April 2019 Anthem Provider Newsletter - Ohio

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Notice of Material Changes/Amendments to Contract and Prior Authorization Changes: April 2019

Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements starred (*) below.

- Medical Policy and Clinical Guidelines Updates – April 2019*
- Specialty Pharmacy Prior Authorization List Updates*
- AIM Clinical Appropriateness Guidelines Updates*
- Reimbursement Policy Updates*
- 2019 Provider Manual is ready for review*
- Medicare and Medicaid Updates*

The 2019 Provider Manual is now available for your review

Anthem Blue Cross and Blue Shield (Anthem) reviews and updates our Provider Manuals annually. We are pleased to notify you that the updated 2019 manual is now available online and you can view it here. Or go to anthem.com > Providers > Provider Overview > *select* Ohio > *select* Find Resources for Your State, *then from the* Provider Home *page* > Communications > Publications.

The 2018 Ohio Provider Manual will also be available until July 1, 2019.

New AIM Rehabilitative program effective July 1, 2019

Effective July 1, 2019, Anthem Blue Cross and Blue Shield (Anthem) will transition medical necessity review of rehabilitative (restoring function) and habilitative (enhancing function) services for fully insured members to AIM Specialty Health® (AIM). Currently, OrthoNet LLC is performing medical necessity reviews for physical and occupational therapy services for

Anthem. These reviews will transition to AIM in addition to adding speech therapy service reviews.

AIM will manage Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST) medical necessity reviews using the following Anthem Clinical Utilization Management (UM) Guidelines:

- CG-REHAB-04 Physical Therapy
- CG-REHAB-05 Occupational Therapy
- CG-REHAB-06 Speech-Language Pathology Services.

Please note, this does not apply to procedures performed in an inpatient or observation setting, or on an emergent basis. The clinical criteria to be used for these reviews can be found on the Anthem Provider website on the Clinical UM Guidelines webpage. A complete list of CPT codes requiring prior authorization for the AIM Rehabilitative program is available on the AIM Rehabilitation microsite. There you can learn more about the program and access helpful information and tools such as order entry checklists and FAQs.

AIM will begin accepting prior authorization requests on June 17, 2019 for dates of service on and after July 1, 2019. To determine if prior authorization review is needed for an Anthem member, please check online or call the pre-service review number located on the back of the member ID card. As of July 1, 2019, self-funded accounts (ASO) that currently have the OrthoNet program will also be offered the AIM Rehabilitative program. The program will also be offered to new local self-funded accounts (ASO) to add to their members' benefit package as of July 1, 2019.

Ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*℠ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number at (800) 554-0580, Monday through Friday, 8:30 a.m. to 7:00 p.m. ET.

AIM Rehabilitation training webinars

Anthem invites you to take advantage of a free informational webinar that will introduce you to the program and the robust capabilities of the AIM ProviderPortalSM. Go to the AIM Rehabilitation microsite to register for an upcoming webinar. If you have previously registered for other services managed by AIM, there is no need to register again. The training will be recorded and can be viewed at a time convenient for you!

Anthem expands specialty pharmacy prior authorization list*

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

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

Anthem Blue Cross and Blue Shield's prior authorization clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

The following clinical guideline will be effective July 1, 2019.

Clinical Guideline	HCPCS or CPT Code(s)	NDC Code(s)	Drug
CG-THER-RAD-03	A9699, C9408	71258-0015-02 71258-0015-22	Azedra®

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 on Interactive Care Reviewer (ICR): Request Clinical Appeals

In February, Anthem Blue Cross and Blue Shield introduced a new feature on Interactive Care Reviewer (ICR) that lets you request a clinical appeal for denied authorizations. Now instead of making a phone call or sending a fax, you can save time making your request online! This

feature is available for authorization requests that were submitted through ICR, phone or fax.

Here's how easy it is to request a clinical appeal using ICR:

Logon to ICR from the Availity Portal and locate the case from ICR's dashboard – **My Organization Requests** or through **Check Case Status** if the case was submitted by phone or fax.

- Select the **Request Tracking ID** link to open the case. If the case is eligible for an appeal you will see the **Request Appeal** menu option on the **Case Overview** screen.
- Select **Request Appeal** to open the **Appeal Details** screen and complete the required fields on the appeal template. (You also have the option of uploading attachments and images to support your request.)
- Select **Submit**.

Want to check the status of your clinical appeal?
The Check Appeal Status feature was added to ICR in December 2018.

- Select **Check Appeal Status** from the ICR top menu bar.
- Type the **Appeal Case ID** and **Member ID** in the allocated fields (do not include the alpha/numeric prefix).
- Select **Submit.**

The appeal status and detail of the decision will open on the bottom of the screen. Additionally, you will be able to access letters associated with the appeal.

Need more information on how to navigate the new ICR Appeals features?
Download the *ICR Clinical Appeals Reference Guide* located on the Availity Portal. Select: **Payer Spaces > Applications > Education and Reference Center > Communication and Education**. Find the link to the reference guide below the ICR menu.

Additional Training
If you are new to ICR or want to get a refresher please attend our monthly ICR webinar.
Register here for the April webinar.

UM Process Change: Courtesy approval determination notifications

Effective April 15, 2019, the Indiana and Ohio local Utilization Management (UM) departments will no longer call providers with courtesy approval determinations.

You can find this information on the Interactive Care Reviewer (ICR), Anthem's online authorization tool. Access to ICR is available exclusively on the Availity Portal.

Is it your first time using ICR on the Availity Portal?
Contact your Availity Administrator and request to be assigned the *Authorization and Referral Inquiry* role. Once you have the role assignment you can immediately access ICR, just log onto Availity and select **Patient Registration > Authorizations & Referrals**. Then choose **Auth/Referral Inquiry**.

Locate the case status and all available provider letters affiliated with the case in a few easy steps.

- **Check Case Status** is the menu item on the ICR tool that you'll use to locate authorization requests associated with your organization's tax ID that were submitted by ICR, phone or fax.
- You have three choices to conduct your search: **By Member**, **By Reference Authorization Request Number** or **By Date Range**. Each search option has required fields and will give you one or more results.
- Once you find the case, select the **Request Tracking ID**. You will land on the *Case Overview* screen. Expand the **Letters Summary** section and select the link to open, save or print a PDF of provider letters associated with the case, including approval determinations.
- Additionally, you can expand the **Service Details** section to view the case decision.

Need more information on how to navigate the inquiry features on ICR?

- Download the *Interactive Care Reviewer Authorization Inquiries Reference Guide* located on the Availity Portal. Select: **Payer Spaces > Applications > Education and Reference Center > Communication and Education**. Find the link to the reference guide below the ICR menu.

Additional Training

- If you are new to ICR or want to get a refresher please attend our monthly ICR webinar. **Register Here** for the next webinar.

Please note: As required, Anthem will continue to provide verbal approval determinations for any Ohio HMO/HIC products

Anthem Commercial Risk Adjustment (CRA) Reporting Update: Accurate coding helps provide a comprehensive picture of patients'

health and services provided

In a continuation of our CRA reporting update in March 2019, Anthem Blue Cross and Blue Shield requests your assistance with respect to our Commercial Risk Adjustment (CRA) reporting processes. There are **two approaches that we take (Retrospective and Prospective) that work to improve risk adjustment reporting accuracy.** We are focusing on performing appropriate interventions and chart reviews **for patients with undocumented Hierarchical Condition Categories (HCC)**, **to close the documentation and coding gaps that we are seeing with our members enrolled in** our Affordable Care Act (ACA) compliant plans.

With both our **Prospective and Retrospective approaches,** accurate documentation and coding are what we are encouraging physicians to achieve. As a physician for our members with ACA compliant plans, you play a vital role in the success of our CRA reporting processes and ACA compliance. **When members visit your office, we encourage you to document ALL of the members' health conditions, especially chronic diseases on the claim. As a result, there will be ongoing documentation that indicates these conditions are being properly assessed and managed. Additional benefits of accurate coding include:**

- **Reduced volume in medical chart requests in the future due to the increased level of specificity in documentation and coding, as part of our Retrospective approach; and**

- **Reduced volume of health assessment requests by ensuring your patients with our ACA compliant plans are seen for their annual exams each and every year, as part of our Prospective approach.**

Please Note: It's important to ensure that all diagnosis codes captured in your EMR system are included on the claims, and are not being truncated by your claims software management system. For example, some EMR systems may capture up to 12 diagnosis codes, but a claim system may only have the ability of capturing 4. If your claim system is truncating some of the listed diagnosis codes, please work with your vendor/clearing house to ensure all codes are being captured.

Reminder about ICD-10 CM coding

As you may be 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, Anthem 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.
- Include all chronic historical codes, as they must be documented each year under the ACA (e.g. an amputee must be coded each and every year even if the visit is not addressing the amputated limb specifically).

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

You want what's best for your patients' health. So, it's challenging when a patient doesn't follow your prescribed treatment plan. Why do 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—the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline—the Titanic-sized, often invisible, patient self-talk that may not get discussed—can create a misalignment between patient and provider.

So we've created an online learning experience for the skills and techniques that may 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 CME credit along the way.

Take the next step. To enhance your skills, go to **MyDiversePatients.com** **> *The Medication Adherence Iceberg: How to navigate what you can't see***. 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

Medical Policy and Clinical Guidelines Updates - April 2019*

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were reviewed on January 24, 2019 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

The current Clinical Guidelines and/or Medical Policies listed below were reviewed and updates were approved.

**Precertification required*

Title	Change	Effective date
CG-SURG-94 Keratoprosthesis	• Content moved from SURG.00115	3/21/19
*CG-SURG-95 Sacral Nerve Stimulation and Percutaneous Tibial Nerve Stimulation for Urinary and Fecal Incontinence; Urinary Retention	• Content moved from SURG.00117 • Previous title: Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence; Urinary Retention	3/21/19
MED.00110 Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting	• Added bioengineered autologous skin-derived products (for example, SkinTE) as Investigational and not medically necessary for all indications. • Existing HCPCS code Q4200 for Skin TE will be considered Investigational & Not Medically Necessary	7/1/19
MED.00126 Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders	• Added nasal nitric oxide as Investigational & Not medically necessary in the diagnosis and monitoring of asthma and other respiratory disorders	7/1/19

*SURG.00037 Treatment of Varicose Veins (Lower Extremities)	• Replaced "non-surgical management" with "conservative therapy" in the MN criteria • Added sclerotherapy used in conjunction with a balloon catheter (for example, KAVS procedure) as INV&NMN • Existing CPT Category III code 0524T will be considered as Investigational & Not Medically Necessary	7/1/19
TRANS.00035 Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases	• Previous title: Mesenchymal Stem Cell Therapy For Orthopedic Indications • Expanded the document's scope to address non-FDA approved uses of mesenchymal stem cell therapy • Revised Position Statement: "Mesenchymal stem cell therapy is considered Investigational & Not medically necessary for the treatment of joint and ligament disorders caused by injury or degeneration as well as autoimmune, inflammatory and degenerative diseases"	7/1/19

The new Medical Policy below will become effective 7/1/19

Title	Change	Effective date
Lab.00036 Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus	• Multiplex autoantigen microarray testing to screen for, diagnose, or manage systemic lupus erythematous is considered Investigational & Not Medically Necessary • Existing PLA code 0062U will be considered Investigational & Not Medically Necessary	7/1/19

Update to AIM Advanced Imaging of the Heart Clinical Appropriateness Guideline*

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Clinical Appropriateness Guidelines for Advanced Imaging of the Heart and AIM Clinical Appropriateness Guidelines for Arterial Ultrasound.

Advanced Imaging of the Heart

- Resting Transthoracic Echocardiography (TTE)
    - o Changes made to address frequency of surveillance of LV function for cardio-oncology.

- TTE
    - o Changes made to address frequency of surveillance echocardiography following transcatheter mitral valve repair. These recommendations follow CMS guidelines.

Arterial ultrasound

- Upper extremity arterial duplex
    - o Indication added for creation of arteriovenous (AV) fistulae for dialysis

- Lower extremity arterial duplex
    - o ACC guideline for management of peripheral arterial disease (2016) indicates that Duplex imaging should be performed only after the decision to revascularize has been made. There is no role for duplex imaging in the initial diagnosis of peripheral arterial disease. The current AIM guideline is not aligned with this position and the proposed changes address that malalignment.
    - o Language changed to account for the fact that critical limb ischemia should include patients with non-healing ulcers and gangrene

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- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number at (800) 554-0580, Monday through Friday, 8:30 a.m. to 7:00 p.m. ET.

Please note, this program does not apply to FEP.

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

Update to AIM Advanced Imaging of the Head and Neck Clinical Appropriateness Guidelines*

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Advanced Imaging of the Head and Neck Clinical Appropriateness Guidelines.

Sinusitis/rhinosinusitis

- Expanded the scope of complicated sinusitis
- Defined a minimal treatment requirement for uncomplicated sinusitis
- Identified reasons for repeat sinus imaging, aligned with Choosing Wisely
- Subacute sinusitis to be treated as more like acute or chronic rhinosinusitis based on the AAO-HNS acute sinusitis guideline
- Defined indications for preoperative planning for image navigation following a clinical policy statement on appropriate use from the AAO-HNS
- Removed CT screening for immunocompromised patients

Infectious disease – not otherwise specified

- Added MRI TMJ to this indication

Inflammatory conditions – not otherwise specified

- Allow MRI TMJ for suspected inflammatory arthritis following radiographs

Trauma

- Radiograph requirement for suspected mandibular trauma
- MRI TMJ in trauma for suspected internal derangement in surgical candidates

Neck mass(including lymphadenopathy)

- Align adult neck imaging guideline with AAO-HNS guideline
- Expand definition of neck mass beyond palpable (seen on laryngoscopy)
- Allow imaging for pediatric neck masses when initial ultrasound is not diagnostic

Parathyroid adenoma

- Further defined the patient population that needs evaluation
- Removed the requirement for aberrant anatomy in preoperative planning
- Position CT as a diagnostic test after both ultrasound and parathyroid scintigraphy
- Remove MRI as a modality to evaluate based on lack of evidence

Temporomandibular joint dysfunction

- Removed standalone “frozen jaw” indication
- Allow ultrasound in addition to radiographs as preliminary imaging
- Allow advanced imaging without preliminary radiographs or US in the setting of mechanical signs or symptoms
- Changed “Panorex” to “Radiographs” to allow for TMJ radiographs
- Added requirement for conservative treatment and planned intervention for suspected osteoarthritis

Cerebrospinal fluid (CSF) leak of the skull base

- Added modalities and criteria to evaluate for CSF leak

Dizziness or vertigo

- Add Tullio's phenomenon for lateral semicircular canal dehiscence
- Expand definition of abnormal vestibular function testing

Hearing loss

- Added indication for sudden onset hearing loss in adult patients
- More clearly delineated appropriate modalities based on types of hearing loss in pediatric patients
- Allow either CT or MRI for mixed hearing loss

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- Access AIM via the Availity Web Portal at availity.com
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Update to AIM Musculoskeletal Joint Surgery Clinical Appropriateness Guidelines*

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Joint Surgery Clinical Appropriateness Guidelines.

General Requirements

- Conservative management: For joint arthroplasty, clarification of

conservative management options provide allowance for conservative management exception. Add intraarticular corticosteroid injections as an option. Remove ice or heat given that it is commonly performed in all patients and hence does not meet the threshold for a non-operative management modality as intended. Addition of physical therapy or home therapy requirement for all non-arthroplasty joint procedures based on preponderance of benefit over harm to conservative care. Remove MOON protocol conservative care requirement throughout the document based on feasibility and standards of practice

- Reporting of symptom severity: Inability felt too restrictive to allow for difficulty performing
- Tobacco Cessation: removed nicotine-free documentation requirement

Subacromial Impingement Syndrome (without Rotator Cuff Tear)Cervical Decompression with or without Fusion

- Drop Arm Test removed due to lack of diagnostic accuracy for subacromial impingement

Synovectomy/Debridement

- New indication for synovectomy/debridement based on review of the evidence and common clinical scenarios

Tendinopathy of the Long Head of the Biceps – Tenodesis or Tenotomy

- Allows both techniques based on no evidence for net benefit of one over the other
- Allow a broader range of clinical symptoms and a lower threshold for imaging evidence of tendinopathy , no requirement for MR evidence as tendinopathy can be a clinical diagnosis

Primary Total Hip Arthroplasty

- Addition of fracture management and hip arthrodesis

Revision Total Hip Arthroplasty

- Addition of appropriate clinical scenarios based on clinical practice

experience and evidence, align terminology to that used in the literature

Resection Arthroplasty of the Hip, Femoral Head Ostectomy, or Girdlestone Resection Arthroplasty

- Addition of appropriate clinical scenarios based on clinical practice experience (limited evidence)

Hip Arthroscopy

- Expanded appropriate techniques for FAI surgery to include acetabuloplasty and femoroplasty

Arthroscopic Treatment of FAIS

- Radiographic and clinical criteria added to include symptoms related to FAI and the likelihood that surgery will be successful

Elective Patellofemoral Arthroplasty

- New guideline for patellofemoral arthroplasty, a unicompartmental procedure based on evidence and standards of practice

Revision of Prior Knee Arthroplasty

- Addition of appropriate clinical scenarios based on clinical practice experience and evidence, align terminology to that used in the literature

Meniscal Repair or Meniscectomy

- Conservative requirement for degenerative meniscus tears
- Definition of acute meniscal tear and symptomatology
- More restrictive use of partial meniscectomy associated with osteoarthritis and degenerative tears

Arthroscopically assisted lysis of adhesions

- New guideline based on evidence and clinical consensus

Manipulation under anesthesia

- New guideline based on evidence and clinical consensus

In-Office Diagnostic Arthroscopy (mi-eye 2™)

- Not medically necessary based on lack of evidence for net benefit

Meniscal Allograft Transplantation of the Knee

- Collagen meniscal implants are considered not medically necessary

Treatment of Osteochondral Defects

- New criteria for talar OCD based on lesion size and prior procedures

Autologous chondrocyte implantation (ACI)

- Allow patellar surface ACI based on evidence for non-inferiority relative to trochlear surface lesions

CPT Code additions

- CPT codes 27120, 27122, 27437, 27445, 27488, 29871, G0428, 28446, and 29892

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

of the current guidelines here.

Update to AIM Sleep Disorder Management Clinical Appropriateness Guidelines*

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Sleep Disorder Management Clinical Appropriateness Guidelines.

- Reconfigured structure of BPAP with and without back-up rate feature criteria for patients with established central sleep apnea (CSA)
- Removed the criteria to try rate support for CSA

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- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number at (800) 554-0580, Monday through Friday, 8:30 a.m. to 7:00 p.m. ET.

Please note, this program does not apply to FEP.

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

New Reimbursement Policy: Partial Hospitalization Program and Intensive Outpatient Program Services Facility*

Beginning with dates of service on or after July 1, 2019, Anthem Blue Cross and Blue Shield will implement the new facility reimbursement policy, Partial Hospitalization Program and Intensive Outpatient Program Services. This policy applies a limit of one (1) unit of service per day for partial hospitalization program and/or intensive outpatient programs. For more information about this new policy, click on the link listed below for the reimbursement policy webpage for your state or visit the anthem.com provider website.

Indiana facility reimbursement policies
Kentucky facility reimbursement policies
Missouri facility reimbursement policies
Ohio facility reimbursement policies
Wisconsin facility reimbursement policies

Update regarding evaluation and management with modifier 25

Anthem Blue Cross and Blue Shield (Anthem) has identified that providers often bill a duplicate Evaluation and Management (E/M) service on the same day as a procedure even when the same provider (or a provider with the same specialty within the same group TIN) recently billed a service or procedure which included an E/M for the same or similar diagnosis. The use of modifier 25 to support separate payment of this duplicate service is not consistent with correct coding or Anthem's policy on use of modifier 25.

Beginning with claims processed on or after May 1, 2019 Anthem may deny the E/M service with a modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record.

If you believe a claim should be reprocessed because there are medical records for related visits that demonstrate an unrelated, significant and separately identifiable E/M service, please submit those medical records for consideration.

Coming soon: Reimbursement for select HEDIS-related CPT II codes for Medicare Advantage members

CPT Category II codes are supplemental tracking codes used to support quality patient care and performance management. CPT II codes are:

- Billed in the procedure code field in the same way as CPT Category I codes.
- Used to describe clinical components usually included in evaluation, management or clinical services.
- Billed with a $0 billable charge amount since they are not usually associated with any relative value.

Under this new incentive program, Anthem will reimburse contracted Medicare Advantage providers for submitting select HEDIS®-related CPT Category II codes for eligible members.

Using these CPT Category II codes for Medicare Advantage members will:

- Help providers address clinical care opportunities.
- Facilitate timely and accurate claims payments.

Detailed information about this program, including a list of applicable codes, will be sent to providers.

Keep up with Medicare news - April 2019

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