Ohio Provider News

June 2020 Anthem Provider News - Ohio

Reimbursement Policies:

Medicare:

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

Published: Jun 1, 2020 - **Administrative**

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 and are noted with a star (*):

- Anthem prior authorization updates for specialty pharmacy are available*
- National Drug Code requirement on outpatient claims*
- Medical Policy and Clinical Guideline Updates – June 2020*
- Transition to AIM Rehabilitative Services Clinical Appropriateness Guidelines*
- REMINDER: AIM Rehabilitative Program Pediatric Exclusions

Other Important Updates

- Medicare and Medicaid News

URL: https://providernews.anthem.com/ohio/article/notice-of-material-changesamendments-to-contract-and-prior-authorization-changes-june-2020

A special thank you to Care Providers

Published: Jun 1, 2020 - **Administrative**

We want to express our most sincere thanks for your dedication to serving the patients in your care. Please take a moment to watch this brief **thank you message** from Anthem Blue Cross and Blue Shield.

URL: https://providernews.anthem.com/ohio/article/a-special-thank-you-to-care-providers-1

UPDATE: New Level of Care Medical Necessity Review of Upper and Lower Endoscopy procedures is delayed

Published: Jun 1, 2020 - **Products & Programs**

Please be aware that the Level of Care Medical Necessity Review of Upper and Lower Endoscopy procedures that was previously announced in the March 2020 edition of Anthem *Provider News* is delayed until further notice. A new program launch date will be communicated prior to implementation of the review.

Anthem invites you to take advantage of an informational webinar that will introduce you to the Level of Care Review of Upper and Lower Endoscopy procedures and the capabilities of the AIM Provider*Portal*$_{SM.}$ Visit the AIM Surgical Procedures microsite to register for an upcoming training session.

469-0620-IN.MO.OH.WI

URL: https://providernews.anthem.com/ohio/article/update-new-level-of-care-medical-necessity-review-of-upper-and-lower-endoscopy-procedures-is-delayed

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Quality Corner: Follow-Up after Hospitalization for Mental Illness

Published: Jun 1, 2020 - **Products & Programs** / Behavioral Health

As a provider, we understand you are committed to providing the best care for our members, including follow up appointments with members after a behavioral health (BH) inpatient stay. Since regular monitoring, follow-up appointments and making necessary treatment recommendations or changes are all part of excellent care, we would like to provide an overview of the related HEDIS measure.

The Follow-Up after Hospitalization for Mental Illness (FUH) HEDIS measure evaluates members age six years and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

- The percentage of behavioral health inpatient discharges for which the member received follow-up within 7 days after discharge.

- The percentage of behavioral health inpatient discharges for which the member received follow-up within 30 days after discharge.

On a regular basis, we continue to monitor if these two consecutive follow-up appointments are being recommended and scheduled during the inpatient stay as part of discharge planning by the eligible behavioral health facilities (such as psychiatric hospitals, freestanding mental health facilities and acute care hospitals with psychiatric units), as well as practicing behavioral health providers.

Please consider the following for improving member outcomes for this measure:

- Early follow up with a BH provider can help with continuing treatment after leaving the hospital.
- With greater emphasis on care coordination, primary care providers can help facilitate the BH follow-up appointments.
- Weekend member discharges have shown to have very inconsistent follow up after discharge. Start discharge planning as soon as possible while members are inpatients so those who are discharged on weekends have scheduled follow-up appointments.
- In addition, other social determinants of health pertinent to the member, such as housing, food, living in a rural area, transportation, job schedule, family and social support, child care, etc., can impact follow-up opportunities. Please address these needs and issues; refer to resources that can help support the member.
- Social workers at the facilities can contact Anthem member services to learn if additional sources of assistance are available through Anthem such as case management and other referrals.
- Telehealth services have been identified as part of follow up for this HEDIS measure available in certain parts of the country. Telehealth follow up may not be the best choice for everyone; however, not having a BH follow up for several weeks can be detrimental to the member can be a reason for relapse.

440-0620-CNT

URL: https://providernews.anthem.com/ohio/article/quality-corner-follow-up-after-hospitalization-for-mental-illness

Anthem prior authorization updates for specialty pharmacy are available - June 2020*

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

Prior authorization updates

Effective for dates of service on and after September 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

Please note, inclusion of NDC code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

To access the Clinical Criteria information please click here.

Anthem's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. *Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company, and are shown in italics in the table below.*

Clinical Criteria	HCPCS or CPT Code(s)	Drug
ING-CC-0161	*C9399* *J3490* *J3590* *J9999*	*Sarclisa*
**ING-CC-0058*	*J2354*	*Bynfezia*

***** Non-oncology use is managed by Anthem's medical specialty drug review team.
Oncology use is managed by AIM.

Step therapy updates

Effective for dates of service on and after September 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process.

To access the step therapy drug list, please click here.

Anthem's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

Clinical Criteria	Status	Drug(s)	HCPCS Code(s)
ING-CC-0003	Non-preferred	Panzyga	J1599
ING-CC-0003	Non-preferred	Xembify	J3490

* 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

458-0620-IN.OH.WI

URL: https://providernews.anthem.com/ohio/article/anthem-prior-authorization-updates-for-specialty-pharmacy-are-available-june-2020-1

Reminder: Anthem requires National Drug Code for professional and facility outpatient claims effective June 15, 2020*

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

In the March edition of *Provider News*, Anthem Blue Cross and Blue Shield (Anthem) notified providers about a new billing requirement to help us determine the correct amount to pay on drug claim lines for commercial professional and facility outpatient claims filed to us. **As a reminder, effective for dates of service on and after June 15, 2020, the following information will be required on claims for all categories of drugs except for those administered in an inpatient facility setting:**

1. Applicable HCPCS code or CPT code
2. Number of HCPCS code or CPT code units
3. Valid 11-digit National Drug Code(s) (NDC), **including the N4 qualifier**
4. Unit of Measurement qualifier (F2, GR, ML, UN, MG)
5. NDC units dispensed (must be greater than 0)

Note: *These billing requirements apply to Local Plan and BlueCard® only.* This notice EXCLUDES claims for members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP) and Coordination of Benefits/secondary claims.

As we shared in the original notification, Anthem will deny any line items on a claim regarding drugs that do not include the above information – effective for dates of service on and after June 15, 2020. Please include the above information on drug claims to help ensure accurate and timely payments.

If you have questions, please contact Provider Services.

* 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

442-0620-IN.OH.WI

URL: https://providernews.anthem.com/ohio/article/reminder-anthem-requires-national-drug-code-for-professional-and-facility-outpatient-claims-effective-june-15-2020-1

Pharmacy information available at anthem.com

Published: Jun 1, 2020 - **Products & Programs** / Pharmacy

Visit Pharmacy Information for Providers on anthem.com 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.

463-0620-IN.OH.WI

URL: https://providernews.anthem.com/ohio/article/pharmacy-information-available-at-anthemcom-23

Anthem introduces lower cost Anthem Health Access Plans on June 1 in response to COVID-19 crisis

Published: Jun 1, 2020 - **Administrative**

Like many, Anthem Blue Cross and Blue Shield (Anthem) is closely monitoring COVID-19 developments and what it means for our customers and our health care provider partners. Anthem is working to help employers who are facing tough decisions on furloughing or reducing hours of their workforce. Anthem is doing this by creating health insurance options that provide continued access to care. We continue to seek ways to support our customers by offering affordable alternate products with more flexibility while ensuring members can continue to see their established physicians.

Beginning June 1, 2020, Anthem is introducing our Anthem Health Access Plans for certain large group employers currently enrolled in our commercial lines of business only.

Anthem Health Access Plans cover the diagnosis and treatment for COVID-19 at 100% in accordance with Anthem guidelines.

These benefit plans cover preventive care, unlimited telemedicine, office visits, prescriptions and more. In addition, members enrolled in these plans have digital ID cards and access to Sydney Health and Sydney Care (Anthem's mobile app that runs on intelligence – as part of our digital strategy).

These plans include some coverage exclusions or limitations. For information about eligibility, available benefits, and a list of exclusions, please visit Availity – our Web-based provider tool at Availity.com.

We are committed to working with our provider partners to help our members focus on their health and well-being. The new Health Access plans give your patients the needed coverage to manage their everyday health needs.

NOTE: As with all eligibility and benefits inquiries on Availity, providers must have the member ID number (including the three-character prefix) and one or more search options of date of birth, first name and last name.

520-0620-CNT

URL: https://providernews.anthem.com/ohio/article/anthem-introduces-lower-cost-anthem-health-access-plans-on-june-1-in-response-to-covid-19-crisis-2

Anthem Commercial Risk Adjustment (CRA) Program Update: Retrospective Program Begins; Prospective Program Continues

Published: Jun 1, 2020 - **Administrative**

Anthem Blue Cross and Blue Shield (Anthem) is committed to collaborating with the provider community and offering flexible options to meet the needs of both the retrospective program and the prospective program. The retrospective program focuses on medical chart collection. The prospective program focuses on member health assessments for patients with undocumented Hierarchical Condition Categories (HCC's), in order to help close patients' gaps in care.

Retrospective Chart Requests

We appreciate that care providers across the country on the front line are committed to providing care during these challenging times, and as such, that care results in a visit where we may need the medical chart. Medical chart collection must be done to obtain undocumented HCC's on your patients in order to be compliant with the provisions of the Affordable Care Act, (ACA), that require our company to collect and report diagnosis code data for ACA membership. This process will begin in June. In order to make these chart requests the most efficient for your office, we have electronic options available:

- EMR Interoperability
    - Allscripts (Opt in – signature required)
    - NextGen
    - Athenahealth
    - MEDENT

- Remote/Direct Anthem access
- Vendor virtual or onsite visit (if the offices are opened back up from COVID-19 closures)
- Secure FTP

The goal of these electronic options is to both improve the medical record data extraction and the experience for Anthem's providers. If you are interested in this type of set up or any other remote access options, please contact the Commercial Risk Adjustment Network Education Representative listed below.

Prospective Patient Outreach

In addition to the office visit reimbursement, physicians are eligible to receive incentive opportunity for properly completed health assessments:

- **$100 for electronic submissions**
  OR
- **$50 for paper submissions**

We encourage members to form a relationship with their Primary Care Physician to complete a clinical assessment to ensure you have a clearer picture of your patients' health. Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. Previous Anthem news updates have given telehealth reimbursement guidance to follow when submitting the claim.

As a reminder, the May newsletter mentioned incentives for prospective program participation ($100 or $50**)**. We would be happy to meet and review incentive opportunities along with other flexible options for program participation and chart collection. Please contact the Commercial Risk Adjustment Network Education Representative at Mary.Swanson@anthem.com to set up a meeting.

Thank you for your continued efforts with the CRA Program.

454-0620-CNT

URL: https://providernews.anthem.com/ohio/article/anthem-commercial-risk-adjustment-cra-program-update-retrospective-program-begins-prospective-program-continues-1

Availity Portal Notification Center

Published: Jun 1, 2020 - **Administrative**

Anthem Blue Cross and Blue Shield (Anthem) is now using the **Notification Center** on the Availity Portal home page to communicate vital, time sensitive information. A **Take Action** call out and a red flag in front of the message will make it easy to see that there is something new requiring your attention.

The Notification Center is currently being used to notify you if there are payment integrity requests for medical records or recommended training in the Custom Learning Center. Select the **Take Action** icon to instantly access the custom learning recommended course.

For membership where the disputes tool is available, Availity will also post a message in the notification center when a dispute request you have submitted is finalized. Selecting the **Take Action** icon will allow easy access to your appeals worklist for details.

Viewing the Notification Center updates should be included as part of your regular workflow so you are always aware of any outstanding action items and can respond timely.

457-0620-CNT

URL: https://providernews.anthem.com/ohio/article/availity-portal-notification-center-1

Quality Corner: CPT® Category II Codes - Collaborating for enhanced patient care

Published: Jun 1, 2020 - **Administrative**

The American Medical Association has an alphabetical listing of clinical conditions with which measures and CPT Category II codes are associated.

The use of CPT Category II Codes and ICD-10-CM codes can reduce the number of medical records that we request during the HEDIS® medical record review season (January – May each year), thus reducing the administrative burden on physician offices.

Below are some commonly used codes for your convenience:

Measure	Description	CPT II Code	Exclusions
Comprehensive Diabetes Care	Whether or not patient age 18-75 years had screening or monitoring for diabetic retinal disease	• **2022F** - Dilated retinal eye exam with interpretation by ophthalmologist or optometrist documented and reviewed with evidence of retinopathy • **2023F** - Dilated retinal eye exam with interpretation by ophthalmologist or optometrist documented and reviewed without retinopathy • **3072F** - Low risk for retinopathy (no evidence of retinopathy in the prior year)	Documentation of gestational diabetes or steroid induced diabetes.
Comprehensive Diabetes Care	Whether or not patient age 18-75 years most recent A1c level is controlled.	• **3044F** - Most recent hemoglobin A1c level < 7.0% • **3051F** - Most recent hemoglobin A1c (HbA1c) level ≥ to 7.0% and < 8.0% • **3052F** - Most recent hemoglobin A1c (HbA1c) level ≥ to 8.0% and ≤ to 9.0% • **3046F** - Most recent hemoglobin A1c level > 9.0%	• Report one of the four Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. • Documentation of medical reasons for not pursuing tight control of A1c level (i.e., steroid-induced or gestational diabetes, frailty and/or advanced illness).

Comprehensive Diabetes Care	Whether or not a patient age 18-75 years received urine protein screening or medical attention for nephropathy	• **3060F** - Positive microalbuminuria test documented and reviewed • **3061F** - Negative microalbuminuria test result documented and reviewed • **3062F** - Positive Macroalbuminuria test result documented and reviewed • **3066F** - Documentation of treatment for nephropathy	Documentation of gestational diabetes or steroid induced diabetes.
Controlling High Blood Pressure	Whether or not the patient aged 18 years and older with a diagnosis of hypertension has: • a blood pressure reading < 140 mm Hg systolic and < 90 mm Hg diastolic **OR** • a blood pressure reading ≥ 140 mm Hg systolic and < 90 mm Hg diastolic and prescribed 2 or more anti-hypertensive agents during the most recent visit	• **3074F** - Most recent systolic blood pressure < 130 mm Hg • **3075F** - Most recent systolic blood pressure 130 to 139 mm Hg • **3077F** - Most recent systolic blood pressure ≥ 140 mm Hg • **3078F** - Most recent diastolic blood pressure < 80 mm Hg • **3079F** - Most recent diastolic blood pressure 80 to 89 mm Hg • **3080F** - Most recent diastolic blood pressure ≥ 90 mm Hg • **4145F** - Two or more anti-hypertensive agents prescribed or currently being taken	• Report one of the three systolic codes; • Report one of the three diastolic codes. • Documentation of reason(s) for not prescribing 2 or more anti-hypertensive medications: - Medical (i.e. allergy, intolerant, postural hypotension or other reason) - Patient (i.e. patient declined, or other patient reason) - System (i.e. financial or other system reason)

Timeliness of Prenatal Care	Women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery.	• **0500F** - Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. (Report also date of visit and, in a separate field, the date of the last menstrual period – LMP) • **0501F** - Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period – LMP *Note:* If reporting **0501F** Prenatal flow sheet, it is not necessary to report **0500F** Initial prenatal care visit	

Timeliness of Postpartum Care	Number of women in the denominator who had a postpartum visit on or between 21 days and 56 days after delivery. Denominator: Women who had live births between November 6 of the year prior to the measurement year and November 5 of the measurement year	**0503F** - Postpartum care visit	

460-0620-CNT

URL: https://providernews.anthem.com/ohio/article/quality-corner-cpt-category-ii-codes-collaborating-for-enhanced-patient-care-1

Medical Policy and Clinical Guideline Updates - June 2020*

Published: Jun 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were reviewed on February 20, 2020 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Below are new medical policies and/or clinical guidelines.

*NOTE *Precertification required*

Title	Information	Effective Date
*DME.00041 Low Intensity Therapeutic Ultrasound for the Treatment of Pain	• The use of a low intensity therapeutic ultrasound device is considered Investigational and Not Medically Necessary (INV&NMN) for all indications - HCPCS DME code K1004; considered INV&NMN	9/1/2020
GENE.00053 Metagenomic Sequencing for Infectious Disease in the Outpatient Setting	• Metagenomic sequencing for infectious diseases in the outpatient setting is considered Investigational and Not Medically Necessary (INV&NMN) for all indications - Existing CPT codes 0112U, 0152U will be considered INV&NMN; also listed NOC code 87999	9/1/2020
GENE.00054 Paired DNA and Messenger RNA (mRNA) Genetic Testing to Detect, Diagnose and Manage Cancer	• Messenger RNA (mRNA) sequence analysis alone or in conjunction with DNA sequence analysis to aid in the classification of variations of uncertain significance or to otherwise detect, diagnose or manage cancer is considered INV&NMN - Existing codes 0133U, 0136U, 0137U and 0138U (effective 10/01/19), 0157U, 0158U, 0159U, 0160U, 0161U and 0162U will be considered INV&NMN	9/1/2020

*SURG.00154 Microsurgical Procedures for the Treatment of Lymphedema	Microsurgery for the treatment of lymphedema (including lymphedema as a result of a mastectomy) is considered INV&NMN, including but not limited to the following: 1. Lymphaticolymphatic bypass; 2. Lymphovenous bypass; 3. Lymphaticovenular anastomosis; 4. Vascularized lymph node transfer; 5. Tissue/Flap transfer (for example, omental flap transfer)	9/1/2020
*SURG.00155 Cryoneurolysis for Treatment of Peripheral Nerve Pain	• Cryoneurolysis for treatment of peripheral nerve pain is considered INV&NMN for all indications, including osteoarthritis of the knee	9/1/2020

Below are current Clinical Guidelines and/or Medical policies that were reviewed and updates were approved.

*NOTE *Precertification required*

Title	Change	Effective date
DME.00011 Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices **Previous title:** Electrical Stimulation as a Treatment for Pain and Related Conditions: Surface and Percutaneous Devices	• Revised title • Revised scope of document to include other conditions and devices • Added cranial electrical stimulation (CES) as INV&NMN for all indications • Added remote electrical neuromodulation (REN) as INV&NMN for all indications - Added HCPCS code K1002 for cranial electrotherapy stimulation systems, considered INV&NMN; no specific code for REN systems (E1399 NOC)	9/1/2020
LAB.00011 Analysis of Proteomic Patterns	• Revised INV&NMN statement to include management of disease	9/1/2020
MED.00120 Gene Therapy for Ocular Conditions **Previous title:** Voretigene neparvovec-rzyl (Luxturna®)	• Revised title • Expanded scope of document to include all gene therapies for ocular conditions • Removed redundant language "gene therapy" • Added the use of all other gene replacement therapies to treat any ocular condition as INV&NMN - Added HCPCS code J3490 NOC	9/1/2020

*SURG.00032 Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention **Previous title:** Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention	• Revised title • Added left atrial appendage closure via surgical (non-percutaneous) implantation of a device as INV&NMN for all indications - Added 33999 NOC; added ICD-10-PCS 02L70CK, 02L70DK, 02L73CK, 02L74CK, 02L74DK considered INV&NMN	9/1/2020
*SURG.00096 Surgical and Ablative Treatments for Chronic Headaches	Added existing CPT codes 14040, 14041, 14060, 14061, 64716, 64771, 64772, 64787 and diagnosis codes G50.1, M54.81, R51 based on inquiries and society guidelines; considered INV&NMN for headache diagnoses	9/1/2020
*CG-SURG-107 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)	• Content moved from SURG.00028 • INV&NMN changed to NMN as a result of Medical Policy (MP) to Clinical UM Guideline (CUMG) transition - Added examples of technologies for prostatic urethral lift, transurethral convective water vapor thermal ablation and waterjet tissue ablation - Added NMN statement for prostatic urethral lift when the intent is to treat symptoms of conditions other than benign prostatic hyperplasia	9/1/2020

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URL: https://providernews.anthem.com/ohio/article/medical-policy-and-clinical-guideline-updates-june-2020

Transition to AIM Rehabilitative Services Clinical Appropriateness Guidelines*

Published: Jun 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

Effective October 1, 2020, Anthem Blue Cross and Blue Shield (Anthem) will transition the clinical criteria for medical necessity review of certain rehabilitative services to AIM Rehabilitative Service Clinical Appropriateness Guidelines as part of the AIM Rehabilitation Program. Reviewed services will include certain physical therapy, occupational therapy and speech therapy services.

As part of this transition of clinical criteria, the following procedures will be subject to prior authorization as part of the AIM Rehabilitation program:

CPT code	Description
90912	Biofeedback training for bowel or bladder control, initial 15 minutes
90913	Biofeedback training for bowel or bladder control, additional 15 minutes
96001	Three-dimensional, video-taped, computer-based gait analysis during walking
0552T	Low-level laser therapy, dynamic photonic and dynamic thermokinetic energies, provided by a physician or other qualified health care professional
S8940	Therapeutic horseback riding, per session
S8948	Treatment with low level laser (phototherapy) each 15 minutes
S9090	Vertebral axial decompression (lumbar traction), per session
20560	Needle insertion(s) without injection(s), 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s), 3 or more muscle(s)
90901	Biofeedback training by any modality (when done for medically necessary indications)
97129	One-on-one therapeutic interventions focused on thought processing and strategies to manage activities
97130	each additional 15 minutes (list separately in addition to code for primary procedure)
92630	Hearing training and therapy for hearing loss prior to learning to speak
92633	Hearing training and therapy for hearing loss after speech

The following procedure will be removed from the program:

CPT code	Description
S9117	back school, per visit

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday–Friday, 8:30 a.m.–7:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

* 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

467-0620-IN.OH.WI

URL: https://providernews.anthem.com/ohio/article/transition-to-aim-rehabilitative-services-clinical-appropriateness-guidelines-3

REMINDER: AIM Rehabilitative Program Pediatric Exclusions

Published: Jun 1, 2020 - **Policy Updates** / Medical Policy & Clinical Guidelines

As previously communicated in the October 2019 and December 2019 editions of Anthem Blue Cross and Blue Shield (Anthem) *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$_{SM}$.

There are many markets that have early childhood programs to protect the health and safety of children. They focus on improving the systems that serve young children and address their physical, emotional, social, cognitive and behavioral growth with the goal for all children to reach physical, social, emotional, behavioral, and cognitive milestones. In alignment with these goals, the AIM Rehabilitative program does not require prior authorization for physical, occupational and speech therapy services for pediatric members from birth to 36 months. Post service claims will not be subject to a medical management review either.

489-0620-CNT

URL: https://providernews.anthem.com/ohio/article/reminder-aim-rehabilitative-program-pediatric-exclusions

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New Reimbursement Policies - Nurse Practitioner and Physician Assistant Services (Professional)*

Published: Jun 1, 2020 - **Policy Updates** / Reimbursement Policies

A new professional reimbursement policy for Nurse Practitioner, and Physician Assistant services, will be implemented beginning with **dates of service on or after September 1, 2020**.

Anthem Blue Cross and Blue Shield (Anthem) will allow reimbursement for services provided by Nurse Practitioner (NP) and Physician Assistant (PA) providers. Unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise, reimbursement is based upon all of the following:

- The service is considered a physicians' service.
- The service is within the NP or PA provider's scope of practice.
- A payment reduction consistent with CMS reimbursement.

Services furnished by the NP or PA should be submitted with their own NPI.

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

* 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

470-0620-IN.OH.WI

URL: https://providernews.anthem.com/ohio/article/new-reimbursement-policies-nurse-practitioner-and-physician-assistant-services-professional-1

Medicare News - June 2020

Published: Jun 1, 2020 - **State & Federal** / Medicare

Please continue to check Important Medicare Advantage Updates for the latest Medicare Advantage information, including:

- Acquisition of Beacon Health Options
- MCG care guidelines – 24th edition

URL: https://providernews.anthem.com/ohio/article/medicare-news-june-2020

2020 Medicare risk adjustment provider trainings

Published: Jun 1, 2020 - **State & Federal** / 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: Offered the first Wednesday of each month from 1 to 2 pm 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 to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at https://bit.ly/2z4A81e.
**Note: Dates may be modified due to holiday scheduling.*

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

Series: Offered on the third Wednesday of every other month at 12 to 1 pm ET

Learning objective: This is a 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 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit 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 for this six-part training series, please see the list of topics and scheduled training dates below:

- **Red Flag HCCs, part one:** 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://bit.ly/3ae9znc

- **Red Flag HCCs, part two**: 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://bit.ly/3abKg52

- **Neoplasms** (*recording link will be available later 2020.)*
- **Acute, Chronic and Status Conditions** (July 15, 2020)

- https://bit.ly/2ygZfNR

- **Diabetes Mellitus and Other Metabolic Disorders** (September 16, 2020)

- https://bit.ly/2XQ9hjZ

- **TBD - This Medicare Risk Adjustment** webinar will cover the critical topics and updates that surface during the year (November 18, 2020)

- https://bit.ly/2xxjhUj

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URL: https://providernews.anthem.com/ohio/article/2020-medicare-risk-adjustment-provider-trainings-11

Updates to AIM Sleep Disorder Management Clinical Appropriateness Guideline

Published: Jun 1, 2020 - **State & Federal** / Medicare

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Specialty Health®* (AIM) Sleep Disorder Management Clinical Appropriateness Guideline.

Sleep Disorder Management Clinical Appropriateness Guideline updates by section:

- Bi-Level Positive Airway Pressure (BPAP) Devices:

- Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and alignment with Medicare requirements for use of BPAP
- Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing:

- Style change for clarity

- Code changes: none

As a reminder, ordering and servicing providers may submit prior authorization (PA) requests to AIM by:

- Accessing AIM's ProviderPortal$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real time, and is the fastest and most convenient way to request PA.
- Accessing AIM via the Availity Portal.*
- Calling the AIM Contact Center at **1-800-714-0040** from 6 a.m. to 6 p.m. CT.

What if I need assistance?
If you have questions related to AIM guidelines, email AIM at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/ohio/article/updates-to-aim-sleep-disorder-management-clinical-appropriateness-guideline-17

Anthem Blue Cross and Blue Shield (Anthem) working with Optum to collect medical records for risk adjustment

Published: Jun 1, 2020 - **State & Federal** / Medicare

Risk adjustment is the process by which the Centers for Medicare & Medicaid Services

(CMS) reimburses Medicare Advantage plans, based on the health status of their members. Risk adjustment was implemented to pay Medicare Advantage plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status.

In 2020, Anthem will work with Optum* who is working with Ciox Health* to request medical records with dates of service for the target year 2019 through present day.

Jaime Marcotte, Medicare Retrospective Risk Program Lead, is managing this project. If you have any questions regarding this program, please contact Jaime at jaime.marcotte@anthem.com or **1-843-666-1970**.

Additional information, including an FAQ, will be available on the provider website at Important Medicare Advantage Updates.

* Optum and Ciox Health are independent companies providing medical record review services on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/ohio/article/anthem-blue-cross-and-blue-shield-anthem-working-with-optum-to-collect-medical-records-for-risk-adjustment-1

Modifier use reminders

Published: Jun 1, 2020 - **State & Federal** / Medicare

Billing for patient treatment can be complex, particularly when determining whether modifiers are required for proper payment. Anthem Blue Cross and Blue Shield (Anthem) reimbursement policies and correct coding guidelines explain the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember

- Review the *CPT® Surgical Package Definition* found in the current year's *CPT Professional Edition*. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current *CPT Professional Edition Appendix A — Modifiers* for the appropriate use of modifiers 25, 57 and 59.

- When an evaluation and management (E&M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E&M service is “above and beyond” or “separate and significant” from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other non-E&M services performed on the same date of service. The modifier 59 represents services **not normally** performed together, but which may be reported together under the circumstances.

If you feel that you have received a denial after appropriately applying a modifier under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the use of the modifier(s) when submitting claims for consideration.

Anthem will publish additional articles on correct coding in provider communications.

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URL: https://providernews.anthem.com/ohio/article/modifier-use-reminders-11

Diabetes HbA1c < 8 HEDIS guidance

Published: Jun 1, 2020 - **State & Federal** / Medicare

Diabetes is a complex chronic illness requiring ongoing patient monitoring. The National Committee for Quality Assurance (NCQA) includes diabetes in its HEDIS® measures on which providers are rating annually.

Since diabetes HbA1c testing is a key measure to assess for future medical conditions related to complications of undiagnosed diabetes, NCQA requires that health plans review claims for diabetes in patient health records. The findings contribute to health plan Star Ratings for commercial and Medicare plans and the Quality Rating System measurement for marketplace plans. A systematic sample of patient records is pulled annually as part of the HEDIS medical record review to assess for documentation.

Which HEDIS measures are diabetes measures?
The diabetes measures focus on members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following assessments:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (> 9%)
- HbA1c control (< 8%)
- Dilated retinal exam
- Medical attention for nephropathy

The American College of Physicians' guidelines for people with type 2 diabetes recommend the desired A1c blood sugar control levels remain between 7% to 8%.[1]

In order to meet the HEDIS measure *HbA1c control < 8*, providers must document the date the test was performed and the corresponding result. For this reason, report one of the four Category II codes and use the date of service as the date of the test, not the date of the reporting of the Category II code.

To report most recent hemoglobin A1c level greater than or equal to 8% and less than 9%, use 3052F. To report most recent A1c level less than or equal to 9%, use codes 3044F, 3051F and 3052F:[2]

1. If the most recent hemoglobin A1c (HbA1c) level is less than 7%, use 3044F.
2. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 7% and less than 8%, use 3051F.
3. If the most recent hemoglobin A1c (HbA1c) level is greater than or equal to 8% and less than or equal to 9%, use 3052F.

Continued management and diverse pathways to care are essential in controlling blood glucose and reducing the risk of complications. While it is extremely beneficial for the patient to have continuous management, it also benefits our providers. As HEDIS rates increase, there is potential for the provider to earn maximum or additional revenue through Pay for Quality, Value-Based Services and other pay-for-performance models.[3]

Racial and ethnic disparities with diabetes
It is also important for providers to be aware of critical diabetes disparities that exist for diverse populations.

Compared to non-Hispanic whites:[4]

- African Americans, Hispanics, and American Indian/Alaska Natives have higher mortality rates from diabetes.
- African Americans and Hispanics have higher rates of complications from uncontrolled diabetes, including lower limb amputation and end-stage renal disease.
- More than half of Asian Americans and nearly half of Hispanic Americans with diabetes are undiagnosed.[5]
- Asian Americans are at risk for type 2 diabetes at a lower body mass index (BMI); therefore, diabetes screening at a BMI of 23 is recommended.[6]

Sources include:

- Diabetes prevalence:
  - 2015 State Diagnosed Diabetes Prevalence, https://www.cdc.gov/diabetes/data.
  - 2012 State Undiagnosed Diabetes Prevalence, Dall et al., “The Economic Burden of Elevated Blood Glucose Levels in 2012”, Diabetes Care, December 2014, vol. 37.
- Diabetes incidence:
  - 2015 State Diabetes Incidence Rates, https://www.cdc.gov/diabetes/data.
- Cost:
  - American Diabetes Association, “Economic Costs of Diabetes in the U.S. in 2017”, Diabetes Care, May 2018.

- Research expenditures:
  - 2017 National Institute of Diabetes and Digestive and Kidney Diseases funding, https://projectreporter.nih.gov.
  - 2017 CDC diabetes funding, https://www.cdc.gov/fundingprofiles.

1 https://www.medicalnewstoday.com/articles/321123#An-A1C-of-7-to-8-percent-is-recommended
2 https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf
3 https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html
4 Office of Minority Health. Minority Population Profiles: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlID=26
5 U.S. Department of Health and Human Services, National Institutes of Health. (2015, September 8), More than half of Asian Americans with diabetes are undiagnosed. Retrieved from https://www.nih.gov/news-events/news-releases/more-half-asian-americans-diabetes-are-undiagnosed.
6 ADA; NCAPIP; AANHPI DC; Joslin Diabetes Center Asian American Diabetes Initiative. (2015, September). Screen at 23. Retrieved from http://screenat23.org/wp-content/uploads/2015/10/Screenat23package-1.pdf.

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URL: https://providernews.anthem.com/ohio/article/diabetes-hba1c-8-hedis-guidance-2