Indiana Provider News

April 2021 Anthem Provider News - Indiana

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Notice of Changes to Prior Authorization Requirements - April 2021

Published: Apr 1, 2021 - **Administrative**

New prior authorization requirements for providers may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements.

Changes to Prior Authorization Requirements

- Important update to provider UM reimbursement penalties and corresponding entry in Provider Manual*
- Updates for specialty pharmacy are available*
- Medical policy and clinical guideline updates*
- Update: Clinical guideline adoption postponed*
- MCG Care Guidelines 25th Edition available*
- Maximizing efficient, high quality COVID-19 screenings*
- New reimbursement policy: Newborn Inpatient Stays for facilities*

URL: https://providernews.anthem.com/indiana/article/notice-of-changes-to-prior-authorization-requirements-april-2021

The health of millennials: Trends in behavioral health conditions

Published: Apr 1, 2021 - **Products & Programs** / Behavioral Health

Millennials with behavioral health conditions were at twice the risk of having a chronic physical condition.

The study included the analysis of millennials' medical claims over a five year period. Those with ongoing behavioral health conditions were twice as likely to have a chronic physical condition as their peers without a behavioral health diagnosis.

Behavioral health conditions driving adverse health for millennials

Condition	Years of Healthy Life Lost	Prevalence Rate per 100, 2018	1-Year Change 2017-2018	5-Year Change 2014-2018
ADHD	1.8	6.9	**1%**	**39%**
Tobacco Use Disorder	0.7	5.9	**5%**	**10%**
Major Depression	7.8	5.6	**12%**	**43%**
Substance Use Disorder	10.2	2.1	**5%**	**17%**
Alcohol Use Disorder	10.0	1.6	**7%**	**5%**
Psychotic Disorders	15.4	0.9	**0%**	**26%**

Reprinted from Blue Cross Blue Shield Association's 2019 report on the Health of Millennials

It's important to follow-up with your patients—millennial, Gen X, Gen Z or baby boomer—who are prescribed antidepressant medications or who have been hospitalized for mental illness or substance use disorders. Not only will patients have better behavioral health outcomes, their physical health could be significantly impacted as well. Follow these HEDIS® measures for additional guidance in closing the gaps in behavioral health conditions for all ages.

A note about telehealth

NCQA now accepts telehealth codes for behavioral health and some physical health measures. The modifiers 95 and GT are defined as telehealth services rendered via interactive audio and video telecommunications system. CPT Codes 90791-90792, 90832-90834, 90836-90838, 90845, 90847, 98960-98962, 99201-99205, 99212-99215, 99231-99233, 99241-99245, 99251-99255, 99307-99310, 99406-99409 and 99495-99496 may be used for reporting synchronous (real-time) telemedicine services when appended by modifier 95.

Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported:

- ***Effective Acute Phase Treatment.*** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
- ***Effective Continuation Phase Treatment.*** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

AMM Billing Codes:

- **BH Outpatient CPT**: 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99510 HCPCS: G0155, G0176-G0177, G0409, G0463, H0002, H0004, H0031, H0034-H0037, H0039-H0040, H2000, H2001, H2010-H2011, M0064, T1015
- **Emergency Department CPT**: 99281-99285 UB Rev: 0450-0452, 0456, 0459, 0981
- **Major Depression ICD-10 CM**: F32.0-F32.4, F32.9, F33.0-F33.3, F33.41, F33.9
- **Telephone Visits CPT:** 98966-98968, 99441-99443
- **Telephone Modifier Value Set:** 95 GT POS: 02
- **Telehealth:** 90791-90792, 90832-90834, 90836-90838, 90845, 90847, 99201-99205, 99212-99215, 99231-99233, 99241-99245, 99251-99255, 98960-98962
- **Telehealth modifier:** 95 or GT
- **Telehealth POS:** 02

Follow-Up After Hospitalization for Mental Illness (FUH): The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the member received follow-up within **30 days after discharge**.
- The percentage of discharges for which the member received follow-up within **7 days after discharge.**

The follow-up visits, within 7 days and 30 days after hospitalization can both be telehealth visits. Telephone visits alone do not meet this criterion.

FUH Billing Codes:

- **Follow-Up Visits CPT**: 90791-2, 90832-40, 90845, 90847, 90849, 90853, 90875-6, 98960-2, 98966-8, 99078, 99201-5, 99211-5, 99217-23, 99231-3, 99238-9, 99241-5, 99251-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99441-3, 99483, 99495-6, 99510 HCPCS: G0155, G0176-7, G0409, G0463, H0002, H0004, H0031, H0034, H0036-7, H0039-40, H2000, H2010-1, H2013-20, M0064, T1015

- **Mental Illness Diagnosis Codes ICD-10**: F03.9x, F20-F25.xx, F28-F34.xx, F39-F45.xx, F48.xx, F50-F53.xx, F59-F60.xx, F63-F66.xx, F68-F69.xx, F80-F82.xx, F84.xx, F88-F93.xx, F95.xx, F98-F99.xx
- **Telehealth visits:** 90791-90792, 90832-90834, 90836-90838, 90845, 90847, 99201-99205, 99212-99215, 99231-99233, 99241-99245, 99251-99255, 98960-98962
- **Telehealth modifier:** 95 or GT
- **Telehealth POS:** 02

Follow-Up After Emergency Department Visit for Mental Illness (FUM): The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within **30 days of the ED visit (31 total days).**
- The percentage of ED visits for which the member received follow-up within **7 days of the ED visit (8 total days).**

The follow-up visits, within 7 days and 30 days after hospitalization, can both be telehealth visits. Telephone visits alone do not meet this criterion.

FUM Billing Codes:

- **Outpatient Follow-Up Visits CPT:** 90791-2, 90832-4, 90836-40, 90845, 90847, 90849, 90853, 90875-6, 98960-2, 98966-8, 99078, 99201-5, 99211-5, 99217-23, 99231-3, 99238-9, 99241-5, 99251-5, 99341-5, 99347-50, 99381-7, 99391-7, 99401-4, 99411-2, 99441-3, 99483, 99495-6, 99510
- **HCPCS:** G0155, G0176-7, G0409, G0463, H0002, H0004, H0031, H0034, H0036-7, H0039-40, H2000, H2010-1, H2013-20, M0064, T1015
- **Mental Illness Diagnosis Codes ICD-10:**9x, F20-25.xx, F28-34. xx, F39-45.xx, F48.xx, F50-53.xx, F59-60.xx, F63-66.xx, F68-69.xx, F80-82.xx, F84.xx, F88-93.xx, F95.xx, F98-99.xx
- **Intentional Self-Harm Diagnosis Codes ICD-10 example:**92XA
- **Other visits:** 90791-90792, 90832-90834, 90836-90838, 90845, 90847, 99201-99205, 99212-99215, 99231-99233, 99241-99245, 99251-99255, 98960-98962
- **Telehealth modifier:** 95 or GT

- **Telehealth modifier POS:** 02

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA): The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within **30 days of the ED visit (31 total days).**
- The percentage of ED visits for which the member received follow-up within **7 days of the ED visit (8 total days).**

The follow-up visits, within 7 days and 30 days after hospitalization, can both be telehealth visits. Telephone visits alone do not meet this criterion.

FUA Billing Codes:

- **Initiation, Engagement and Treatment Follow-Up Visits CPT**: 98960-2, 99078, 99201-5, 99211-5, 99241-5, 99341-50, 99384-7, 99394-7, 99401-4, 99408-9 99411-2, 99483, 99510
- **Alcohol Counseling or Other Follow-Up Visits CPT**: 99408-9 HCPCS: G0396-7, G0443, H0005, H0007, H0016, H0022, H0050, H2035-6, T1006, T1012 AOD
- **Medication Treatment HCPCS**: G2067-77, G2080, G2086-7, H0020, H0033, J0570, J0571-5, J2315, Q9991-2, S0109
- **Substance Use Disorder Diagnosis Codes ICD-10:** F10-16.xx, F18-19.xx
- **Telehealth modifier:** 95 or GT
- **Telephone visits:** 98966 - 98968, 99441- 99443
- **Other visits:** 90791-90792, 90832-90834, 90836-90838, 90845, 90847, 99201-99205, 99212-99215, 99231-99233, 99241-99245, 99251-99255, 99408-99409, 98960-98962
- **Telehealth modifier POS:** 02

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI): The percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

- The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **30 days after the visit or discharge**.
- The percentage of visits or discharges for which the member received follow-up for substance use disorder within the **7 days after the visit or discharge**.

Article Attachments

FUI Billing Codes:

- **Opioid Abuse and Dependence ICD-10:**10; F11.120; F11.121; F11.122; F11.129
- **Other Drug Abuse and Dependence ICD-10:**10; F12.120; F12.121; F12.122; F12.129
- **Alcohol Abuse and Dependence ICD-10:**10; F10.120; F10.121; F10.14; F10.150
- **Telephone Visits CPT:** 98966-98968; 99411-99443
- **Online Assessments CPT:** 98969-98972; 99421-99423; 99444; 99458
- **IET Stand Alone Visits CPT:** 98960-98962; 99201-99205; 99211-99215

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

[1]Millennial Health: Trends in Behavioral Health Conditions. https://www.bcbs.com/the-health-of-america/reports/millennial-health-trends-behavioral-health-conditions

1079-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/the-health-of-millennials-trends-in-behavioral-health-conditions

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Correction: Updated formulary lists for commercial health plan pharmacy benefit effective April 1, 2021

Published: Apr 1, 2021 - **Products & Programs** / Pharmacy

In the February 2021 edition of *Provider News*, we announced updates to the formulary lists for Commercial health plans effective April 1, 2021.

Be advised that this is the link to **the correct summary of formulary changes**. Please disregard the list published in the February article.

We apologize for any inconvenience this may have caused.

1113-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/correction-updated-formulary-lists-for-commercial-health-plan-pharmacy-benefit-effective-april-1-2021-2

Updates for specialty pharmacy are available - April 2021*

Published: Apr 1, 2021 - **Products & Programs** / Pharmacy

Effective for dates of service on and after July 1, 2021, 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 National Drug Code (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.

Prior authorization clinical review of non-oncology use of specialty pharmacy drugs is managed by the medical specialty drug review team. Review of specialty pharmacy drugs for oncology use is managed by AIM Specialty Health® (AIM).

Clinical Criteria	HCPCS or CPT Code(s)	Drug
*ING-CC-0027	J0897	Xgeva

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

Quantity Limit Updates

Effective for dates of service on and after July 1, 2021, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our quantity limit review process.

Please note, 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.

To access the Clinical Criteria information please click here.

Prior authorization clinical review of non-oncology use of specialty pharmacy drugs is managed by the medical specialty drug review team. Review of specialty pharmacy drugs for oncology use is managed by AIM Specialty Health® (AIM).

Clinical Criteria	HCPCS or CPT Code(s)	Drug
*ING-CC-0027	J0897	Xgeva

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

1090-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/updates-for-specialty-pharmacy-are-available-april-2021-1

Pharmacy information available at anthem.com

Published: Apr 1, 2021 - **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 website 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.

1037-0421-PN-IN.OH.WI

URL: https://providernews.anthem.com/indiana/article/pharmacy-information-available-at-anthemcom-31

Important update to provider UM reimbursement penalties and corresponding entry in Provider Manual*

Published: Apr 1, 2021 - **Administrative**

Effective for dates of service on and after July 1, 2021, Anthem Blue Cross and Blue Shield (Anthem) will increase the reimbursement penalty for failure to comply with the utilization management (UM) program's prior authorization requirements for services rendered to commercial plan members. Late prior authorizations, and late notices in the case of emergency admissions, are currently subject to a penalty and will be subject to the increase in the penalty.

Failure to comply with Anthem's prior authorization requirements, and late notice requirements in the case of emergency admissions, will result in a 100% reduction in reimbursement to the provider and facility.

As a reminder, Anthem requires prior authorization prior to the delivery of certain elective services in both the inpatient and outpatient settings. For an emergency admission, prior authorization is not required; however, you must notify Anthem of the admission within the timeframe specified in the Provider Manual or as otherwise required by law.

Failure to give timely notification for emergency admissions will also result in reimbursement penalties of 100% to providers and facilities.

Enforcement of the program requirement will lead to greater consistency in our processes. This notice updates Anthem's UM program reimbursement penalties and the corresponding sections of the Provider Manual to reflect this change to the reimbursement penalty for non-compliance. These updates will be reflected in the next updated version of the Provider Manual. As a reminder, providers and facilities may not balance bill the member for any such reduction in payment.

1096-0421-PN-IN.MO.WI

URL: https://providernews.anthem.com/indiana/article/important-update-to-provider-um-reimbursement-penalties-and-corresponding-entry-in-provider-manual

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Does your practice offer telehealth services? Let us know!

Published: Apr 1, 2021 - **Administrative**

Beginning in April 2021, our online directories will identify professional providers who offer telehealth services in their practice.

We encourage providers to utilize the online Provider Maintenance Form to notify us about your telehealth services and we will add a telehealth indicator to your online provider directory profile.

Visit anthem.com to locate the online Provider Maintenance Form. Please contact Provider Services if you have any questions.

1003-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/does-your-practice-offer-telehealth-services-let-us-know-2

Information Center - Access important policies, forms and helpful resources

Published: Apr 1, 2021 - **Administrative**

We're changing!

The **Information Center** has replaced the Education and Reference Center application in Payer Spaces on the Availity Portal. There you'll find important policies, forms and helpful resources.

If you're looking for specific education materials, we invite you to visit the Custom Learning Center in Availity, which was designed to offer education/training content and to be a learning environment. Content previously posted in the Communication & Education tab have now migrated there. Find the Custom Learning Center tool in Payer Spaces > Applications > Access the Custom Learning Center.

Locate the **Information Center** in Payer Spaces. Depending on your market, the **Information Center** contains a number of sections:

- Administrative support
- Behavioral health
- Clinical resources
- Medicaid
- Medicare
- Federal Employee Program (FEP)

To view content in both of these valuable tools, visit Payer Spaces today.

1060-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/information-center-access-important-policies-forms-and-helpful-resources

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Understanding Availity roles for electronic data interchange (EDI)

Published: Apr 1, 2021 - **Administrative**

Did you know your Availity administrator for your organization is the key to opening doors to self-service transaction roles such as EDI. A **role** is a group of job functions, also known as permissions. Each role consists of one or more permissions. Assigning roles is part of the process when you add a new Availity user with the **Add User** feature.

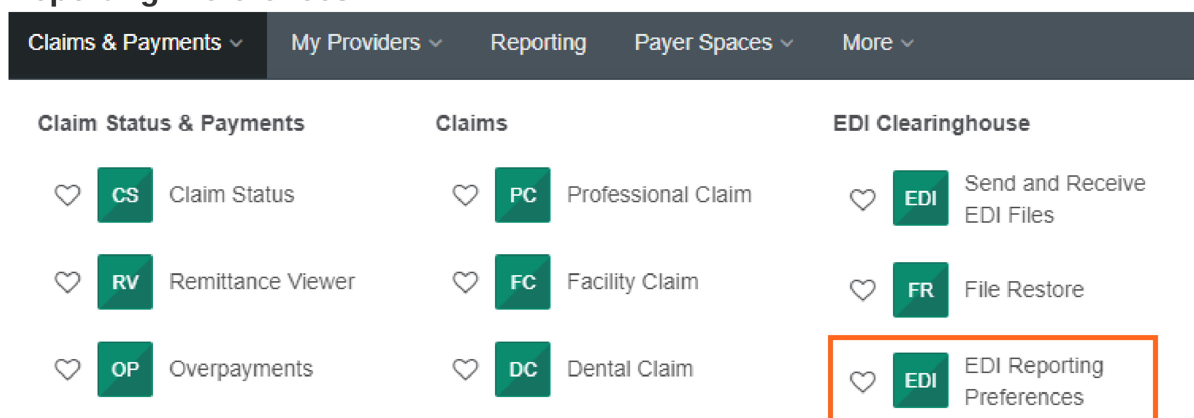
What EDI roles do I need?

EDI Management – This role consists of the following permissions available under EDI File Management in the Availity menu:

- **EDI Reporting Preferences** – Specify the EDI batch report files you want users at your organization to receive, along with file formats and other reporting preferences.
- **EDI Send and Receive Files** – Review EDI batch report files for batch files submitted using Availity's EDI File Management feature. In addition, review payer responses to Availity Web-based claim forms submitted to payers that process claims in batches.
- **File Restore** – Restore archived EDI files to your **ReceiveFiles**

Set up EDI Reporting Preferences

Availity's batch EDI processing generates response files for each batch file that you submit. The administrator for an organization can set reporting preferences that specify which response files are generated. In the Availity Portal menu, click **Claims & Payments** > **EDI Reporting Preferences**.



Enroll for the Direct Data Entry Transaction

You must be assigned the Claims role to submit professional claims or encounters. If you cannot access the claim form, contact your administrator to assign the Claims role to you. Submit transactions through manual data entry in Availity Portal.

In the Availity Portal menu, click **Claims & Payments** > **Professional Claim/Facility Claim/Dental Claim** > Confirm which organization and payer you would like to submit claims for and continue to complete the fields to be directed to the **simple and time saving claim form** to enter claim information.

Article Attachments

Need More Help?

The EDI Connection Services Startup Guide is a helpful resource to help you get started, set up your EDI reporting preferences and submit transactions through manual data entry in Availity Portal. Contact Availity

- Select **Help & Training** > **Get Trained** to display the Availity Learning Center (ALC) in a new browser tab. Search the catalog to locate and enroll in courses. Based on your needs.
- Select **Help & Training** > **Find Help** to display Availity Help in a new browser window. Use Contents to display topics. Depending on your needs, consider exploring these topics:
  - Administrator
  - Claim Submission
  - Electronic Data Interchange (EDI)
  - Glossary

- Select **Help & Training** > **Availity Support** to:
  - Open a ticket to request support
  - Get support via Chat

1061-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/understanding-availity-roles-for-electronic-data-interchange-edi-2

Make the change to digital authorization/referral and hospital admission notifications using EDI

Published: Apr 1, 2021 - **Administrative**

Anthem Blue Cross and Blue Shield (Anthem) and Availity are excited to announce the Prior Authorization and Referrals (278) and Inpatient Admission and Discharge Notification (278N) 5010 transactions functionality.

Prior Authorization and Referral Request (278)
Use this transaction to electronically submit authorization and referral requests. You have the option to transmit this transaction in real-time or batch mode, and you will receive confirmation numbers to validate receipt of request.

- An authorization is a review and approval of specific services
- A referral is used to refer a patient to a specialty provider

Hospital Admission Notification (278N)
Use this transaction to electronically submit **hospital admission notifications between your facility and health plan.** The EDI 278N is the easiest, most efficient way to communicate facility admissions. Just like the 278, you can also transmit in either batch or real-time format which includes the ability to update a previously submitted date.

What are your benefits for using these transactions?

- Streamline administrative tasks and increase productivity
- Reduce administrative costs through automation
- Increase data accuracy by reducing manual errors
- Confirm a notification of admission is on file in the form of a service reference number that is generated upon registration
- Submit notification of discharge
- Accomplish more with less – fewer phone calls, faxes or keying

Getting Started

- If you use a clearinghouse or vendor work with them to ensure they have the capability to exchange these transactions.
- If you use practice management software have your Availity administrator use the following path to enroll:
  - My Providers > Enrollment Center > Transaction Enrollment

Useful Documents

- Availity EDI Companion Guide communicates Availity-specific requirements and other information that supplements requirements and information already provided in standard EDI and HIPAA communications.
- Anthem specific companion guide communicates requirements for submitting these transactions. These are located on the company website at – anthem.com/edi
- The Availity Quick Start Guide will assist you with any EDI connection questions you might have.

If you need assistance, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 8 p.m. Eastern Time.

1082-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/make-the-change-to-digital-authorizationreferral-and-hospital-admission-notifications-using-edi-2

Attention facilities: Sending admission, discharge and transfer data results in improved care management for patients

Published: Apr 1, 2021 - **Administrative**

The Centers for Medicare & Medicaid Services (CMS) has issued an Interoperability and Patient Access Policy to reduce the burden of certain administrative processes. The CMS policy requires providers to implement Application Programming Interfaces (APIs) to improve the electronic exchange of healthcare data between patient, provider and payer. The policy reiterates, that in partnership with the Office of the National Coordinator for Health Information (ONC), CMS has identified Health Level 7® (HL7) as the foundational standard to support data exchange via secure API. Implementation of this CMS mandate is expected by July 1, 2021.

Anthem Blue Cross and Blue Shield (Anthem) Clinical Data Acquisition Group has integrated Admission, Discharge and Transfer (ADT) data from facility providers, health information exchanges and third-party aggregators. ADT data exchange can help Anthem:

- Better support members with care coordination and discharge planning, leading to healthier outcomes for our members—your patients.
- Proactively manage care transitions to avoid waste.
- Close care gaps and educate members about appropriate care settings to better manage out-of-pocket expenses.

Anthem would like to digitally exchange HLT ADT messaging data for our members using secure data collection and transmission capabilities currently in use by facility systems. Facilities with network connections through vendors or health information exchanges can integrate ADT data with Anthem through these channels as well. Near real time HL7 ADT messaging data, or at least within 24-hours of admission, discharge or transfer, enables Anthem to most effectively manage care transitions.

Contact the Clinical Data and Analytics team to get started today. Email us at ADT_Intake@anthem.com.

1081-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/attention-facilities-sending-admission-discharge-and-transfer-data-results-in-improved-care-management-for-patients

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Chat directly with a prior authorization specialist

Published: Apr 1, 2021 - **Administrative**

If you have questions about prior authorizations (PA), you now have a new option to have them answered quickly and easily. With Anthem Chat, providers can have a real-time, online discussion with a PA specialist.

- Faster access to PA provider services experts
- Real-time answers to your questions about PA and live help for submissions, similar to the call experience
- Access to denial information and clinical team for resolution
- The same high level of safety and security you have come to expect with Anthem Blue Cross and Blue Shield (Anthem)

Chat is one example of how Anthem is using digital technology to improve the healthcare experience, with a goal to save you valuable time. To start, access the service through *Payer Spaces* on Availity.

To access chat: log on to Availity at Availity.com. Select *Payer Spaces* then select the health plan. Once in *Payer Spaces*, select the *Chat with Payer* box from *Applications*.

1092-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/chat-directly-with-a-prior-authorization-specialist-2

Keeping up with routine vaccination during COVID-19

Published: Apr 1, 2021 - **Administrative**

In May 2020, the Centers for Disease Control (CDC) released a report that showed a drop in routine childhood vaccinations as a result of COVID-19; a result of stay at home orders and concerns about infection during well-child visits. Both the American Academy of Pediatrics and the CDC recommend the continuation of routine childhood vaccinations during the COVID-19 pandemic, noting they are essential services.

To encourage well-visits and vaccinations, here are some extra steps you can take, if you haven’t already, to make visits as safe as possible for both patients and staff. They include:

- Scheduling sick visits and well-child visits during different times of the day.

- Asking patients to remain outside until it's time for their appointment to reduce the number of people in waiting rooms.
- Offering sick visits and well-child visits in different locations.

It's important to identify those children who have missed immunizations and well-child visits to schedule these essential in-person appointments. To help, the CDC has published vaccine catch-up guidance on their website.

Helpful information for keeping babies and children healthy
Childhood Immunization Schedule (CIS) HEDIS® measures require that all children are immunized by the age of two:

- Four DTaP (diphtheria, tetanus and acellular pertussis)
- Three IPV (polio)
- One MMR (measles, mumps, rubella)
- Three HiB (H influenza type B)
- Three HepB (hepatitis B)
- One VZV (chicken pox)
- Four PCV (pneumococcal conjugate)
- One HepA (hepatitis A)
- Two or Three RV (rotavirus)
- Two Influenza (flu)

Billing codes:

- **MMR** CPT: 90707, 90710 ICD-10-CM: B05.0-4, B05.81, B05.89, B05.9
- **Mumps** ICD-10-CM: B26.0-3, B26.81-85, B26.89, B26.9
- **Rubella** ICD-10-CM: B06.00-02, B06.09, B06.81-82, B06.89, B06.9
- **Rubella** CPT: 90706
- **Rubella antibody** CPT: 86762
- **Hepatitis A (Hep A)** CPT: 90633 ICD-10-CM: B15.0, B15.9
- **Influenza** CPT: 90655, 90657, 90661, 90662, 90673, 90685, 90686, 90687, 90688, 90689
- HCPCS: G0008

- **Rotavirus vaccine (RV)** CPT: 90681 (two-dose) and 90680 (three-dose)

Article Attachments

Children should be fully immunized by 13 years of age to meet the Immunization for Adolescents (IMA) HEDIS® measure:

- One meningococcal vaccine (MCV) injection between 11 to 13 years of age
- One tetanus, diphtheria toxoids and acellular pertussis vaccine (TDAP/TD) between 10 to 13 years of age
- Two or three HPV vaccines between 9 to 13 years of age

Billing Codes:

- **Meningococcal** CPT: 90734
- **Tdap** CPT: 90715
- **HPV** CPT: 90649, 90650, 90651

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

For a complete list of HEDIS® measures, descriptions and coding tips, visit anthem.com.

1080-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/keeping-up-with-routine-vaccination-during-covid-19

Interactive bilingual website taking action for our health

Published: Apr 1, 2021 - **Administrative**

Having the common goal of reaching all Latinos in the US, Anthem, Inc., the Beckman Research Institute of City of Hope, the National Hispanic Medical Association, and Pfizer, Inc., announce the launch of Tomando Acción por Nuestra Salud/Taking Action for Our

Health, a free interactive bilingual website aimed at eliminating health disparities in the Latino community. The website encourages preventive health screenings for cancer, emotional health, heart health, and prediabetes. It also provides tools to help people care for the emotional health of their families and themselves in the language of their preference.

The interactive website highlights the importance of health screenings, addresses barriers and provides information on access to low and no cost healthcare services in the community. The easy to use website, guides participants through four programs where they can learn about risk factors, take action to get screened, monitor their progress, and share their results with their doctors, health care teams or family and friends to let them know they are taking steps to protect their health and help encourage others to participate as well.

The website is not exclusive for Anthem members. Health care providers are encouraged to share the website with all of their Latino patients.

The website identifies four major targets of undue poor health outcomes for Latinos. In response, *Tomando Acción por Nuestra Salud/Taking Action for Our Health* strives to help increase cancer screening, screening for depression/anxiety-risk, heart diseases and prediabetes and provides tools to address emotional health. The website includes a 4-part workshop series “Compartiendo el Café y el Chocolate/Coffee and Chocolate” to help people care for the emotional health of their family and themselves. This is a program, specifically for Hispanics, that uses a holistic approach to emotional stability. It builds on cultural strengths to balance four key items—community, body, mind, and spirit.

To access *Tomando Acción por Nuestra Salud/Taking Action for Our Health* visit:
Taking Action for Our Health.

1038-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/interactive-bilingual-website-taking-action-for-our-health-1

Join Anthem in talking about racism and its impact on health

Published: Apr 1, 2021 - **Administrative**

Healthcare and mental healthcare professionals have a vital role in identifying, treating, and addressing racial trauma and injustice, moving our communities towards racial equity, and improving the health and wellbeing of all Americans.

We can impact the injustice of racism together.
Anthem has partnered with Motivo*, the first HIPAA-compliant digital platform that connects mental health therapists and clinical supervisors, to take on the challenge of facilitating conversations on racial injustice, trauma, and inequality among our providers and associates.

We are hosting Racial Equity forums on a quarterly basis to keep the conversation going. Please register for the next forum, Deconstructing Bias, to learn more about the impact of racism on healthcare and the people we serve, and what we can do about it.

In Pursuit of Racial Equity: Deconstructing Bias
Wednesday, June 9, 2021
4:00 pm – 5:30 pm Eastern / 3:00 pm – 4:30 pm Central
Register today!

Our racial equity forums focus on:

- Exploring how racism takes shape in healthcare.
- Discussing how to identify racism in your practice and how to be an ally to your patients.
- Understanding the impact of prolonged exposure to racism on people of .
- Providing you with actionable resources to put an end to racism in your practice.

Since October 2020, Anthem has sponsored two virtual forums featuring healthcare professionals from Anthem and Motivo: Racial Trauma in America and The Road to Allyship: Playing Your Part in Racial Equity.

We know we are on the right track because the Racial Equity Forum participants say so.

- 90% received meaningful information about the influence that racism and White privilege may have on their perspectives and gained an understanding on what actions they can take to make a difference and be an ally.
- 86% obtained useful information and resources that will enhance their ability to serve patients.
- 75% agreed that the forum helped them understand a different perspective.

- 76% had some of their perspectives and beliefs challenged.

Systematic racism is a part of today's healthcare system.

- US physicians underestimate the pain level of Black patients 47% of the time vs. 33.5% of the time for White patients (PNAS).
- Black women die from pregnancy or childbirth 243% more often than White women (CDC).

The first step to addressing racism is to recognize its existence, subtle or otherwise. These conversations can be uncomfortable, but this is how you can do something about racial injustice now.

At Anthem, we are determined to reduce racism in our communities with your support and participation.

*Motivo is an independent company providing a virtual forum on behalf of Anthem.

1089-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/join-anthem-in-talking-about-racism-and-its-impact-on-health-1

Medical policy and clinical guideline updates - April 2021*

Published: Apr 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were reviewed on February 11, 2021 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

To view medical policies and utilization management guidelines applicable to members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (commonly referred to as the Federal Employee Program® (FEP®)), please visit www.fepblue.org > Policies & Guidelines.

The new Medical Policies listed below have been approved.

*Note: *Precertification required*

Title	Information	Effective date
GENE.00056 Gene Expression Profiling for Bladder Cancer	• Gene expression profiling for diagnosing, managing and monitoring bladder cancer is considered INV&NMN -- Existing CPT codes 0012M, 0013M (Cxbladder GEP) moved from LAB.00011, still considered INV&NMN; CPT 0016M effective 01/01/2021 for Decipher TURBT® will be considered INV&NMN	7/1/2021
LAB.00038 Cell-free DNA Testing to Aid in the Monitoring of Kidney Transplants for Rejection	• Cell-free DNA testing is considered INV&NMN as a non-invasive method of determining the risk of rejection in kidney transplant recipients - Existing code 0118U for Vitacor TRAC will be considered INV&NMN for kidney transplant diagnoses; no specific codes for other tests, listed 81479, 81599 NOC codes	7/1/2021
LAB.00039 Pooled Antibiotic Sensitivity Testing	• Pooled antibiotic sensitivity testing is considered INV&NMN in the outpatient setting for all indications - No specific codes for these tests (eg Guidance® assay for UTI [Pathnostics, Inc.]), considered INV&NMN; listed NOC codes 81479, 87999	7/1/2021

SURG.00159 Focal Laser Ablation for the Treatment of Prostate Cancer	• Focal laser ablation is considered INV&NMN for the treatment of prostate cancer - No specific code for focal laser ablation of prostate for cancer, considered INV&NMN; listed 55899 NOC and associated ICD-10-PCS code; also listed 0655T (will be effective 07/01/2021) considered INV&NMN	7/1/2021
*TRANS.00037 Uterine Transplantation	• Uterine transplantation is considered INV&NMN for all uses, including but not limited to the treatment of uterine factor infertility due to nonfunctioning or absent uterus - No specific CPT code for uterine transplant services, considered INV&NMN; listed 58999 NOC and associated ICD-10-PCS codes, also listed 0664T-0670T (will be effective 07/01/2021) considered INV&NMN	7/1/2021

The current Medical policies and/or Clinical Guidelines listed below were reviewed and updates were approved.

*Note: *Precertification required*

Title	Change	Effective date
*CG-GENE-22 Gene Expression Profiling for Managing Breast Cancer Treatment	• Content moved from GENE.00011 • INV&NMN changed to NMN as a result of MP to CUMG transition • Removed Insight DX test (no longer marketed) and added Insight TNBC type test as NMN	4/7/2021
*CG-GENE-23 Genetic Testing for Heritable Cardiac Conditions	• Content moved from GENE.00007 and GENE.00017 • INV&NMN changed to NMN as a result of MP to CUMG transition • No other change to clinical indications	4/7/2021
*ANC.00008 Cosmetic and Reconstructive Services of the Head and Neck	• Removed the word “physical” from the term “physical functional impairment” in Facial Plastic Surgery, Otoplasty, Rhinophyma, Rhinoplasty or Rhinoseptoplasty and Cranial Nerve Procedures position statements • Added otoplasty using a custom-fabricated device, including but not limited to a custom fabricated alloplastic implant, as COS&NMN - No specific code for implanted auricular prosthesis, added L8699 NOC, considered COS&NMN for specific implants	7/1/2020
*CG-OR-PR-04 Cranial Remodeling Bands and Helmets (Cranial Orthotics)	• Removed condition requirement from REC criteria • Replaced current diagnostic REC criteria with criteria based on one of the following cephalometric measurements: the cephalic index, the cephalic vault asymmetry index, the oblique diameter difference index, or the cranioproportional index of plagiocephelometry	7/1/2021

*CG-SURG-82 Bone-Anchored and Bone Conduction Hearing Aids	• Reorganized Clinical Indications section • Reorganized and clarified bilateral hearing loss MN criteria • Clarified MN criteria for transcutaneously-worn bone conduction hearing aids for both bilateral and unilateral hearing loss • Revised audiologic pure tone average bone conduction threshold criteria for unilateral implant for bilateral hearing loss • Moved device-specific threshold information to the Discussion section • Clarified MN criteria for transcutaneously worn and fully- or partially-implantable bone conduction hearing aids for unilateral hearing loss • Added NMN statement for when MN criteria have not been met • Clarified NMN statement regarding replacement parts or upgrades • Added bone conduction hearing aids using an adhesive adapter behind the ear as NMN for all indications	7/1/2021
*****CG-GENE-14 Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management	• Reorganizing genetic testing topics: Moved the content of the following topics into CG-GENE-14 Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management - CG-GENE-02 Analysis of RAS Status - CG-GENE-03 BRAF Mutation Analysis - CG-GENE-12 PIK3CA Mutation Testing for Malignant Condition - CG-GENE-20 Epidermal Growth Factor Receptor [EGFR] Testing)	

• Added circulating tumor DNA (ctDNA) to guide targeted cancer therapy in individuals with solid tumor(s) as MN when criteria are met • Added NMN criteria on circulating tumor DNA (ctDNA) when the medically necessary criteria are not met, including to detect the recurrence of a solid tumor, including ectal cancer, and to test for solid tumor cancer susceptibility - Content addressing ctDNA involving 4 or fewer genes or gene variants, moved from GENE.00049 Circulating Tumor DNA Panel Testing for Cancer (Liquid Biopsy) and added to this document (CG-GENE-14) - Content addressing ctDNA involving 5 or more genes or gene variants (gene panel), will continue to be addressed in GENE.00049 - Added PLA code 0229U (Colvera® 2-gene test) considered NMN (moved from GENE.00049, was considered INV&NMN); added specific codes from merged guidelines (PIK3CA 81309, 0155U, 0177U; RAS 81275, 81276, 81311, 0111U; BRAF 81210; EGFR 81235) and genes to Tier 2 codes, with no changes	4/1/2021

1062-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/medical-policy-and-clinical-guideline-updates-april-2021

Update: Clinical guideline adoption postponed*

Published: Apr 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

This update is for Anthem Blue Cross and Blue Shield in Indiana, Kentucky, Missouri, Ohio and Wisconsin.

We previously announced that clinical guideline CG-Surg-104, Intraoperative Neuromonitoring, would be adopted effective February 1, 2021.
We are postponing adoption of this clinical guideline.

We will announce the new date for adoption once it is available.

1032-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/update-clinical-guideline-adoption-postponed

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MCG Care Guidelines 25th Edition available*

Published: Apr 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

Effective July 1, 2021, we will upgrade to the 25th edition of MCG care guidelines for the following modules: Inpatient & Surgical Care (ISC), General Recovery Care (GRC), Chronic Care (CC), Recovery Facility Care (RFC), and Behavioral Health Care (BHC). The below tables highlight new guidelines and changes that may be considered more restrictive.

Goal Length of Stay (GLOS) for Inpatient & Surgical Care (ISC)

MCG Code	Guideline	24th Edition GLOS	25th Edition GLOS
S-152	Aortic Coarctation, Angioplasty	Ambulatory or 1 day postoperative	Ambulatory
W0016	Cardiac Septal Defect: Atrial, Transcatheter Closure	Ambulatory or 1 day postoperative	Ambulatory
S-445	Esophageal Diverticulectomy, Endoscopic	Ambulatory or 1 day postoperative	Ambulatory
S-510	Gastrectomy, Partial - Billroth I or II	4 or 6 days postoperative	5 days postoperative
S-1305	Hernia Repair (Non-Hiatal)	Ambulatory or 1 day postoperative	Ambulatory
S-1200	Pancreatectomy	5 or 7 days postoperative	6 days postoperative
S-990	Pyloroplasty and Vagotomy	4 or 6 days postoperative	4 days postoperative
W0097	Cervical Laminectomy	2 days postoperative	Ambulatory or 2 days postoperative
W0091	Lumbar Diskectomy, Foraminotomy, or Laminotomy	Ambulatory or 1 day postoperative	Ambulatory
S-530	Removal of Posterior Spinal Instrumentation	1 day postoperative	Ambulatory or 1 day postoperative
W0138	Shoulder Hemiarthroplasty	1 day postoperative	Ambulatory or 1 day postoperative
W0156	Spine, Scoliosis, Posterior Instrumentation, Pediatric	4 days postoperative	3 days postoperative
S-190	Bladder Resection: Cystectomy with Urinary Diversion, Conduit or Continent	5 or 6 days postoperative	5 days postoperative

S-970	Prostatectomy, Transurethral Resection (TURP)	Ambulatory or 1 day postoperative	Ambulatory
S-1172	Urethroplasty	Ambulatory or 1 day postoperative	Ambulatory

New Guidelines for Behavioral Health Care (BHC) and Recovery Facility Care (RFC)

MCG Code	Body System	Guideline Title
B-031-IP	Withdrawal Management	Withdrawal Management, Adult: Inpatient Care
B-031-IOP	Withdrawal Management	Withdrawal Management, Adult: Intensive Outpatient Program
B-031-AOP	Withdrawal Management	Withdrawal Management, Adult: Outpatient Care
B-031-PHP	Withdrawal Management	Withdrawal Management, Adult: Partial Hospital Program
B-031-RES	Withdrawal Management	Withdrawal Management, Adult: Residential Care
M-5197	Cardiology	Hypertension
M-7087	Cardiology	Peripheral Vascular Disease (PVD)
M-7095	Nephrology	Rhabdomyolysis
M-7100	Nephrology	Encephalopathy
M-5545	Thoracic Surgery	Rib Fracture

Anthem Customizations to MCG care guideline 25th Edition

Effective July 1, 2021, the following MCG care guideline 25th edition customizations will be implemented:

Transcranial Magnetic Stimulation, W0174 (previously ORG: B-801-T) - Revised Clinical Indications for Procedure and added the following:

- Need for acute TMS treatment, up to 6 weeks
- Acute treatment course needed as indicated by (a) Initial course of treatment for major depressive disorder (severe), or (b) Relapse of symptoms after remission
- Continuation of acute treatment, up to 6 months

- TMS is considered not medically necessary for all other indications not listed above, including but not limited to, the following:
  - Maintenance TMS treatment
  - Continuation of acute TMS treatment for longer than 6 months
  - TMS treatment of conditions other than major depressive disorder (severe), including but not limited to, the following: Alzheimer's disease, Anxiety disorders, Bipolar depression, Neurodevelopmental disorders, Obsessive-compulsive disorder, Peripartum depression, Post-traumatic stress disorder, Substance use disorders, Tourette's syndrome.

To view a detailed summary of customizations, visit the Clinical Guidelines page, scroll down to other criteria section and select Customizations to MCG Care Guidelines 25th Edition.

For questions, please contact the provider service number on the back of the member's ID card.

1049-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/mcg-care-guidelines-25th-edition-available-2

Maximizing efficient, high quality COVID-19 screenings*

Published: Apr 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

Identifying the most appropriate COVID-19 testing codes, testing sites and type of test to use can be confusing. The guidance below can make it easier for you to refer your patients to high-quality, lower-cost COVID-19 testing sites, find Anthem Blue Cross and Blue Shield (Anthem) contracted laboratories and identify the proper CPT codes to use.

Contact your Anthem representative if you need additional information or visit anthem.com/coronavirus/providers.

COVID-19 testing coding guidelines

- For a new or established patient, CPT code 99211 would be appropriate if patient is being seen for no other services besides a specimen collection.
- For a patient assessment in addition to a specimen collection it is appropriate to bill the applicable E&M service, CPT codes 99202-99215. Specimen collection is a component of the E&M service and not separately reimbursable.
- Effective April 1, 2021, CPT codes G2023 and G2024 are appropriate when billed by clinical laboratories only and are not appropriate for provider practices.

Refer patients to anthem.com/coronavirus to find convenient testing locations

If an Anthem member requests a COVID-19 test, you may refer them to anthem.com or the Sydney Health mobile app to find testing locations near them. Our test-site finder gives members important information about each site, including days and hours of operation, and if they offer:

- Appointments or walk-ins
- Drive-through service
- Rapid test results
- Antibody testing
- Testing for children

Send swab tests to Anthem-contracted laboratories

When providing COVID-19 molecular testing services to our members, consider utilizing the following additional in-network, high-quality labs to assist in helping to ensure that our members are receiving high value health care.

In-network lab	Telephone	Website
Eurofins NTD	(888) 683-5227	https://www.ntd-eurofins.com/
Eurofins Viracor	(800) 305-5198	https://www.viracor-eurofins.com/test-menu/8300-coronavirus-covid-19-sars-cov-2-rt-pcr/
Eurofins Boston Heart	(877) 425-1252	https://bostonheartdiagnostics.com/
Fulgent Therapeutics	(626) 350-0537	https://www.fulgentgenetics.com/covid19
Invitae Corporation	(650) 466-7242	https://www.invitae.com/en/partners/
Gravity Diagnostics	(855) 841-7111	https://gravitydiagnostics.com/covid-19-coronavirus-testing-partners/
Mako Medical Laboratories	(919) 351-6256	https://makomedical.com/

Consider Antigen testing when rapid test results are needed

Antigen tests can be a quicker way to detect COVID-19 than nucleic acid amplification tests (NAAT), e.g. PCR. Antigen tests offer a reasonable and lower cost alternative when screening asymptomatic or low-risk patients and may be most useful for individuals within the first five to seven days of symptoms when virus replication is at its highest.

Antigen tests can be used to detect current infection, are relatively easy to use, and most can provide point-of-care testing results. The Centers for Disease Control and Prevention (CDC) notes that proper interpretation of antigen test results (and confirmatory testing with NAAT when indicated) is important for accurate clinical management of patients with suspected COVID-19; more information can be found **here**.

The Center for Disease Control and Prevention (CDC) notes that when molecular tests are unavailable or rapid turnaround time is needed, antigen tests can generally be used for diagnosis of COVID-19.

Antigen tests are typically less sensitive and clinicians should interpret negative results carefully. When symptoms are present or a high clinical suspicion exists, negative antigen tests should be confirmed with a molecular test.

When antigen tests are used in symptomatic patients, positive antigen tests can be interpreted as indicative of SARS-CoV-2 infection and do not usually require follow-up testing.

Consider using COVID-19 and flu combination testing when appropriate

According to the Center of Disease Control and Prevention (CDC), clinicians should consider testing for other causes of respiratory illness, including infections such as influenza, when clinically appropriate.

1099-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/maximizing-efficient-high-quality-covid-19-screenings-3

Update for Commercial providers: AIM sleep program CPT code E1399, NOC: Durable medical equipment, miscellaneous

Published: Apr 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

CPT Code E1399 is not an appropriate billable code for CPAP/APAP/BiPAP.

When providers are requesting CPAP/APAP/BIPAP, please do NOT use a NOC code. Use the specific appropriate code for each of these devices.

E1399 will no longer be part of AIM's Sleep Therapy program as of April 1, 2021 and should not be submitted to AIM for review for CPAP/APAP/BiPAP.

1051-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/update-for-commercial-providers-aim-sleep-program-cpt-code-e1399-noc-durable-medical-equipment-miscellaneous

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HEDIS 2021 Federal Employee Program® medical record request requirements

Published: Apr 1, 2021 - **State & Federal** / Federal Employee Plan (FEP)

Reveleer is the contracted vendor to gather member medical records on behalf of the Blue Cross and Blue Shield Federal Employee Program. We value the relationship with our providers, and ask that you respond to the detailed requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe.

Reveleer will work with you to obtain records via fax, mail, remote electronic medical record (EMR) access, or onsite scanning/EMR download (as necessary). We ask that you please promptly comply **within five (5) business days of the record requests**.

If you have any questions, you can reach a Reveleer representative by calling 855-454-6182 or contact Ify Ifezulike with Blue Cross Blue Shield Federal Employee Program at (202) 626-4839.

1091-0421-PN-CNT

URL: https://providernews.anthem.com/indiana/article/hedis-2021-federal-employee-program-medical-record-request-requirements-2

Coding spotlight: Overview of the 2021 evaluation and management changes

Published: Apr 1, 2021 - **State & Federal** / Medicaid

Why are these changes necessary?
Changes are meant to simplify code selection criteria, make coding more clinically relevant and to reduce documentation overload for office-based evaluation and management (E/M) services, while continuing to differentiate payment based on complexity of care.

Key elements of major revisions for 2021:

- Physicians may choose their documentation based on **medical decision making (MDM)** or **total time** (including non-face-to-face services).
- History and exam are still important parts of the notes and may contribute to both time and MDM, but they will no longer be scored for determining the level of the E/M visit.
- MDM criteria has moved away from simply adding up tasks to instead focusing on tasks that affect the management of a patient’s condition.
- Code 99201 was deleted.
- Codes 99202 to 99215 were revised.

Changes to time documentation
Time will now be defined as the **total** time spent by the provider (both face-to-face and time spent on non-face-to-face activities related to this patient's visit performed on the same day as the visit). This may include the services listed below but should not include time spent on separately billable services (such as X-ray interpretation).

Effective January 1, 2021:

- The total time spent must be documented clearly by the provider for the E/M level to be determined by time and does not include ancillary staff time.
- Time will no longer need to be dominated by counseling.
- All time used for leveling the E/M must be on the same day as the face-to-face visit.

Services included in total time:

- Preparing for the visit (for example, reviewing test results)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering tests, medications, prescriptions or procedures after the visit
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the patient's medical record
- Independently interpreting results (not separately reportable) and communicating results to the patient/family/caregiver
- Care coordination (not separately reportable)

New patient E/M code	Typical time (2020)	Total time (2021)
99201	10 minutes	Code deleted
99202	20 minutes	15 to 29 minutes
99203	30 minutes	30 to 44 minutes
99204	45 minutes	45 to 59 minutes
99205	60 minutes	60 to 74 minutes

Established patient E/M code	Typical time (2020)	Total time (2021)
99211	5 minutes	Time component removed
99212	10 minutes	10 to 19 minutes
99213	15 minutes	20 to 29 minutes
99214	25 minutes	30 to 39 minutes
99215	40 minutes	40 to 54 minutes

Prolonged office services

2021 changes include addition of a new add-on code **(currently labeled 99417)** for prolonged office visits *when time is used for code level selection*, including face-to-face and non-face-to-face provider time of at least 15 additional minutes on the same date of service for level five office visits (99205, 99215).

Medical decision making (MDM)

Using the new MDM table, medical decision making for office/outpatient visits will be based on meeting (or exceeding) two out of three categories:

MDM must meet two out of three elements				
Code	**Level of MDM**	Number and complexity of problems addressed	Amount and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal	Minimal or none	Minimal
99203 99213	Low	Low	Limited	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

Number and complexity of problems addressed at the encounter:

- **Straightforward:** One self-limited or minor problem
- **Low:** Two or more self-limited or minor problems; one stable chronic illness, one acute, uncomplicated illness or injury
- **Moderate:** One or more chronic illnesses with exacerbation, progression or side effects of treatments; two or more stable chronic illnesses; one undiagnosed new problem with uncertain prognosis; one acute illness with systemic symptoms; one acute complicated injury
- **High**: One or more chronic illnesses with severe exacerbation, progression or side effects of treatment; one acute or chronic illness or injury that poses a threat to life or bodily function.

Amount and/or complexity of data to be reviewed and analyzed
The 2021 guidelines list three categories for data:

1. Tests, documents or independent historians.
2. Independent interpretation of tests
3. Discussion of management or test interpretation.

- **Straightforward:** Minimal or none
- **Low** (one category required):
  - Two tests/documents or independent historian
- **Moderate** (one category required):
  - Three tests, documents and/or independent historian
  - Independent interpretation of a test
  - Discussion of management or test interpretation
- **High** (two categories required):
  - Three items between documents and independent historian
  - Independent interpretation of a test

- Discussion of management or test interpretation

Risk of complications and/or morbidity or mortality of patient management
For the purposes of MDM, level of risk is based upon the consequences of the problem(s) addressed at the encounter *when appropriately treated.* Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization:

- **Minimal:** Rest, gargle, elastic bandages, superficial dressings
- **Low:** OTC drugs, physical therapy, minor surgery with no identified risk factors, IV fluids without additives
- **Moderate:** Management of a prescription drug, minor surgery with identified risk factors, decision regarding major surgery without identified risk factors, diagnosis or treatment
- **High:** Need to discuss higher risk problems that could happen for which physician or other qualified health care professional will watch or monitor.

Tips to prepare your practice for E/M office visit changes:

- Identify project lead
- Schedule team preparation time
- Update practice protocols
- Consider coding support
- Review business liability coverage
- Guard against fraud/abuse
- Update compliance plan
- Check with your electronic health record (EHR) vendor
- Assess financial impact
- Understand medical liability coverage

Resources:

1. CPT® Professional Edition, 2021. AMA

2. AMA Elements of Medical Decision Making. https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

3. AMA Press Release 2021 CPT code set. https://www.ama-assn.org/press-center/press-releases/ama-releases-2021-cpt-code-set

4. Major E/M Changes Coming Soon. Are you prepared? https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx

URL: https://providernews.anthem.com/indiana/article/coding-spotlight-overview-of-the-2021-evaluation-and-management-changes-4

Updates to AIM clinical appropriateness guidelines for advanced imaging

Published: Apr 1, 2021 - **State & Federal** / Medicaid

Click here for more information about the updates to AIM Clinical Appropriateness Guidelines for Advanced Imaging

URL: https://providernews.anthem.com/indiana/article/updates-to-aim-clinical-appropriateness-guidelines-for-advanced-imaging-10

Access to more claim denial information is now self-service

Published: Apr 1, 2021 - **State & Federal** / Medicaid

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

Through predictive analytics, healthcare teams can now receive real-time solutions to claim denials.

Anthem is committed to providing digital first solutions. Healthcare teams can now use self-service tools to reduce the amount of time spent following up on claim denials. **Through the application of predictive analytics, Anthem has the answers before you ask the questions.** With an initial focus on claim-level insights, Anthem has streamlined claim denial inquiries by making the reasons for the claim denial digitally available. In addition to the reason for the denial, we supply you with the next steps needed to move the claim to payment. This eliminates the need to call for updates and experience any unnecessary delays waiting for the *EOP*.

Access the *Claims Status Listing* on Payer Spaces from anthem.com/inmedicaiddoc using the Log In button or through the secure provider portal via Availity.* We provide a complete list of claims, highlight those claims that have proactive insights, provide a reason for the denial, and the information needed to move the claim forward.

Claim resolution daily
Automated updates make it possible to refresh claims history daily. As you resolve claim denials, the claim status changes, other claims needing resolution are added, and claims are resolved faster.

Anthem made it easier to update and supply additional information, too. While logged into the secure provider portal, you have the ability to revise your claim, add attachments, or eliminate it if filed in error. Even if you did not file the claim digitally, you can access the proactive insights. Predictive analytics supplies the needed claim denial information online — all in one place.

Predictive proactive issue resolution and near real-time digital claim denial information is another example of how Anthem is using digital technology to improve the healthcare experience. If you have questions, please reach out to your Provider Relations representative.

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

URL: https://providernews.anthem.com/indiana/article/access-to-more-claim-denial-information-is-now-self-service-14

Does your practice offer telehealth services? Let us know!

Published: Apr 1, 2021 - **State & Federal** / Medicare

Beginning in April 2021, our online directories will identify professional providers who offer telehealth services in their practice.

We encourage providers to utilize the online Provider Maintenance Form to notify us about your telehealth services and we will add a telehealth indicator to your online provider directory profile.

Visit anthem.com to locate the online Provider Maintenance Form. Please contact Provider Services if you have any questions.

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URL: https://providernews.anthem.com/indiana/article/does-your-practice-offer-telehealth-services-let-us-know-7

Access to more claim denial information is now self-service

Published: Apr 1, 2021 - **State & Federal** / Medicare

Through predictive analytics, healthcare teams can now receive real-time solutions to claim denials.

Anthem is committed to providing digital first solutions. Healthcare teams can now use self-service tools to reduce the amount of time spent following up on claim denials. **Through the application of predictive analytics, Anthem has the answers before you ask the questions.** With an initial focus on claim-level insights, Anthem has streamlined claim denial inquiries by making the reasons for the claim denial digitally available. In addition to the reason for the denial, we supply you with the next steps needed to move the claim to payment. This eliminates the need to call for updates and experience any unnecessary delays waiting for the *EOP*.

Access the *Claims Status Listing* on Payer Spaces from anthem.com/provider/medicare-advantage/ using the Log In button or through the secure provider portal via Availity.* We provide a complete list of claims, highlight those claims that have proactive insights, provide a reason for the denial, and the information needed to move the claim forward.

Claim resolution daily

Automated updates make it possible to refresh claims history daily. As you resolve claim denials, the claim status changes, other claims needing resolution are added, and claims are resolved faster.

Anthem made it easier to update and supply additional information, too. While logged into the secure provider portal, you have the ability to revise your claim, add attachments, or eliminate it if filed in error. Even if you did not file the claim digitally, you can access the proactive insights. Predictive analytics supplies the needed claim denial information online — all in one place.

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URL: https://providernews.anthem.com/indiana/article/access-to-more-claim-denial-information-is-now-self-service-16

In-Office Assessment program

Published: Apr 1, 2021 - **State & Federal** / Medicare

Welcome to the 2021 In-Office Assessment (IOA) program. The IOA program is designed to help providers ensure that all active conditions are continuously being addressed and documented to the highest level of specificity for all Medicare Advantage plan patients of providers participating in the program. This program is designed to help improve all patient quality of care (preventive medicine screening, managing chronic illness and prescription management), as well as care for older adults when generated for a Special Needs Plan member.

If you are interested in learning about the electronic modalities available, please contact your representative or the Optum* Provider Support Center at **1-877-751-9207**, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time.

Success stories

Below are some achievements that Anthem Blue Cross and Blue Shield (Anthem) was able to accomplish with provider groups through the IOA program:

- As a result of leveraging different types of resources offered by the IOA program (for example, technology), providers' offices were able to see an increase in staff productivity.
- Providers who have taken advantage of the IOA program resources have seen an increase in their documentation and coding accuracy.

COVID-19 update

Anthem knows this is a difficult time for everyone, as the situation continues to evolve each day. Anthem has considered the severity of the situation and is following CDC Guidelines. For the IOA program, all nonessential personal are required to work with provider groups telephonically/electronically until further notice.

Anthem continues to evaluate the situation and guidelines, and will keep you notified of any changes. If you have any questions or concerns about the IOA program and COVID-19 updates, please call the Optum Provider Support Center at **1-877-751-9207**, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time.

Dates and tips to remember:

- To review their population as soon as possible, Anthem strongly encourages participating providers to deliver and continually maintain proper care management, as well as care coordination of their patient population. This will further ensure the current and active conditions that impact patient care, treatment and/or management are continually addressed.
- At the conclusion of each office visit with the patient, providers participating in the IOA program are asked to complete and return a patient assessment. The assessment should be completed based on information regarding the patient's health collected during the office visit. Participating providers may continue to use the 2021 version of the assessment for encounters that take place on or before December 31, 2021; Anthem will accept the 2021 version of the assessment for 2021 encounters until midnight January 31, 2022.
- If not already submitted, participating providers are required to submit an Account Setup Form, *W-9* and completed direct deposit enrollment by March 31, 2022. Participating providers should call the Optum Provider Support Center at 1-877-751-9207, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time, if they have any questions

regarding this requirement. Failure to comply with this requirement will result in forfeiture of the provider payment for submitted 2021 assessments, if applicable.

Questions
If you have questions about this communication or the IOA program, please contact your representative or the Optum Provider Support Center at 1-877-751-9207, Monday through Friday, from 8 a.m. to 7 p.m. Eastern time.

* Optum is an independent company providing care services on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/indiana/article/in-office-assessment-program-10

Oncology dose reduction program beginning July 1, 2021

Published: Apr 1, 2021 - **State & Federal** / Medicare

Anthem Blue Cross and Blue Shield (Anthem) is committed to being a valued healthcare partner in identifying ways to achieve better health outcomes, lower costs and deliver access to better healthcare experiences for consumers.

Effective for dates of service on or after July 1, 2021, providers for our Medicare Advantage plan members covered by Anthem will be asked in selective circumstances to voluntarily reduce the requested dose to the nearest whole vial for over 40 oncology medications, listed below. Reviews for these oncology drugs will continue to be administered by the reviewing company, either AIM Specialty Health®* or IngenioRx.*

Providers will be asked whether or not they will accept the dose reduction at the initial review point in the prior authorization process. Within the provider portal, a pop-up question will appear related to dose reduction. If the patient is considered unable to have his or her dose reduced, then a second question will appear asking for the provider’s clinical reasoning. For requests made outside of the provider portal (for example, called-in or faxed-in prior authorization requests), the same questions will be asked by the registered nurse or medical director who is reviewing the request. **Since this program is voluntary, the decision made regarding dose reduction will not affect the final decision on the prior authorization.**

The dose reduction questions will appear **only** if the originally requested dose is within 10% of the nearest whole vial. This threshold is based on current medical literature and recommendations from the Hematology and Oncology Pharmacists Association (HOPA) that it is appropriate to consider dose rounding within 10%. HOPA recommendations can be found here.

The Voluntary Dose Reduction Program only applies to specific oncology drugs, listed below. Providers can view prior authorization requirements for Anthem members on the *Medical Policy and Clinical Utilization Management Guidelines* page at anthem.com/medicareprovider.

Drug name	HCPCS code	Drug name	HCPCS code
Abraxane (paclitaxel protein-bound)	J9264	Istodax (romidepsin)	J9315
Actimmune (interferon gamma-1B)	J9216	Ixempra (ixabepilone)	J9207
Adcetris (brentuximab vedotin)	J9042	Jevtana (cabazitaxel)	J9043
Alimta (pemetrexed)	J9305	Kadcyla (ado-trastuzumab emtansine)	J9354
Asparlas (calaspargase pegol-mknl)	J9118	Keytruda (pembrolizumab)	J9271
Avastin (bevacizumab)	J9035	Kyprolis (carfilzomib)	J9047
Bendeka (bendamustine)	J9034	Lartruvo (olaratumab)	J9285
Besponsa (inotuzumab ozogamicin)	J9229	Lumoxiti (moxetumomab pasudotox-tdfk)	J9313
Blincyto (blinatumomab)	J9039	Mylotarg (gemtuzumab ozogamicin)	J9203
Cyramza (ramucirumab)	J9308	Neupogen (filgrastim)	J1442
Darzalex (daratumumab)	J9145	Oncaspar (pegaspargase)	J9266
Doxorubicin liposomal	Q2050	Opdivo (nivolumab)	J9299
Elzonris (tagraxofusp-erzs)	J9269	Padcev (enfortumab vedotin-ejfv)	J9177
Empliciti (elotuzumab)	J9176	Polivy (polatuzumab vedotin-piiq)	J9309

Enhertu (fam-trastuzumab deruxtecan-nxki)	J9358	Rituxan (rituximab)	J9312
Erbitux (cetuximab)	J9055	Sarclisa (isatuximab-irfc)	J9999
Erwinase (asparginase)	J9019	Sylvant (siltuximab)	J2860
Ethyol (amifostine)	J0207	Treanda (bendamustine)	J9033
Granix (tbo-filgrastim)	J1447	Vectibix (panitumumab)	J9303
Halaven (eribulin mesylate)	J9179	Yervoy (ipilimumab)	J9228
Herceptin (trastuzumab)	J9355	Zaltrap (ziv-aflibercept)	J9400
Imfinzi (durvalumab)	J9173		

Providers should continue to verify eligibility and benefits for all members prior to rendering services.

If you have questions, please call the Provider Service phone number on the back of the member's ID card.

Note: In some plans, *dose reduction to nearest whole vial* or *waste reduction* may be the term used in benefit plans, provider contracts or other materials instead of or in addition to *dose reduction to nearest whole vial*. In some plans, these terms may be used interchangeably. For simplicity, we have uses *dose reduction* (*to nearest whole vial*).

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. IngenioRx, Inc. is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/indiana/article/oncology-dose-reduction-program-beginning-july-1-2021-2

Clinical criteria updates notification - November 2020

Published: Apr 1, 2021 - **State & Federal** / Medicare

On June 18, 2020, August 21, 2020, and November 20, 2020, 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. If you have questions or would like 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
March 26, 2021	ING-CC-0183*	Sogroya (somapacitan-beco)	New
March 26, 2021	ING-CC-0148*	Agents for Hemophilia B	Revised
March 26, 2021	ING-CC-0149*	Select Clotting Agents for Bleeding Disorders	Revised
March 26, 2021	ING-CC-0065	Agents for Hemophilia A and von Willebrand Disease	Revised
March 26, 2021	ING-CC-0125	Opdivo (nivolumab)	Revised
March 26, 2021	ING-CC-0119	Yervoy (ipilimumab)	Revised
March 26, 2021	ING-CC-0121*	Gazyva (obinutuzumab)	Revised
March 26, 2021	ING-CC-0048 *	Spinraza (nusinersen)	Revised
March 26, 2021	ING-CC-0002*	Colony Stimulating Factor Agents	Revised
March 26, 2021	ING-CC-0034*	Hereditary Angioedema Agents	Revised
March 26, 2021	ING-CC-0041*	Complement Inhibitors	Revised
March 26, 2021	ING-CC-0071*	Entyvio (vedolizumab)	Revised
March 26, 2021	ING-CC-0064*	Interleukin-1 Inhibitors	Revised
March 26, 2021	ING-CC-0042*	Monoclonal Antibodies to Interleukin-17	Revised
March 26, 2021	ING-CC-0066*	Monoclonal Antibodies to Interleukin-6	Revised
March 26, 2021	ING-CC-0050*	Monoclonal Antibodies to Interleukin-23	Revised
March 26, 2021	ING-CC-0078*	Orencia (abatacept)	Revised
March 26, 2021	ING-CC-0063*	Stelara (ustekinumab)	Revised
March 26, 2021	ING-CC-0062*	Tumor Necrosis Factor Antagonists	Revised
March 26, 2021	ING-CC-0003*	Immunoglobulins	Revised
March 26, 2021	ING-CC-0039*	GamaSTAN [immune globulin (human)]	Revised
March 26, 2021	ING-CC-0053	Injectable Hydroxyprogesterone for Prevention of Preterm Birth	Revised
March 26, 2021	ING-CC-0073*	Alpha-1 Proteinase Inhibitor Therapy	Revised
March 26, 2021	ING-CC-0075	Rituximab Agents for Non-Oncologic Indications	Revised

March 26, 2021	ING-CC-0072	Selective Vascular Endothelial Growth Factor (VEGF) Antagonists	Revised
March 26, 2021	ING-CC-0027*	Denosumab Agents	Revised
March 26, 2021	ING-CC-0019*	Zoledronic Acid Agents (Reclast, Zometa)	Revised
March 26, 2021	ING-CC-0011*	Ocrevus (ocrelizumab)	Revised
March 26, 2021	ING-CC-0174*	Kesimpta (ofatumumab)	Revised

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URL: https://providernews.anthem.com/indiana/article/clinical-criteria-updates-notification-november-2020

Clinical criteria updates notification - December 2020

Published: Apr 1, 2021 - **State & Federal** / Medicare

On December 18, 2020, and December 22, 2020, 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. If you have questions or would like 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.

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
April 8, 2021	ING-CC-0185*	Oxlumo (lumasiran)	New
April 8, 2021	ING-CC-0184*	Danyelza (naxitamab-gqgk)	New
April 8, 2021	ING-CC-0154	Givlaari (givosiran)	Revised
April 8, 2021	ING-CC-0124	Keytruda (pembrolizumab)	Revised
April 8, 2021	ING-CC-0002	Colony Stimulating Factor Agents	Revised
April 8, 2021	ING-CC-0032*	Botulinum Toxin	Revised
April 8, 2021	ING-CC-0015	Infertility and HCG Agents	Revised

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URL: https://providernews.anthem.com/indiana/article/clinical-criteria-updates-notification-december-2020

Updates to AIM clinical appropriateness guidelines for advanced imaging

Published: Apr 1, 2021 - **State & Federal** / Medicare

Click here for more information about the updates to AIM Clinical Appropriateness Guidelines for Advanced Imaging

URL: https://providernews.anthem.com/indiana/article/updates-to-aim-clinical-appropriateness-guidelines-for-advanced-imaging-11