CCM service per service period (month). Three CCM codes are included in this payment policy change: 99490, 99487and 99489.

Advance care planning (ACP) is a face-to-face service between a physician or other qualified health care professional and a patient discussing advance directives with or without completing relevant legal forms. An advance directive is a document in which a patient appoints an agent and/or records the wishes of a patient pertaining to their medical treatment at a future time if they cannot decide for themselves at that time. No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary. Two ACP codes are included in the payment policy change: 99497 and 99498

Anthem requires patient consent prior to CCM or ACP service(s) being provided. Please refer to the current *Claims Requiring Additional Documentation* policy for more information. For more information, review our Bundled Services and Supplies policy dated February 23, 2019 by visiting the reimbursement policy page for your state, Indiana, Kentucky, Missouri, Ohio, Wisconsin, found on anthem.com.

HEDIS® 2019 starts early February

We will begin requesting medical records in February via a phone call to your office followed by a fax.

The fax will contain 1) a cover letter with contact information your office can use to contact us if there are any questions; 2) a member list, which includes the member and HEDIS measure(s) the member was selected for; and 3) an instruction sheet listing the details for each HEDIS measure. **As a reminder, under HIPAA, releasing PHI for HEDIS data**

collection is permitted and does not require patient consent or authorization. HEDIS and release of information is permitted under HIPAA since the disclosure is part of quality assessment and improvement activities [45 CFR 164.506(c) (4)]. For more information, visit www.hhs.gov/ocr/privacy.

HEDIS review is time sensitive, so please submit the requested medical records within **five business days**.

To return the medical record documentation back to us in the recommended 5-day turnaround time, simply choose one of these options:

1. Upload to our secure portal. This is quick and easy. Logon to www.submitrecords.com, enter the password included with your HEDIS Member List and select the files to be uploaded. Once uploaded you will receive a confirmation number to retain for your records.

OR

2. Send a secure fax to **1-888-251-2985**

OR

3. Mail to us via the **US Postal Service** to:
   Anthem, Inc., 66 E. Wadsworth Park Drive, Suite 110H, Draper, UT 84020

Please contact your Provider Network Representative to let them know if you have a specific person in your organization that we should contact for HEDIS medical records.

Thank you in advance for your support of HEDIS.

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

Simplifying medication prior authorization processes

Anthem Blue Cross and Blue Shield (Anthem) is committed to offering efficient and streamlined solutions for submitting prior authorizations (PAs). This helps reduce the administrative burden while improving the member experience for their patients.

Anthem's *Proactive PA* process approves select drugs in real time, using an automated prior authorization (PA) process. *Proactive PA* uses integrated medical and pharmacy data to seamlessly approve medication prior authorization requests where diagnoses are required.

Anthem's prior authorization process helps to ensure clinically appropriate use of medications.

Providers can take advantage of the electronic prior authorization (ePA) submission process by logging in at covermymeds.com. Creating an account is FREE, and many prior authorizations are approved in real time. Read more about the ePA submission process in the article published in December 2018. To access this article, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin

Additionally, providers may be able to access real-time, patient-specific prescription drug benefits information through their electronic medical record (EMR) system. To learn more about this feature, refer to the article published in October 2018. To access this article, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin

Update regarding drugs not approved by the FDA

Anthem Blue Cross and Blue Shield (Anthem) continually monitors and updates the list of drugs not approved by the Food and Drug Administration (FDA), which are considered non-covered under prescription drug benefits. When drugs are added to this list, Anthem notifies impacted members that the drug is not FDA approved and will no longer be covered.

Effective December 1, 2018, these drugs were added to our list of drugs not approved by the FDA. For new members just beginning an Anthem plan or not yet having used one of these non-FDA-approved drugs, coverage for these drugs ended December 1, 2018.

Existing members who had been identified as already using at least one of the drugs added to the list received a letter to let them know their drug(s) will no longer be covered after December 31, 2018. However, if the patient had a prior authorization for a drug on this list, coverage for that drug continued until the prior authorization expired on December 31, 2018.

Eligible facilities to bill modifiers JG and TB on 340B drugs

On November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) issued its 2018 Outpatient Prospective Payment System "OPPS" Final Rule, CMS CY2018 OPPS Final Rule, which finalized the Medicare Part B payment for certain drugs acquired through the 340B Program.

As appropriate, the 340B Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations and covered entities at significantly discounted prices.

As described in the Final Rule, CMS established two new modifiers to identify 340B drugs – the “JG” and “TB” modifiers. Beginning January 1, 2018, affected entities were required to report these modifiers on outpatient claims for certain separately payable drugs or biologicals that are acquired through the 340B program and administered or dispensed to patients.

Beginning **April 1, 2019**, for our Commercial lines of business, Anthem Blue Cross and Blue Shield will require that all facilities eligible for the 340B Program bill these modifiers on all outpatient claims impacted by these modifiers.

These facilities are *excluded* from this billing requirement:

- Sole community hospitals (“SCHs”)
- Children’s hospital
- PPO-exempt cancer hospitals
- Critical access hospitals (“CAHs”)
- Drugs administered/dispensed in non-excepted hospital off-campus outpatient departments (“HOPDs”)

Pharmacy information available at anthem.com

Visit anthem.com/pharmacyinformation for more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs.

The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October).

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. AllianceRX Walgreens Prime is the specialty pharmacy program for the FEP. You can view the 2018 Specialty Drug List or call us at 888-346-3731 for more information.

New Codes for Applied Behavior Analysis (ABA)

Anthem Blue Cross and Blue Shield (Anthem) in Ohio would like to make you aware of upcoming changes to the Ohio Anthem Blue Cross and Blue Shield coding for Applied Behavior Analysis (ABA). The new coding will apply to covered services rendered on or after January 1, 2019 for plans that use the Blue Traditional®, Blue Access®, Blue Preferred®, and the Exchange/Off Exchange Networks.

As you submit new and renewing treatment plans for your Anthem members, beginning with dates of service January 1, 2019, please request ABA services using the new codes set forth by the American Medical Association (AMA).

Current ABA treatment authorizations that have already been approved through 2019 will be updated to reflect the new codes for the portion of the service that falls in 2019. Updated authorization letters reflecting the changes to the authorization will be sent to members and providers. You do not need to call and request that this update to current authorization take place. Claims submitted for 2019 dates of service should reflect the new codes.

If you have a question about any code you do not see on this list, we encourage you to access the online tool at *MyAnthem* via the Availity web portal. Go to anthem.com/provider > select *Ohio* > select *Find Resources for Ohio* > and on the left side of the Provider home page log in to the Availity portal. Or go to availity.com and select the Anthem Provider Portal.

Please note that the online fee schedules provide allowable amounts for current as well as historical codes and rates. Fee schedules with an effective date of January 1, 2019 may be available online at Availity after December 20, 2018.

For treatment plans authorized effective January 1, 2019 or after, the only codes payable to Applied Behavior Analysts will be the new codes approved by the AMA. All other codes will be denied.

Requests for concurrent reviews and/or new authorizations will reflect the coding changes and should be billed to match what is authorized. Coding other than what is reflected in an authorization for ABA services should not be billed and is not covered.

Please contact Network Development for any additional questions.

Reminder: HCPCS code A0998 Ambulance response and treatment with no transport is active and available for use

In early 2018, Anthem Blue Cross and Blue Shield (Anthem) became one of the first major

insurers to reimburse EMS providers for appropriate and medically necessary care billed under HCPCS code A0998 (Ambulance response and treatment, no transport). The code, which has been active since January 2018 for most standard Anthem benefit plans, allows EMS providers to receive reimbursement for treatment rendered in response to an emergency call to a member's home or scene, when transportation to the hospital emergency room (ER) was not provided. Previously, Anthem reimbursed EMS providers for treatment rendered only when a patient was transported to the ER.

Important reminders:

- The code is currently active and available for EMS use.
- If an EMS provider responds to an emergency call and provides appropriate treatment at-home or on-site without transporting to the ER, code A0998 can be used.
- The EMS provider must render treatment to the patient per EMS protocols which are approved by the medical director at the local or state level.
- Billing of A0998 when treatment is not rendered is not appropriate.
- Anthem will apply medical necessity review to A0998 using clinical guideline CG-ANC-06.
- HCPCS code A0998 applies to all of Anthem's commercial health plans, and reimbursement will be made in accordance with the member's benefits.

Questions?

- For contract questions, please reach out to your contract representative.
- For questions about using code A0998, please reach out to Jay Moore, Senior Clinical Director for Anthem, Inc.

Anthem offers risk adjustment and documentation training

Anthem Blue Cross and Blue Shield (Anthem) will offer general and condition-specific Medicare risk adjustment, documentation and coding training in 2019. Additional information will be available at Important Medicare Advantage Updates at anthem.com/medicareprovider.

Paradigm Senior Care Advantage a delegated provider for Akron MA membership

Effective, January 1, 2019, Anthem will enter into a provider collaboration agreement with Pioneer Physicians in the Akron Ohio market called Paradigm Senior Care Advantage. Anthem delegated responsibility for medical claims payment, prior authorizations, case

management, provider credentialing and inpatient and outpatient utilization management to Paradigm Senior Care Advantage for individual Medicare Advantage HMO members attributed to Pioneer Physicians in Summit, Stark, Portage, Medina, Wayne, Carroll, Columbiana, Tuscarawas, Mahoning, Cuyahoga, Trumbull, Lake and Geauga counties. The delegation will be effective January 1, 2019. Members under this arrangement will have **Paradigm Senior Care Advantage** on their member ID card.

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

Medicare Advantage member Explanation of Benefits redesigned

Anthem Blue Cross and Blue Shield (Anthem) recently introduced a redesigned monthly Explanation of Benefits (EOB) to Medicare Advantage members.

The new EOB includes:

- Personalized tips to help members save on health care expenses.
- A preventive care checklist — to point out opportunities for screenings or other care.
- Alerts when a claim needs immediate attention.

If you or your members have any questions about how to read the new EOB, please call the number on the back of the member ID card.

Keep up with Medicare news

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

- New provider service phone number beginning January 1, 2019
- Medicare Advantage Reimbursement Policy: October Provider Bulletin
- Prior authorization requirements for Part B drugs: Moxetumomab Pasudotox, Cemiplimab and Fulphila
- Submit prior authorization medication requests electronically; new phone number for Medicare Advantage prescription prior authorizations

- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective January 1, 2019
- Inpatient Readmissions