January 2020 Anthem Provider News - Ohio

Notice of Material Changes/Amendments to Contract and Prior Authorization Changes -- January 2020

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.

Medical Policies/Clinical Guidelines

- Important Update: Milliman Care Guideline [MCG], 23rd Edition (MAC)

Reimbursement Policies

- Outpatient Facility Edit Implementation (MAC)

Other Important Updates

- Medicare and Medicaid News

Postponed: Review of professional claims with emergency room level 5 E/M codes

Anthem Blue Cross and Blue Shield (Anthem) communicated to you on May 1, 2019 that we were initiating post-payment reviews for professional ER claims billed with level 5 ER E/M codes 99285 and G0384. Anthem implementation of this policy has been postponed. This update relates only to the policy announced May 1, 2019. All other current policies applicable to you, including, but not limited to, other audit or reimbursement policies pertaining to ER claims are unaffected by this update. We will keep you informed about the initiation of the review process; however, as always, we require proper coding and billing to ensure prompt and accurate payment.

Availity: Upcoming retirement planned for legacy Medical Attachment submission tool

The **Medical Attachment tool** makes the process of submitting electronic documentation in support of a claim, simple and streamlined. We are now in the final stages of migration from the Medical Attachments link to the Attachments-New option.

What is happening to the current attachment tool?

- The legacy tool will be retired soon* with access via **Attachments-New** option available now.
- The history of the information you have previously submitted is still available on the legacy tool for now*.
- Read only access to the history is in the final stages*

**Look for messaging on the legacy attachment tool for specific dates*

How to Access *solicited* Medical Attachments for Your Office
Availity Administrator, complete these steps:

1. From **My Account Dashboard,** select **Enrollments Center > Medical Attachments Setup,** and complete the following sections:
2. Select Application>choose **Medical Attachments Registration**
3. Provider Management>Select **Organization** from the drop-down. Add NPIs and/or Tax IDs
4. Assign user access by checking the box in front of the user's name

Using Medical Attachments
Availity User, complete these steps:

1. Log in to www.availity.com
2. Select **Claims and Payments** > **Attachments-New** >**Send Attachment** Tab
3. Complete all required fields of the form
4. Attach supporting documentation
5. Submit

Need Training?
To access additional training for this Availity feature: Log in and select **Help & Training** > **Get Trained** to open the Availity Learning Center (ALC) Catalog in a new browser tab. Search the Catalog by keyword **(attachments)** to find training demo and on-demand courses. Select **Enroll** to enroll for a course and then go to your Dashboard to access it any time.

Let Us Help You Accomplish Your 2020 "To-Do List" Early - EDI Migration

The New Year always gives us an opportunity to set new goals. Starting in 2020, we want to help you check off a few "to do" items. As the Availity migration continues full speed ahead, let's get you started on your first goals of the year.

Don’t Delay and Transition to Availity today!
All EDI transmissions currently sent or received today via the Anthem EDI Gateway are now available on the Availity EDI Gateway.

- 837 – Institutional and Professional
- 837 – Dental
- 835 – Electronic Remittance Advice
- 276/277 – Claim Status
- 270/271 – Eligibility Request
- 275 – Medical Attachments

Below are the options you can choose from to exchange EDI transmissions with the Availity EDI Gateway:

- Migrate your direct connection with Anthem and become a direct submitter with Availity.
- Use your existing Clearinghouse or Billing Company for your EDI transmissions. Work with them to ensure connectivity to the Availity EDI Gateway.
- Use Direct Single Claim entry through the Availity Portal.

Availity setup is simple and at no cost for you!
Use this “Welcome” link below to get started today:
https://apps.availity.com/web/welcome/#/anthem

Learn Something New!
Enroll in one of Availity’s free courses and training demos. Making the switch to Availity's EDI Gateway is easy if you have all the resources that you need.

Follow these steps to register at www.Availity.com :

1. Log in to the Availity Portal and select **Help & Training** | **Get Trained** to access the Availity Learning Center (ALC).
2. Select Sessions from the menu under the search catalog field.
3. Scroll Your Calendar to locate your webinar.
4. Select View Course and then Enroll. The ALC will email you instructions to attend.

If you and your clearinghouse have already migrated, you are a step ahead! If not, take action today to make the transition.

For questions contact Availity Client Services at 1-800-Availity (1-800-282-4548) for assistance Monday – Friday 8 a.m. – 7 p.m. ET.

The New Year brings New ID Cards for many Anthem members

Now is the time to ask all of your patients to present their current ID card. Many members were assigned new identification numbers effective January 1, 2020 and new ID cards were provided digitally or mailed to all affected members in late December 2019. To ensure claims are processed appropriately, here is some helpful information.

Tips for Success: When Anthem members arrive at your office or facility, ask to see their current member identification card at each visit. Many of our members no longer receive a paper card so they will present you with their digital card on their mobile device. Doing so will help you:

- Identify the member's product
- Obtain health plan contact information
- Speed claims processing

Note: Claims submitted with an incorrect ID number may be unable to be processed and may be returned for correction and resubmission with the correct ID.

Tips for Success: When you contact a member about a claim returned for an invalid ID, and they do not recall receiving a new ID card or they misplaced their ID card, please ask the member to confirm their member ID using one of the following options:

- Log in to their member account on anthem.com
- Use the Anthem mobile app *Sydney* (formerly *Anthem Anywhere)* to access their electronic ID card
- Fax or email their most current card from anthem.com or the mobile app to your office if needed
- Call their Anthem member services number

Following the tips above will result in a successful start to your New Year.

Receive and respond to post pay audit medical record requests via Availity beginning February 10, 2020

We are launching the use of Availity's medical attachment functionality to begin requesting medical records and itemized bill information from providers electronically instead of paper requests. This change applies only to the process of requesting and receiving medical records; it is not a change to the audit program. We began transitioning providers in an active limited launch to this new process in October 2019. We will complete the transition by February 10, 2020.

Important facts regarding this change:

- This change only affects providers who use Availity and who have opted into using the medical attachment functionality through the permissions in Availity's enrollment center.
- The new functionality is for medical record requests for post pay claims for the Payment Integrity Quality Claims Review (provider audit) department only.
- There will be no duplicate requests (both paper and electronic).
- In Availity, the request will come into the provider's Medical Attachment "inbox"
    - The original letter historically sent via paper is accessible through a hyperlink in the Availity system as a pdf electronic copy. The letter content is exactly the same as it was in paper format.
    - Each electronic request letter will have a timeframe for responding to the request. After the timeframe has passed for that letter, you will not be able to respond to that electronic letter. If you wish to upload medical records after the response time has expired, please refer to the Availity training referenced below.
    - Providers can respond to the request by uploading records in Availity. The attachments are received in almost real time and are delivered electronically to the payer's systems through secure means - nothing is stored in Availity.
- The following are not included or not impacted:
    - Vendor requests for medical records on behalf of the payer.
    - Providers that do not use Availity or have not turned on permissions for Medical Attachments within Availity.
    - The request timing or verbiage in the request letter.
    - At this time, the Program Integrity Special Investigations Unit (SIU) post pay review, but they will be included at a future date.

Resources
Training is available in Availity located here Availity Training on Electronic Medical Records for Program Integrity.

Can I start using the functionality earlier?
Yes. If you chose to opt in earlier, please ensure you are configured within Availity. You may request early access via this email address: dl-Prod-Availity-Provider-Support@anthem.com.

For additional information see our Frequently Asked Questions below:

How will I know I have access to this new functionality?
If you are a user with this privilege, you will receive an initial notification through the Availity Notifications center letting you know when the functionality is available. There will also be a link to the training in that notification.

Once I activate the new Medical Attachment functionality, what will happen?

Once you activate the functionality, it will notify the payer and from that date forward, the letters will come through electronically and will no longer be sent via paper.

What happens if I use Availity and am using this functionality, and then remove the privilege in Availity?
Once you deactivate the functionality, it will notify the payer and from that date forward, the letters switch from Availity back to paper copy.

If we have feedback for you, who should we contact?
Provide feedback to this email address dl-Prod-Availity-Provider-Support@anthem.com.

Can we still submit via paper?
Yes, you may still follow the instructions in the letter to submit medical records using the other means available.

After the records are submitted, can I still see what was sent?
Yes, you will have an electronic record of the submission in the “history” tab.

Will I be notified when a request comes in?
Yes, Availity will send you an email and add a notification in the notifications area to be alerted that there is a new request in the inbox.

What about the timelines?
The request will be in alignment with the current timelines for the letter. If the letter indicates you have 30 days to upload the records, within Availity the request will show the countdown of the days until the request will expire. Once it expires, the request will move to the History tab. If you did not respond to the first notice, it will expire, and a second notice with the next due date will appear, until the final notice appears and then expires. If all notices have expired, you may still upload the medical attachments using Availity through the **Send Attachments** option in the Attachments application.

This is for Availity. What about other provider portals?
We continue to look for system enhancements to improve the provider experience. We will advise you as enhancements are rolled out.

Is there a file size upload limitation?
The current upload is 100MB in cumulative. For example, you can upload two files that are each 50MB, or one file that is 100MB.

What do I do if the files are larger than 100MB?
Feel free to reach out to the Provider Call Center to communicate this is an issue for you.

Continue to submit the medical records that you can through the portal, and for additional medical records, use the **Send Attachment** option in the attachments application in Availity. You may continue to send records in the other means listed in the letter.

New Musculoskeletal and Pain Management Solution Effective for Select National ASO Accounts January 1, 2020

Musculoskeletal care and interventional pain management (MSK) pose substantial challenges for employers as costs rise, the population ages and physician practice patterns vary widely. With disorders affecting one in every two American adults[1], the need for evidence-based care and proactive consumer engagement is essential to better managing care and cost.

With that in mind, we are pleased to announce that select National Accounts will utilize the comprehensive Musculoskeletal and Pain Management Solution, administered by AIM Specialty Health. The new MSK program reviews certain spine and joint surgeries/procedures, and interventional pain services against clinical appropriateness criteria to help ensure that care aligns with established evidence-based medicine.

Transition Period
To ensure continuity of care, we will have a 90-day transition of care for members in active treatment for pain management or for members that have received prior approval through the Anthem precertification. Providers do not need to obtain authorization through AIM portal for services already in progress or where prior authorization has been obtained with Anthem.

Please contact anthem.com or call the number on the back of the member ID card for member eligibility.

1 American Academy of Orthopedic Surgeons

Important Update: Milliman Care Guideline (MCG), 23rd Edition, ORG: W0163 Pelvic Organ Prolapse Repair*

Effective for dates of service on and after May 1, 2020, the updated clinical UM guideline MCG ORG: W0163 Pelvic Organ Prolapse Repair will now include the medical necessity review for pelvic organ prolapse repair surgery.

Initially, the clinical guideline only applied for pelvic organ prolapse length of stay review. With this update it will also address the pre-operative and post-service medical necessity

review of pelvic organ prolapse repair procedures. This change is effective for dates of service on and after May 1, 2020.

This notice does not apply to Federal Employee Program® (FEP®), Medicare and Medicaid.

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Outpatient Facility Edit Implementation*

Beginning with claims processed on and after April, 26, 2020, we will be enhancing our outpatient facility edits for revenue codes, Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) and modifiers. Enhanced edits include appropriate use of various code combinations which can include, but are not limited to:

- Procedure code to revenue code
- HCPCS to revenue code
- Type of bill to procedure code
- Type of bill to HCPCS code
- Procedure code to modifier
- HCPCS to modifier

These edits are based on national correct coding guidelines and principles. The following coding resources are excellent resources to use for guidance; (CPT) codebook, (HCPCS) codebook, National Uniform Billing Committee (NUBC) and the Uniform Billing (UB) Editor codebook. Additionally, Anthem will begin adoption of the National Correct Coding Initiatives (NCCI) for Outpatient Facilities to include industry-standard column one and column two procedure-to-procedure (PTP) codes.

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2020 FEP® Benefit information available online

To view the 2020 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org > select Benefit Plans > Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2020.

For questions please contact FEP 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 -- January 2020

Category: Medicare

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

- Ohio 2020 Medicare Advantage plan changes
- Medical Policies and Clinical Utilization Management Guidelines update
- Pharmacy benefit manager change to IngenioRx
- Prior authorization requirements for E0784, K0553 and K0554
- City of Cincinnati Retirement System to offer Medicare Advantage option
- City of Marietta offers Medicare Advantage Option

Postponed -- Review of professional claims with emergency room level 5 E/M codes

Category: Medicare

Anthem Blue Cross and Blue Shield communicated to you in an article published on June 1, 2019 that we were initiating post-payment reviews for professional emergency room (ER) claims billed with level 5 ER evaluation and management (E/M) codes 99285 and G0384.

The implementation of this policy has been postponed.

This update relates only to the policy announced June 1, 2019. All other current policies applicable to you, including but not limited to other audit or reimbursement policies pertaining to ER claims, are unaffected by this update. We will keep you informed about the initiation of the review process; however, we require proper coding and billing to ensure prompt and accurate payment.

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Introducing ConcertoHealth

Category: Medicare

Beginning September 1 2019, Anthem Blue Cross and Blue Shield (Anthem) will began working with ConcertoHealth® to offer health care administrative services at no additional cost to qualifying Medicare Advantage HMO and Dual-Special Needs Plan members.

ConcertoHealth connects patients with needed preventive care at your office or with in-network screening facilities. Examples of needed care include:

- Scheduling patients for annual wellness visits or physical examinations.
- Arranging patients for mammography or colorectal screenings, including sending at-home kits, as appropriate.
- Facilitating transportation to and from appointments based on benefit plan availability.
- Addressing Rx needs, including medication adherence, medication review or reconciliation, particularly post-discharge.
- Connecting qualifying patients to additional Anthem partners for in-home assessments.

ConcertoHealth will bring visibility to clinical documentation gap closure in conjunction with existing Anthem provider partnership efforts. Your offices and patients will receive phone calls from the patient outreach specialists, pharmacists, and nurses at ConcertoHealth weekdays from 8 a.m. to 5 p.m. Eastern time.

502754OHPENABS

Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ

Category: Medicare

The Group Retiree Medicare Advantage PPO plans for Anthem BlueCross BlueShield (Anthem) members may include the National Access Plus benefit, which allows retirees to receive services from any provider, as long as the provider is eligible to receive payments from Medicare and accepts the member's PPO plan. These PPO plans also offer benefits that original Medicare doesn't cover, including an annual routine physical exam, hearing, vision, chiropractic care, acupuncture, LiveHealth Online and SilverSneakers®.

If you are already part of our Medicare Advantage PPO network, thank you.

The attached FAQ will be helpful as you grow your practice and serve members who may be new to our Group Retiree PPO plans.

Out-of-network providers are paid Medicare allowable rates for covered services, less the members' copayment, coinsurance and/or deductible. **No contract is required.**

With the National Access Plus benefit, the member's cost share doesn't change — whether local or nationwide; doctor or hospital; in- or out-of-network.

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Electric Boat offers Medicare Advantage options

Category: Medicare

Effective January 1, 2020, Electric Boat retirees who are eligible for Medicare Parts A and B will be enrolled in a Medicare PPO plan under Anthem Blue Cross and Blue Shield (Anthem). The plan includes the National Access Plus benefit, which allows retirees the freedom to receive services from any provider as long as the provider is eligible to receive payments from Medicare. Additionally, Electric Boat retirees will have the same cost share for both in-network and out-of-network covered services. The Medicare Advantage plan offers the same hospital and medical benefits that original Medicare covers, as well as additional benefits that original Medicare does not cover, such as an annual routine physical exam, LiveHealth Online and SilverSneakers.

The prefix on Electric Boat ID cards will be **ZDX**.
The cards will also show the National Access Plus icon.

Providers can submit claims electronically using the electronic payer ID for the Anthem plan in their state or submit a *UB-04* or *CMS-1500* form to the Anthem plan in their state.

Claims should not be filed with original Medicare.

Detailed prior authorization requirements also are available to contracted providers by accessing the provider self-service tool at availity.com.

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Ohio IAM Local 2848 Retiree VEBA moves to Medicare Advantage plan under Anthem

Category: Medicare

Effective January 1, 2020, the International Association of Machinists (IAM) Local 2848 Voluntary Employees Beneficiary Association (VEBA) will offer an Anthem Medicare Preferred (PPO) plan. Anthem Blue Cross and Blue Shield (Anthem) will provide medical benefits for the IAM Local 2848 Retiree VEBA retirees through the Local Preferred Provider Organization (LPPO) product under Anthem. 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.

Non-contracted providers may continue treating IAM Local 2848 Retiree VEBA members and will be reimbursed at 100% of Medicare's allowed amount for covered services, less any member cost share.

IAM Local 2848 Retiree VEBA members' copay or coinsurance percentage will be the same whether their provider is in- or out-of-network. Locally or nationwide, doctors or hospitals, in- or out-of-network — the member's cost share doesn't change.

The Medicare Advantage plan offers the same hospital and medical benefits that Medicare covers and also covers additional benefits that Medicare does not, such as hearing, LiveHealth® Online and SilverSneakers®.

The prefix on Medicare Advantage ID cards is **ZVR**.

Providers may call Provider Services at 1-833-848-8730 for eligibility, prior authorization (PA) requirements and any questions about the IAM Local 2848 Retiree VEBA member benefits or coverage.

Detailed PA requirements are also available to contracted providers by accessing the

provider self-service tool via availity.com.

Providers will follow their normal claim filing procedures for IAM Local 2848 Retiree VEBA member claims.

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2020 Medicare risk adjustment provider trainings

Category: Medicare

The Medicare Risk Adjustment Regulatory Compliance team at Anthem Blue Cross and Blue Shield offers two provider training programs regarding Medicare risk adjustment and documentation guidelines. Information for each training is outlined below.

Medicare Risk Adjustment and Documentation Guidance (general)

When: This training is offered the first Wednesday of each month from 1 p.m. to 2 p.m. ET.

Learning objective: This onboarding training will 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*, from January 8, 2020, to December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us, register for one of the monthly training sessions at the link below:
https://antheminc.webex.com/antheminc/onstage/g.php?PRID=ebf3cdd26235fc183d9bea237e3abb9b

Note: Dates may be modified due to holiday scheduling.

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

When: This training is offered on the third Wednesday of every other month from noon to 1 p.m. ET.

Learning objective: This is a collaborative learning event with Enhanced Personal Health Care to provide in-depth disease information training pertaining to specific conditions, including an overview of their corresponding HCCs and guidance on documentation and coding.

Credits: An application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

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

- Session 1: Red flag HCCs, part one — January 15, 2020 Training will cover HCCs most commonly reported in error as identified by CMS, including chronic kidney disease (stage five), ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina, other acute ischemic heart disease, and end-stage liver disease.
    - Event info: https://antheminc.webex.com/antheminc/onstage/g.php?MTID=e9f358c5563cc4c0829bb138c8696cb83
- Session 2: Red flag HCCs,part two — March 18, 2020 Training will cover HCCs most commonly reported in error as identified by CMS, including atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, and diabetes with ophthalmologic or unspecified manifestation.
    - Event info: https://antheminc.webex.com/antheminc/onstage/g.php?MTID=e8428badb6c0750857cdbcafbdff4ec2b
- Session 3: Neoplasms — May 20, 2020
    - Event info: https://antheminc.webex.com/antheminc/onstage/g.php?MTID=e6735e986e707cac0ac75fa93838acb77
- Session 4: Acute, chronic and status conditions — July 15, 2020
    - Event info: https://antheminc.webex.com/antheminc/onstage/g.php?MTID=ed7adf53b5ed42dfd49654713106235bb
- Session 5: Diabetes mellitus and other metabolic disorders — September 16, 2020
    - Event info: https://antheminc.webex.com/antheminc/onstage/g.php?MTID=e0d6675828816ea1a678a3261888dbbb8
- Session 6: TBD (This Medicare risk adjustment webinar will cover the critical topics and updates that surface during the year.) — November 18, 2020

- Event info: https://antheminc.webex.com/antheminc/onstage/g.php?MTID=ee60adfa56727e0d4253800c7818fcf21

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Medicare preferred continuous glucose monitors

Category: Medicare

On January 1, 2020, Anthem Blue Cross and Blue Shield (Anthem) will implement a preferred edit on Medicare-eligible continuous glucose monitors (CGMs). Currently, there are two CGM systems covered by CMS under the Medicare Advantage Part D (MAPD) benefit; these are Dexcom and Freestyle Libre. The preferred CGM for Medicare Advantage Part D individual members covered by Anthem will be Freestyle Libre. This edit will only affect members who are newly receiving a CGM system. Members will need to obtain their CGM system from a retail or mail order pharmacy – not a durable medical equipment (DME) facility. For Dexcom coverage requests, call **1-833-293-0661**.

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August 2019 Medical drug benefit Clinical Criteria updates

Category: Medicare

On August 16, 2019, the Pharmacy and Therapeutics (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, and the effective dates will be reflected in the *Clinical Criteria Web Posting August 2019*. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.

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September 2019 Medical drug benefit Clinical Criteria updates

Category: Medicare

On September 19, 2019, the Pharmacy and Therapeutics (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, and the effective dates will be reflected in the *Medicare Advantage Clinical Criteria Web Posting September 2019.* Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.

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Help protect your patients by providing medical ID protection - best practices

Category: Medicare

Overview
Many of our members have reported that they received unsolicited calls (or emails) from an individual or company offering to provide durable equipment devices, such as back or leg braces, or items such as topical creams at little or no cost. While it may be tempting to want to receive something for free, members should know that there is a cost.

Although our members may not receive a bill for these devices or medications, the items are billed to the insurance companies, costing hundreds or even thousands of dollars each.

How does this impact members?
Members should also know that the cost may be more than monetary. Allergic reactions may occur when using medications that are not properly prescribed. Ill-fitting leg or back braces, or equipment that is not specifically intended for the pain experienced by the member, could do more harm than good.

This problem is prevalent throughout the country, so all of our members should be aware. Billions of unsolicited telemarketing calls are made each year, many of which are promoting health care services. Calls often spoof local phone numbers or numbers that appear familiar to trick the recipient into accepting the call.

How can I help protect my patients?
While the ultimate purpose of these telemarketing calls is to sell these items, the immediate goal of the person or company placing the call is to obtain valuable personally identifiable information (PII) from the member. Without this personal information, such as a social security number or insurance identification number, selling these devices and medications is much more difficult. Share this information with you patients to help them learn how to protect their PII.

You can help protect your patients and their personally identifiable information from scams by reminding them of the following:

- Don’t fall prey to scams!
- Take a few moments to review your *Explanation of Benefits (EOB)* and the services listed.
- When receiving robotic (robo) or telemarketing calls:
    - Simply hang up the phone.
    - Beware of threatening or urgent language used by the caller.
    - Do not provide any personally identifiable information such as your social security number or insurance identification number. The caller may imply that they have your information and ask you to provide it to confirm that they have the correct information. Do not provide the information or confirm it if they do happen to have any identification information.
- When receiving emails:
    - Do not open email attachments you weren’t expecting.
    - Check for spelling mistakes and poor grammar.
    - Do **not** click on the links you are sent. You can type the link into a new browser.
    - Online scams can come from anywhere. Take a few moments to review your *EOB* and confirm that you received the services listed on the *EOB*.
- Additional ways to protect yourself:
    - Shred or destroy obsolete documents that contain medical claims information or *EOBs*.
    - Do not use social media to share medical treatment information.

How to report when you receive what you suspect is a scam call or email:

1. To file a complaint with the Federal Trade Commission, you can go to: https://ftc.gov/complaint or call **1-877-FTC-HELP**.
2. Members may contact their plan’s Member Services department.

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Reminder: Medicare claims for secondary payer must be submitted after the 30-day Medicare remittance period

Category: Medicare

Claims will deny when a provider submits a Medicare claim to Anthem Blue Cross and Blue Shield (Anthem) as a secondary payer if the claim has been received prior to the 30-day Medicare remittance period. Providers submitting a paper claim for Medicare claims that are filed with Medicare as the first payer must not file with Anthem as the secondary payer until the 30-day remittance period has expired.

These claims rejections are a result of improper timely filing by providers. To eliminate claims rejections when Anthem is the secondary payer, submit the claim 30 days after the Medicare Remittance period.

For additional information, call the number on the back of the member's ID card.

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Healthcare Quality Patient Assessment Form and Patient Assessment Form

Category: Medicare

Anthem Blue Cross and Blue Shield (Anthem) offers the *Healthcare Quality Patient Assessment Form (HQPAF)/Patient Assessment Form (PAF)*. This newsletter focuses on key tips that may help participating providers successfully close out their 2019 *HQPAF/PAF*.

Dates and tips to remember:

1. Anthem encourages you to review your patient population as soon as possible. You can help patients schedule an in-office visit. These appointments help the patient manage chronic conditions, which impact the health status of the patient.
2. At the conclusion of each office visit with the patient, providers who are participating in the *HQPAF/PAF* program are asked to complete and return a *HQPAF/PAF*. The form should be completed based on information collected during the visit. Participating providers may continue to use the 2019 version of the *HQPAF/PAF* for encounters taking place on or before December 31, 2019. Anthem will accept the 2019 version of the *HQPAF/PAF* for 2019 encounters until midnight on January 31, 2020. Important note: *HQPAF/PAF* for 2019 dates of service that are rejected due to provider error and

corrected by the provider may be submitted through March 31, 2020.

3. **If not already submitted, participating providers are required to submit** an *Account Setup Form (ASF)*, *W9* and a completed direct deposit enrollment by March 31, 2020. Participating providers should call **1-877-751-9207** if they have questions regarding this requirement. Failure by a participating provider to comply with this requirement will result in forfeiture of the provider payment for submitted 2019 *HQPAF/PAF* program, if applicable.

If you have any questions about the PAF or HQPAF programs, please call **1-877-751-9207** from 9:30 a.m. to 7:30 p.m. Eastern time, Monday to Friday.

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