December 2019 Anthem Provider News - Ohio

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Verifying and updating your provider information

Maintaining accurate provider information is critically important to ensure our members have timely and accurate access to care.

Additionally, Anthem Blue Cross and Blue Shield (Anthem) is required by Centers for Medicare and Medicaid Services (CMS) to include accurate information in provider directories for certain key provider data elements. For Anthem to remain compliant with federal and state requirements, changes must be communicated 30 days in advance of a change or as soon as possible.

Key data elements

The data elements required by CMS and crucial for member access to care are:

- Physician name
- Location (such as address, suite if appropriate, city/state, zip code)
- Phone number
- Accepting new patient status
- Hospital affiliations
- Medical group affiliations

Anthem is also encouraged (and in some cases required by regulatory/accrediting entities) to include accurate information for the following provider data elements:

- Physician gender
- Languages spoken
- Office hours
- Provider specialty/specialties
- Physical disabilities accommodations
- Indian Health Service status
- Licensing information (i.e., medical license number, license state, National Provider Identifier - NPI)
- Email and website address

How to verify and update your information

To verify information, go to anthem.com and select “Providers,” and then under “Provider Resources” select “Find a Doctor” tool. Use “Search as a Guest” at the bottom. If your information is not correct, please update the information as soon as possible.

To update information, go to anthem.com and select “Providers,” and then under “Provider Resources” select “Provider Maintenance” and follow the online prompts.

Anthem works to simplify payment recovery process for National Accounts membership

In Anthem Blue Cross and Blue Shield (Anthem)'s ongoing efforts to streamline and simplify our payment recovery process, we will be consolidating our National Accounts membership to a central system. With this change we will be aligning the payment recovery processes to be the same as the majority of our other lines of business.

Our recovery process for National Accounts membership is reflected on the Electronic Remittance Advice (835) in the PLB segment. The requested recovered amount on the Electronic Remittance Advice (835) is displayed at the time of the recovery.

As National Accounts membership transitions and claims are adjusted for recovery on the central system, the requested recovered amount will be held for 49 days. This will 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" section.

After 49 days, the requested recovered amount is reflected on the Electronic Remittance Advice (835) in the PLB segment.

If you have any questions or concerns, please contact the E-Solutions Service Desk toll free at (800) 470-9630.

Retrieve your Anthem Patient's HEDIS® care gaps through Patient360 located on the Availity portal

Patient360 is a Longitudinal Patient Record (LPR) where you can access the complete view of Anthem Blue Cross and Blue Shield (Anthem) information associated with an Anthem member.

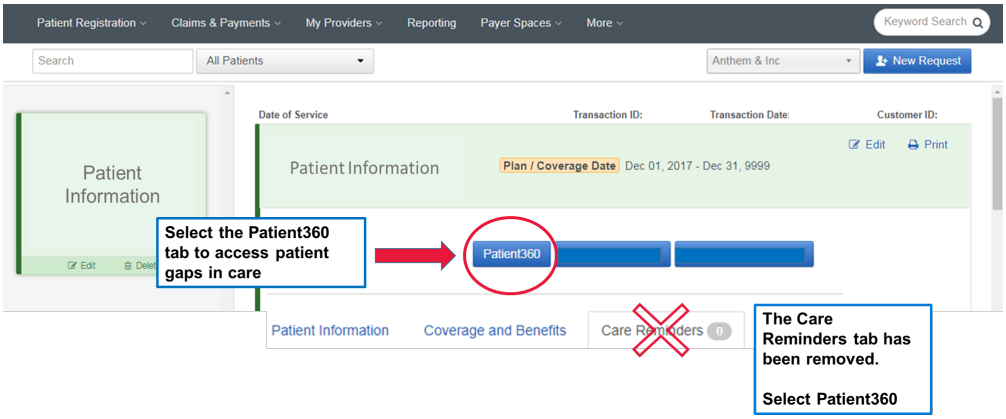
You may have noticed that the Care Reminders tab on your Anthem patient's Eligibility and Benefits return on Availity was recently removed. You can still retrieve these important patient gaps in care through Patient360.

You are required to have the Patient360 role assigned to you by your Availity administrator to see the Patient360 tab located at the top of the patient's Eligibility and Benefits return. To

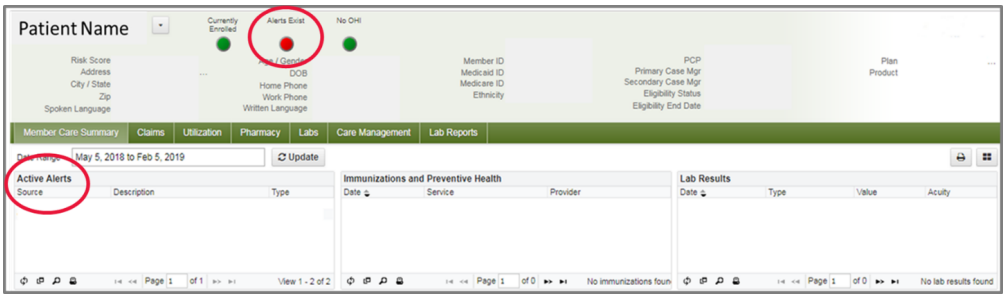
access Patient360 select the tab and follow the steps to open the application.

If your patient does have a gap in care, you will see the red alert button on the top of Patient360 Member Care Summary. Details of the care gap can be found in the Active Alerts section.

Availity Eligibility and Benefits: Patient360 access



Patient360 Active Alerts located on the Member Care Summary



Case management program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross and Blue Shield (Anthem) is available to offer assistance in these difficult moments with our case management program. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process

utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

State	CM Email Address	CM Telephone Number	CM Business Hours
Indiana	centregcmref@anthem.com *National:* nationalpriorityrefe@ChooseHMC.com	888-662-0939 866-962-1214 (IN only) *National:* 1-800-737-1857 Transplant: 800-824-0581 *FEP:* 1-800-711-2225	Monday - Friday 8:00 am - 7:00 pm EST *National:* Monday - Friday 8:00 am - 9:00 pm EST Saturday 9:00 am - 5:30 pm EST Transplant: Monday - Friday 8:30 am - 5:00 pm EST *FEP:* 8:00 am - 7:00pm EST
Kentucky	centregcmref@anthem.com	888-662-0939 800-944-0339 (KY only) *FEP:* 1-800-711-2225	Monday - Friday 8:00 am - 7:00 pm CST *FEP:* 8:00 am - 7:00 pm EST
Missouri	centregcmref@anthem.com	888-662-0939 866-534-4348 (MO only) *FEP:* 1-800-711-2225	Monday - Friday 8:00 am - 7:00 pm CST *FEP:* 8:00 am - 7:00 pm EST
Ohio	centregcmref@anthem.com	888-662-0939 *FEP:* 1-800-711-2225	Monday - Friday 8:00 am - 7:00 pm EST *FEP:* 8:00 am - 7:00 pm EST
Wisconsin	centregcmref@anthem.com	888-662-0939 866-216-4091 (WI only) *FEP:* 1-800-711-2225	Monday - Friday 8:00 am - 7:00 pm CST *FEP:* 8:00 am - 7:00pm EST

Coordination of care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross and Blue Shield (Anthem) would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:

- Diagnosis
- Treatment plan
- Referrals
- Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available on the Provider website including a Coordination of Care Form and Coordination of Care Letter Templates for both Behavioral Health and other Medical Practitioners*. Behavioral Health tools are available, which includes forms, brochures, and screening tools for Substance Abuse, ADHD, and Autism. Please refer to the website for a complete list**.

**Access to the forms and template letters are available at www.anthem.com/provider/forms/*

**Access to the Behavioral Health tools are www.anthem.com/provider/forms/*

Important information about utilization management

Anthem Blue Cross and Blue Shield (Anthem)'s 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 under-utilization. Anthem's medical policies are available on Anthem's website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us at the toll-free numbers listed below. UM criteria are also available on the web. Just go to anthem.com, then scroll down and select Tools for Providers > Find Resources for Your State > select your State > Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements.

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll free from 8:30 a.m. – 5:00 p.m. EST Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program (FEP) hours are 8:00 a.m. – 7:00 p.m. EST.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The grid below lists the phone lines for physicians and their staffs. Members should call the customer service number on their health plan ID card.

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

	To discuss UM Process and Authorizations	To Discuss Peer-to-Peer UM Denials w/Physicians	To Request UM Criteria
Indiana	800-345-4348, 877-814-4803 Behavioral Health: 866-582-2293 Transplant: 800-824-0581 Autism: 844-269-0538	888 870 9342	877-814-4803
Kentucky	800-568-0075 KEHP: 844-402-5347 Behavioral Health: 866-582-2293 Transplant: 800-824-0581 Autism: 844-269-0538	877-814-4803	877-814-4803
Missouri	800-992-5498 866-398-1922 Behavioral Health: 866-302-1015 Transplant: 800-824-0581 Autism: 844-269-0538	800-992-5498 866-398-1922 CDHP/Lumenos: 866-398-1922	800-992-5498, 866-398-1922
Ohio	800-752-1182 Behavioral Health: 866-582-2293 Transplant: 800-824-0581 Autism: 844-269-0538	877-814-4803	877-814-4803
Wisconsin	800-242-1527, 800-472-6909, 800-472-8909, 866-643-7087 Transplant: 800-824-0581 Autism: 844-269-0538	800-242-1527, 800-472-6909, 866-643-7087	800-242-1527, 800-472-6909
FEP/ National	FEP: 800-860-2156 Fax: 800 732-8318 (UM), Fax: 877 606-3807 (ABD)	FEP: 800-860-2156 National: 800-821-1453; 866-776-4793	FEP: 800-860-2156 Fax: 800 732-8318 (UM) Fax: 877 606-3807 (ABD)

TTY Information:

		TTY	Voice
Indiana	711 or	1-800-743-3333 (V/T)	1-800-743-3333 (V/T)
Kentucky	711 or	1-800-648-6056 (T/ASCII/HCO)	1-800-648-6057 (V)
Missouri	711 or	1-800-735-2966 (TTY/ASCII)	1-866-735-2460 (V)
Ohio	711 or	1-800-750-0750 (TTY/Voice/HCO)	1-800-750-0750 (TTY/Voice/HCO)
Wisconsin	711 or	1-800-947-3529 (TTY/HCO)	1-800-947-6644 (V)

For language assistance, members can simply call the Customer Service phone number

on the back of their ID card and a representative will be able to assist them.

Members' rights and responsibilities

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.

It can be found on our Web site. To access, go to the "Provider" home page at anthem.com. From there, select "Provider," > "Providers Overview," select your State, "Find Resources," > then Health & Wellness > Quality Improvement Standards > Member Rights & Responsibilities.

Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

Clinical practice and preventive health guidelines available

Anthem Blue Cross and Blue Shield (Anthem) clinical practice and preventive health guidelines available on anthem.com.

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research.

All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website at anthem.com. Select Provider/Provider Overviews > scroll down and select Find Resources for your State > Health and Wellness > Practice Guidelines.

Reminder: New AIM Rehabilitative Program effective November 1, 2019

As previously communicated in the October 2019 edition of Anthem Blue Cross and Blue Shield (Anthem)'s *Provider News*, the AIM Rehabilitative program for Anthem's commercial membership relaunched November 1, 2019. AIM Specialty Health® (AIM), a separate company, will perform prior authorization review of physical, occupational and speech therapy services. Requests may be submitted via the *AIM ProviderPortal* for dates of service November 1, 2019 and after.The OrthoNet program is no longer active in applicable markets.

The AIM Rehab Program follows the Anthem Clinical Guidelines (CG-Rehab-04) that state the skilled services must be delivered by a licensed physical therapist or other qualified licensed health care professional. Qualified providers acting within the scope of their license, including chiropractors, who intend to provide the CPT codes for PT, OT or ST services referenced in this Clinical Guideline should request prior authorization (where permitted by law) for those services through AIM.

New Changes to AIM's Rehab Program

Anthem and AIM Specialty Health are working together to make improvements to the clinical review of PT, OT, and ST services when used to treat Autism Spectrum Disorder or Pervasive Developmental Delays as defined by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

Effective November 1, 2019 in the states of Indiana, Kentucky, Missouri, Ohio and Wisconsin, prior authorization is not required for PT, OT, or ST outpatient therapy services when receiving skilled treatment for Autism Spectrum Disorder or Pervasive Developmental Delays for members with Anthem commercial plans. You may file your claims without a prior authorization number if you are billing with one of the following ICD-10 codes: F84.0, F84.2, F84.3, F84.5, F84.8, or F84.9. Please note that benefit limits, if applicable, will still be applied.

For the Medicaid states of Indiana and Wisconsin, there are no changes to the existing program.

Anthem is also transitioning vendors for review of Rehabilitative Services for our *Medicare members to include outpatient PT, OT, and SLP, to AIM Specialty Health. Anthem has decided to delay the implementation of this transition. The AIM Rehab program will now begin in April 2020. Prior authorization will not be required for the above mentioned services through March 2020.

*This does not apply to members in the states of Florida, New Jersey and New York for whom prior authorization will still be required.

Be sure to check upcoming editions of Provider News for more information about the AIM Rehabilitative Program for Medicare members.

Coding tip for psychological and neuropsychological testing

On January 01, 2019, a change to CPT codes for Psychological and Neuropsychological test administration and evaluation services was released. The new codes did not crosswalk on a one-to-one basis with the deleted codes.

The coding changes separated test administration from test evaluation, psychological testing from neuropsychological testing, and defined the testing performed by a professional or technician. The new codes are as follows:

Neurobehavioral status exams are clinical interview examinations performed by a psychologist or neuropsychologist to assess thinking, reasoning and judgment. Providers should continue to use CPT code 96116 when billing for the first hour and new code 96121 when billing for each additional hour.

Testing evaluation services include the selection of the appropriate tests to be administered; integration of patient data; interpretation of standardized test results and clinical data; clinical decision-making; treatment planning; and reporting and interactive feedback to the patient, family members, or caregivers, when performed. Providers should now use CPT code 96130 to bill for the first hour of psychological testing evaluation services and 96131 for each additional hour. Neuropsychological evaluation services should now be billed using CPT code 96132 for the first hour and 96133 for each additional hour.

Test administration and scoring by a psychologist or neuropsychologist (two or more tests using any method) should now be billed using CPT code 96136 for the first 30 minutes and 96137 for each additional 30 minutes.

Test administration and scoring by a technician (two or more tests using any method) should now be billed using CPT code 96138 for the first 30 minutes and 96139 for each additional 30 minutes.

Single automated test administration should be reported with newly created code 96146 for a single automated psychological or neuropsychological instrument that is administered via electronic platform and formulates an automated result. Psychologists should not use this code if two or more electronic tests are administered and/or if administration is performed by the professional or technician. Instead, the psychologist should use the appropriate codes

listed above for test administration and scoring.

Screening and risk assessment (repetitive assessment after screening) include brief emotional/behavioral assessment with scoring and documentation, per standardized instrument, should now be billed using CPT code 96127 separately from testing.

References: apa.org

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.

New Reimbursement Policies: Durable Medical Equipment, Rent to Purchase Durable Medical Equipment, and Modifiers (Professional)

Beginning with dates of service on or after December 1, 2019, Anthem Blue Cross and Blue Shield (Anthem)’s current Durable Medical Equipment (DME) policy will be retired and will be replaced by the new Durable Medical Equipment – Rent to Purchase policy and the new Durable Medical Equipment – Modifiers policy. The new Durable Medical Equipment – Rent to Purchase policy has the same reimbursement guidelines and requirements as the current Durable Medical Equipment policy. The new Durable Medical Equipment – Modifiers policy has the same reimbursement guidelines for DME Modifiers as the current Durable Medical Equipment policy.

For more information about these new policies, visit Anthem's **professional** reimbursement policies on anthem.com, select your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

System updates for 2020 (Professional)

As a reminder, we will update our claim editing software monthly throughout 2020 with the most common updates occurring in quarterly in February, May, August and November of 2020. These updates will:

- Reflect the addition of new, and revised codes (e.g. CPT, HCPCS, ICD-10, modifiers) and their associated edits
- Include updates to National Correct Coding Initiative (NCCI) edits
- Include updates to incidental, mutually exclusive, and unbundled (rebundled) edits
- Include assistant surgeon eligibility in accordance with the policy
- Include edits associated with reimbursement policies including, but not limited to, frequency edits, medically unlikely edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare and Medicaid Services (CMS)
- Apply to any provider or provider group (tax identification number) and may apply to both institutional and professional claim types

Coordination of benefits for an FEP® member

Anthem Blue Cross and Blue Shield values the relationship we have with our providers, and we always look for opportunities to help expedite the claim processing. When a Federal employee visits the provider office, the provider should obtain the most current medical insurance information, which will help to establish the primary carrier and will alleviate claim denials and support accurate billing.

For questions please contact the Federal Employee Customer Service at:
Indiana: 800-382-5520
Kentucky: 800-456-3967
Missouri: 800-392-8043
Ohio: 800-451-7602
Wisconsin: 800-242-9635

Medicare News -- December 2019

Category: Medicare

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

- 2020 Medicare Advantage individual benefits and formularies
- Blue Cross Blue Shield Association mandate about Medicare Advantage care management and provider engagement
- CMS reminder: expedited/urgent requests
- Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates
- Learn more about the Group Retiree PPO plans
- Prior authorization requirements for E0784, K0553 and K0554
- **MO only:** Aspire Health for Medicare members in need of palliative care

Provider training series

Category: Medicare

The Medicare Risk Adjustment Regulatory Compliance team at Anthem Blue Cross and Blue Shield team developed the following two provider training series titled:

Medicare risk adjustment and documentation guidance (general)

Series: Offered the first Wednesday of each month from 1 to 2 p.m. Eastern time

Learning objective: Provide an overview of Medicare Risk Adjustment, including the Risk Adjustment Factor and the Hierarchical Condition Category (HCC) Model, with guidance on medical record documentation and coding.

Credits: This live activity, Medicare Risk Adjustment and Documentation Guidance, offered from December 5, 2018, through December 4, 2019, has been reviewed and is acceptable for

up to 1.00 prescribed credit(s) by the American Academy of Family Physicians.

Registration: Those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process should register for one of the monthly training sessions at the link below: https://antheminc.adobeconnect.com/admin/show-event-catalog?folder-id=38826374.

Medicare Risk Adjustment, Documentation and Coding Guidance (condition specific)

Series: Offered bimonthly on the fourth Wednesday from noon to 1 p.m. (ET)

Learning Objective: Collaborative learning event with Enhanced Personal Health Care (EPHC) to provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.

Credits: This Live series activity, Medicare Risk Adjustment, Documentation and Coding Guidance, from January 23, 2019, to November 27, 2019, has been reviewed and is acceptable for credit by the American Academy of Family Physicians.

Registration: For those interested in joining us for this six-part training series, please see the list of topics and scheduled training dates below:

1. **Red flag HCCs, part one —** Register for recording of live session. Training will cover HCCs most commonly reported in error as identified by CMS: chronic kidney disease (stage 5), ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, end-stage liver disease. *Recording will play upon registration.* https://antheminc.cosocloud.com/e4i5k4h7cf3j/event/registration.html.
2. **Red flag HCCs, part two —** Register for recording of live session. Training will cover HCCs most commonly reported in error as identified by CMS: atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation. *Recording will play upon registration.* https://antheminc.cosocloud.com/enfndbyedd5g/event/event_info.html.
3. **Opioids and more: Substance Abuse and Dependence —** *Recording will play upon registration.* https://antheminc.cosocloud.com/ekx3tooh22f7/event/registration.html.
4. **Acute, chronic and status conditions —** *Recording will play upon registration.* https://antheminc.cosocloud.com/eeq7am1fht49/event/registration.html.
5. **Diabetes Mellitus and Other Metabolic Disorders —** *Recording will play upon registration*. https://antheminc.cosocloud.com/egjswhu5fv73/event/registration.html.

6. **Behavioral health —** *Recording will be available in early December and will play upon registration*. https://antheminc.cosocloud.com/p5ss84h25ww/.

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Medical drug Clinical Criteria updates

Category: Medicare

On June 20, 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 are publicly available on the provider website, and the effective dates will be reflected in the link to web posting. Visit Clinical Criteria to search for specific policies.

For questions or additional information, email us at druglist@anthem.com.

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Group Retiree Solutions Kentucky and Ohio HMO Medicare Advantage plans

Category: Medicare

Effective January 1, 2020, Anthem Blue Cross and Blue Shield (Anthem) group Medicare Advantage plan members will receive new ID cards. All members will be assigned a new alpha prefix and group number. New ID cards will be mailed to members in December 2019.

Effective January 1, 2020, Anthem members enrolled in a group HMO Medicare Advantage plan will be assigned the following prefixes: YAC (Kentucky HMO Medicare Advantage) and AFH (Ohio HMO Medicare Advantage). Members with alpha prefixes YAC and AFH may have new prior authorization and utilization management requirements effective January 1, 2020.

Please continue to check member ID cards to ensure you have the most up-to-date eligibility and benefit information. We encourage providers to request a copy of the member's ID card, particularly at the beginning of the year when members may have new ID cards and new benefits.

For any questions related to this communication, providers will need to review the back of the member's ID card for the Provider Services phone number. Providers should submit claims to their local Anthem plan for processing.

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State Auto Insurance Companies to offer Medicare Advantage option

Category: Medicare

Effective January 1, 2020, State Auto Insurance Companies will offer Anthem Medicare Preferred (PPO), a Medicare Advantage plan from Anthem Blue Cross and Blue Shield, which will include prescription drug benefits under Medicare Advantage Part D (MAPD). Retirees with Medicare Parts A and B are eligible to enroll in the MAPD plan. The plan includes the National Access Plus benefit, which allows members to receive services from any provider as long as the provider is eligible to receive payments from Medicare. The MAPD plan offers the same hospital and medical benefits that Original Medicare covers, as well as additional benefits such as an annual routine physical exam, hearing exam, LiveHealth Online and SilverSneakers®.

The prefix on State Auto Insurance Companies member ID cards will be ZVR. The cards will also show the State Auto Insurance Companies logo and National Access Plus icon.

Providers may submit claims electronically using the electronic payer ID for the Blue Cross Blue Shield plan in their state or submit a UB-04 or CMS-1500 from the Blue Cross Blue Shield plan in their state. Claims should not be filed with Original Medicare. Contracted and non-contracted providers may call the provider services number on the back of the member ID card for benefit eligibility, prior authorization requirements and any questions about State Auto Insurance Companies member benefits or coverage.

Detailed prior authorization requirements also are available to contracted providers by accessing the Provider Self-Service Tool at availity.com.

505046MUPENABS

Reminder to Medicare Advantage providers

Category: Medicare

As a reminder, PCPs may only refer Anthem Blue Cross and Blue Shield (Anthem) members to in-network Medicare Advantage providers.

Anthem has contracted with specialists to ensure adequate care of our members. The use of contracted network specialists will ensure continuity of appropriate clinical background data and coordination of care with the PCP.

Should there be a need to refer the member outside the contracted network, contact Anthem directly for prior authorization (PA). Referring a Medicare Advantage member out-of-network, who does not have out-of-network benefits, could result in claim denials with member liability unless the service is urgent, emergent, out-of-area dialysis or if PA was approved by the plan.

Although not required, PA is encouraged for preferred provider organization (PPO) members who want to receive notification of advanced coverage when utilizing an out-of-network provider for services.

As a reminder to all providers, the referring physician name and NPI must be reported on the claim when the PCP does not provide the service rendered. This will reduce the number of rejections issued during initial claim processing.

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