Virginia Provider News

April 2019 Anthem Provider Newsletter - Virginia

Medicaid:

Medicare:

CORRECTION: Alpha prefix is “VQW” for Anthem’s Exclusive Provider Organization benefit plans

Published: Apr 1, 2019 - **Administrative**

In our December 2018 edition of our provider newsletter, Anthem Blue Cross and Blue Shield announced the rollout of three new Exclusive Provider Organization (EPO) health benefit plans in the Virginia Small Group market. We stated incorrectly that these new EPO benefit plans would use the alpha prefix “VLX.” **However, the correct alpha prefix is “VQW” for the new EPO benefit plans.** We regret this error and apologize for any inconvenience this situation may have caused you.

As a reminder, these EPO plans became effective **January 1, 2019,** and will use our KeyCare network which is currently also used by our PPO plans. One new EPO plan is offered in each of the Bronze, Gold and Platinum metal levels of our health benefit plans. No Silver EPO plans are offered at this time.

The notable difference from our standard PPO plans will be the exclusion of out-of-network benefits – except in medical emergencies and for certain authorized services. The EPO plans will not have gatekeeper referral requirements. As such, they will be referred to as “open access” and will accordingly have the letters “OAEPO” in their names. Like the rest of our 2019 Small Group portfolio, they will have a primary care physician (PCP) assignment requirement and only be sold OFF the Health Insurance Marketplace or commonly called the exchange. The authorization process and reimbursement fee schedule will also follow what we have in place for PPO plans.

If you have questions, please contact our customer service area using the phone number on the back of the member’s ID card.

URL: https://providernews.anthem.com/virginia/article/correction-alpha-prefix-is-vqw-for-anthems-exclusive-provider-organization-benefit-plans

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Billing for private room stays

Published: Apr 1, 2019 - **Administrative**

As a reminder, Anthem Blue Cross and Blue Shield continues to require the submission of

value codes and the value code amounts (FL39 - FL41) on all inpatient facility claims when submitting private room revenue codes (011x and 014x). This requirement continues to align with industry standards implemented in March 2007 for UB-04 claims by the Centers for Medicare & Medicaid Services (CMS) and the National Uniform Billing Committee (NUBC).

The value codes to be submitted when billing private room revenue codes according to the UB-04 Specifications Manual are:

- "01" (semi-private room facility) must be accompanied by the semi-private room rate when facility offers semi-private rooms and the patient's stay is in a private room

- "02" indicating "private room only" facility with $0.00 when the facility is private room only

If the facility has semi-private rooms but none is available report "condition code" 38 or if a private room is medically necessary, report "condition code" 39 (FL-18 - FL28).

Below is a listing of the private room revenue codes that will require a Value code of "01" with the average semi-private room rate or "02" with $0.00.

011x or 014x Room and Board-Private (Medical or General) Revenue Codes

Note: Routine service charges for single bedrooms. Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Standard Abbreviations
0 – General Classification	Room-Board/ PVT
1 – Medical/Surgical/GYN	MED-SUR-GYN/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT

8 – Rehabilitation	REHAB/PVT
9 – Other	OTHER/PVT

URL: https://providernews.anthem.com/virginia/article/billing-for-private-room-stays

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How you can help patients adhere to their prescribed treatment plans and medications

Published: Apr 1, 2019 - **Administrative**

You want what's best for your patients' health. So, it's challenging when a patient doesn't follow your prescribed treatment plan. Why do approximately 50 percent of patients with chronic illness stop taking their medications within one year of being prescribed?[1] What can be done differently?

The missed opportunity may be that you're only aware of the tip of the iceberg – the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline – the Titanic-sized, often invisible, patient self-talk that may not get discussed – can create a misalignment between patient and provider.

So we've created an online learning experience for the skills and techniques that may help you navigate these uncharted patient waters. After completing the learning experience, you'll have additional tools to help identify barriers, use each appointment as an opportunity to build trust, and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence – and you'll earn continuing medical education (CME) credit along the way.

Take the next step. Go to **MyDiversePatients.com** **> *The Medication Adherence Iceberg: How to navigate what you can't see*** to enhance your skills. The course is approximately one hour and accessible by smart phone, tablet or desktop at no cost.

[1] Centers for Disease Control and Prevention. (2017, Feb 1). Overcoming Barriers to Medication Adherence for Chronic Conditions. Retrieved from https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm

URL: https://providernews.anthem.com/virginia/article/how-you-can-help-patients-adhere-to-their-prescribed-treatment-plans-and-medications

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Anthem's Commercial Risk Adjustment reporting update: Accurate coding helps provide a comprehensive picture of patients' health and services provided

Published: Apr 1, 2019 - **Administrative**

In a continuation of our Commercial Risk Adjustment (CRA) reporting update that we shared in the March 2019 edition of our *Provider News*, Anthem Blue Cross and Blue Shield requests your assistance with respect to our CRA reporting processes. There are **two approaches that we take (Retrospective and Prospective) that work to improve risk adjustment reporting accuracy.** We are focusing on performing appropriate interventions and chart reviews **for patients with undocumented Hierarchical Condition Categories (HCC)**, **to close the documentation and coding gaps that we are seeing with our members enrolled in** our Affordable Care Act (ACA) compliant plans.

With both our **Prospective and Retrospective approaches,** accurate documentation and coding are what we are encouraging physicians to achieve. As a physician for our members with ACA compliant plans, you play a vital role in the success of our CRA reporting processes and ACA compliance. **When members visit your office, we encourage you to document ALL of the members' health conditions, especially chronic diseases on the claim. As a result, there will be ongoing documentation that indicates these conditions are being properly assessed and managed. Additional benefits of accurate coding include:**

- **Reduced volume in medical chart requests in the future due to the increased level of specificity in documentation and coding, as part of our Retrospective approach; and**

- **Reduced volume of health assessment requests by ensuring your patients with our ACA compliant plans are seen for their annual exams each and every year, as part of our Prospective approach.**

Please Note: It's important to ensure that all diagnosis codes captured in your electronic medical record (EMR) system are included on the claims, and are not being truncated by your claims software management system. For example, some EMR systems may capture up to 12 diagnosis codes, but a claim system may only have the ability of capturing four. If your claim system is truncating some of the listed diagnosis codes, please work with your vendor/clearing house to ensure all codes are being captured.

Reminder about ICD-10 CM coding

As you may be aware, the ICD-10 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, Anthem uses ICD-10 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.
We encourage you to follow the principles below for **diagnostic** coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.

- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider's overall management or treatment of that patient in the remaining positions.

- Include all chronic historical codes, as they must be documented each year under the ACA. (For example, an amputee must be coded each and every year even if the visit is not addressing the amputated limb specifically).

URL: https://providernews.anthem.com/virginia/article/anthems-commercial-risk-adjustment-reporting-update-accurate-coding-helps-provide-a-comprehensive-picture-of-patients-health-and-services-provided

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Register now for the Anthem webinar on April 10

Published: Apr 1, 2019 - **Administrative**

On April 10, 2019, Anthem will offer a provider education webinar. Designed for our network-participating providers, the webinars address Anthem business updates and billing guidelines that impact your business interactions with us.

For your convenience, we offer these informative, hourly sessions online to eliminate travel time and help minimize disruptions to your office or practice. The date for the scheduled webinar is:

- **Wednesday, April 10, 2019, from 10 a.m. to 11 a.m. ET**

Please take time to register today for the webinar using the registration form to the right under the “article attachments” section. If you have already registered for the April webinar, please ensure you have received a fax confirmation or a confirmation from an Anthem representative to ensure we’ve received your registration form. Please contact stacey.marsh@anthem.com if you need to confirm your registration.

URL: https://providernews.anthem.com/virginia/article/register-now-for-the-anthem-webinar-on-april-10

Receive email notifications via our Network eUPDATE

Published: Apr 1, 2019 - **Administrative**

Our provider newsletter is our primary source for providing important information to health care providers and professionals. The newsletter is published monthly and is posted to our

website on the Virginia provider section of anthem.com for easy 24/7 access.

Note that in addition to this newsletter and our website, we also use our email service – Network eUPDATE – to communicate new information. If you are not yet signed up to receive Network eUPDATEs, we encourage you to enroll now so you'll be sure to receive all information we will be sending about billing, upcoming changes, coverage guidelines and other pertinent topics.

Reminder notifications sent via email

When you sign up, you'll not only receive an email reminder for each newsletter posted online, you'll also be notified of other late breaking news and important information you'll need when providing services and filing claims for our members. It's easy to sign up – just select Virginia and access the provider home page. There, you'll find a link to register for our Network eUPDATE.

URL: https://providernews.anthem.com/virginia/article/receive-email-notifications-via-our-network-eupdate-2

Clinical guideline effective April 1, 2019

Published: Apr 1, 2019 - **Guideline Updates** / Coverage and Clinical Guidelines

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following clinical guideline effective **April 1, 2019,** to support the review of unnecessary inter-facility transfers. This guideline impacts our commercial PPO and Anthem HealthKeepers (non-Medicaid) products. Furthermore, the guideline was among those recently approved at the quarterly Medical Policy and Technology Assessment Committee meeting held on January 24, 2019.

The inpatient services addressed in this clinical guideline will require advance authorization prior to the inter-facility transfer. Failure to complete advance review may result in a not medically necessary denial for the transfer.

Inpatient Inter-Facility Transfers (CG-ANC-07)

This guideline addresses the clinical features of a hospitalized individual who may require services unavailable at an initial acute care facility (originating facility) necessitating a

transfer to a second acute care facility (receiving facility).

Inter-facility transfers are considered medically necessary when one or more of the following criteria are met:

- The individual requires a medically necessary diagnostic or therapeutic service (for example, organ transplantation) which is not available at the originating facility; or

- The individual requires a level of care (for example, neonatal care unit or level 1 trauma center) which is not available at the originating facility; or

- The individual requires the services of a specialist to evaluate, diagnose or treat his or her condition when that specialist is not available in a timely manner at the originating facility (Note: Timeliness of care is a case/individual specific attribute. It may be appropriate for a medically stable individual to await availability of a specialist for several days while a medically unstable individual may require care more quickly); or

- The individual has received care at a specific prior institution for a condition not normally managed at the originating facility (for example, organ transplant recipient) and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.

Inter-facility transfers between an originating facility and a receiving facility are considered not medically necessary when:

- The criteria above have not been met; or

- The services are primarily for the convenience of the individual, the individual’s family, the physician or the originating facility.

Coverage Guidelines effective July 1, 2019

Published: Apr 1, 2019 - **Guideline Updates** / Coverage and Clinical Guidelines

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective ***July 1, 2019.*** These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), the Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan, Medicare Advantage, and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP). Furthermore, the guidelines were among those recently approved at the Medical Policy and Technology Assessment Committee meeting held on January 24, 2019.

The services addressed in these coverage guidelines in this section and in the attachment under "Article Attachments" on the right will require authorization for all of our HealthKeepers, Inc. products with the exception of Anthem HealthKeepers Plus (Medicaid), the Anthem CCC Plus plan, Medicare Advantage, and the Federal Employee Program.

A pre-determination can be requested for our PPO products.

Services related to specialty pharmacy drugs (non-cancer related) require a Medical Necessity review, which includes site of care criteria, as outlined in the applicable coverage or clinical UM guideline listed below.

The guidelines address in this edition are:

- Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus (LAB.00036)

- Treatment of Varicose Veins (Lower Extremity) (SURG.00037)

- Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases (TRANS.00035)

- Genetic Testing for DMD Mutations (Duchenne or Becker Muscular Dystrophy) (CG-GENE-05)

- Paraesophageal Hernia Repair (CG-SURG-92)

URL: https://providernews.anthem.com/virginia/article/coverage-guidelines-effective-july-1-2019

Update to AIM Advanced Imaging of the Heart Clinical Appropriateness Guideline

Published: Apr 1, 2019 - **Guideline Updates**

Effective for dates of service on and after **June 29, 2019,** the following updates will apply to the AIM Clinical Appropriateness Guidelines for Advanced Imaging of the Heart and AIM Clinical Appropriateness Guidelines for Arterial Ultrasound.

Advanced Imaging of the Heart

Resting Transthoracic Echocardiography (TTE)

- Changes made to address frequency of surveillance of LV function for cardio-oncology.

TTE

- Changes made to address frequency of surveillance echocardiography following transcatheter mitral valve repair. These recommendations follow CMS guidelines.

Arterial ultrasound

Upper extremity arterial duplex

- Indication added for creation of arteriovenous (AV) fistulae for dialysis

Lower extremity arterial duplex

- ACC guideline for management of peripheral arterial disease (2016) indicates that Duplex imaging should be performed only after the decision to revascularize has been made. There is no role for duplex imaging in the initial diagnosis of peripheral arterial disease. The current AIM guideline is not aligned with this position and the proposed changes address that malalignment.

- Language changed to account for the fact that critical limb ischemia should include patients with non-healing ulcers and gangrene.

As a reminder, ordering and servicing provders 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: 866-789-0397, Monday - Friday, 8 a.m. to 5 p.m. ET.

Please note, this program does not apply to the Blue Cross and Blue Shield Service Benefit Plan – also known as the Federal Employee Program (FEP).

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 guidelines**.

URL: https://providernews.anthem.com/virginia/article/update-to-aim-advanced-imaging-of-the-heart-clinical-appropriateness-guideline-3

Update to AIM Advanced Imaging of the Head and Neck Clinical Appropriateness Guidelines

Published: Apr 1, 2019 - **Guideline Updates**

Effective for dates of service on and after **June 29, 2019,** the following updates will apply to the AIM Advanced Imaging of the Head and Neck Clinical Appropriateness Guidelines.

Sinusitis/rhinosinusitis

- Expanded the scope of complicated sinusitis
- Defined a minimal treatment requirement for uncomplicated sinusitis
- Identified reasons for repeat sinus imaging, aligned with Choosing Wisely
- Subacute sinusitis to be treated as more like acute or chronic rhinosinusitis based on the AAO-HNS acute sinusitis guideline
- Defined indications for preoperative planning for image navigation following a clinical policy statement on appropriate use from the AAO-HNS
- Removed CT screening for immunocompromised patients

Infectious disease – not otherwise specified

- Added MRI TMJ to this indication

Inflammatory conditions – not otherwise specified

- Allow MRI TMJ for suspected inflammatory arthritis following radiographs

Trauma

- Radiograph requirement for suspected mandibular trauma
- MRI TMJ in trauma for suspected internal derangement in surgical candidates

Neck mass (including lymphadenopathy)

- Align adult neck imaging guideline with AAO-HNS guideline
- Expand definition of neck mass beyond palpable (seen on laryngoscopy)
- Allow imaging for pediatric neck masses when initial ultrasound is not diagnostic

Parathyroid adenoma

- Further defined the patient population that needs evaluation
- Removed the requirement for aberrant anatomy in preoperative planning
- Position CT as a diagnostic test after both ultrasound and parathyroid scintigraphy
- Remove MRI as a modality to evaluate based on lack of evidence

Temporomandibular joint dysfunction

- Removed standalone “frozen jaw” indication
- Allow ultrasound in addition to radiographs as preliminary imaging
- Allow advanced imaging without preliminary radiographs or US in the setting of mechanical signs or symptoms
- Changed “Panorex” to “Radiographs” to allow for TMJ radiographs

- Added requirement for conservative treatment and planned intervention for suspected osteoarthritis

Cerebrospinal fluid (CSF) leak of the skull base

- Added modalities and criteria to evaluate for CSF leak

Dizziness or vertigo

- Add Tullio's phenomenon for lateral semicircular canal dehiscence
- Expand definition of abnormal vestibular function testing

Hearing loss

- Added indication for sudden onset hearing loss in adult patients
- More clearly delineated appropriate modalities based on types of hearing loss in pediatric patients
- Allow either CT or MRI for mixed hearing loss

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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 guidelines**.

URL: https://providernews.anthem.com/virginia/article/update-to-aim-advanced-imaging-of-the-head-and-neck-clinical-appropriateness-guidelines-4

Update to AIM Musculoskeletal Joint Surgery Clinical Appropriateness Guidelines

Published: Apr 1, 2019 - **Guideline Updates**

Effective for dates of service on and after **June 29, 2019,** the following updates will apply to the AIM Joint Surgery Clinical Appropriateness Guidelines.

General Requirements

- Conservative management: For joint arthroplasty, clarification of conservative management options provide allowance for conservative management exception. Add intraarticular corticosteroid injections as an option. Remove ice or heat given that it is commonly performed in all patients and hence does not meet the threshold for a non-operative management modality as intended. Addition of physical therapy or home therapy requirement for all non-arthroplasty joint procedures based on preponderance of benefit over harm to conservative care. Remove MOON protocol conservative care requirement throughout the document based on feasibility and standards of practice

- Reporting of symptom severity: Inability felt too restrictive to allow for difficulty performing

- Tobacco Cessation: removed nicotine-free documentation requirement

Subacromial Impingement Syndrome (without Rotator Cuff Tear)Cervical Decompression with or without Fusion

- Drop Arm Test removed due to lack of diagnostic accuracy for subacromial impingement

Synovectomy/Debridement

- New indication for synovectomy/debridement based on review of the evidence and common clinical scenarios

Tendinopathy of the Long Head of the Biceps – Tenodesis or Tenotomy

- Allows both techniques based on no evidence for net benefit of one over the other

- Allow a broader range of clinical symptoms and a lower threshold for imaging evidence of tendinopathy , no requirement for MR evidence as tendinopathy can be a clinical diagnosis

Primary Total Hip Arthroplasty

- Addition of fracture management and hip arthrodesis

Revision Total Hip Arthroplasty

- Addition of appropriate clinical scenarios based on clinical practice experience and evidence, align terminology to that used in the literature

Resection Arthroplasty of the Hip, Femoral Head Ostectomy, or Girdlestone Resection Arthroplasty

- Addition of appropriate clinical scenarios based on clinical practice experience (limited evidence)

Hip Arthroscopy

- Expanded appropriate techniques for FAI surgery to include acetabuloplasty and femoroplasty

Arthroscopic Treatment of FAIS

- Radiographic and clinical criteria added to include symptoms related to FAI and the likelihood that surgery will be successful

Elective Patellofemoral Arthroplasty

- New guideline for patellofemoral arthroplasty, a unicompartmental procedure based on evidence and standards of practice

Revision of Prior Knee Arthroplasty

- Addition of appropriate clinical scenarios based on clinical practice experience and evidence, align terminology to that used in the literature

Meniscal Repair or Meniscectomy

- Conservative requirement for degenerative meniscus tears

- Definition of acute meniscal tear and symptomatology

- More restrictive use of partial meniscectomy associated with osteoarthritis and degenerative tears

Arthroscopically assisted lysis of adhesions

- New guideline based on evidence and clinical consensus

Manipulation under anesthesia

- New guideline based on evidence and clinical consensus

In-Office Diagnostic Arthroscopy (mi-eye 2™)

- Not medically necessary based on lack of evidence for net benefit

Meniscal Allograft Transplantation of the Knee

- Collagen meniscal implants are considered not medically necessary

Treatment of Osteochondral Defects

- New criteria for talar OCD based on lesion size and prior procedures

Autologous chondrocyte implantation (ACI)

- Allow patellar surface ACI based on evidence for non-inferiority relative to trochlear surface lesions

CPT Code additions

- CPT codes 27120, 27122, 27437, 27445, 27488, 29871, G0428, 28446, and 29892

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

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- Access AIM via the Availity Web Portal at availity.com.

- Call the AIM Contact Center toll-free number: 866-789-0397, Monday - Friday, 8 a.m. to 5 p.m. ET.

Please note, this program does not apply to the Blue Cross and Blue Shield Service Benefit Plan – also known as the Federal Employee Program (FEP).

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 guidelines**.

URL: https://providernews.anthem.com/virginia/article/update-to-aim-musculoskeletal-joint-surgery-clinical-appropriateness-guidelines-3

Update to AIM Sleep Disorder Management Clinical Appropriateness Guidelines

Published: Apr 1, 2019 - **Guideline Updates**

Effective for dates of service on and after **June 29, 2019,** the following updates will apply to the AIM Sleep Disorder Management Clinical Appropriateness Guidelines.

- Reconfigured structure of BPAP with and without back-up rate feature criteria for patients with established central sleep apnea (CSA)

- Removed the criteria to try rate support for CSA

As a reminder, **ordering and servicing** providers may submit prior authorization requests for 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.

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- Call the AIM Contact Center toll-free number: 866-789-0397, Monday - Friday, 8 a.m. to 5 p.m. ET.

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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 guidelines**.

URL: https://providernews.anthem.com/virginia/article/update-to-aim-sleep-disorder-management-clinical-appropriateness-guidelines-4

Clinical practice and preventive health guidelines available on the Web

Published: Apr 1, 2019 - **Guideline Updates**

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

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

URL: https://providernews.anthem.com/virginia/article/clinical-practice-and-preventive-health-guidelines-available-on-the-web-15

Anthem Blue Cross and Blue Shield expands specialty pharmacy prior authorization list

Published: Apr 1, 2019 - **Products & Programs** / Pharmacy

Effective for dates of service on and after **July 1, 2019,** the following specialty pharmacy codes from the current clinical guideline will be included in our prior authorization review process.

Please note, inclusion of the National Drug Code (NDC) on your claim will shorten the claim processing time of drugs billed with a Not Otherwise Classified (NOC) code.

For Anthem Blue Cross and Blue Shield along with our affiliate HealthKeepers, Inc., pre-service clinical review of these specialty pharmacy drugs will be managed by Anthem. Drugs

used for the treatment of Oncology will still require pre-service clinical review by AIM Specialty Health® (AIM), a separate company.

This would apply to members with Preferred Provider Organization (PPO), Anthem HealthKeepers (HMO), POS AdvantageOne, and Act Wise (CDH plans).

The following clinical guideline will be effective **July 1, 2019.**

Clinical Guideline	HCPCS or CPT Code(s)	NDC Code(s)	Drug
CG-THER-RAD-03	A9699, C9408	71258-0015-02 71258-0015-22	Azedra®

URL: https://providernews.anthem.com/virginia/article/anthem-blue-cross-and-blue-shield-expands-specialty-pharmacy-prior-authorization-list

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Pharmacy information available on anthem.com

Published: Apr 1, 2019 - **Products & Programs** / Pharmacy

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, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The commercial and marketplace drug lists are posted to the website quarterly (the first of the month for January, April, July and October).

To locate Marketplace Select formulary and pharmacy information, scroll down to “Select Drug Lists.” *For State-sponsored Business, visit SSB Pharmacy Information.* This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

URL: https://providernews.anthem.com/virginia/article/pharmacy-information-available-on-anthemcom-32

Urgent: Update to behavioral health claims processing

Published: Apr 1, 2019 - **State & Federal** / Medicaid

View the updates to behavioral health claims processing.

URL: https://providernews.anthem.com/virginia/article/urgent-update-to-behavioral-health-claims-processing

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Coverage Guidelines and Clinical Utilization Management Guidelines update

Published: Apr 1, 2019 - **State & Federal** / Medicaid

For updated information, see the *Coverage Guidelines and Clinical Utilization Management (UM) Guidelines.*

URL: https://providernews.anthem.com/virginia/article/coverage-guidelines-and-clinical-utilization-management-guidelines-update-2

Latest updates to Electronic Data Interchange Gateway migration

Published: Apr 1, 2019 - **State & Federal** / Medicaid

See the latest updates online about the EDI Gateway migration.

URL: https://providernews.anthem.com/virginia/article/latest-updates-to-electronic-data-interchange-gateway-migration

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Practitioners' rights during credentialing process

Published: Apr 1, 2019 - **State & Federal** / Medicaid

View more information online about practitioners' rights during credentialing.

URL: https://providernews.anthem.com/virginia/article/practitioners-rights-during-credentialing-process-9

Anthem HealthKeepers Plus provider surveys

Published: Apr 1, 2019 - **State & Federal** / Medicaid

Each year, HealthKeepers, Inc. may reach out to you to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers.

Thank you for participating in our network, for providing quality health care to our members and for your timely completion of any surveys you receive.

URL: https://providernews.anthem.com/virginia/article/anthem-healthkeepers-plus-provider-surveys

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Clinical Criteria updates

Published: Apr 1, 2019 - **State & Federal** / Medicaid

Read additional information online about the Clinical Criteria updates.

URL: https://providernews.anthem.com/virginia/article/clinical-criteria-updates-3

Help prevent preeclampsia with prenatal aspirin

Published: Apr 1, 2019 - **State & Federal** / Medicaid

View additional information online to Help prevent preeclampsia with prenatal aspirin.

URL: https://providernews.anthem.com/virginia/article/help-prevent-preeclampsia-with-prenatal-aspirin-2

Reminder: Precertification requirements

Published: Apr 1, 2019 - **State & Federal** / Medicaid

Read additional information online about the Reminder: precertification requirements.

URL: https://providernews.anthem.com/virginia/article/reminder-precertification-requirements

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Anthem HealthKeepers Plus emergency transportation claims update

Published: Apr 1, 2019 - **State & Federal** / Medicaid

Check out additional information online about the Anthem HealthKeepers Plus emergency transportation claims update.

URL: https://providernews.anthem.com/virginia/article/anthem-healthkeepers-plus-emergency-transportation-claims-update

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Wound care treatment request update

Published: Apr 1, 2019 - **State & Federal** / Medicaid

View more information online about the wound care treatment request update.

URL: https://providernews.anthem.com/virginia/article/wound-care-treatment-request-update-1

Correction: Cervical length measurement by transvaginal ultrasound

Published: Apr 1, 2019 - **State & Federal** / Medicaid

Read the Correction: Cervical length measurement by transvaginal ultrasound update online.

URL: https://providernews.anthem.com/virginia/article/correction-cervical-length-measurement-by-transvaginal-ultrasound-4

Quality of Care and Critical Incidents training

Published: Apr 1, 2019 - **State & Federal** / Medicaid

Read more information online about the Quality of Care and Critical Incidents training.

URL: https://providernews.anthem.com/virginia/article/quality-of-care-and-critical-incidents-training

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Update regarding evaluation and management with modifier 25 same day as procedure when a prior E/M for the same or similar service has occurred

Published: Apr 1, 2019 - **State & Federal** / Medicare

Anthem has identified that providers often bill a duplicate Evaluation and Management (E/M) service on the same day as a procedure even when the same provider (or a provider with the same specialty within the same group TIN) recently billed a service or procedure which included an E/M for the same or similar diagnosis. The use of modifier 25 to support separate payment of this duplicate service is not consistent with correct coding or Anthem's policy on use of modifier 25.

Beginning with claims processed on or after May 1, 2019, Anthem may deny the E/M service with a modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record.

If you believe a claim should be reprocessed because there are medical records for related visits that demonstrate an unrelated, significant and separately identifiable E/M service, please submit those medical records for consideration.

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URL: https://providernews.anthem.com/virginia/article/update-regarding-evaluation-and-management-with-modifier-25-same-day-as-procedure-when-a-prior-em-for-the-same-or-similar-service-has-occurred-6

Coming soon: Reimbursement for select HEDIS-related CPT II codes for Medicare Advantage members

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CPT Category II codes are supplemental tracking codes used to support quality patient care and performance management. CPT II codes are:

- Billed in the procedure code field in the same way as CPT Category I codes.
- Used to describe clinical components usually included in evaluation, management or clinical services.
- Billed with a $0 billable charge amount since they are not usually associated with any relative value.

Under this new incentive program, Anthem will reimburse contracted Medicare Advantage providers for submitting select HEDIS®-related CPT Category II codes for eligible members.

Using these CPT Category II codes for Medicare Advantage members will:

- Help providers address clinical care opportunities.
- Facilitate timely and accurate claims payments.

Detailed information about this program, including a list of applicable codes, will be sent to providers.

ABSCARE-0006-19

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URL: https://providernews.anthem.com/virginia/article/coming-soon-reimbursement-for-select-hedis-related-cpt-ii-codes-for-medicare-advantage-members-4

Keep up with Medicare news

Published: Apr 1, 2019 - **State & Federal** / Medicare

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

- Revision to Facility Emergency Department Reimbursement Policy
- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus
- Prior authorization requirements for DME repair and portable oxygen
- 2019 risk adjustment provider training
- New provider learning opportunity: Put the AIM ProviderPortal to work for you
- New provider service phone number beginning January 1, 2019

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URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicare-news-51
