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Notice of Changes to Prior Authorization Requirements -- June 2019

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

Medical Policies and Clinical Guidelines

- Medical Policy and Clinical Guideline Updates - June 2019*
- New Clinical Guideline: Inpatient Inter-Facility Transfers effective September 1, 2019*

Reimbursement Policies

- New Reimbursement Policy: Ambulance Transportation – Professional*
- Reimbursement Policy Update: Frequency Editing – Professional*

Pharmacy Updates

- Anthem expands specialty pharmacy prior authorization list*
- Anthem announces changes in medical non-oncology specialty drug reviews effective June 15, 2019

Other Important Updates

- AIM programs may require additional prior authorization documentation*
- Medicare and Medicaid News

Reminder and update: new Rehabilitative Program effective July 1, 2019

As previously communicated in the April 2019 provider newsletter, AIM Specialty Health® (AIM), a separate company, will begin to perform prior authorization review of rehabilitative (restoring function) and habilitative (enhancing function) services for **Anthem Blue Cross and Blue Shield (Anthem) commercial fully insured members beginning July 1, 2019**. Currently, OrthoNet LLC is performing medical necessity reviews for physical and occupational therapy services for Anthem. These reviews, in addition to speech therapy service reviews, will transition to AIM.

The AIM Rehabilitative Program began April 1, 2019 for Anthem Medicaid members in Indiana and Wisconsin.

AIM will manage Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)

medical necessity reviews and will require prior authorization for all outpatient facility and office-based rehabilitative and habilitative services following the initial evaluation. AIM will use the following Anthem Clinical UM Guidelines:

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

The clinical criteria used for these reviews can be found on our anthem.com Clinical UM Guidelines page. A complete list of CPT codes requiring prior authorization for the AIM Rehabilitative Program is available on the AIM Rehabilitation microsite. There you can access additional helpful information such as order entry checklists and FAQs.

AIM will now begin accepting prior authorization requests on **June 24, 2019** for dates of service on and after 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 800-554-0580, 8:30 a.m.–7:00 p.m. ET.

Need training?
Anthem invites you to take advantage of an informational webinar that will introduce you to the Rehabilitative Program and the robust capabilities of the AIM **Provider***Portal*SM. Visit the AIM Rehab microsite to register for an upcoming training session.

Anthem expands specialty pharmacy prior authorization list*

Effective for dates of service on and after September 1, 2019, the following specialty pharmacy codes from new or current clinical criteria or 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.

The following clinical criteria or guideline will be effective September 1, 2019.

Clinical Criteria/ Guideline	HCPCS or CPT Code(s)	NDC Code(s)	Drug
CG-DRUG-98	C9042 J9999	42367-0520-25	Belrapzo™
ING-CC-0088	C9399 J9999	72187-0401-01	Elzonris™
ING-CC-0087	C9399 J3590	72171-0501-01 72171-0505-01	Gamifant®
ING-CC-0041	C9399 J3590	25682-0022-01	Ultomiris™
ING-CC-0086	J3490	50458-0028-00 50458-0028-02 50458-0028-03	Spravato™

Anthem announces changes in medical non-oncology specialty drug reviews effective June 15, 2019

We continue to streamline our medical specialty drug reviews by transitioning another drug review process from AIM Specialty Health® (AIM) to Anthem Blue Cross and Blue Shield (Anthem)'s medical specialty drug review team.

As a reminder, beginning on January 2019, providers are able to visit the Pharmacy Information page to review clinical criteria for all injectable, infused or implanted prescription drugs.

What is changing?
Beginning on June 15, 2019, for all requests, regardless of service date, providers will need to submit a new prior authorization request by contacting Anthem's medical specialty drug review team:

- By phone at 1-833-293-0659 or
- By fax at 1-888-223-0550 or
- Online access at www.Availity.com available 24/7.

All inquiries about an existing request (initially submitted to AIM or Anthem), peer-to-peer review, or reconsideration will be managed by Anthem's medical specialty drug review team.

What is not changing?

- AIM will continue to be responsible for performing **medical oncology drug** reviews for existing commercial medical benefit for our employer group business.

- Medical policies and clinical guidelines **for non-drug specialty topics** will continue to reside on the Policies webpage on anthem.com.
- Post Service Clinical Coverage Reviews and Grievance and Appeals process and teams will not change.

For your convenience here is a summary of the medical specialty drug changes:

Prior to June 15, 2019

Action	Contact
Submit a new prior authorization request Inquire about an existing request	Call AIM at 866-714-1107, 8 a.m. – 5 p.m. *or* Access online at www.availity.com available 24/7

Beginning June 15, 2019

Action	Contact
Submit a new prior authorization request for medical specialty drug reviews	Call Anthem at 1-833-293-0659 or fax us at 1-888-223-0550 *or* Access online at www.availity.com available 24/7
Inquire about an existing request (initially submitted to AIM or Anthem, peer-to-peer review, or reconsideration	Call Anthem at 1-833-293-0659

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
- 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.

AIM programs may require additional prior authorization documentation*

Providers currently submit prior authorization requests to AIM Specialty Health® (AIM) for outpatient diagnostic imaging services, cardiac procedures and sleep studies. As part of our ongoing quality improvement efforts, we want you to know that certain review requests require documentation that supports the clinical appropriateness of the request to be uploaded during the intake process.

When requested, providers must submit documentation from the patient's medical record and/or participate in a prior authorization consultation with an AIM physician reviewer. If medical necessity is not supported through documents submitted, the request may be denied as not medically necessary.

Anthem Commercial Risk Adjustment (CRA) Reporting Update: Retrospective Program begins; benefits of direct connection access to your EMR

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

As a reminder, there are **two approaches that we take (Retrospective and Prospective) 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.

This month we'd like to focus on the Retrospective approach, and the request to our Providers:

As a reminder from our March newsletter, the Retrospective Program focuses on medical chart collection. We continue to request members' medical records to obtain undocumented

HCC's. This particular effort is part of Anthem's compliance with provisions of the ACA that require our company to collect and report diagnosis code data for our ACA membership. The members' medical record documentation helps support this data requirement.

2019 chart collection is about to begin
Retrospective chart collection begins in June and is known as Round 1. Round 2 follows in November, which is our primary chase and largest volume of requests. Round 3 is our last chart collection period and begins in January, 2020.

Electronic options for chart collections
Submitting medical charts to payers is extremely burdensome and time consuming for your staff. Utilizing an electronic option can alleviate the constraints on both staff resources and time.

1.) Remote/Direct Anthem Access
The most efficient electronic option is to allow the Anthem medical coder team to have direct connection access to your EMR system, so that we may retrieve the records ourselves. Our team has collaborated with several Providers and Facilities to have direct access to their EMR system so we collect the charts within our own team. This allows for no vendor interventions and fewer handoffs of the records. *To address compliance concerns, please note that as a health plan, Anthem is a covered entity under the HIPAA Privacy Rule and is bound to protect PHI.*

Benefits of providing EMR direct connection access

- Your Medical Records staff resources would be minimally contacted for the charts we are requesting
    - o Depending on your EMR system, requests may also be handled electronically through "push" notifications
- Your Medical Records staff will release only those records we request into the EMR queue for which we have access
- Cost savings from less administrative impact on staff, as well as, no paper copying costs incurred
- Better privacy/security measures for not having to save the medical record to a desktop and then copy/save before transmittal

2.) EMR Interoperability -- we have electronic options already in place for the following EMR systems:

- Allscripts (Opt in - signature required -- please work directly with the CRA Representative for your region)
- NextGen (Opt out - auto-enrolled)

- Athenahealth (Opt out - auto-enrolled)
- MEDENT (Opt in - signature required -- please work directly with the CRA Representative for your region)

3.) Inovalon virtual visit or onsite -- Inovalon will work directly with your office to utilize electronic connectivity for a virtual visit, or they will have their staff go into the office for medical record retrieval based on a scheduled time that is convenient.

4.) Secure FTP -- Set up directly with our vendors as a temporary secure FTP to transfer medical records.

If you are interested in any of these electronic options, or would like to grant our Anthem medical coders with direct access to your EMR, please contact our CRA Representative Natalie.Wilder@anthem.com

Thank you for your continued efforts with our CRA Program, and expediting these medical chart collection requests that will begin soon.

Find A Doctor -- New Sort Option

Anthem Blue Cross and Blue Shield (Anthem)'s Find A Doctor tool provides Anthem members with the ability to search for in-network providers using the member portal at anthem.com. Find A Doctor currently offers multiple sorting options, such as sorting providers based on distance or name.

In May 2019, Anthem added a new sorting option to Find A Doctor. The new sorting option is called "Personalized Match" and is based on algorithms which use a combination of provider location, quality, cost results and member information to intelligently sort and display results for a member's search. The sorting results take into account member factors such as the member's medical conditions, and medications as well as provider factors such as areas of specialty, quality and efficiency measures, volumes of patients treated across various disease conditions, and outcome-based quality measures. These member and provider features combine to generate a unique ranking of providers for each member conducting the search. Providers with the highest overall ranking within the search radius are displayed first with other providers displayed in descending order based on overall rank and proximity to the center of the search radius. Members will continue to have the ability to sort from a variety of sorting orders (such as distance), and this enhancement in sorting methodology will have no impact on member benefits.

Please note, the sorting option "Personalized Match" has been available on Care and Cost

Finder since November 12, 2018.

Additional information about Personalized Match:

- Provider factors will be updated on a quarterly basis.
- Providers may review a copy of the sorting methodology here.
- If you have general questions about this sorting option in Find A Doctor and the Care and Cost Finder tool, please contact Provider Customer Service.
- If you would like detailed information about quality or cost factors used as part of this unique sorting or you would like to request reconsideration of those factors you may do so by emailing personalizedmatchsorting@anthem.com or by calling 833-292-2601.

Anthem will continue to focus and expand our consumer tools and content to assist members in making more informed and personalized health care decisions.

Coming Soon: Anthem Electronic Attachments

As we prepare for potential regulatory proposed standards for electronic attachments, Anthem Blue Cross and Blue Shield (Anthem) will be implementing what is called the X12 275 5010 version of electronic attachments transactions for claims.

Standard electronic attachments will bring value to you by eliminating the need for mailing paper records and reduced processing time overall.

Anthem and Availity will be piloting Electronic Data Interchange (EDI) batch electronic attachments with previously selected providers. Both solicited and unsolicited attachments will be included in our pilots.

Solicited Attachment
Provider sends a claim, and the payer determines there is insufficient information to process the claim. Payer then sends the provider a request for additional information (currently via letter). Provider can then send the solicited attachment transaction with the documentation requested to process the claim.

Unsolicited Attachment
When the provider knows that the payer requires additional information to process the claim, the provider then sends the X12 837 claim with the “Paper Work Included” (PWK) segment tracking number. Next, the provider sends the X12 275 attachment transaction with the additional information and includes the tracking number that was sent on the claim for matching purposes.

What you can do now
We encourage you to start having conversations with your Clearinghouse and/or Electronic Healthcare Records (EHR) vendor to determine their ability to set up the X12 275 attachment transaction capabilities.
Look for more information about the general availability of this time-saving option later this summer and details on how to work with Anthem and Availity to send your attachments via electronic batch.

New ICR Immediate Decision List posted on Availity Payer Spaces

The Interactive Care Reviewer (ICR), our online authorization tool offers a real time authorization decision for some inpatient and outpatient authorization requests. Recently we updated the list of services that may result in an immediate authorization decision.

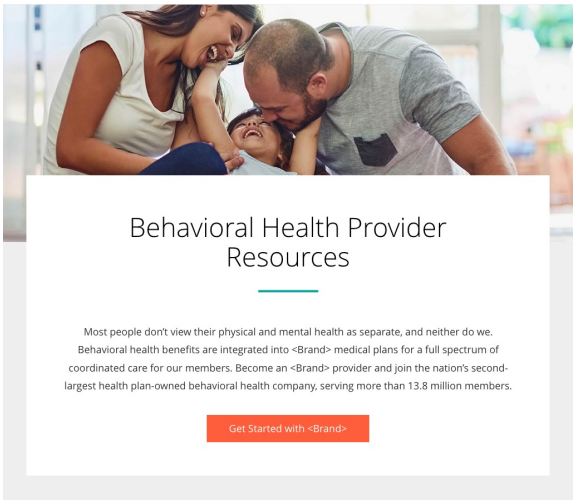
To locate the Immediate Decision list* and review the specific details on those services, go to the Availity Portal and select **Payer Spaces** then choose the Anthem BCBS logo. Scroll down and select **Education and Reference Center | Communication & Education**. From the Communication & Education dropdown menu, select **Interactive Care Reviewer | ICR Immediate Decision List.**
Access ICR from the Availity Portal, select **Patient Management** | **Authorizations & Referrals**. To request an authorization you will need to have the Authorization Referral Request Role assigned to you by your Availity administrator.

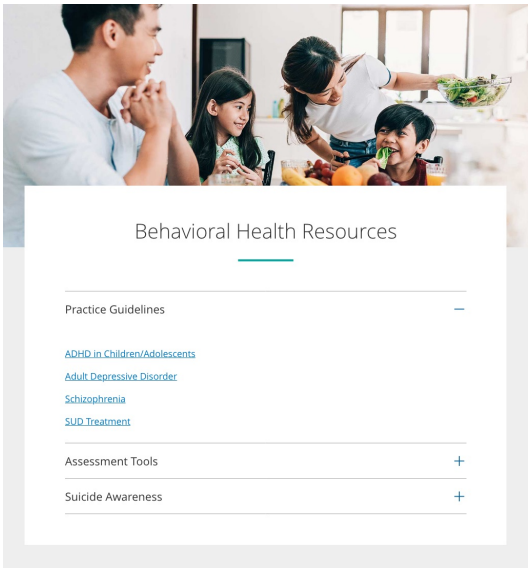
Attend one of our upcoming webinars and learn about the features that will help you to optimize your ICR experience! Register here.

*Excludes: some Medicare Advantage, some Medicaid, Federal Employee Program® (FEP), BlueCard® and some National Account members
Requests involving transplant services
Services administered by vendors such as AIM Specialty Health
Services administered by OrthoNet LLC (Indiana ,Kentucky ,Missouri, Ohio, Wisconsin, California, Colorado and Nevada)
For the above requests, follow the same precertification process that you use today.

Anthem launches additional changes to anthem.com for Q2

This quarter, anthem.com will release more exciting enhancements to the public provider site. The next wave of changes includes a new Behavioral Health page that will provide easy and clear access to content and resources, including newsletters, collaboration documents, and other relevant information for providers. The image below illustrates the new Behavioral Health page.





We will continue to provide updates as we move forward with migrating content to the new provider pages.

Medical Policy and Clinical Guideline Updates -- June 2019*

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were reviewed on March 21, 2019 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Below are 2 new Medical policies

*NOTE *Precertification required*

Title	Information	Effective Date
*GENE.00050 Gene Expression Profiling for Coronary Artery Disease	• The use of gene expression profiling for coronary artery disease is considered Investigational and Not Medically Necessary (INV&NMN) • Moved the Corus CAD test from GENE.00043 o CPT code 81493 moved from GENE.00043 to this new document	9/1/19

*SURG.00152 Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing	• Wireless CRT for left ventricular pacing is considered INV&NMN for all indications, including heart failure. o CPT Category III codes 0515T, 0516T, 0517T, 0518T, 0519T, 0520T, 0521T, 0522T will be considered INV&NMN	9/1/19

These current Clinical Guidelines and/or Medical policies were reviewed and updates were approved

NOTE *Precertification required

Title	Change	Effective Date
CG-GENE-06 Preimplantation Genetic Diagnosis Testing	• Content moved from GENE.00002 • INV&NMN changed to not medically necessary as a result of MP to CUMG transition	5/9/19
CG-GENE-07 BCR-ABL Mutation Analysis	• Content moved from GENE.00005 • INV&NMN changed to NMN as a result of MP to CUMG transition	5/9/19
*CG-GENE-08 Genetic Testing for PTEN Hamartoma Tumor Syndrome	Content moved from GENE.00031 • INV&NMN changed to NMN as a result of MP to CUMG transition	5/9/19
CG-GENE-09 Genetic Testing for CHARGE Syndrome	• Content moved from GENE.00040 • INV&NMN changed to NMN as a result of MP to CUMG transition	5/9/19
*CG-SURG-97 Cardioverter Defibrillators	• Content moved from SURG.00033 • INV&NMN changed to NMN as a result of MP to CUMG transition CPT codes 33270, 33271 for subcutaneous ICD will be considered always NMN (were INV&NMN)	6/24/19
*CG-SURG-99 Panniculectomy and Abdominoplasty	• Content moved from SURG.00048 • Clarified that document only addresses liposuction when used for the removal of excess abdominal fat • Clarified Cosmetic and Not medically necessary (COS&NMN) statement addressing repair of diastasis recti	5/9/19

CG-DME-44 Electric Tumor Treatment Field (TTF)	• Added the use of enhanced computer treatment planning software (such as NovoTal) as NMN in all cases No specific code for this software; part of code for treatment planning 77299 (NOC)	9/1/19
CG-MED-72 Hyperthermia for Cancer Therapy	• Clarified MN and NMN statements addressing frequency of treatment	9/1/19
*CG-SURG-09 Temporomandibular Disorders	• Clarified MN and NMN criteria and removed requirement for FDA approval of prosthetic implants Added HCPCS codes D9130, D9920 for TMJ non-invasive therapies, behavior management as additional examples of TMJ procedures, removed D9940 (deleted)	9/1/19
*GENE.00043 Genetic Testing of an Individual's Genome for Inherited Diseases	• Removed INV&NMN statement and all other language and coding related to Corus CAD testing • Corus CAD testing now addressed in GENE.00050 Removed CPT code 81493 for Corus CAD; added existing CPT codes 81205, 81250, 81302, 81303, 81304, 81331, 81332, S3850 and Tier 2 codes 81400, 81401, 81402, 81407 which will now be reviewed for MN or INV&NMN; also added applicable genes to Tier 2 code	9/1/19
*GENE.00012 Preconception or Prenatal Genetic Testing of a Parent or Prospective Parent	Added existing CPT codes 81205, 81250, 81302, 81303, 81304, 81331, 81332, S3850 and Tier 2 codes 81400, 81401, 81402, 81407, 81408 which will now be reviewed for MN or INV&NMN; also added applicable genes to Tier 2 codes	9/1/19
*CG-GENE-01 Janus Kinase 2, CALR, and MPL Gene Mutation Assays Previous title: Janus Kinase 2 (JAK2)V617F and JAK2 exon 12 Gene Mutation Assays	Revised title • Reformatted MN clinical indications • Added CALR and MPL gene mutation testing as MN when criteria are met • Added CALR and MPL gene mutation testing as NMN when MN criteria are not met Added CPT Tier 1 code 81219 and Tier 2 code 81402 for MPL and CALR genes to pend for review of criteria	9/1/19

MED.00101 Physiologic Recording of Tremor using Accelerometer(s) and Gyroscope(s)	Added CPT Category III codes 0533T, 0534T, 0535T, 0536T described as 'non-invasive kinetigraphy' (Note codes effective 01/01/19)	9/1/19
SURG.00139 Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery with Radiofrequency Spectroscopy or Optical Coherence Tomography	Added CPT Category III code 0546T which will be effective 07/01/19 for assessment of margins using radiofrequency spectroscopy	9/1/19

New Clinical Guideline: Inpatient Inter-Facility Transfers effective September 1, 2019*

Anthem Blue Cross and Blue Shield (Anthem) will implement the following clinical guideline **effective September 1, 2019** to support the review for unnecessary inter-facility transfers. This guideline impacts our commercial PPO and HMO products.

The inpatient services addressed in this clinical guideline will require advance prior authorization before the inter-facility transfer.

Inpatient Inter-Facility Transfers (CG-ANC-07)

This guideline addresses the clinical features of a hospitalized individual who may require services unavailable at an initial acute care facility (originating facility) necessitating a transfer to a second acute care facility (receiving facility).

Inter-facility transfers are considered medically necessary when one or more of the following criteria are met:

- The individual requires a medically necessary diagnostic or therapeutic service (for example, organ transplantation) which is not available at the originating facility; or
- The individual requires a level of care (for example, neonatal care unit or level 1 trauma center) which is not available at the originating facility; or
- The individual requires the services of a specialist to evaluate, diagnose or treat his or her condition when that specialist is not available in a timely manner at the originating facility (Note: Timeliness of care is a case/individual specific attribute. It may be appropriate for a medically stable individual to await availability of a specialist for

several days while a medically unstable individual may require care more quickly); or
- The individual has received care at a specific prior institution for a condition not normally managed at the originating facility (for example, organ transplant recipient) and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.

Inter-facility maternal transfer to allow birth mother to remain with neonate is considered medically necessary when neonate transfer meets the medically necessary criteria listed above and the birth mother requires continued hospitalization due to birth complications or other medically necessary conditions.

Inter-facility transfers between an originating facility and a receiving facility are considered not medically necessary when:

- The criteria above have not been met; or
- The services are primarily for the convenience of the individual, the individual's family, the physician or the originating facility.

New Reimbursement Policy: Ambulance Transportation -- Professional*

Beginning with dates of service on or after September 1, 2019, Anthem Blue Cross and Blue Shield (Anthem) will implement the new professional reimbursement policy, Ambulance Transportation. This policy allows reimbursement for ambulance transport and services and supplies associated with transport to the nearest facility equipped to treat the member. The policy details services that are included in the base rate, services reimbursed separately from the base rate, when ambulance response and treatment with no transport is reimbursable, and when services are not reimbursable.

For more information about this new policy, visit Anthem's professional reimbursement policies on anthem.com for your state.
Indiana: Reimbursement Policies-Professional
Kentucky: Reimbursement Policies-Professional
Missouri: Reimbursement Policies-Professional
Ohio: Reimbursement Policies-Professional
Wisconsin: Reimbursement Policies-Professional

Reimbursement Policy Update: Frequency Editing -- Professional*

The following changes will be made to Anthem Blue Cross and Blue Shield (Anthem)'s

Frequency Editing policy effective September 1, 2019:

- In the February 2018 edition of Network Update, we advised that we were revising our Frequency Editing policy to remove the frequency limits of one (1) per date of service and 18 per 365 days for definitive drug testing for **HCPCS codes G0482 and G0483**. Please note we are adding the language back into our policy dated September 1, 2019 to reflect that we still limit the frequency for these two codes.

- Beginning with dates of service on or after September 1, 2019, we will add a frequency limit of one (1) per date of service not to exceed one every three (3) years for **CPT code 81528** – *Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result, such as Cologuard®*

- Beginning with dates of service on or after September 1, 2019, the following language will be removed:

The Health Plan will apply per day frequency maximums based on the CPT/HCPCS codes listed on the CMS Medically Unlikely Edit (MUE) listing that have a per day MUE Medicare Adjudication Indicator (MAI) 2.

The policy will apply frequency maximums based on CMS Medically Unlikely Edit (MUE), industry standards and/or code description.

For more information about this Frequency Editing policy, visit Anthem's professional reimbursement policies on anthem.com for your state.
Indiana: Reimbursement Policies-Professional
Kentucky: Reimbursement Policies-Professional
Missouri: Reimbursement Policies-Professional
Ohio: Reimbursement Policies-Professional
Wisconsin: Reimbursement Policies-Professional

Keep up with Medicare News -- June 2019

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

- Medicare risk adjustment provider training
- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus
- Prior authorization requirements for DME repair and portable oxygen
- Submitting corrected claims
- 2019 Utilization Management Affirmative Statement concerning utilization management decisions

75743MUPENMUB

Review of professional claims with emergency department level 5 E&M codes

This article applies to Medicare Advantage members

Anthem Blue Cross and Blue Shield (Anthem) has identified an increased trend in billing emergency department level 5 evaluation and management (E&M) codes. To ensure documentation meets or exceeds the components necessary to support its billing, beginning September 1, 2019, Anthem will initiate post-pay reviews for emergency department professional claims billed with level 5 99285 or G0384. Emergency department professional claims with the highest potential for up-coding will be selected.

Anthem will request documentation for identified claims. Professional reviews will evaluate the appropriate use of the emergency department level 5 code based on the American Medical Association CPT coding manuals and Anthem guidelines. Reimbursement should be based on the emergency department E&M code the submitted documentation supports.

Please note, these coding reviews are not related to any prior notification reviews which examine the appropriate use of emergency departments for non-emergencies, nor do they include the examination of emergent versus non-emergent reasons patients utilize emergency room services.

ABSCRNU-0020-19

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. 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 prescribed[1]. 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.

ABSCRNU-0007-19

Medicaid News -- June 2019

Please continue to check Provider Communications & Updates on the provider website for the latest information, including:

- Why do patients stop taking their prescribed medications and what can you do to help them?
- Prior authorization requirement update
- 2019 Utilization Management Affirmative Statement concerning utilization management decisions

Latest updates to Electronic Data Interchange Gateway migration

This communication applies to the Medicaid and Medicare Advantage programs for Anthem Blue Cross and Blue Shield (Anthem) serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect and Medicare Advantage.

Anthem designated Availity to operate and serve as the electronic data interchange (EDI) entry point — also called the EDI Gateway. The EDI Gateway is a no-cost option for providers who choose to submit their own EDI claims to Anthem. Those who prefer to use a clearinghouse or billing company should work with them to ensure connectivity.

Note, it is required that all trading partners who currently submit directly to the Anthem EDI Gateway transition to the Availity EDI Gateway.

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

Becoming a trading partner with Availity
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 EDI transmissions with Anthem.

***835 Electronic Remittance Advices* (*ERA*)**
Use Availity to register and manage account changes for *ERA*. If you previously registered to receive *ERA*, you must register using Availity to manage account changes. To enroll for *835 ERA* delivery, log in to Availity and select My Providers > Enrollments Center > ERA Enrollment.

Electronic funds transfers (EFT)
To register or manage account changes for EFT, use the EnrollHub™ — a CAQH Solutions™ enrollment tool and secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

Need assistance?

- To access live and on-demand resources created just for you, log in to Availity and select **Help & Training | Get Trained**. In the *Availity Learning Center*, search for

song in the *Catalog*.
- The Availity Quick Start Guide can assist you with any EDI connection questions you may have.
- If you have additional questions, contact Availity Client Services at **1-800-AVAILITY** (**1-800-282-4548**) Monday through Friday between 8 a.m. and 7:30 p.m. ET.

AIN-NU-0099-19

Complex Case Management program

Managing illness can be a daunting task for our members. It is not always easy to understand test results or know how to obtain essential resources for treatment or who to contact with questions and concerns.

Anthem Blue Cross and Blue Shield is available to offer assistance in these difficult moments with our **Complex Case Management program**. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals working to support members, families, primary care physicians and caregivers. The Complex Case Management process utilizes the experience and expertise of the Case Coordination team to educate and empower our members by increasing self-management skills. The Complex Case Management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Member Services number located on the back of their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can contact us by phone at:

- Hoosier Healthwise: **1-866-408-6132**
- Healthy Indiana Plan: **1-844-533-1995**
- Hoosier Care Connect: **1-844-284-1798**

Case Management business hours are Monday through Friday from 8 a.m. to 5 p.m. ET.

AIN-NU-0110-19

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 underutilization. Our medical policies are available on our provider website at https://www.anthem.com/ca/provider/policies.

You can request a free copy of our UM criteria from our Medical Management department. Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the numbers listed below. To access UM criteria online, go to https://www.anthem.com/ca/provider/policies.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests by:

- Calling us at:
  - Hoosier Healthwise: **1-866-408-6132**
  - Healthy Indiana Plan: **1-844-533-1995**
  - Hoosier Care Connect: **1-844-284-1798**
- Faxing us at:
  - Inpatient medical fax: **1-866-406-2803**
  - Outpatient medical fax: **1-866-406-2803**
    - Pharmacy fax: **1-866-406-2803**
    - Behavioral Health inpatient fax: **1-877-434-7578**
  - Behavioral Health outpatient fax: **1-866-877-5229**

Have questions about utilization decisions or the UM process?
Call our Clinical team at the numbers below Monday through Friday from 8 a.m. to 5 p.m. ET:

- Hoosier Healthwise: **1-866-408-6132**
- Healthy Indiana Plan: **1-844-533-1995**
- Hoosier Care Connect: **1-844-284-1798**

AIN-NU-0110-19

Members' Rights and Responsibilities Statement

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, Anthem Blue Cross and Blue Shield has adopted a *Members' Rights and Responsibilities Statement*.

The *Members' Rights and Responsibilities Statement* is located within the provider manual.

AIN-NU-0110-19