Ohio Provider News

April 2022 Anthem Provider News - Ohio

The Anthem, Inc. name is changing

Published: Apr 1, 2022 - **Administrative**

The new name will reflect the company's exciting strategy for the future.

We are very excited to share the news that our parent company, Anthem, Inc., has filed a preliminary proxy statement to change its name. The new name, pending shareholder approval, will be Elevance Health.

Please know that if the name change is approved by shareholder vote, **the following will not change:**

- Your contract, reimbursement, or level of support
- Your patients' plan or coverage

We will continue to do business as Anthem Blue Cross and Blue Shield.

Why the change?
The upcoming name change reflects the company's strategy to elevate the importance of whole health and to advance health beyond healthcare for our customers, their families, and our communities.

Our path forward is clear
We are thrilled to share our journey with you as our parent company continues its evolution from a traditional health benefits organization to a health company that looks beyond the traditional scope of physical health and how to best support it.

For more information, please read the **press release.**

Thank you for being our trusted health partner.

Bryony Winn
President, Anthem Health Solutions
Anthem, Inc.

Article Attachments

1811-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/the-anthem-inc-name-is-changing-29

Updated provider manual now available

Published: Apr 1, 2022 - **Administrative**

We want to make you aware of upcoming changes to the Anthem Blue Cross and Blue Shield (Anthem) Provider Manual.

This update to the Anthem Blue Cross and Blue Shield Base Provider Agreement will replace the current Provider Manual with the updated Provider Manual, **effective July 1, 2022.**

We have posted the updated Provider Manual to the public provider website at anthem.com. To view the new manual, visit **anthem.com**, select **Provider,** and select the **Policies, Guidelines & Manuals**. Select **Ohio** followed by **Provider Manual Download the Manual** or **click here**.

1157-0422-PN-OH

URL: https://providernews.anthem.com/ohio/article/updated-provider-manual-now-available-12

Reminder on Botox for Anthem members

Published: Apr 1, 2022 - **Administrative**

This is a reminder that effective January 1, 2022, CVS Specialty Pharmacy and IngenioRx Specialty Pharmacy no longer dispense the brand name drug Botox®. However, Botox is still be available to Anthem Blue Cross and Blue Shield (Anthem) members through other vendors.

Please note:

- This is not a change in member benefits. This is a change in the Botox vendor only.
- If the member is not using IngenioRx Specialty Pharmacy or CVS Specialty Pharmacy to obtain Botox, no action is needed.
- This change does not affect any other specialty pharmacy coverage.

Medical specialty pharmacy benefits

Our members who obtained Botox through CVS Specialty Pharmacy using their **medical specialty pharmacy benefits** must move this prescription, as of January 1, 2022. Here are the options:

- Providers can purchase Botox for their patients, then supply it to Anthem members. Providers would then bill Anthem for the drug and administration of the drug. This will require a new prior authorization to notify Anthem of this change.
- If the Anthem member's pharmacy benefit manager is IngenioRx, providers can transition the Botox prescription to receive the drug from any in-network pharmacy using their pharmacy benefits. Transferring the coverage will require a new prescription and new prior authorization.

For questions regarding a member's **medical specialty pharmacy benefits**, call Provider Services using the information on the back of the member's ID card.

Pharmacy benefits manager benefits

Effective January 1, 2022, members who obtained Botox through IngenioRx Specialty Pharmacy using their **pharmacy benefits** must move this prescription from IngenioRx Specialty Pharmacy to another in-network specialty pharmacy that dispenses Botox. If there are refills still available on the current prescription, members can transfer it to the new pharmacy. If not, members will need a new prescription.

For questions regarding a member's **pharmacy benefits**, call Pharmacy Member Services using the information on the back of the member's ID card.

1485-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/reminder-on-botox-for-anthem-members-2

CAA: Update your provider directory information

Published: Apr 1, 2022 - **Administrative**

The Consolidated Appropriations Act (CAA) effective January 1, 2022, contains a provision that requires online provider directory information be reviewed and updated (if needed) at least every 90 days. We are asking that you take a few minutes to review your online provider directory information to help ensure Anthem Blue Cross and Blue Shield (Anthem) members can locate your most current information.

If changes are needed, please take the time to update your information by submitting updates and corrections to us on our online Provider Maintenance Form. Online update options include:

- add/change an address location
- name change
- tax ID changes
- provider leaving a group or a single location
- phone/fax number changes
- closing a practice location

Once you submit the Provider Maintenance Form, you will receive an email acknowledging receipt of your request. Visit the Provider Maintenance Form landing page for complete instructions.

1572-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/caa-update-your-provider-directory-information-2

HEDIS 2022: Summary of changes from NCQA

Published: Apr 1, 2022 - **Administrative**

The National Committee for Quality Assurance (NCQA) has changed, revised, and retired HEDIS for measurement year 2022. Below is a summary of some of the key changes to be aware of:

Diabetes measures

NCQA has separated the Comprehensive Diabetes indicators into stand-alone measures:

- Hemoglobin A1c Control for Patients with Diabetes (HBD) (HbA1c Control <8 and Poor Control HbA1c)
- Eye Exam Performed for Patients with Diabetes (EED)
- Blood Pressure for Patients with Diabetes (BPD)
- Kidney Health Evaluation for Patients with Diabetes (KED)

The process measure Comprehensive Diabetes HbA1c testing was retired as the goal is to move towards more outcome measures.

Race/ethnicity stratification

To address health care disparities, the first step is reporting and measuring performance. Given this, NCQA has added race and ethnicity stratifications to the following HEDIS measures:

- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for patients with Diabetes (HBD)
- Prenatal and Post-Partum Care (PPC)
- Child and Adolescent Well Care Visits (WCV)

NCQA plans to expand the race and ethnicity stratifications to additional HEDIS measures over several years to help reduce disparities in care among patient populations. This effort builds on NCQA's existing work dedicated to the advancing health equity in data and quality measurement.

New measures

Antibiotic Utilization for Respiratory Conditions (AXR). Measures the percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. This measure was added given antibiotics prescribed for acute respiratory conditions are a large driver of antibiotic overuse.

Tracking antibiotic prescribing for all acute respiratory conditions will provide context about overall antibiotic. Given this new measure, the Antibiotic Utilization measure has been retired.

Deprescribing of Benzodiazepines in Older Adults (DBO). The percentage of Medicare members 65 years of age and older who were dispensed benzodiazepines and achieved a 20 percent decrease or greater in benzodiazepine dose during the measurement year.

Guidelines recommend that benzodiazepines be avoided in older adults, and deprescribing benzodiazepines slowly and safely, rather than stopping use immediately. There is an opportunity to promote harm reduction by assessing progress in appropriately reducing benzodiazepine use in the older adult population.

Advanced Care Planning (ACP). Measures the percentage of adults 65 to 80 years of age, with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older, who had advance care planning during the measurement year.

Advance care planning is associated with improved quality of life, this measure will allow an understanding if it is provided to those who are most likely to benefit from it. Given this new measure, the Care for Older Adults measure has been retired.

Measure changes

Use of Imaging Studies for Low Back Pain (LBP). This measure was expanded to the Medicare line of business and the upper age limit for this measure was expanded to age 75. Additional exclusions to the measure were also added.

A complete summary of 2022 HEDIS changes and more information, can be found at NCQA HEDIS 2022.

Source: NCQA.org

1232-0422-PN-CNT

Importance of behavioral healthcare after-hours messaging

Published: Apr 1, 2022 - **Administrative**

The annual after-hours access studies performed by our vendor, North American Testing Organization based in California, were resumed and fielded in the third quarter of 2021. The purpose is to assess adequate phone messaging for our members with perceived emergency or urgent situations after regular office hours. Unfortunately, most of the Anthem Blue Cross and Blue Shield (Anthem) plans assessed fell short of the expectation of having a live person or a directive in place after hours.

The main challenges the vendor encounters while attempting to collect this required, essential data are related to an inability to reach the provider and/or the lack of after-hours messaging altogether. They include:

- inaccurate provider information in Anthem's demographic database to allow assessment of the after-hours messaging
- no voicemail or messaging at all
- voicemail not reflecting the practitioner's name
- calls being auto forwarded with no identification, no voicemail or messaging

Update your office information

To help both your patients' and Anthem's ability to reach your practice, we ask that you update your office information using the online Provider Maintenance Form. Also, review your after-hours messaging regarding connectivity for patients' urgent accessibility.

What this means for our members and your patients

The annual member experience survey of Anthem enrollees indicated that of those needing advice, a sizable number sometimes, or never, reached the provider's office for urgent instructions. To improve upon these instances of failing to meet our member's needs, implement these steps:

1. Have accessibility 24/7/365. Arrange to have your phone calls forwarded to a service or hospital, or have the appropriate messaging for the caller.

2. Be sure to turn on the messaging mechanism when you leave the office.
3. Be sure you are using the acceptable messaging for compliance with your contract.
4. A live person or recording must express if there are prior arrangements with patients for after hour needs, to be compliant.

Be compliant
To be compliant, per the Provider Manual, have your messaging or answering service include appropriate instructions, specifically:

- **Emergency situations:** *Compliant* response for an *emergency* instructs the caller/patient to hang up and call 911 or go to ER or connects the caller directly to the practitioner.
- **Emergent / Urgent situations:** *Compliant* responses for *urgent* needs after hours:
  - Live person, via a service, advises their practitioner or on call practitioner is available and connects.
  - Live person or recording directs or directly connects caller/patient to Urgent Care, 24-hour crisis services, 911 or ER.
  - Mechanism connects the caller to their practitioner or the practitioner on call. (Must directly connect)

Non-compliant responses for urgent needs after hours include:

- No provisions for after hour accessibility.
- Live person or recording **only** directs the caller/patient to a mechanism for contacting their practitioner (via cell phone, pager, text, email, voicemail, etc.) or to get a call back for urgent questions or instructions. These scenarios are non-compliant because there is no direct connection to their practitioner. This prompt can be used in addition to, but not in place of instructions.

Is your practice compliant?

1311-0422-PN-CNT

Catching up on routine vaccines

Published: Apr 1, 2022 - **Administrative**

The Centers for Disease Control and Prevention (CDC) public sector vaccine ordering data shows a 14% drop in 2020 and 2021 compared to 2019, and measles vaccine is down by more than 20%. Children need to get caught up now, so they are protected as they get back to regular schedules, play times and prepare for summer camps. Healthcare providers can identify families whose children have missed doses and contact them to schedule appointments.[1]

Well-child visits

A well-child visit is an opportunity for parents to get regular updates about their child's growth and development. For adolescents, it can be lifesaving, particularly when you discuss HPV, which isn't always easy. The CDC has developed several resources for providers about how to recommend the HPV vaccine and how to talk to parents about the HPV vaccine. Get these resources from cdc.gov.

Adults need preventive care, too

Getting good medical care that finds problems early and treats them effectively is an essential part of staying healthy. That's why it is important for your adult patients to get those annual check-ups. It's an opportunity for you to provide essential health services such as blood pressure, cholesterol and diabetes screenings. It is the perfect time to talk to your patients about their physical activity, their diet, and their overall wellbeing. Scheduling annual visits with your adult patients can lead to better health outcomes.

Measure Up

Adults' Access to Preventive/ Ambulatory Health Services (AAP) HEDIS® measure includes members 20 years of age and older who have completed an ambulatory or preventive care visit during the measurement year.

Coding AAP

Ambulatory visit	**CPT:** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99483 HCPCS: G0402, G0438, G0439, G0463, T1015 **ICD-10-CM**: Z00.00, Z00.121, Z00.129, Z00.3, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
Other ambulatory visits	**CPT:** 92002, 92004, 92012, 92014, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 **HCPCS:** S0620, S0621 **UBREV**: 0524, 0525
Telephone visits	**CPT**: 98966, 98967, 98968, 99441, 99442, 99443
Online assessments	**CPT**: 98969, 98970, 98971, 98972, 98972, 99421, 99422, 99423, 99444, 99457, 99458 HCPCS: G0071, G2010, G2012, G2061, G2062, G2063

Child and Adolescent Well Care Visits (WCV) measures the percentage of members 3 to 21 years of age who had a least one comprehensive well-care visit with a PCP or an OB/GYN during the measurement year.

Coding WCV

This is an abbreviated list of codes associated with the WCV measure.

Well-care	**CPT:** 99381-99385, 99391-99395, 99461
Encounter for routine child health check with abnormal findings	**ICD-10:** Z00.121
Encounter for routine child health check without abnormal findings	**ICD-10:** Z00.129
Encounter for examination for period of rapid growth in childhood	**ICD-10**: Z00.2

Healthcare Effectiveness Data and Information Set (*HEDIS*®) is a *registered trademark* of *NCQA*.

[1]cdc.gov. https://www.cdc.gov/vaccines/partners/childhood/downloads/childVax-infographic.pdf

1489-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/catching-up-on-routine-vaccines-2

Evaluation and management documentation guidelines

Published: Apr 1, 2022 - **Administrative**

Anthem Blue Cross and Blue Shield (Anthem) appreciates your commitment to delivering quality care to our members and improving the overall health of our communities. To help ensure accurate claims processing, providers should report evaluation and management (E/M) services in accordance with the American Medical Association CPT® manual and CMS guidelines for billing E/M service codes: *Documentation Guidelines for Evaluation and Management*. We have created a summary of the CMS guidance that may assist you with the documentation requirements necessary to support the level of service submitted on claims.

Effective January 1, 2021, documentation guidelines for office and other outpatient visits are based on two components:

- Medical decision making (MDM)
- Total time

Total time is the complete time spent on the date of the encounter and may now include the time spent before, during, and after the visit, as well as the time spent documenting the visit. Previous components of history and physical exams are no longer used to determine the level of service; however, a medically appropriate history and exam are required.

The 2021 guidance for time allows providers to receive credit with appropriate supporting documentation for the following elements:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

The intent of the revised documentation criteria is not to eliminate the need for providers to support medical appropriateness, but to provide them with the ability to account for additional **time** elements that were previously excluded.

CMS guidelines state the provider must help ensure that medical record documentation supports the level of service reported to a payer. Providers should not use the volume of documentation to determine which specific level of service to bill. The **total time** spent on the date of the encounter will determine the specific level of service billing. Services must meet specific medical necessity requirements in the statute, regulations, and American Medical Association and CMS manuals, and specific medical necessity criteria defined by national coverage determinations and local coverage determinations. For every service billed, providers should indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

Clear and concise documentation is imperative to providing quality care. It is the provider's responsibility to help ensure the documentation furnished reflects services provided to receive accurate and timely reimbursement.

References:

American Medical Association CPT® 2021 Professional Edition
CMA Evaluation and Management Services Guide Booklet, MLN06764
Documentation Guidelines for Evaluation and Management

1162-0422-PN-IN.MO.OH.WI

URL: https://providernews.anthem.com/ohio/article/evaluation-and-management-documentation-guidelines

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Procedure searches in Find Care

Published: Apr 1, 2022 - **Administrative** / Digital Tools

Find Care, the physician finder and transparency tool in Anthem Blue Cross and Blue Shield (Anthem)'s online directory, allows Anthem members to search and compare cost and quality measures for in-network providers. Find Care allows members to sort providers based on distance, name, or personalized match. In 2018, we introduced the personalized match tool for searches by provider type. In 2021, the enhanced personalized match sorting option became available to search by procedure type in addition to provider type. We later expanded the number of procedure searches. **On or after May 20, 2022, we will further refine both our provider and procedure search models.**

Sorting provider searches

The algorithms used to sort provider searches use a combination of member and provider features to sort and display the results for a member's search. The sorting results take into account member factors such as the member's medical conditions and demographics.

Quality and compliance for provider searches are based on over 100 quality of care rules that monitor member prevention, medication, diagnostic testing and various additional aspects of care based on HEDIS and other process metrics that are proven indicators of the pursuit of high quality care. Quality rules are updated periodically as standard of care guidelines evolve (applies to specialist/provider searches).

Sorting procedure searches

The algorithm used to sort procedure searches also takes into account provider factors such as surgeon-facility pairing (an individual provider who performs a procedure at a specific facility), cost efficiency measures, volumes of patients treated across various disease conditions, and outcome-based quality measures.

Combined member and provider features generate a unique ranking of surgeon-facility pairings or facility providers for each member conducting the procedure search. Displayed first are surgeon-facility pairings with the highest overall ranking within the search radius. Remaining pairings are displayed in descending order based on overall rank and proximity to the center of the search radius.

Changes coming in May

We are:

- Adding maternity related searches to our suite of Find Care Personalized Match surgeon-facility/provider and procedure searches. Maternity searches will contain updated quality scoring to reflect separate scores for C-section and vaginal delivery.
- Standardizing the procedure search methodology such that the groupers used across all procedures are consistent.
- Adding a new provider search capability for Physical Therapy/Occupational Therapy.

Access Availity to review updated methodology

You may review a copy of the updated methodology by going to Availity.com and then using the following navigation:
Payer Spaces > Anthem > Information Center > Administrative Support > Personalized Match Search Methodology.pdf.

Have questions?

If you have general questions about the Find Care tool or the change to the quality measures for procedure searches, please contact your local Anthem Provider Experience Consultant.

If you would like detailed information about quality or cost factors used as part of this unique sorting or you would like to request reconsideration of those factors, you may do so by emailing personalizedmatchsorting@anthem.com or by calling 833-292-2601.

1341-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/procedure-searches-in-find-care-9

Specialty pharmacy updates - April 2022*

Published: Apr 1, 2022 - **Products & Programs** / Pharmacy

***Notice of Material Amendment/Change to Contract (MAC)**

Specialty pharmacy updates for Anthem Blue Cross and Blue Shield (Anthem) are listed below.

Prior authorization clinical review of ***non-oncology*** use of specialty pharmacy drugs is managed by Anthem's medical specialty drug review team. Review of specialty pharmacy drugs for ***oncology*** use is managed by AIM Specialty Health® (AIM), a separate company.

Important to note: Currently, your patients may be receiving these medications without prior authorization. As of the effective date below, you may be required to request prior authorization review for your patients' continued use of these medications.

Inclusion of National Drug Code (NDC) code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

Prior authorization updates

Effective for dates of service on and after July 1, 2022, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

Access our Clinical Criteria to view the complete information for these step therapy updates.

Clinical Criteria	Drug	HCPCS or CPT Code(s)
ING-CC-0166*	Herzuma	Q5113
ING-CC-0166*	Ogivri	Q5114
ING-CC-0166*	Ontruzant	Q5112
ING-CC-0166*	Trazimera	Q5116

* Oncology use is managed by AIM.

Note: Prior authorization requests for certain medications may require additional documentation to determine medical necessity.

Step therapy updates

Effective for dates of service on and after July 1, 2022, 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.

Access our Clinical Criteria to view the complete information for these step therapy updates.

Clinical Criteria	Status	Drug	HCPCS or CPT Code(s)
ING-CC-0209	Non-preferred	Leqvio	J3490
ING-CC-0107*	Preferred	Avastin	J9035
		Mvasi	Q5107
	Non-preferred	Zirabev	Q5118
ING-CC-0166*	Preferred	Herceptin**	J9355
		Kanjinti**	Q5117
	Non-preferred	Herzuma	Q5113
		Ogivri	Q5114
		Ontruzant	Q5112
		Trazimera	Q5116

*Oncology use is managed by AIM.
**Herceptin and Kanjinti are preferred trastuzumab agents that do not require prior authorization or step therapy.

1449-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/specialty-pharmacy-updates-april-2022-1

Designated specialty pharmacy network updates*

Published: Apr 1, 2022 - **Products & Programs** / Pharmacy

Notice of Material Amendment/Change to Contract (MAC)

As we previously communicated, Anthem Blue Cross and Blue Shield (Anthem)'s Designated Specialty Pharmacy Network requires providers who are not part of the Designated Specialty Pharmacy Network to acquire certain select specialty pharmacy medications administered in the hospital outpatient setting through CVS Specialty Pharmacy.

This update is to advise of the following changes:

Effective for dates of service on and after July 1, 2022, the following specialty pharmacy medications will be **added** to the Designated Medical Specialty Pharmacy drug list. Accordingly, hospitals that are not in the Designated Specialty Pharmacy Network will be required to acquire these specialty medications administered in the hospital outpatient setting from CVS Specialty Pharmacy.

HCPCS	Description	Brand Name
J9272	Dostarlimab-gxly	Jemperli
J9316	Pertuzumab/Trastuzumab/Hyaluronidase-zzxf	Phesgo

To access the current Designated Medical Specialty Pharmacy drug list, please visit anthem.com, select *Providers*, select *Forms and Guides* (under the Provider Resources column), select your state, scroll down and select *Pharmacy* in the Category drop down. The Designated Medical Specialty Pharmacy drug list may be updated periodically by Anthem.

If you have questions or would like to discuss the terms and conditions to be included as a Designated Specialty Pharmacy Network provider, please contact your Anthem Contract Manager. Thank you for your continued participation in the Anthem networks and the services you provide to our members.

1482-0422-PN-OH

URL: https://providernews.anthem.com/ohio/article/designated-specialty-pharmacy-network-updates-8

Pharmacy information available at anthem.com

Published: Apr 1, 2022 - **Products & Programs** / Pharmacy

Visit the Drug Lists page 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.

1399-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/pharmacy-information-available-at-anthemcom-41

Save time by using CPT II codes: Introducing FEP Quality Reimbursement Program for PPO providers

Published: Apr 1, 2022 - **State & Federal** / Federal Employee Plan (FEP)

The Federal Employee Program (FEP) is introducing a new Quality Reimbursement Program for PPO providers. Coding for CPT II Category Codes for A1c results, blood pressure readings and the first prenatal visit **will now be reimbursed at $10 per code.**

CPT II codes are supplemental tracking codes that are used to measure quality performance. The use of these tracking codes decreases the need for record submissions and chart reviews, minimizing administrative burden on physicians and other healthcare professionals.

How to use CPT II codes
Use these CPT II codes when submitting a claim. In field 24F on the CMS-1500 claim form, enter the CPT II code along with the amount of $10. In order to receive reimbursement, the exact dollar amount ($10) and the date of service must be entered on the claim along with the appropriate code for the service performed.

Blood Pressure – Receive $10 for the Systolic and the Diastolic readings:

3074F	Most recent systolic blood pressure less than 130 mm Hg
3075F	Most recent systolic blood pressure 130-139 mm Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	Most recent diastolic blood pressure less than 80 mm Hg
3079F	Most recent diastolic blood pressure 80-89 mm Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Hemoglobin A1c:

3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
3046F	Most recent hemoglobin A1c (HbA1c) level greater than 9.0%
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%

Blood Pressure – The first prenatal visit date of service must be on the claim (Field 24A, CMS-1500 claim form) with the appropriate code:

0500F	Initial prenatal care visit (report at first prenatal encounter with healthcare professional providing obstetrical care. Report also date of visit, and in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
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) (Prenatal)

For additional information about the Quality Reimbursement Program, email us at FEPproviderGIC@anthem.com.

1503-0422-PN-CNT

URL: https://providernews.anthem.com/ohio/article/save-time-by-using-cpt-ii-codes-introducing-fep-quality-reimbursement-program-for-ppo-providers-2

The Anthem, Inc. name is changing

Published: Apr 1, 2022 - **State & Federal** / Medicare

The new name will reflect the company's exciting strategy for the future.

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For more information, please read the **press release.**

Thank you for being our trusted health partner.

Bryony Winn
President, Anthem Health Solutions
Anthem, Inc.

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URL: https://providernews.anthem.com/ohio/article/the-anthem-inc-name-is-changing-33

Keep up with Medicare News - April 2022

Published: Apr 1, 2022 - **State & Federal** / Medicare

Please continue to read news and updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Medical policies and clinical utilization management guidelines update
- AIM Specialty Health Outpatient Rehabilitative and Habilitative Services Clinical Appropriateness Guidelines updates
- Anthem expands specialty pharmacy precertification list

URL: https://providernews.anthem.com/ohio/article/keep-up-with-medicare-news-april-2022

Implementation update for the NYC Medicare Advantage Plus plan, an alliance between Empire BlueCross BlueShield and EmblemHealth

Published: Apr 1, 2022 - **State & Federal** / Medicare

We want to provide you with an update regarding the offering for City of New York retirees – the NYC Medicare Advantage Plus plan, an alliance between Empire BlueCross BlueShield and EmblemHealth.

The NYC Medicare Advantage Plus plan is not being implemented on April 1, 2022. All retirees will remain in their current plans until further notice.

What does this mean?
City of New York retirees will remain in their current plan until further notice and will not transition to the NYC Medicare Advantage Plus plan on April 1, 2022. At this time, City of New York retirees do not need to opt out of the NYC Medicare Advantage Plus plan in order to remain in senior care or their current plan.

Where should I submit claims?
Please continue to follow your current processes for claims submission for the City of New York retirees under your care. Those processes will not change on April 1, 2022, as City of New York retirees will remain in their current plan.

When will City of New York retirees transition to the NYC Medicare Advantage Plus plan?
A new effective date has not yet been determined. Detailed information will be made available regarding the new effective date once it has been established.

Thank you for your continued care for City of New York retirees.

ABSCRNU-0324-22

URL: https://providernews.anthem.com/ohio/article/implementation-update-for-the-nyc-medicare-advantage-plus-plan-an-alliance-between-empire-bluecross-blueshield-and-emblemhealth-6

Reimbursement policy update: Inpatient readmissions

Published: Apr 1, 2022 - **State & Federal** / Medicare

Policy G-13001, effective 07/01/22

Effective July 1, 2022, when a member is readmitted within 30 days as part of a planned readmission and placed on a leave of absence, the admissions are considered to be one admission, and only one diagnosis-related group (DRG) will be reimbursed.

For additional information, please review the Inpatient Readmission reimbursement policy at https://www.anthem.com/medicareprovider.

ABSCRNU-0301-21

URL: https://providernews.anthem.com/ohio/article/reimbursement-policy-update-inpatient-readmissions-2

The impact of listening

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As a provider, every patient encounter is an opportunity to demonstrate how well you can listen and understand their needs and concerns. Likewise, to ensure your patients can implement your plan of care, you want to be sure that your patients are truly listening and understanding the advice you are giving.

Strategies to improve your communication to patients
One way to figure out if your communication with a patient is effective is by asking them to repeat back the plan of care you discuss with them. You will be able to identify gaps in their understanding and clarify by asking a patient to repeat the next steps back to you.

If you have just shared information with your patient, ask them to repeat back what you told them. For example, you could say, “I just shared a lot of information with you about the new medication I think you should try. Can you please repeat it back to me so we can make sure you remember all of the important points?”.

How does your patient know you are listening to them?
To make sure your patient knows you are listening, repeat back to them what you have heard. A quick summary helps assure you heard correctly. For example, you might say, “I want to make sure that I understand all of the important information you just shared. Let me repeat back what I heard so you can verify I didn’t miss anything.” This will help your patients know you are understanding their needs.

ABSCRNU-0312-22

URL: https://providernews.anthem.com/ohio/article/the-impact-of-listening-1

Clinical Criteria updates

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On November 19, 2021, December 13, 2021, and January 10, 2022, the Pharmacy and Therapeutics (P&T) Committee approved the following 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.

Visit ***Clinical Criteria*** to search for specific policies. For questions or additional information, use this **email**.

Please see the explanation/definition for each category of Clinical Criteria below:

- New: newly published criteria
- Revised: addition or removal of medical necessity requirements, new document number
- Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive

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

Please note: The Clinical Criteria listed below applies only to the medical drug benefits contained within the member's medical policy. This does not apply to pharmacy services.

Effective date	Document number	*Clinical Criteria* Title	New or revised
04/08/2022	*ING-CC-0205	Fyarro (sirolimus albumin bound)	New
04/08/2022	*ING-CC-0206	Besremi (ropeginterferon alfa-2b-njft)	New
04/08/2022	*ING-CC-0207	Vyvgart (efgartigimod alfa-fcab)	New
04/08/2022	*ING-CC-0208	Adbry (tralokinumab)	New
04/08/2022	*ING-CC-0209	Leqvio (inclisiran)	New
04/08/2022	ING-CC-0124	*Keytruda (pembrolizumab)*	Revised
04/08/2022	ING-CC-0079	*Strensiq (Asfotase Alfa)*	Revised
04/08/2022	ING-CC-0015	*Infertility and HCG Agents*	Revised
04/08/2022	ING-CC-0102	*Gonadotropin releasing hormone (GNRH) Analogs for Oncologic Indications*	Revised
04/08/2022	ING-CC-0168	*Tecartus (brexucabtagene autoleucel)*	Revised
04/08/2022	ING-CC-0029	*Dupixent (dupilumab)*	Revised
04/08/2022	*ING-CC-0004	*Repository Corticotropin Injection*	Revised
04/08/2022	ING-CC-0072	*Selective Vascular Endothelial Growth Factor (VEGF) Antagonists*	Revised

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URL: https://providernews.anthem.com/ohio/article/clinical-criteria-updates-44

Evaluation and management documentation guidelines

Published: Apr 1, 2022 - **State & Federal** / Medicare

This communication applies to the Commercial and Medicare Advantage programs for Anthem Blue Cross and Blue Shield (Anthem).

Anthem appreciates your commitment to delivering quality care to our members and improving the overall health of our communities. To help ensure accurate claims processing, providers should report evaluation and management (E/M) services in accordance with the American Medical Association CPT® manual and CMS guidelines for billing E/M service codes: Documentation Guidelines for Evaluation and Management. We have created a summary of the CMS guidance that may assist you with the documentation requirements necessary to support the level of service submitted on claims.

Effective January 1, 2021, documentation guidelines for office and other outpatient visits are based on two components:

- Medical decision making (MDM)
- Total time

Total time is the complete time spent on the date of the encounter and may now include the time spent before, during, and after the visit, as well as the time spent documenting the visit. Previous components of history and physical exams are no longer used to determine the level of service; however, a medically appropriate history and exam are required.

The 2021 guidance for time allows providers to receive credit with appropriate supporting documentation for the following elements:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

The intent of the revised documentation criteria is not to eliminate the need for providers to support medical appropriateness, but to provide them with the ability to account for additional **time** elements that were previously excluded.

CMS guidelines state the provider must help ensure that medical record documentation supports the level of service reported to a payer. Providers should not use the volume of documentation to determine which specific level of service to bill. The **total time** spent on the date of the encounter will determine the specific level of service billing. Services must meet specific medical necessity requirements in the statute, regulations, and American Medical Association and CMS manuals, and specific medical necessity criteria defined by national coverage determinations and local coverage determinations. For every service billed, providers should indicate the specific sign, symptom, or patient complaint that makes the service reasonable and necessary.

Clear and concise documentation is imperative to providing quality care. It is the provider's responsibility to help ensure the documentation furnished reflects services provided to receive accurate and timely reimbursement.

References:

American Medical Association CPT® 2021 Professional Edition
CMA Evaluation and Management Services Guide Booklet, MLN06764
Documentation Guidelines for Evaluation and Management

ABSCRNU-0318-22

URL: https://providernews.anthem.com/ohio/article/evaluation-and-management-documentation-guidelines-2

Model of Care required training

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As a contracted provider for a Special Needs Plan (SNP) from Anthem Blue Cross and Blue Shield (Anthem), you are required to participate in an annual training on Anthem's Model of Care. This training includes a detailed overview of SNPs and program information highlighting cost sharing, data sharing, participation in the Interdisciplinary Care Team (ICT), where to access the member's health risk assessment results, plan of care, and benefit coordination.

Training for Anthem's SNP product is self-paced and available on the Availity* Portal at Availity.com.

How to access the *Custom Learning Center* on the Availity Portal:

- Log in to Availity at Availity.com.
- At the top, select *Payer Spaces* and select the appropriate payer.
- On the Payer Spaces landing page, select *Access Your Custom Learning Center from Applications*.
- In the Custom Learning Center, select *Required Training*.
- Select *Special Needs Plan and Model of Care Overview*.
- Select *Enroll*.
- Select *Start*.
- Once the course is completed, select *Begin Attestation* and complete.

Not registered for the Availity Portal?
Have your organization's designated administrator register your organization for Availity.

- Visit Availity.com to register.
- Select *Register*.
- Select your organization type.
- In the Registration wizard, follow the prompts to complete the registration for your organization.

Complete registration instructions are available on the Availity website.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

ABSCRNU-0307-22

URL: https://providernews.anthem.com/ohio/article/model-of-care-required-training-1
