September 2019 Anthem Provider News - Ohio

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

- Clinical Guideline Updates*

Reimbursement Policies

- New Reimbursement Policies: Maternity Services and Multiple Delivery - Professional*
- New Reimbursement Policy: Intensity Modulated Radiation Therapy Planning and Delivery – Professional*

Pharmacy Updates

- Clinical criteria and prior authorization updates for specialty pharmacy are available*

Other Important Updates

- Medicare and Medicaid News

Reminder: Changes to timely filing requirements coming in October

Anthem Blue Cross and Blue Shield (Anthem) continues to look for ways to improve our processes and align with industry standards. With that in mind, it is also our goal to help providers receive their Anthem payments quickly and efficiently. Timely receipt of medical claims for your patients, our members, helps our chronic condition care management programs work most effectively, and also plays a crucial role in our ability to share information to help you coordinate patient care. In an effort to simplify processes, improve efficiencies, and better support coordination of care, we are changing all professional agreements to adopt a common time frame for the submission of claims to us.

Notification was sent on July 1, 2019 to providers of applicable networks and contracts.

Effective **for all claims received by Anthem on or after October 1, 2019**, all impacted contracts will require the submission of all professional claims within ninety (90) days of the date of service.

This means claims **submitted on or after October 1, 2019** will be subject to a ninety (90) day timely filing requirement, and Anthem will refuse payment if submitted more than ninety (90) days after the date of service[1].

If you have any questions, please contact your local network representative.

1 If Plan is the secondary payer, the ninety (90) day period will not begin until Provider receives notification of primary payer's responsibility.

Provider Transparency Update

A key goal of Anthem Blue Cross and Blue Shield's provider transparency initiatives is to improve quality while managing health care costs. One of the ways this is done is by giving certain providers ("Payment Innovation Providers") in Anthem's various Payment Innovation Programs (*e.g., Enhanced Personal Health Care, Bundled Payments, Medical Home programs, etc.*) (the "Programs") quality, utilization and/or cost information about the health care providers ("Referral Providers") to whom the Payment Innovation Providers may refer their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in their getting more referrals from Payment Innovation Providers. The converse should be true if Referral Providers are lower quality and/or higher cost.

Providing this type of data, including comparative cost information, to Payment Innovation Providers helps them make more informed decisions about managing health care costs and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Additionally, employers and group health plans (or their representatives or vendors) may also be given quality/cost/utilization information about Payment Innovation Providers and Referral Providers so that they can better understand how their health care dollars are being spent and how their health benefits plans are being administered. This will, among other things, give them the opportunity to educate their employees and plan members about the benefits of using higher quality and/or lower cost health care providers.

Anthem will share data on which it relied in making these quality/cost/utilization evaluations upon request, and will discuss it with Referral Providers - including any opportunities for improvement. For questions or support, please refer to your local Market Representative or Care Consultant.

Anthem launches Sydney on September 1; new app offers better digital health care support to members

Anthem Blue Cross and Blue Shield (Anthem) is working to deliver a new digital ecosystem that better supports our members. To that end, our new platform is designed to give our members a more personal, simplified experience. Anthem is driving meaningful change through technology and Artificial Intelligence (AI) powered innovation to deliver an easier to use, more complete Web and mobile health care experience.

We're excited to announce the launch of ***Sydney*** – our new mobile app that runs on intelligence – as part of our digital strategy. Launching **September 1, 2019,** the new app replaces *Anthem Anywhere* and provides the same services that members receive from *Anthem Anywhere*, plus we'll phase in other features and new capabilities over time. In return, members will get a truly integrated mobile experience with even more personalized information to fit their unique needs. These changes will lead to a more personal experience, better engagement and improved health outcomes.

Beginning September 1, members enrolled in our commercial health benefit plans* (including those plans members purchase on or off the Health Insurance Marketplace) and Medicare health benefit plans will have with *Sydney* a personalized health assistant that connects questions to answers – and people to the right resources. It's all part of a more seamless digital experience, bringing together fully integrated benefit details, claims information, care finder tools, access to spending accounts and wellbeing programs. Members can download *Sydney* at the app stores starting September 1.

As part of our rollout efforts on September 1, Anthem will also launch – using a phased approach – a digital solution called *My Family Health Record (MyFHR)*. *MyFHR* offers several benefits for members and providers. Members will be better able to manage their own health, address care gaps, and have the ability to download electronic medical records (EMR) from one or more providers. With *MyFHR*, members will also have the ability to share EMR information with family, caregivers, and providers.

Watch for information on future enhancements to *Sydney* and *MyFHR* in upcoming editions of *Provider News*.

*Excludes Medicaid health benefit plans.

Anthem Commercial Risk Adjustment (CRA) Reporting Update: Risk

Adjustment Data Validation (RADV) Audit happening now

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

The Centers for Medicare & Medicaid Services (CMS) is conducting a Risk Adjustment Data Validation (RADV) Audit beginning **June 2019 through January 2020**. This audit is in accordance with the provisions of the Patient Protection and Affordable Care Act (PPACA) and its risk adjustment data validation standards.

For this audit, CMS will select a statistically valid sample of Anthem's members enrolled in an Affordable Care Act (ACA) compliant plan. Providers whose patients during the **benefit year 2018** were selected for this audit will receive requests and must provide copies of medical record(s)/chart(s). This audit is to verify that diagnosis codes, which have been submitted on claims and reported to CMS, are accurate, properly documented, and coded with accurate levels of specificity.

In the event your patients are selected for this RADV audit, please note that Anthem is working with several vendors to collect the needed medical records and signature attestations (if applicable). Representatives from Anthem or our vendors may reach out to you to request the required medical records and signature attestations. We appreciate your assistance and patience during this process.

Be advised that Anthem is **not** requesting copies of "psychotherapy notes" as defined by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, psychotherapy notes are defined as "notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical record. However, any data excluded from the definition of psychotherapy notes must be provided where applicable and pursuant to this request.

The following list of items are not included in the definition of "Psychotherapy notes" and therefore, can be included pursuant to HIPAA:

- Medication prescription and monitoring
- Counseling session start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests; and
- Summary of the following:
    - Diagnosis
    - Functional status

- Treatment plan
- Symptoms
- Prognosis; and
- Progress to date

If you have any RADV audit questions/concerns, please contact Evelyn.Rey-Hipolito@anthem.com.

If you have any questions regarding our reporting process, please contact our CRA Network Education Representative Mary.Swanson@anthem.com.

Claims requiring additional documentation facility reimbursement policy update

As we advised you in the April 2018 *Network Update* and September 2018 *Network eUpdate*, in our efforts to improve payment accuracy and reduce post-payment recoveries, beginning with dates of service on or after July 13, 2018, we updated our Claims Requiring Additional Documentation policy to include the following requirement:

- Inpatient stay claims reimbursed at a percent of charge with billed charges above $40,000 require an itemized bill to be submitted with the claim.

We continue to receive claims without the required itemized bill causing the claims to be returned for the itemization. *To help ensure accuracy and eliminate delays in the adjudication of your claims, the itemized bill must be included with qualifying claim submissions*.

For more information about this policy, visit the facility reimbursement page on our anthem.com provider website for your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

In addition, visit our anthem.com provider website to view the instructions on how to submit your itemized bill to Anthem Blue Cross and Blue Shield.

PCP after-hours access requirements

Anthem has been advising via this publication and letters to your offices, of the requirement that your practice provide continuation of care for our members outside of regular business hours. We have annually conducted after-hours access studies to assess how well practices

are meeting this provision, and a high percentage of PCP offices do not have the basic messaging for our members for perceived emergency or urgent situations after regular office hours.

To be compliant, have your messaging or answering service include appropriate instructions.

Emergency situations
The compliant response for an *emergency* instructs the caller/patient to hang up and call 911 or go to ER or connects caller directly to the doctor.

Urgent situations
The compliant response for *urgent* would direct the caller to Urgent Care or ER, to call 911 or directly connect the caller to their doctor or the doctor on call.

Messaging that only gives callers the option of contacting their health care practitioner (via transfer, cell phone, pager, text, email, voicemail, etc.) or to get a call back for urgent questions or instructions is not complaint, as there is no direct connection to their health care practitioner.

Is your practice compliant?

Clinical criteria and prior authorization updates for specialty pharmacy are available*

Prior authorization list expansion for specialty pharmacy

Effective for dates of service on and after December 1, 2019, the following non-oncology specialty pharmacy codes from current clinical criteria 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.

Clinical Criteria	HCPCS or CPT Code(s)	NDC Code(s)	Drug
ING-CC-0031	J3490	71879-0136-01	Yutiq™

ING-CC-0003	J3490 J3590 C9399	68982-0810-01 68982-0810-02 68982-0810-03 68982-0810-04 68982-0810-05 68982-0810-06	Cutaquig®
ING-CC-0003	J1599	69800-0250-01	Asceniv™

Anthem's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Clinical criteria updates for specialty pharmacy

Clinical criteria ING-CC-0061 addresses the use of gonadotropin releasing hormone analogs for the treatment of non-oncologic indications.

Effective for dates of service on and after December 1, 2019, the use of Zoladex for the treatment of endometriosis will be limited to six months.

Click here to access the Clinical Criteria page on anthem.com.

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Access requirements for behavioral health care services

Anthem has been advising, via this publication and the Provider Manual, of the requirement that your practice provide the capability for a new patient appointment within a given timeframe. We annually conduct appointment access studies to assess how well practices are meeting this provision and a high percentage of Behavioral Health (BH) offices do not have timely access for new patients.

To be compliant, providers are expected to make best efforts to meet the following access standards:

- ***Initial Routine office visit*** – A new patient must be seen in the office by a designated BH practitioner or another equivalent practitioner in the practice within ten business days.

Explanation – This is a routine call for a new patient defined as a patient with non-urgent symptoms, which present no immediate distress and can wait to schedule an appointment without any adverse outcomes. It can be after the practitioners intake assessment or a direct referral from a treating practitioner.

Is your practice compliant?

Clinical Guideline Updates -- September 2019*

The following Anthem Blue Cross and Blue Shield clinical guideline was reviewed on June 6, 2019 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

New Clinical Guideline

Title	Information	Effective Date
CG-GENE-11 Genotype Testing for Individual Genetic Polymorphisms to Determine Drug-Metabolizer Status	• Created this new clinical UM guideline with non-panel components (which include single polymorphisms of metabolizing enzymes for specific drugs) leaving the drug metabolizing panels to remain in GENE.00010 • Added Genotype testing to determine the presence of CYP2C9 genotype before administration of siponimod (Mayzent®) as MN. Moved codes 81225, 81226, 81227, 81230, 81231, 81232, 81346; 81350; 81355, 81381, G9143; 0031U, 0032U, 0033U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U from GENE.00010 to this document; existing CPT code 81227 for CYP2C9 will change from deny to pend for review of MN criteria for diagnosis of MS (ICD-10-CM G35)	9/4/2019

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New Reimbursement Policies: Maternity Services and Multiple Delivery - Professional*

Beginning with dates of service on or after December 1, 2019, Anthem Blue Cross and Blue Shield (Anthem)'s current Routine Obstetrics policy will be retired and will be replaced by the new Maternity Services policy and the new Multiple Delivery policy.

The new Multiple Delivery policy has the same reimbursement guidelines and requirements as the current Routine Obstetrics policy.

The new Maternity Services policy has the same reimbursement guidelines for global billing as the current Routine Obstetrics policy with an update to the postpartum period. The postpartum period for CPT code 59430 (postpartum care only) will change from 45 days to a 90 day period.

To find Anthem's professional reimbursement policies online, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

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New Reimbursement Policy: Intensity Modulated Radiation Therapy Planning and Delivery - Professional*

Beginning with dates of service on or after December 1, 2019, Anthem Blue Cross and Blue Shield (Anthem) will implement a new professional reimbursement policy, Intensity Modulated Radiation Therapy Planning and Delivery. This policy applies limitations to the Intensity Modulated Radiation Therapy (IMRT) planning, delivery, development and field setting services.

To find Anthem's professional reimbursement policies online, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

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Claim editing update for Excludes1 notes

Beginning with claims processed on and after September 29, 2019, we will be implementing

revised claims edit logic tied to Excludes1 notes from ICD-10 coding guidelines. We recognize that the editing tied to Excludes1 notations found in ICD-10-CM, which was implemented in March 2019, contained some conflicts between Excludes1 and Excludes2 notes which caused a need for claims to be re-adjudicated. We have taken steps to modify the logic and remove such conflicts.

To help ensure the accurate processing of claims, use ICD-10-CM Coding Guidelines when selecting the most appropriate diagnosis for patient encounters. ICD-10-CM has two types of excludes notes. Each type has a different definition for use but they are similar since they indicate that codes excluded from each other are independent of each other. One of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes1 notes. An Excludes1 note indicates that the excluded code identified in the note should not be used at the same time as the code or code range listed above the Excludes1 note. These notes are located under the applicable section heading or specific ICD-10-CM code to which the note is applicable. When the note is located following a section heading, it applies to all codes in the section.

Remember to review diagnosis code(s) for any Excludes1 notes prior to submitting your claims to help ensure proper adjudication of your claims.

Some examples of Excludes1 scenarios in ICD-10-CM, where both diagnosis codes should not be billed together include:

- Reporting both M54.2 (cervicalgia) with M50.XX (cervicalgia due to intervertebral disc disorder) - M54.2 has an Excludes1 note for M50.XX
- Reporting both M54.5 (low back pain) with S39.012X (strain of muscle, fascia and tendon of lower back) - M54.5 has an Excludes1 note for S93.012X
- Reporting both M54.5 (low back pain) with M54.4X (lumbago with sciatica) - M54.5 has an Excludes1 note for M54.4X
- Reporting J03.XX (acute tonsillitis) with J02.XX (acute sore throat), J02.0 (streptococcal sore throat), J02.9 (sore throat NOS), J35.1 (hypertrophy of tonsils) or J36 (peritonsillar abscess) -J03.XX has an Excludes1 note for J02.XX, J02.0, J02.9, J35.1 and J36
- Reporting N89 (other inflammatory disorders of the vagina) with R87.62 (abnormal results from vaginal cytological exam), D07.2 (vaginal intraepithelial neoplasia), R87.623 (HGSIL of vagina), N76.XX (inflammation of the vagina), N95.2 (senile [atrophic] vaginitis) or A59.00 (trichomonal leukorrhea) -N89 has an Excludes1 note for R87.62, D07.2, R87.623, N76.XX, N95.2, D07.2 and A59.00

Finally, if you believe an Excludes1 note denial should be reviewed, please follow the normal claims dispute process and include medical records that support the usage of the diagnosis combination when submitting claims for consideration.

Medicare News -- September 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
- Bill Medicare Part D for shingles or tetanus vaccination claims

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Coming soon: Electronic attachments

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

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

Anthem and Availity will pilot electronic data interchange batch electronic attachments with previously selected providers. Both solicited and unsolicited attachments will be included in our pilots.

Attachment types

- *Solicited attachments:* The provider sends a claim and the payer determines there is not enough information to process the claim. The payer will then send the provider a request for additional information (currently done via letter). The 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 will then send the X12 837 claim with the Paper Work Included segment tracking number. Then, the provider will send the X12 275 attachment transaction with the additional information and include the tracking number that was sent on the claim for matching.

What you can do

As we prepare for this change, you can help now by having conversations with your clearinghouse and/or electronic healthcare records vendor to determine their ability to set up the X12 275 attachment transaction capabilities.

In addition, you should be on the lookout for additional information and details about working with Anthem and Availity to send attachments via electronic batch.

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Clinical Criteria updates

On March 29, 2019, April 12, 2019 and May 1, 2019, the Pharmacy and Therapeutic (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Anthem Blue Cross and Blue Shield. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider website anthem.com/medicareprovider, and the effective dates will be reflected in the *Clinical Criteria Q2 update*. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, email us at druglist@ingenio-rx.com.

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Customizations to the 23rd edition of the MCG Care Guidelines

Effective November 1, 2019, customizations will be implemented for Chemotherapy and Inpatient & Surgical Care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:

- Clinical indications for admission; examples will also be added for:
  - Aggressive hydration needs that cannot be managed in an infusion center.
  - Prolonged marrow suppression.
- Regimens that cannot be managed outpatient; examples will also be added.

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations

online by selecting **Customizations to MCG Care Guidelines 23rd Edition**.

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Changes to prior authorization (PA) requirements

Beginning **December 1, 2019**, prior authorization (PA) requirements will change some codes covered by Anthem Blue Cross and Blue Shield (Anthem) for Medicare Advantage members. Federal and state law, state contract language and CMS guidelines (including definitions and specific contract provisions and exclusions) take precedence over these rules and must be considered first when determining coverage. Anthem will deny claims that are noncompliant with the new rules.

PA requirements will be added to the following:

- **T1019** – Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
- **C9740** – Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
- **E0953** – Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware
- **E1031** – Rollabout chair, any and all types with castors 5 inches or greater
- **E1090** – High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- **E1130** – Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests
- **E1140** – Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- **E1260** – Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- **E1285** – Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest
- **E1290** – Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- **E2207** – Wheelchair accessory, crutch and cane holder
- **E2378** – Power wheelchair component, actuator, replacement only
- **K0039** – Leg strap, H style

Not all PA requirements are listed here. Detailed prior authorization requirements are

available to contracted providers by accessing the Provider Self-Service Tool at availity.com. Contracted and non-contracted providers who are unable to access the Availity Portal may call the number on the back of your patient's Anthem ID card for PA requirements.

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Pharmacy benefit manager change to IngenioRx

Effective January 1, 2020, IngenioRx will become our new pharmacy benefit manager (PBM) and will start managing prescription coverage for your Medicare Advantage individual and group retiree plan patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications.

Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for patients currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy later this year. For patients receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Most patients will be able to fill their prescriptions at their same retail pharmacy outlet. If your patient's pharmacy will not be available, we will notify your patient by letter and include a list of three alternative pharmacies near his or her home.

Prescriptions for controlled substances currently being filled at Express Scripts Mail Order Pharmacy or Accredo cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

For providers	Then
Who use ePrescribing	There are no changes – Simply select IngenioRx.

Who do not use ePrescribing	You should send your mail order and specialty prescriptions to IngenioRx. IngenioRx will begin accepting prescriptions January 1, 2020. Please consider the days' supply of the prescription when making these requests. **IngenioRx Mail Order Pharmacy new prescriptions:** Phone: **1-833-203-1742** Fax: **1-800-378-0323** **IngenioRx Specialty Pharmacy:** Prescriber phone: **1-833-262-1726** Prescriber fax: **1-833-263-2871**

You can confirm whether your patient has transitioned to IngenioRx through the Availity Portal.

Your patient's PBM information can be located in the *Patient Information* section of their patient profile as part of the eligibility and benefits inquiry.

If you have immediate questions, you can contact the Provider Service phone number on the back of your patient's ID card or call the number you normally use for questions.

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