July 2019 Anthem Provider News - Ohio

Notice of Material Changes/Amendments to Contract and Prior Authorization Changes -- July 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.

Clinical Guidelines

- Updates to AIM Advanced Imaging Clinical Appropriateness Guidelines*

Reimbursement

- Clinical Validation: Professional*
- Update to Provider UM reimbursement penalties and corresponding update to Provider Manual*

Other Important Updates

- **Pharmacy**: Clinical criteria updates for specialty pharmacy
- **FEP:** Anthem Federal Employee Health Benefit Program® (FEP) PPO Members will now require prior approval for specific Specialty Drugs and Site of Care

Medicare and Medicaid News

Reminder to providers: Fee schedule information

Fee Schedule information is confidential and proprietary to Anthem Blue Cross and Blue Shield (Anthem) in your Provider Agreement (the “Agreement”). The Agreement has general restrictions regarding disclosure of such confidential information.

For example, neither Anthem nor Provider may disclose confidential and proprietary information except:
1) as required by Regulatory Requirements;
2) upon the express written consent of the parties;
3) as required to perform the obligations of the Agreement; or
4) as required to deliver Health Services or administer a Health Benefit Plan.

Please refer to your specific Agreement for a complete list of disclosure restrictions.

Anthem provider agreements restrict the disclosure of confidential information, including Fee

Schedule information, to third-parties (e.g., consultants, lenders, legal advisors, and business advisors). Absent Anthem's written consent, those restrictions surrounding disclosure extends to those third parties that conduct business on behalf of providers.

Upon disclosure, all third parties are subject to the confidentiality requirements as set forth in the Agreement.

Disclosure of confidential and proprietary information, in violation of the terms of the Agreement, could subject Provider to penalties.

Update to Provider UM reimbursement penalties and corresponding update to Provider Manual*

Effective for dates of service beginning October 1, 2019, and after, Anthem Blue Cross and Blue Shield (Anthem) will increase the reimbursement penalty for failure to comply with the Utilization Management (UM) program's prior authorization requirements for services rendered to commercial plan members. Late prior authorizations, and late notices in the case of emergency admissions, are currently subject to a penalty and will be subject to the increase in the penalty. Failure to comply with Anthem's prior authorization requirements, and late notice requirements in the case of emergency admissions, will result in a 50% reduction in reimbursement to the Provider and Facility.

As a reminder, Anthem requires prior authorization prior to the delivery of certain elective services in both the inpatient and outpatient settings. For an emergency admission, prior authorization is not required; however, you must notify Anthem of the admission within the timeframe specified in the Provider Manual or as otherwise required by law, as failure to give timely notification for emergency admissions will also result in reimbursement penalties of 50% to providers and facilities.

Enforcement of the program requirement will lead to greater consistency in our processes. This notice updates Anthem's UM program reimbursement penalties and the corresponding sections of the Provider Manual effective October 1, 2019, to reflect this change to the reimbursement penalty for non-compliance. As a reminder, Providers and Facilities may not balance bill the member for any such reduction in payment.

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Anthem Works to Simplify Payment Recovery Process for National Accounts Membership

In our company'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.

Make the move to the Availity EDI Gateway today

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 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.

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

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 by emailing Natalie.Wilder@anthem.com.

Clinical criteria updates for specialty pharmacy

In the December 2018 newsletter, 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. You can go online to access the Clinical Criteria information.

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 prior authorization 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

Clinical Criteria coding updates for specialty pharmacy are available

Due to 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. These coding updates may result in a "not medically necessary" determination.

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

Clinical Criteria Document Number	Clinical Criteria Name
ING-CC-0073	Alpha-1 Proteinase Inhibitor Therapy

You can go online to access the Clinical Criteria information.

Updates to AIM Advanced Imaging Clinical Appropriateness Guidelines*

Effective for dates of service on and after September 28, 2019, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines.

Brain Imaging Guideline contains updates to the following:

- Infection
- Multiple sclerosis and other white matter diseases
- Movement disorders (Adult only)
- Neurocognitive disorders (Adult only)
- Trauma
- Pituitary adenoma
- Tumor
- Hematoma or hemorrhage – intracranial or extracranial

- Hydrocephalus/ventricular assessment
- Pseudotumor cerebri
- Spontaneous intracranial hypotension
- Abnormality on neurologic exam
- Ataxia
- Dizziness or Vertigo
- Headache
- Hearing loss
- Tinnitus

Extremity Imaging Guideline contains updates to the following:

- Congenital or developmental anomalies of the extremity (Pediatric only)
- Discoid meniscus (Pediatric only)
- Soft tissue infection
- Osteomyelitis
- Septic arthritis
- Bursitis
- Capitellar osteochondritis
- Fracture
- Patellar dislocation
- Patellar sleeve avulsion
- Trauma complications
- Bone lesions
- Soft tissue mass – not otherwise specified
- Lisfranc injury
- Labral tear – hip
- Labral tear – shoulder
- Meniscal tear and ligament tear of the knee
- Rotator cuff tear (Adult only)
- Avascular necrosis
- Lipohemarthrosis (Pediatric only)
- Paget’s disease – new multimodality indication
- General Perioperative Imaging (including delayed hardware failure) not otherwise specified

Spine Imaging Guideline contains updates to the following:

- Multiple sclerosis or other white matter disease
- Spinal infection
- Cervical injury
- Thoracic or lumbar injury

- Paget's disease
- Spontaneous (idiopathic) intracranial hypotension (SIH)
- Perioperative Imaging, including delayed hardware failure, not otherwise specified
- Neck pain (cervical)
- Mid-back pain (thoracic)

As a reminder, ordering providers may submit genetic testing 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.

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 on the Availity website.

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Clinical Validation: Professional*

Effective with dates of service on or after October 1, 2019, we will update our audit process for claims with modifiers used to bypass claim edits by conducting modifier reviews through a pre-payment clinical validation review process. Claims with modifiers such as -25, -59, -57, LT/RT, and other anatomical modifiers will be part of this review process.

In accordance with published reimbursement policies which document proper usage and submission of modifiers, the clinical validation review process will evaluate the proper use of these modifiers in conjunction with the edits they are bypassing (such as National Correct Coding Initiative). Clinical analysts who are registered nurses and coders will review claims pended for validation, along with any related services, to determine whether it is appropriate for the modifier to bypass the edit.

If you believe a claim reimbursement decision should be reviewed, please follow the normal claims dispute process and include medical records that support the usage of the modifier applied when submitting claims for consideration.

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Modifier 79 reminder: Professional

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.

Modifier 63 reminder: Professional

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.

ICD-10-CM Coding Guidelines and Laterality: Professional

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. For specific guidance for reporting a diagnosis that designates a condition on the left and right versus a bilateral diagnosis, 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. 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.

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

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 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).

Outpatient Rehabilitation Program transitioning to AIM

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 physical, occupational and speech therapy 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****Portal*[SM]. 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.

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Medical Policies and Clinical Utilization Management Guidelines update -- July 2019

The *Medical Policies* and *Clinical Utilization Management (UM) Guidelines* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. The *Medical Policies* and *Clinical UM Guidelines* below are followed in the absence of Medicare guidance.

Please share this notice with other members of your practice and office staff.

To view a guideline, visit **https://www11.anthem.com/search.html.**

Updates:

- **MED.00110 — Growth Factors, Silver-Based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting** was revised to add bioengineered autologous skin-derived products (for example, SkinTE) as investigational and not medically necessary.

- **MED.00126 — Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders** was revised to add nasal nitric oxide as investigational and not medically necessary in the diagnosis and monitoring of asthma and other respiratory disorders.

- **SURG.00037 — Treatment of Varicose Veins (Lower Extremities)** was revised to replace "non-surgical management" with "conservative therapy" in the medically necessary criteria and to add sclerotherapy used in conjunction with a balloon catheter (for example, KAVS procedure) as investigational and not medically necessary.

- **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)** was revised to expand the scope to address non-FDA-approved uses of mesenchymal stem cell therapy; the position statement has been revised to the following: "Mesenchymal stem cell therapy is considered INV & NMN for the treatment of joint and ligament disorders caused by injury or degeneration as well as autoimmune, inflammatory and degenerative diseases."

- The following **AIM Specialty Health® updates** took effect on January 24, 2019: Advanced Imaging (imaging of the heart and imaging of the head and neck), Arterial Ultrasound and Joint Surgery.

Medical Policies
On January 24, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Anthem Blue Cross and Blue Shield (Anthem).

Publish Date	Medical Policy	Medical Policy Title	New or revised
2/27/2019	LAB.00036	Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus	New

2/27/2019	SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
1/31/2019	DRUG.00088	Atezolizumab (Tecentriq®)	Revised
2/27/2019	MED.00126	Fractional Exhaled Nitric Oxide and Exhaled Breath Condensate Measurements for Respiratory Disorders	Revised
2/27/2019	MED.00110	Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting	Revised
2/27/2019	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*	Revised
1/31/2019	OR-PR.00003	Microprocessor Controlled Lower-Limb Prosthesis	Revised
1/31/2019	DRUG.00071	Pembrolizumab (Keytruda®)	Revised
2/27/2019	SURG.00037	Treatment of Varicose Veins (Lower Extremities)	Revised

Clinical UM Guidelines

On January 24, 2019, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. These guidelines were adopted by the medical operations committee for Medicare Advantage members on March 28, 2019.

Publish Date	Clinical UM Guideline	Clinical UM Guideline Title	New or revised
1/31/2019	CG-ANC-07	Inpatient Interfacility Transfers	New
1/31/2019	CG-DRUG-50	Paclitaxel, protein-bound (Abraxane®)	Revised
1/31/2019	CG-DRUG-99	Elotuzumab (Empliciti™)	Revised
1/31/2019	CG-LAB-09	Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain	Revised
1/31/2019	CG-REHAB-02	Outpatient Cardiac Rehabilitation	Revised
1/31/2019	CG-SURG-27	Sex Reassignment Surgery	Revised
1/31/2019	CG-SURG-83	Bariatric Surgery and Other Treatments for Clinically Severe Obesity	Revised
2/27/2019	CG-DRUG-106	Brentuximab Vedotin (Adcetris®)	Revised

2/27/2019	CG-GENE-05	Genetic Testing for DMD Mutations (Duchenne or Becker Muscular Dystrophy)	New
2/27/2019	CG-MED-73	Hyperbaric Oxygen Therapy (Systemic/Topical)	Revised
2/27/2019	CG-SURG-77	Refractive Surgery	Revised
2/27/2019	CG-SURG-92	Paraesophageal Hernia Repair	New
2/27/2019	CG-SURG-93	Angiographic Evaluation and Endovascular Intervention for Dialysis Access Circuit Dysfunction	New
3/21/2019	CG-SURG-94	Keratoprosthesis	New
3/21/2019	CG-SURG-95	Sacral Nerve Stimulation and Percutaneous Tibial Nerve Stimulation for Urinary and Fecal Incontinence; Urinary Retention	New
3/21/2019	CG-SURG-96	Intraocular Telescope	New

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Home health billing guidelines for contracted providers

*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. 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.

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Sepsis diagnosis coding and billing reminder

To help ensure compliance with the coding and billing of Sepsis, Anthem Blue Cross and Blue Shield reviews clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for Sepsis applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent Sepsis-3 clinical criteria published in the Journal of the American Medical Association, February 2016. At discharge, clinicians and facilities should apply the Sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of Sepsis. The claim may be subject to an adjustment in reimbursement when Sepsis is not supported based on the Sepsis-3 definition and criteria.

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Keep up with Medicare News -- July 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

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