Missouri Provider News

August 2020 Anthem Provider News - Missouri

Medicare:

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Anthem to update formulary lists for commercial health plan pharmacy benefit

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

Effective with dates of service on and after October 1, 2020, and in accordance with the IngenioRx Pharmacy and Therapeutics (P&T) process, Anthem Blue Cross and Blue Shield (Anthem) will update its drug lists that support commercial health plans. Updates include changes to drug tiers and the removal of medications from the formulary.

As certain brand and generic drugs will no longer be covered, providers are encouraged to determine if a covered alternative drug is appropriate for their patients whose current medication will no longer be covered.

Please note, this update does not apply to the Select Drug List and does not impact Medicaid and Medicare plans.

To ensure a smooth member transition and minimize costs, providers should review these changes and consider prescribing a drug on formulary or on a lower tier, if appropriate.

View a summary of changes here.

IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross and Blue Shield.

598-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/anthem-to-update-formulary-lists-for-commercial-health-plan-pharmacy-benefit-5

Voluntary site of care outreach for oncology checkpoint inhibitors beginning August 1, 2020

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

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

Effective with dates of service on or after August 1, 2020, members with commercial plans covered by Anthem will be contacted to voluntary redirect services to home infusion site of care from hospital outpatient site of care for certain immuno-oncology drugs (Bavencio® [avelumab], Imfinzi® [durvalumab], Keytruda® [pembrolizumab], Opdivo® [nivolumab], Tecentriq® [atezolizumab], and Yervoy® [ipilimumab]). Reviews for these oncology drugs will continue to be administered by AIM Specialty Health® (AIM).

The voluntary site of care redirection only applies to these specific drugs administered in an outpatient hospital setting. This does not apply to requests for these specific drugs when administered in a non-hospital setting or as part of an inpatient stay. The redirection also does not apply when Anthem is the secondary payer.

Please note, this review does not apply to the following plans: BlueCard®, Federal Employee Program® (FEP®), Medicaid, Medicare Advantage, Medicare Supplemental plans. Providers can view prior authorization requirements for Anthem members on the Medical Policy & Clinical UM Guidelines page at anthem.com.

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 "site of service" or another term such as "setting" or "place of service" may be the term used in benefit plans, provider contracts or other materials instead of or in addition to "site of care" and in some plans, these terms may be used interchangeably. For simplicity, we will hereafter use "site of care."

580-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/voluntary-site-of-care-outreach-for-oncology-checkpoint-inhibitors-beginning-august-1-2020-1

Anthem prior authorization updates for specialty pharmacy are available - August 2020

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

Quantity limit updates

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

To access the Clinical Criteria information please click here.

Anthem Blue Cross and Blue Shield (Anthem)'s prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

Clinical Criteria	HCPCS or CPT Code(s)	Drug
ING-CC-0044	J1428	Exondys 51
ING-CC-0058	J2354	Bynfezia
ING-CC-0072	J0179	Beovu
ING-CC-0075	Q5119	Ruxience
ING-CC-0152	J1429	Vyondys 53
ING-CC-0153	C9053	Adakveo

Clinical criteria updates

Effective for dates of service on and after November 1, 2020, the following clinical criteria document was revised and might result in services that were previously covered but may now be found to be not medically necessary in our prior authorization review process.

To access the Clinical Criteria information please click here.

ING-CC-0003 Immunoglobulins: Updated medical necessity criteria for myasthenia gravis to include specific drug failures and chronic inflammatory demyelinating polyneuropathy to include requirements regarding disease duration, specific electrodiagnostic criterion, and objective measures for continuation.

Correction to a prior authorization update

In the May 2020 edition of *Provider News,* we published a prior authorization update regarding clinical criteria **ING-CC-0157** on the drug Padcev**.**

- One HCPCS code, J9309, was listed in error. This is not a valid code for the drug Padcev.
- One HCPCS code has been added, J9999. This is a valid code for the drug Padcev.

We apologize for any inconvenience.

581-0820-PN-CNT

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

Pharmacy information available on anthem.com

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

Visit Pharmacy Information for Providers on anthem.com for more information on:

- Copayment/coinsurance requirements and their applicable drug classes
- Drug lists and changes
- Prior authorization criteria
- Procedures for generic substitution
- Therapeutic interchange
- Step therapy or other management methods subject to prescribing decisions
- Any other requirements, restrictions, or limitations that apply to using certain drugs

The **commercial** and **marketplace** drug lists are posted to the web site 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.” 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.

575-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/pharmacy-information-available-on-anthemcom-70

Provider contract and fee schedule notifications coming soon

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

We are excited to announce the release of Provider Contract and Fee Schedule Notifications! Starting in Mid-July, when Anthem Blue Cross and Blue Shield (Anthem) notifies you of a statewide fee schedule update or provider contract amendment, you can log into Availity.com and download a digital copy of your content.

Over the last few months, we have been tirelessly working to improve our service and believe that online Provider Contract and Fee Schedule Notifications will help you appreciate your experience with Anthem even more.

In order to be ready for the digital downloads, you should log in to Availity, access the Provider Online Reporting application and register your authorized users. Going forward, you will see newsletter articles notifying you when you can download content, or if your state requires a mail notification, you may receive a letter or postcard notifying you of content ready for download.

See details below on how to log in and access your reports:

Provider Online Reporting Reference Guide

How to get started

This document will familiarize you with the Provider Online Reporting application found on the Availity Portal. Using our web-based reporting application, you will be able to access regularly updated reports.

- For Availity Administrators – How to assign access
- For Users – How to navigate to the reports

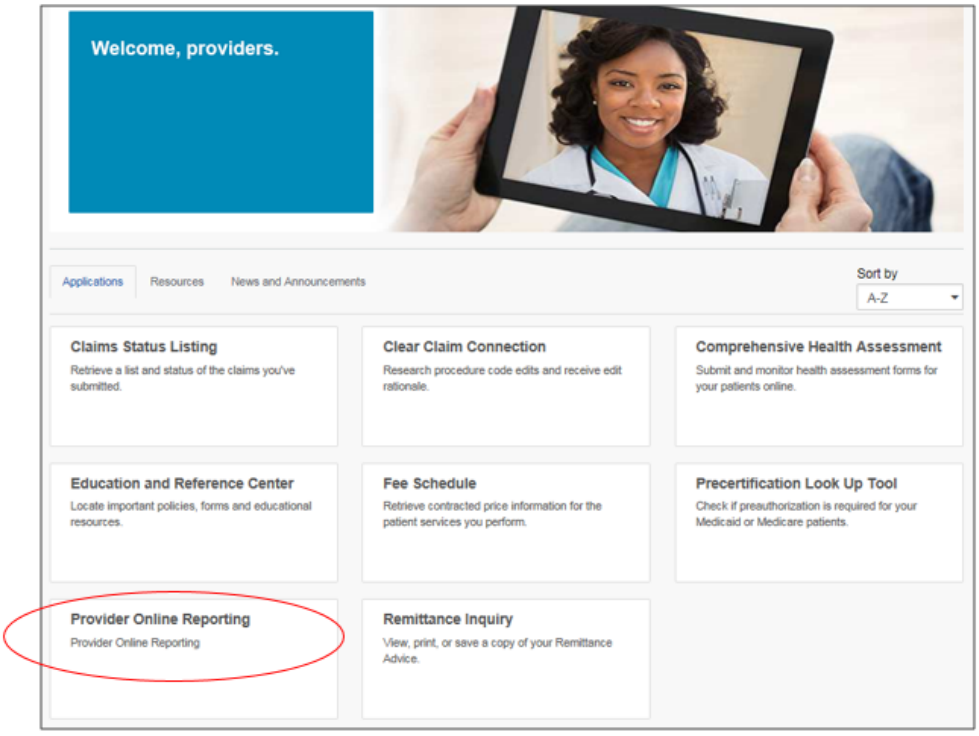
If your organization is not currently registered for the Availity Portal, go to www.availity.com and select **Register** to complete the online application.

Your Administrator will need to take the following steps to **assign access to Provider Online Reporting**:

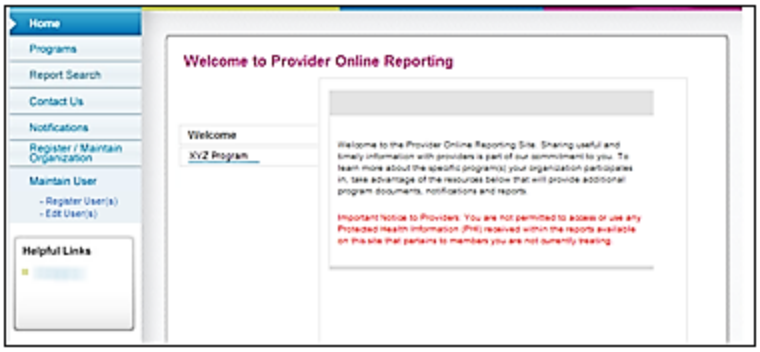
1. Assign the user role of Provider Online Reporting to your Availity access.
2. Select **Payer Spaces** in the navigation bar and then choose the payer tile that corresponds to the market.
3. Accept the User Agreement (once every 365 days).
4. On the *Applications* tab, select **Provider Online Reporting**.
5. Choose the organization and select **Submit**.
6. In the Provider Online Reporting application, register the tax ID by selecting **Register/Maintain Organization**.
7. Last, register users to the program by selecting **Register Users** and completing the required fields.

Accessing reports:

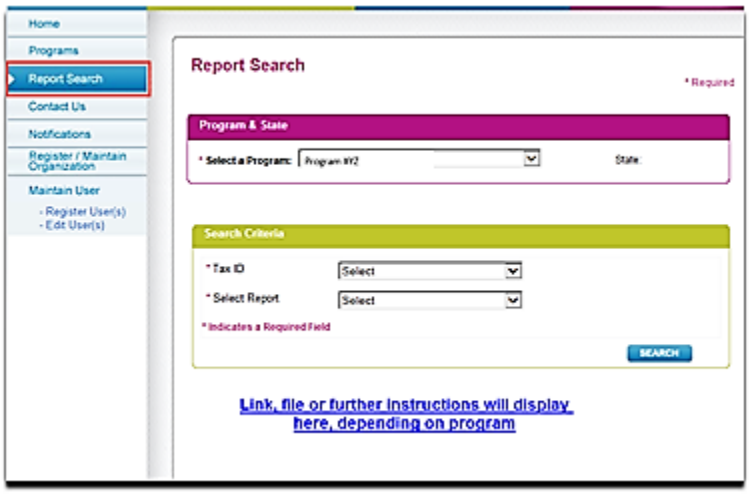
1. After logging in to Availity, select **Payer Spaces** in the navigation bar and then choose the payer tile that corresponds to the market.
2. Accept the User Agreement (once every 365 days).
3. On the *Applications* tab, select **Provider Online Reporting**.
4. Choose the organization and select **Submit**.
5. Select **Report Search**, choose **the type of report,** and then launch your program's reporting application.



The Home page in Provider Online Reporting will open. The page lists all programs the organization is eligible for.
Use the navigation options on the left side of the page to easily move around within the tool.



The *Report Search* page launches the corresponding reporting application for your program.
Select the appropriate program from drop-down menu.



Article Attachments

For further assistance with Availity, please contact Availity Client Services at 1-800-282-4548.
For other questions, contact your local contract advisor, consultant or Provider Relations representative.

579-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/provider-contract-and-fee-schedule-notifications-coming-soon-2

Resources to support diverse patients and communities

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

We've heard it all our lives: To be fair, you should treat everybody the same. But the challenge is that everybody is not the same, and these differences can lead to critical disparities not only in how patients access health care, but their outcomes as well. The current health crisis illuminates this quite clearly. It is imperative to offer care that is tailored to the unique needs of patients, and Anthem Blue Cross and Blue Shield is committed to supporting our providers in this effort.

MyDiversePatients.com offers education resources to help you support the needs of your diverse patients and address disparities, including:

Article Attachments

- Free Continuing Medical Education (CME) learning experiences about disparities, potential contributing factors and opportunities for providers to enhance care.
- Real life stories about diverse patients and the unique challenges they face.
- Tips and techniques for working with diverse patients to promote improvement in health outcomes.

Stronger Together offers free resources to support the diverse health needs of all people where they live, learn, work and play. These resources were created by our parent company in collaboration with national organizations and are available for you to share with your patients and communities.

While there is no single easy answer to the issue of health care disparities, the vision of MyDiversePatients.com and Stronger Together is to start reversing these trends…one person at a time.

Embrace the knowledge, skills, ideals, strategies, and techniques to accelerate your journey to becoming your patients' trusted health care partner by visiting these resources today.

My Diverse Patients

Stronger Together Health Equity Resources

584-0820-PN-CNT

Evaluation and management services correct coding (Professional)

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

Anthem Blue Cross and Blue Shield (Anthem) continues to be dedicated to delivering access to quality care for our members, providing higher value to our customers, and helping improve the health of our communities. In an ongoing effort to promote accurate claims processing and payment, Anthem is taking additional steps to assess selected claims for evaluation and management (E/M) services submitted by professional providers. Beginning on November 1, 2020, we will be using an analytic solution to facilitate a review of whether coding on these claims is aligned with national industry coding standards.

Providers should report E/M services in accordance with the American Medical Association's (AMA's) CPT® Manual and the Centers for Medicare and Medicaid Services (CMS) guidelines for billing E/M service codes: Documentation Guidelines for Evaluation and Management. The appropriate level of service is based primarily on the documented medical history, examination, and medical decision-making. Counseling, coordination of care, the nature of the presenting problem, and face-to-face time are considered contributing factors. The coded service should reflect and not exceed that needed to manage the member's condition(s).

Claims will be selected from providers who are identified as coding at a higher E/M level as compared to their peers with similar risk-adjusted members. The maximum level of service for E/M codes will be based on the complexity of the medical decision-making and reimbursed at the supported E/M code level and fee schedule rate. This initiative will not impact every level 4 or 5 E/M claim. Providers whose coding patterns improve and are no longer identified as an outlier are eligible to be removed from the program.

Providers that believe their medical record documentation supports reimbursement for the originally submitted level for the E/M service will be able to follow the dispute resolution process (including submission of such documentation with the dispute).

For questions on this program, please contact your Provider Solutions representative.

Migrate your EDI transactions to Availity today

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

There is no doubt the coronavirus (COVID-19) crisis has taken a toll on all of us. The pandemic *has* led to immeasurable challenges but we are here to help you ease back into business. We want to remind you, as the Availity migration continues full speed ahead, Anthem Blue Cross and Blue Shield (Anthem) will guide you to make it a smooth transition Just as all good things end, such as summer, the Availity EDI migration also has a target **closing date of September 15, 2020**.

Take Action Today: Availity setup is simple and at no cost for you!

Use this “Welcome” link to get started today: https://apps.availity.com/web/welcome/#/

All EDI transmissions currently sent or received today via the Anthem gateway are now available on the Availity EDI Gateway.

- 837 Institutional and Professional
- 837 Dental
- 835 Electronic Remittance Advice
- 276/277 Claim Status
- 270/271 Eligibility Request
- 275 Medical Attachments
- 278 Prior Authorization/Referrals
- 278N Inpatient Admission and Discharge Notification

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

- Migrate your direct connection with Anthem and become a direct submitter with Availity.

- Use your existing Clearinghouse or Billing Company for your EDI transmissions. (Work with them to ensure connectivity to the Availity EDI Gateway).
- Use Direct Single Claim entry through the Availity Portal.

Show your team what you learned this summer!

Enroll in one of Availity's free courses and training demos at your convenience. Making the switch to Availity's EDI Gateway is easy if you have all the resources that you need.

Follow these steps to register at availity.com :

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

If you and your clearinghouse have already migrated over to Availity, thank you and you are a step ahead! If not, start the process now to make the transition before September 15, 2020.

For questions, contact Availity Client Services at 1-800-Availity (1-800-282-4548) for assistance Monday through Friday, 8 a.m. to 7 p.m. Eastern time.

585-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/migrate-your-edi-transactions-to-availity-today-1

Electronic claims submission - Clinical Laboratory Improvement Amendments (CLIA)

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

The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). The objective of the CLIA program is to ensure quality laboratory testing.

A valid CLIA Certificate Identification number is required and must be included on each electronic claim billed for laboratory services, subject to CLIA legislation. You may not receive reimbursement for your electronic claims if the required certification number is missing.

How to apply for a CLIA Certificate

This CMS mandate went in to effect on May 1, 2020. Please work with your software vendor or clearinghouse to ensure that the required information is included in your electronic files to avoid EDI claim rejections.
Link: https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories

For detailed information on the tests subject to CLIA, please refer to the CMS link below:
https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/

586-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/electronic-claims-submission-clinical-laboratory-improvement-amendments-clia-1

Anthem electronic attachments - X12 275 5010

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

Anthem Blue Cross and Blue Shield (Anthem) and Availity Electronic Data Interchange (EDI) is excited to announce the X12 275 5010 version of electronic attachments transactions for claims functionality is now available for you.

The X12 275 5010 version of electronic attachments transactions for claims will:

- Bring value to you by eliminating the need for mailing paper records.
- Electronic acknowledgment provides a transaction audit trail – proof of delivery/receipt.
- Reduces administrative cost associated with manual processing
- Save time waiting for paper correspondents

This new functionality includes both solicited and unsolicited attachments.

- **Solicited Attachment** – Documentation submitted in response to a specific request.
- **Unsolicited Attachment** – Documentation is known to be needed and submitted at the same time as the claim.

How to send a 275 transaction

Your practice management software or billing service/clearinghouse must have the ability to send a 275. We encourage you to have a conversation with them to determine their ability to set up the X12 275 attachment transaction capabilities.

Where to find help

The new EDI batch process, X12 275 5010v Companion Guide, assists with specific attachment requirements and enables providers to electronically submit attachments based on your business needs.

The companion guide can be download at: anthem.com/edi

Availity documentation can be found at: availity.com

Use the “Availity Welcome Application” below to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions.

EDI Welcome App: apps.availity.com/web/welcome/#/

For questions, contact Availity Client Services at 1-800-Availity (1-800-282-4548) for assistance Monday through Friday, 8 a.m. to 7 p.m. Eastern time.

587-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/anthem-electronic-attachments-x12-275-5010-1

Coming soon: Enhance your prior authorization and inpatient admission and discharge notification via electronic and digital self-service for 2020

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

Anthem Blue Cross and Blue Shield (Anthem) and Availity Electronic Data Interchange (EDI) is excited to announce the **Prior Authorization/ Referrals 278 and Inpatient Admission and Discharge Notification 278N** 5010 transactions functionality is coming soon.

Prior Authorization and Referral Request (278)

The EDI 278 transaction supports healthcare providers to submit an authorization and referral requests electronically.

A **prior authorization** issued by Anthem provides you the go-ahead to perform the necessary service and a referral used to refer a member to a specialty provider. Transmit this transaction in real-time or batch mode. You will receive confirmation numbers to validate receipt of request.

Inpatient Admission and Discharge Notification 278N

Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and Anthem in a standard format. Similar to the HIPAA 278 transaction that you may already use to submit authorizations or referrals, the EDI 278N is the simplest, most efficient way to communicate facility admissions. You can also transmit through Availity in either batch or real-time format.

What are the benefits of 278 and 278N transaction?

Both transactions offer:

- Simplify administrative tasks and increase productivity.
- Reduce administrative costs through automation and fewer phone calls, faxes or keying.
- Increase data accuracy by reducing manual errors.

Specifically for 278N, hospitals that have implemented EDI 278N:

- Experience an improvement in notification submissions within 24 hours.
- Can confirm a notification of admission is on file in the form of a service reference number generated upon registration.
- Submit notification of discharge.

How to send a 278 and 278N Transaction

Look for more communications coming soon around how to work with your practice management software vendor or billing/service clearinghouse or view a companion guide to send a 278 or 278N transaction.

588-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/coming-soon-enhance-your-prior-authorization-and-inpatient-admission-and-discharge-notification-via-electronic-and-digital-self-service-for-2020

Medical record standards

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

Quality health care requires standard documentation requirements to ensure consistency for the care of our members. These standards are reviewed annually to ensure they align with our current policies. These standards ensure effective medical record documentation and provide clear and consistent guidelines to ensure that providers maintain records in a current, organized, and effective manner. The medical record criteria that is encouraged for our network of independently contracted providers are outlined below.

1. Every page in the medical record contains the patient name or ID number.
2. Allergies/No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
4. The important diagnoses are summarized or highlighted.
5. A problem list is maintained and updated for significant illnesses and medical conditions.

6. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.

7. History and physical exam documentation identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan documentation is consistent with findings.

8. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or non-compliance to care plan).

9. Documentation of Advance Directive/Living Will/Power of Attorney discussion (including copies of any executed documents) in a prominent part of the medical record for adult patients is encouraged.

10. Documentation of continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical review will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/report from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/ provider reports.

11. Age appropriate routine preventive services/risk screening is consistently noted, i.e. childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

582-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/medical-record-standards-1

Appropriate coding helps provide a comprehensive picture of patients' health

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

We appreciate the role you play in managing the health of our members. As the physician of a patient who has coverage compliant with the Affordable Care Act (ACA), you play a vital role in accurately documenting the health of the patient to help ensure compliance with ACA program reporting requirements. **When patients visit your practice, we encourage you to document ALL of their health conditions, especially chronic diseases. Ensuring that**

the coding on the claim submission is to the greatest level of specificity can help reduce the number of medical record requests from us in the future.

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

Reminder about ICD-10 coding

The ICD-10 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 codes submitted on claims to monitor health care trends, cost, and disease management. Additionally, the Centers for Medicare & Medicaid Services (CMS) uses ICD-10 as part of the risk adjustment program created under the ACA to determine the risk score associated with a patient's health.

Using specific ICD-10 diagnosis codes will help convey the true complexity of the conditions being addressed in each visit.

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure.
- Include any secondary diagnosis codes that are actively being managed.
- Include all chronic historical codes, as they must be documented each year pursuant to the ACA. (Such as an amputee must be coded each and every year even if the visit is not addressing the amputated limb specifically).

Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. ICD-10 coding guidelines still apply, so please ensure coding on a telehealth visit claim is to the highest specificity with all diagnosis codes. Previous Anthem *Provider News* editions provide telehealth reimbursement guidance to follow for claims submission.

If you are interested in a coding training session specific to risk adjustable conditions, please contact the Commercial Risk Adjustment Network Education Representative: Mary.Swanson@anthem.com

567-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/appropriate-coding-helps-provide-a-comprehensive-picture-of-patients-health-5

Medical policy and clinical guideline updates - August 2020

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

The following Anthem Blue Cross and Blue Shield medical polices and clinical guidelines were reviewed on May 14, 2020 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Below are new medical policies and/or clinical guidelines.
*NOTE: *Precertification required*

Title	Information	Effective Date
DME.00042 Electronic Positional Devices for the Treatment of Obstructive Sleep Apnea	• Electronic positional therapy devices are considered investigational/not medically necessary (INV&NMN) in the treatment of obstructive sleep apnea Code K1001 (effective 01/01/20) for OSA positional devices will be considered INV&NMN for all indications	11/1/2020
MED.00131 Electronic Home Visual Field Monitoring	• The use of electronic home visual field monitoring is considered INV&NMN for all indications Existing codes 0378T, 0379T will be considered INV&NMN for all indications	11/1/2020
*MED.00132 Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures	New criteria • Outlines the MN, REC, and COS&NMN indications for autologous fat grafting Criteria moved from existing medical policies (ANC.00007 & MED.00110) with no change to criteria • Autologous adipose-derived regenerative cell therapy (for example, Lipogems) is considered INV&NMN for all indications • Outlines the MN, REC, and COS&NMN indications for injectable soft tissue fillers - Added codes 15771, 15772, 15773, 15774 (effective 01/01/20) for injectable autologous fat grafts to be reviewed for MN, REC, and COS&NMN indications; - Added codes 31574, C1878, L8607 for soft tissue (vocal cord) bulking agents to be reviewed for MN criteria (previously addressed in SURG.00011); - Transitioned codes from ANC.00007 for dermal fillers and from MED.00110 for regenerative therapy unchanged	7/1/2020

MED.00133 Ingestion Event Monitors	• Ingestion event monitors are considered INV&NMN for medication monitoring and adherence and for all other indications	11/1/2020
*THER-RAD.00012 Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation	• The use of electrophysiology-guided noninvasive stereotactic cardiac radioablation is considered INV&NMN as a treatment modality for all indications, including drug and ablation refractory ventricular tachycardia and cardiomyopathy related to premature ventricular contractions - Existing codes 77373, 77435 for stereotactic body radiation therapy will be considered INV&NMN for specified cardiac diagnoses; no specific codes for treatment planning, listed 77299, 77399 NOC	11/1/2020

The previously adopted clinical guidelines or medical policies have changes noted below.

*NOTE: *Precertification required*

Title	Change	Effective date
*CG-GENE-02 Analysis of RAS Status	• Clarified scope of document includes HRAS • Added HRAS as NMN. Added Tier 2 genetic codes 81403, 81404 to pend; when specified as HRAS considered NMN; removed associated code 88363 (not specific)	11/1/2020
CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)	Revised the MN statement to state: • Transcatheter radiofrequency ablation or cryoablation of arrhythmogenic foci in the pulmonary veins is considered MN as a treatment of symptomatic individuals with one of the following: - Recurrent (2 or more episodes) paroxysmal (terminates spontaneously or with intervention within 7 days of onset) atrial fibrillation as an alternative to medical therapy; or - Persistent (sustained greater than 7 days) atrial fibrillation when refractory or intolerant to one or more antiarrhythmic drugs (or has a contraindication to all appropriate antiarrhythmic drug therapy)	11/1/2020
DME.00011 Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices	• Added transcutaneous electrical modulation pain reprocessing as INV&NMN for all indications including, but not limited to, treatment of acute and chronic pain • Reordered statements in alphabetical order - Added existing Category III code 0278T for pain reprocessing (Scrambler) therapy, considered INV&NMN	11/1/2020

MED.00004 Technologies for the Evaluation of Skin Lesions (including Dermatoscopy, Epiluminescence Microscopy, Videomicroscopy, Ultrasonography)	• Added reflectance confocal microscopy for the evaluation of skin lesions as NMN in all cases • Removed Cosmetic (COS) &NMN statement - Added existing CPT codes 96931, 96932, 96933, 96934, 96935, 96936 for reflectance confocal microscopy for skin lesions, considered NMN	11/1/2020

The following Anthem Blue Cross and Blue Shield clinical guideline will be adopted as a prior authorization requirement for Indiana, Kentucky, Missouri, Ohio and Wisconsin.
*NOTE *Precertification required*

Title	Information	Effective Date
* CG-MED-41 Moderate to Deep Anesthesia Services for Dental Surgery in the Facility Setting	This document addresses the use of moderate to deep anesthesia services utilized in the facility setting when used to treat individuals undergoing dental procedures. This **excludes** the office setting. Codes applicable: *CPT:* 00170, 41899, 99151, 99152, 99153, 99155, 99156, 99157, CPT Physical Status Modifiers: P1, P2, P3, P4 *HCPCS:* D9222, D9223 *ICD-10 DX:* K00.0-K00.9, K01.0-K01.1, K02.3-K02.9, K03.0-K03.9, K04.0-K04.99, K08.0-K08.119, M26.70-M26.79, M26.81-M26.82	11/1/2020

564-0820-PN-CNT

Expansion of AIM Musculoskeletal Program effective November 1, 2020

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

Effective November 1, 2020, the AIM Musculoskeletal Program will be expanded to include medical necessity reviews for certain elective surgeries of the small joints for Anthem Blue Cross and Blue Shield members. AIM Specialty Health® (AIM) will perform the expanded musculoskeletal program and will review certain lower extremity small joint surgeries for clinical appropriateness of the procedure and the setting in which the procedure is performed (level of care review). The clinical guidelines adopted by Anthem and used by AIM to review for medical necessity and level of care are located here: AIM Small Joint Surgery Guideline and AIM Level of Care Guidelines for Musculoskeletal Surgery and Procedures.

AIM will begin accepting prior authorization requests on October 26, 2020, for dates of service on and after November 1, 2020. To determine if prior authorization is required, please call the prior authorization number located on the back of the member's ID card.

Members included in the new program
All fully insured and administrative services only (ASO) members currently participating in the AIM Musculoskeletal Program are included. For ASO groups that currently do not participate in the AIM Musculoskeletal Program, the program will be offered to ASOs to add to their members' benefit package as of November 1, 2020.

Prior authorization review requirements
For surgeries scheduled to begin on or after November 1, 2020, all providers must contact AIM to obtain prior authorization for the following non-emergency modalities:

Small joint replacement (including all associated revision surgeries)

- Total joint replacement of ankle
- Correction of Hallux Valgus
- Hammertoe repair

Surgeries performed as part of an inpatient admission are included.

To place a review request:

- **Online:** Get fast, convenient, online service via the AIM ***Provider****Portal*$_{SM}$, available 24 hours a day, seven days a week, processing requests in real-time using clinical criteria. Go to aimspecialtyhealth.com/goweb to register.
- **Phone:** Call AIM Specialty Health toll-free at 800-554-0580, Monday through Friday, 8:30 a.m. to 7 p.m.

For more information:
Go to www.aimprovider.com/msk for resources to help your practice get started with the musculoskeletal and pain management program. Our website provides access to helpful information and tools such as order entry checklists, clinical guidelines and FAQs.

We value your participation in our network and look forward to working with you to help improve the health of our members.

571-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/expansion-of-aim-musculoskeletal-program-effective-november-1-2020-2

Reimbursement Policy Update: Claims requiring additional documentation (Facility)

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

In the May 2020 edition of the *Provider News*, we announced an upcoming change to our Claims Requiring Additional Documentation policy (Facility) effective August 1, 2020. Please be advised we are delaying the implementation date to October 1, 2020.

Effective for dates of service on or after October 1, 2020:

Outpatient facility claims reimbursed at a percent of charge with billed charges above $20,000 will require an itemized bill to be submitted with the claim.

For more information about this policy, visit the Reimbursement Policies page at anthem.com provider website.

570-0820-PN-CNT

URL: https://providernews.anthem.com/missouri/article/reimbursement-policy-update-claims-requiring-additional-documentation-facility-15

Medicare News - August 2020

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

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

- Submit behavioral health authorizations via our online Interactive Care Reviewer (ICR) tool
- Updates to AIM musculoskeletal program clinical appropriateness guidelines
- Provider data update
- Waived copays, deductibles and coinsurance for CCM, complex CCM and TCM
- AIM Musculoskeletal program expansion
- New MCG Care Guidelines 24th edition

URL: https://providernews.anthem.com/missouri/article/medicare-news-august-2020

Medical drug benefit clinical criteria updates

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

On November 15, 2019, February 21, 2020, and March 26, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem Blue Cross and Blue Shield. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the Clinical Criteria Web Posting March 2020. Visit Clinical Criteria to search for specific policies.

If you have questions or would like additional information, use this email.

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URL: https://providernews.anthem.com/missouri/article/medical-drug-benefit-clinical-criteria-updates-37

2020 Medicare risk adjustment provider trainings

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

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

Medicare Risk Adjustment and Documentation Guidance (general)

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

Learning objective: This onboarding training will provide an overview of Medicare risk adjustment, including the risk adjustment factor and the hierarchical condition category (HCC) model with guidance on medical record documentation and coding.

Credits: This live activity, Medicare Risk Adjustment and Documentation Guidance, from January 8, 2020, to December 2, 2020, has been reviewed and is acceptable for up to one prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

For those interested in joining us to learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at: Training Registration.
**Note:* Dates may be modified due to holiday scheduling.

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

When: This training is offered on the third Wednesday of every other month from 12 noon to 1 p.m. Eastern time.

Learning objective: This training series will provide in-depth disease information pertaining to specific conditions, including an overview of their corresponding hierarchical condition categories (HCC), with guidance on documentation and coding.

Credits: This live series activity, Medicare Risk Adjustment Documentation and Coding Guidance, from January 15, 2020, to November 18, 2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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

Session 1: Red Flag HCCs, part one: Training will cover HCCs most commonly reported in error as identified by CMS, including chronic kidney disease (stage five), ischemic or unspecified stroke, cerebral hemorrhage, aspiration and specified bacterial pneumonias, unstable angina and other acute ischemic heart disease, and end-stage liver disease.
Recording will play upon registration.
2020 Medicare Risk Adjustment Documentation and Coding Guidance: Red Flag HCCs-Part 1
Password: sDBNERC3

Session 2: Red Flag HCCs, part two: Training will cover HCCs most commonly reported in error as identified by CMS, including atherosclerosis of the extremities with ulceration or gangrene, myasthenia gravis/myoneural disorders and Guillain-Barre syndrome, drug/alcohol psychosis, lung and other severe cancers, diabetes with ophthalmologic or unspecified manifestation.
Recording will play upon registration.
2020 Medicare Risk Adjustment Documentation and Coding Guidance: Red Flag HCCs-Part 2

Password: PnPAF4py

Session 3: Neoplasms
Recording will play upon registration.
2020 Medicare Risk Adjustment Documentation and Coding Guidance: Neoplasms
Password: PfUWPcs6

Session 4: Acute, Chronic and Status Conditions
Recording link will be provided after October 1, 2020.

Session 5: Diabetes Mellitus and Other Metabolic Disorders - September 16, 2020
DM and other Endocrine, Nutritional and Metabolic Disorders

Session 6: Coinciding Conditions in Risk Adjustment Models - November 18, 2020
Medicare Risk Adjustment Documentation and Coding Guidance: Coinciding Conditions in Risk Adjustment Models

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URL: https://providernews.anthem.com/missouri/article/2020-medicare-risk-adjustment-provider-trainings-16
