Virginia Provider News

December 2019 Anthem Provider News - Virginia

Medicare:

Anthem works to simplify payment recovery process for National Accounts membership

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

In our company's ongoing efforts to streamline and simplify our payment recovery process, we will be consolidating our National Accounts membership to a central system. With this change, we will be aligning the payment recovery processes to be the same as the majority of our other lines of business.

Our recovery process for National Accounts membership is reflected on the electronic remittance advice (835) transaction in the PLB segment. The requested recovered amount on the electronic remittance advice is displayed at the time of the recovery.

As National Accounts membership transitions and claims are adjusted for recovery on the central system, the requested recovered amount will be held for 49 days. This will allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remittances ***only*** within the "Deferred Negative Balance" section.

After 49 days, the requested recovered amount is reflected on the electronic remittance advice in the PLB segment.

If you have any questions or concerns, please contact the E-Solutions Service Desk toll free at (800) 470-9630.

URL: https://providernews.anthem.com/virginia/article/anthem-works-to-simplify-payment-recovery-process-for-national-accounts-membership-7

Verifying and updating your provider information

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

Maintaining accurate provider information is critically important to ensure our members have timely and accurate access to care.

Additionally, Anthem Blue Cross and affiliate HealthKeepers, Inc. are required by the Centers for Medicare & Medicaid Services (CMS) to include accurate information in provider

directories for certain key provider data elements. For Anthem to remain compliant with federal and state requirements, changes must be communicated 30 days in advance of a change or as soon as possible.

Key data elements

The data elements required by CMS and crucial for member access to care are:

- Physician name
- Location (such as address, suite if appropriate, city/state, zip code)
- Phone number
- Accepting new patient status
- Hospital affiliations
- Medical group affiliations

Anthem is also encouraged (and in some cases required by regulatory/accrediting entities) to include accurate information for the following provider data elements:

- Physician gender
- Languages spoken

- Office hours
- Provider specialty/specialties
- Physical disabilities accommodations
- Indian Health Service status
- Licensing information (such as medical license number, license state, and National Provider Identifier - NPI)
- Email and website address

How to verify and update your information

To verify information, go to anthem.com and select “Providers,” and then under “Provider Resources” select “Find a Doctor” tool. Use “Search as a Guest” option at the bottom. If your information is not correct, please update the information as soon as possible.

To update information, go to anthem.com and select “Providers,” and “Find Resources for Virginia.” On the Virginia provider home page, select the Answers@Anthem tab. Next, select "Provider Forms" and then the “Provider Maintenance Form.” Follow the online prompts to complete the form.

See our **Provider Maintenance Form Guide** for further information if you have questions.

URL: https://providernews.anthem.com/virginia/article/verifying-and-updating-your-provider-information-5

Anthem makes improvements to interactive voice response system

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

Anthem Blue Cross and Blue Shield (Anthem) respects your time, and we want your service experience to be exceptional. Effective **November 22, 2019,** we've made some slight changes to the prompts within our interactive voice response (IVR) system when you dial Anthem's Provider Service areas in Virginia. These enhancements are designed to make it easier for you to get the information you need quickly when you call and to streamline your call-in experience – saving you time in the process.

Calls to our Provider Service areas will now require that you enter either your provider National Provider Identifier (NPI) or Tax ID number. The member's health care identification number (HCID) and date of birth will also be required in order to continue with the self-service options or to be transferred to an Anthem associate. Please have the member's most current ID card on file and available when you are calling Anthem. Going forward, we'll continue to work to deliver exceptional service to you.

URL: https://providernews.anthem.com/virginia/article/anthem-makes-improvements-to-interactive-voice-response-system

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Accessibility standards for services provided by primary care physicians, specialists and behavioral health practitioners

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

Anthem Blue Cross and Blue Shield of Virginia and affiliate Healthkeepers, Inc. would like to remind all participating providers of their contractual obligation to ensure our members have prompt access to care and services. We use several methods to monitor adherence to these standards. Several of those methods include:

- Assessing the availability of appointments via phone calls by our staff or designated vendor to the provider's office

- Analysis of member complaint data and

- Analysis of member satisfaction

Providers are expected to make best efforts to meet these access standards for all members.

Guidelines for primary care physicians (PCPs):

Preventive care – members scheduling periodic routine exams (well care/preventive visits), appointments should be available within 60 calendar days of a member's call. Care provided to prevent illness or injury.

Urgent care appointment with acute symptoms – appointments should be available within 24 hours of the member's call. Care provided for a non-emergent illness or injury with acute symptoms that require immediate care.

Routine check-up – must have access to care within 10 business days of the member's call. Care provided for non-symptomatic visits for health check.

After-hours access – members must have access to care 24 hours a day, 7 days a week, 365 days a year. PCPs must arrange after-hours care to provide 24 hour coverage for our members by a network provider during non-business office hours.

Compliance requires that a recording or live person directs callers to Urgent Care, 911, the ER, or connects the call to the caller's physician or the physician on call. In addition to these measures, but not in place of them, the messaging can give callers the option of contacting their health care practitioner (via transfer, cell phone, pager, text, email or voicemail) or an opportunity to ask for a call back for urgent questions or instructions.

Guidelines for specialists:

Urgent care appointment with acute symptoms – appointments should be available within 24 hours of the member's call. Care provided for a non-emergent illness or injury with acute symptoms that require immediate care.

Routine check-up – must have access to care within 30 calendar days of the member's call. Care provided for non-symptomatic visits for health check.

Guidelines for behavioral health practitioners (BHPs):

Non-life threatening emergency needs – must be seen, or have appropriate coverage directing the member, within six (6) hours. Or, if appointment is unavailable, patient directed to 911, ER or 24-hour crisis services as appropriate. Emergent behavioral health care provided when a member is in crisis, experiencing acute distress and/or other symptoms and needs immediate attention; no risk of loss of life.

Urgent needs – must be seen, or have appropriate coverage directing the member, within 24 hours. Non-emergent behavioral health illness that requires immediate care; member is experiencing significant psychological distress with symptoms that impairs daily functioning; no risk of loss of life.

Initial routine office visit – must be seen within 10 business days. New patient non-urgent appointment scheduled after intake assessment or a direct referral from a treating practitioner.
Follow-up routine visit – must be seen within 30 calendar days. Non-urgent behavioral health care; member has been scheduled for a non-urgent consultation or requires services including, but not limited to, follow-up and existing medication management.

After-hours access – members must have access to care 24 hours a day, 7 days a week, 365 days a year. Must have arrangement for after-hours care to provide 24-hour coverage for our members by a network provider during non-business office hours. Compliance requires that a recording or live person directs callers to Urgent Care, 911, the ER, or connects the call to the caller's physician or the physician on call. In addition to these measures, but not in place of them, the messaging can give callers the option of contacting their health care practitioner (via transfer, cell phone, pager, text, email or voicemail) or an opportunity to ask for a call back for urgent questions or instructions.

These guidelines are also included in all participation agreements. To obtain a copy, providers should contact their Anthem provider network manager.

URL: https://providernews.anthem.com/virginia/article/accessibility-standards-for-services-provided-by-primary-care-physicians-specialists-and-behavioral-health-practitioners

Retrieve your Anthem patient's HEDIS® care gaps through Patient360 located on the Availity Portal

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

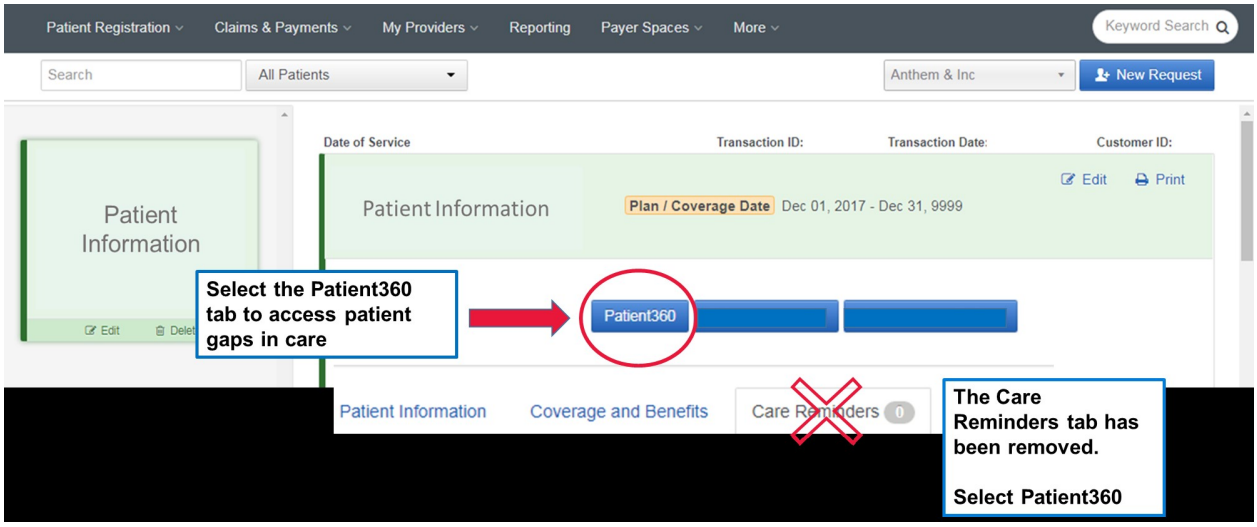
Patient360 is a Longitudinal Patient Record (LPR) where you can access the complete view of Anthem information associated with our members.

You may have noticed that the Care Reminders tab on your Anthem patient's Eligibility and Benefits return on Availity was recently removed. You can still retrieve these important patient gaps in care through Patient360.

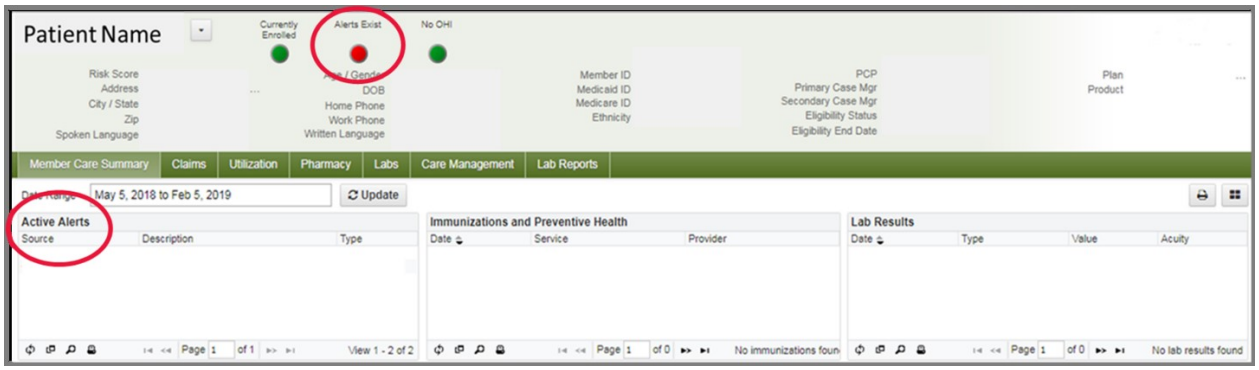
You are required to have the Patient360 role assigned to you by your Availity administrator to see the Patient360 tab located at the top of the patient's Eligibility and Benefits return. To access Patient360, select the tab and follow the steps to open the application.

If your patient does have a gap in care, you will see the red alert button on the top of Patient360 Member Care Summary. Details of the care gap can be found in the Active Alerts section.

Availity Eligibility and Benefits: Patient360 access



Patient360 Active Alerts located on the Member Care Summary



URL: https://providernews.anthem.com/virginia/article/retrieve-your-anthem-patients-hedis-care-gaps-through-patient360-located-on-the-availity-portal-3

Important information about utilization management

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

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as members' coverage according to their health plans. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem's coverage guidelines are available on our website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us at the toll-free numbers listed below. UM criteria are also available on the Web. Just go to anthem.com, then scroll down and select Providers>Select Review Policies box>Scroll down and click on the View Coverage & UM Guidelines orange box to view guidelines.

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll free from 8:30 a.m. - 5 p.m., Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8 a.m. – 7 p.m. Eastern.

- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.

- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

Discuss UM Process and Authorizations	**Discuss Peer-to-Peer UM Denials with Physicians**	**Request UM Criteria**
Check Member ID Card for provider number 800-533-1120 833-592-9956 Transplant: 800-824-0581 Behavioral Health: 800-991-6045 Autism: 844 269 0538		

Federal Employee Program Phone: 800-860-2156 FAX: 855-757-7243 (UM) FAX: 855-757-7242 (ABD)	1-800-533-1120 Prompts 2,5,4,4,1 1-833-592-9956 Prompts 2,3 Behavioral Health: 800-991-6045 Federal Employee Program Phone: 800-860-2156	1-800-533-1120 Prompts 2,5,4,4,1 1-833-592-9956 Prompts 2,3 Behavioral Health: 800-991-6045 Federal Employee Program Phone: 800-860-2156 FAX 855-757-7243 (UM) FAX 855-757-7242 (ABD)

TTY/TDD
711 or

TTY	**Voice**
800-828-1120 (TTY)	800-828-1140(Voice)

For language assistance**, members can simply call the Customer Service phone number on the back of their ID card, and a representative will be able to assist them.**

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

Case Management Program

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

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a health care puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross and Blue Shield in Virginia is available to offer assistance in these difficult moments with our *Case Management Program*. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals who are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, better understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

How do you contact us?

Case Management Email Address (if available)	Case Management Telephone Number	Case Management Business Hours
VA.CM@Anthem.com National: VANatlAccts-CM@wellpoint.com	877-332-8193 (Local/Commercial Only)	

National: 1-877-447-6481 800-824-0581 (Transplant)	Monday – Friday, 8 a.m. – 7 p.m. EST National: Monday – Friday, 8 a.m. - 9 p.m. EST, Saturday, 9 a.m. - 5:30 p.m. EST
Federal Employee Program: 1-800-711-2225	Monday – Friday, 8:30 a.m.- 5 p.m. EST (Transplant) Federal Employee Program: 8 a.m. - 7 p.m. EST

URL: https://providernews.anthem.com/virginia/article/case-management-program-16

Coordination of Care

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

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem Blue Cross and Blue Shield (Anthem) and affiliate HealthKeepers, Inc. would like to take this opportunity to stress the importance of communicating with your patients' other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all practitioners to obtain the appropriate permission from these patients to coordinate care between behavioral health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

Discuss with the patient the importance of communicating with other treating practitioners.

Obtain a signed release from the patient and file a copy in the medical record.

Document in the medical record if the patient refuses to sign a release.

Document in the medical record if you request a consultation.

If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.

Document evidence of clinical feedback (such as consultation report) that includes, but is not limited to:

- Diagnosis
- Treatment plan
- Referrals
- Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem in Virginia has several tools available on the Provider website including a Coordination of Care Form and Coordination of Care Letter Templates for both behavioral health and other medical practitioners.* Behavioral health tools are available, including forms, brochures, and screening tools for Substance Abuse, Attention-Deficit/Hyperactivity Disorder (ADHD), and Autism. Please refer to the website for a complete list.**

**Access to the forms and template letters are available at www.anthem.com/provider/forms/*

***Access to the behavioral health tools are at www.anthem.com/provider/forms/*

URL: https://providernews.anthem.com/virginia/article/coordination-of-care-13

Members' Rights and Responsibilities

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

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, **Anthem Blue Cross and Blue Shield** has adopted a Members' Rights and Responsibilities statement.

The statement can be found on our website at anthem.com. Access anthem.com and select "Providers." Next, select "Find Resources for Virginia," > then Health & Wellness tab> Select Quality Improvement Standards > Member Rights & Responsibilities. Practitioners may access the Federal Employee Program (FEP) member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

URL: https://providernews.anthem.com/virginia/article/members-rights-and-responsibilities-13

Clinical practice and preventive health guidelines available on anthem.com

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

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

All guidelines are reviewed annually and updated as needed. The current guidelines are available on our website at anthem.com. Select the providers tab at the top on anthem.com. Next, select “Policies and Guidelines” under the “Provider Resources” column and then scroll down to find clinical practice guidelines and preventive health guidelines.

URL: https://providernews.anthem.com/virginia/article/clinical-practice-and-preventive-health-guidelines-available-on-anthemcom-14

System updates for 2020: Professional

Published: Dec 1, 2019 - **Guideline Updates** / Reimbursement Policies

As a reminder, we will update our claim editing software monthly throughout 2020 with the most common updates occurring in quarterly in February, May, August and November of 2020. These updates will:

- Reflect the addition of new, and revised codes (such as CPT, HCPCS, ICD-10, modifiers) and their associated edits
- Include updates to National Correct Coding Initiative (NCCI) edits
- Include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- Include assistant surgeon eligibility in accordance with the policy
- Include edits associated with reimbursement policies including, but not limited to, frequency edits, medically unlikely edits, bundled services and global surgery preoperative and post-operative periods assigned by the Centers for Medicare & Medicaid Services (CMS)

- Apply to any provider or provider group (tax identification number) and may apply to both institutional and professional claim types

URL: https://providernews.anthem.com/virginia/article/system-updates-for-2020-professional-5

Pharmacy information available on anthem.com

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

For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation.

The commercial and marketplace drug lists are posted to the website quarterly (the first of the month for January, April, July and October).

To locate “Marketplace Select Formulary” and pharmacy information, scroll down to “Select Drug Lists.” *For State-sponsored Business, visit* anthem.com, select Medicaid, select your state and then select Pharmacy. This drug list is also reviewed and updated regularly as needed.

Federal Employee Program (FEP) Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

URL: https://providernews.anthem.com/virginia/article/pharmacy-information-available-on-anthemcom-51

Coding tips for Psychological and Neuropsychological Testing

Published: Dec 1, 2019 - **Products & Programs** / Behavioral Health

Earlier in the year on January 1, 2019, a change to CPT codes for Psychological and Neuropsychological test administration and evaluation services was released. The new codes did not crosswalk or map to on a one-to-one basis with the deleted codes.

The coding changes separated test administration from test evaluation, psychological testing from neuropsychological testing, and defined the testing performed by a professional or technician. The new codes were as follows:

Neurobehavioral status exams are clinical interview examinations performed by a psychologist or neuropsychologist to assess thinking, reasoning and judgment. Providers should continue to use CPT code 96116 when billing for the first hour and new code 96121 when billing for each additional hour.

Testing evaluation services include the selection of the appropriate tests to be administered; integration of patient data; interpretation of standardized test results and clinical data; clinical decision-making; treatment planning; and reporting and interactive feedback to the patient, family members, or caregivers, when performed. Providers should now use CPT code 96130 to bill for the first hour of psychological testing evaluation services and 96131 for each additional hour. Neuropsychological evaluation services should now be billed using CPT code 96132 for the first hour and 96133 for each additional hour.

Test administration and scoring by a psychologist or neuropsychologist (two or more tests using any method) should now be billed using CPT code 96136 for the first 30 minutes and 96137 for each additional 30 minutes.

Test administration and scoring by a technician (two or more tests using any method) should now be billed using CPT code 96138 for the first 30 minutes and 96139 for each additional 30 minutes. Single automated test administration should be reported with newly created code 96146 for a single automated psychological or neuropsychological instrument that is administered via electronic platform and formulates an automated result. Psychologists should not use this code if two or more electronic tests are administered and/or if administration is performed by the professional or technician. Instead, the psychologist should use the appropriate codes listed above for test administration and scoring.

Screening and risk assessment (repetitive assessment after screening) include brief emotional/behavioral assessment with scoring and documentation, per standardized instrument, should now be billed using CPT code 96127 separately from testing.

References: **www.apa.org**

URL: https://providernews.anthem.com/virginia/article/coding-tips-for-psychological-and-neuropsychological-testing

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Coordination of benefits for members enrolled in the Federal Employee Program®

Published: Dec 1, 2019 - **State & Federal** / Federal Employee Plan (FEP)

Anthem Blue Cross and Blue Shield values the relationship we have with our providers, and we always look for opportunities to help expedite claims processing. When a Federal employee visits the provider's office, the provider should obtain the most current medical insurance information to:

- Help establish the primary carrier
- Alleviate claim denials
- Support accurate billing

For questions, please contact the Federal Employee Customer Service toll free at **800-552-6989.**

URL: https://providernews.anthem.com/virginia/article/coordination-of-benefits-for-members-enrolled-in-the-federal-employee-program

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Coding spotlight: Provider's guide to coding behavioral and emotional disorders

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

Category: Medicaid

HealthKeepers, Inc. is reaching out with this information to help Anthem HealthKeepers Plus providers stay current on best practices for coding.

ICD-10-CM coding

Codes within categories F90 through F98 represent behavioral and emotional disorders with onset usually occurring in childhood and adolescence and may be used regardless of the age of the patient.

Attention deficit hyperactivity disorder (ADHD) is among these common childhood disorders. While ADHD is not a learning disability, it can impact the ability to learn. This disorder is characterized by classic symptoms of inattention, hyperactivity and impulsivity.

Three subtypes of ADHD have been identified:

- Hyperactive/impulsive type — The patient does not show significant inattention.
- Inattentive type – The patient does not show significant hyperactive-impulsive behavior.
- Combined type – Patient displays both inattentive and hyperactive-impulsive symptoms.

Other disorders that sometimes accompany ADHD include Tourette's syndrome, oppositional defiant disorder, conduct disorder, anxiety, depression and bipolar disorder. ADHD continues into adulthood in about 50% of people with childhood ADHD. Attention deficit hyperactivity disorders are coded based on a behavior type:

- F90.0 — Attention deficit hyperactivity disorder, *predominantly inattentive type*
- F90.1 — Attention deficit hyperactivity disorder, *predominantly hyperactive type*

- F90.2 — Attention deficit hyperactivity disorder, *combined type*
- F90.8 — Attention deficit hyperactivity disorder, *other type*
- F90.9 — Attention deficit hyperactivity disorder, *unspecified type*

F90 category includes:

- Attention deficit disorder with hyperactivity
- Attention deficit syndrome with hyperactivity

ICD-10-CM lists the following conditions as special exclusions (Excludes2) to ADHD:

- Anxiety disorders (F40.-, F41.-)
- Mood (affective disorders) (F30-F39)
- Pervasive developmental disorders (F84.-)
- Schizophrenia (F20.-)

Note**:** *Excludes2* means *not included here*.

This type of exclusion in ICD-10-CM is indicative of conditions that are not included in the F90 category. However, the patient may have both conditions at the same time. For example, if a patient presents with ADHD and anxiety, then both conditions should be coded according to the *Excludes2* list. ICD-10-CM often lists conditions in either an *Excludes1* or *Excludes2* note. It is important that all exclusion notes be followed carefully for coding accuracy. Keep in mind that documentation drives code selection, and that the medical record must support all codes submitted on claims.

HEDIS® quality measures for attention-deficit/hyperactivity disorder (ADHD)

Quality measures are in place to help ensure that patients with specific conditions are receiving the appropriate care and follow-up to successfully manage their conditions. The measure listed below is applicable to those with attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD).

Follow-Up Care for Children Prescribed ADHD Medication (ADD)

This HEDIS measure looks at the percentage of children ages 6 to 12 years who have newly prescribed ADHD medication and have had at least three follow-up care visits within a 10-month period; the first visit should be within 30 days of the first ADHD medication dispensed.

Two rates are reported:

- Initiation phase — Follow-up visit with prescriber occurred within 30 days of prescription.

- Continuation and maintenance phase — Patient remained on ADHD medication and had two more visits within nine months.

When prescribing a new ADHD medication:

- Be sure to schedule a follow-up right away — The visit must occur within 30 days of ADHD medication initially prescribed or restarted after a 120-day break.

- Schedule follow-up visits while members are still in the office.

- Have your office staff call members at least three days before appointments.

- After the initial follow-up visits, schedule at least two more office visits in the next nine months to monitor the patient's progress.

- Be sure that follow-up visits include the diagnosis of ADHD.

Helpful tips:

- Educate your members and their parents, guardians, or caregivers about the use of and compliance with long-term ADHD medications and the condition.

- Collaborate with other organizations to share information, research best practices about ADHD interventions, appropriate standards of practice and their effectiveness and safety.

- Contact your Provider Relations representative for copies of ADHD-related patient materials.

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

Resources:

ICD-10-CM Expert for Physicians. The complete official code set. Optum360, LLC. 2019.
ICD-10-CM/PCS Coding. Theory and practice. 2019/2020 Edition. Elsevier
NCQA: HEDIS & Performance Management. **https://www.ncqa.org/hedis/measures**

URL: https://providernews.anthem.com/virginia/article/coding-spotlight-providers-guide-to-coding-behavioral-and-emotional-disorders-2

Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates

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

Category: Medicaid

Effective **February 1, 2020**, prior authorization (PA) requirements will change for the following services. These services will require PA by HealthKeepers, Inc. for Anthem HealthKeepers Plus members. Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following codes:

- **43238:** esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus

- **43242:** esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound)

- **43253:** esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s)

- **78459:** myocardial imaging, positron emission tomography (PET), metabolic evaluation
- **78491:** myocardial PET; single study, rest/stress
- **78492:** myocardial PET; multiple studies, rest and/or stress
- **78608:** brain imaging, PET; metabolic evaluation
- **78609:** brain imaging, PET; perfusion evaluation
- **78811:** PET imaging; limited area (for example, chest, head/neck)
- **78812:** PET imaging; skull base to mid-thigh
- **78813:** PET imaging; skull base to mid-thigh
- **78814:** PET with concurrently acquired computed tomography (CT) for attenuation correction
- **78815:** PET with concurrently acquired CT for attenuation correction
- **78816:** PET with concurrently acquired CT for attenuation correction

- **81227:** Cyp2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (for example, drug metabolism), gene analysis, common variants (for example, *2, *3, *5, *6)

- **81231:** CYP3A5 (cytochrome P450, family 3, subfamily A, member 5) (for example, drug metabolism), gene analysis, common variants (including *2, *3, *4, *5, *6, *7)

- **81232:** DPYD (dihydropyrimidine dehydrogenase) (for example, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (including *2A, *4, *5, *6)

- **81346:** TYMS (thymidylate synthetase) (for example, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (for example, tandem repeat variant)

- **0031U:** CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(for example, drug metabolism) gene analysis, common variants (including *1F, *1K, *6, *7)

- **0032U:** COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G > A (rs4680) variant

- **0070U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (for example, drug metabolism) gene analysis, common and select rare variants (including *2, *3, *4, *4N, *5, *6, *7, *8, *9)

- **0072U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (for example, drug metabolism) gene analysis, targeted sequence analysis (including CYP2D6 to 2D7 hybrid gene)

- **0073U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (for example, drug metabolism) gene analysis, targeted sequence analysis (including CYP2D7 to 2D6 hybrid gene)

- **0074U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (for example, drug metabolism) gene analysis, targeted sequence analysis (including nonduplicated gene)

- **0075U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (for example, drug metabolism) gene analysis, targeted sequence analysis (including 5 gene duplication/ multiplication)

- **0076U:** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (for example, drug metabolism) gene analysis, targeted sequence analysis

- **0091U:** oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result

- **0092U:** oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk score for likelihood of **malignancy**

- **0093U:** prescription drug monitoring, evaluation of 65 common drugs by LC-MS/MS, urine, each drug reported detected or not detected

- **0098U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 14 targets

- **0099U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 20 targets (adenovirus, coronavirus 229E, coronavirus)

- **0100U:** respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 21 targets (adenovirus, coronavirus 229E, coronavirus)

- **J9036:** injection, bendamustine hydrochloride (Belrapzo®), 1 mg

- **81479:** unlisted molecular pathology procedure

- **81599:** unlisted multianalyte assay with algorithmic analysis

- **0094U:** genome (for example, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis

- **0101U:** hereditary colon cancer disorders (for example, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis)

- **0102U:** hereditary breast cancer-related disorders (for example, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer)

- **0103U:** hereditary ovarian cancer (for example, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of next-generation sequencing, Sanger sequencing, multiplex ligation-dependent probe amplification

- **0408T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters

- **0409T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters

- **0410T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters

- **0411T:** insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed and programming of sensing and therapeutic parameters

- **0412T:** removal of permanent cardiac contractility modulation system; pulse generator only

- **0413T:** removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)

- **0414T:** removal and replacement of permanent cardiac contractility modulation system pulse generator only

- **0415T:** repositioning of previously implanted cardiac contractility modulation transvenous electrode (atrial or ventricular lead)

- **0416T:** relocation of skin pocket for implanted cardiac contractility modulation pulse generator

- **0417T:** programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values

- **0418T:** interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac

- **0512T:** extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound

- **0513T:** extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; each additional wound

- **0544T:** transcatheter mitral valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach, including transseptal puncture

- **0545T:** transcatheter tricuspid valve annulus reconstruction with implantation of adjustable annulus reconstruction device, percutaneous approach

- **0548T**: transperineal periurethral balloon continence device; bilateral placement, including cystoscopy and fluoroscopy

- **0549T:** transperineal periurethral balloon continence device; unilateral placement, including cystoscopy and fluoroscopy

- **0550T:** transperineal periurethral balloon continence device; removal, each balloon

- **0551T:** transperineal periurethral balloon continence device; adjustment of balloon(s) fluid volume

- **E2599:** accessory for speech generating device, not otherwise classified

- **G9143:** warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)

- **J3490:** unclassified drugs (Avastin®, Mvasi™)

- **S3870:** comparative genomic hybridization microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability

Request PA via:

- Web: **https://www.availity.com**

- Phone:
    - Provider Services: **1-800-901-0020**
    - Anthem CCC Plus Provider Services: **1-855-323-4687**.

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers by accessing the Provider Self-Service Tool on the Availity Portal by going to **https://mediproviders.anthem.com/va** > Login.

Contracted and noncontracted providers unable to access Availity can go to **https://mediproviders.anthem.com/va** > Home > Precertification > Precertification Lookup Tool or call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**.

URL: https://providernews.anthem.com/virginia/article/global-3m19-medical-policy-and-technology-assessment-committee-prior-authorization-requirement-updates-2

Medical drug benefit Clinical Criteria updates

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

Category: Medicaid

On August 16, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the Anthem HealthKeepers Plus **medical drug benefit** for HealthKeepers, Inc. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider website, and the effective dates will be reflected in the ***Clinical Criteria Web Posting August 2019***. Visit ***Clinical Criteria*** to search for specific policies.

For questions or additional information, use this **email**.

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

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Keep up with Medicaid news

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

Category: Medicaid

Please continue to check our website https://mediproviders.anthem.com for the latest Medicaid information for members enrolled in HealthKeepers, Inc.'s Anthem HealthKeepers Plus and the Commonwealth Coordinated Care Plus (Anthem CCC Plus) benefit plans. Here is a topic we're addressing in this edition:

Reimbursement for early elective deliveries

URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicaid-news-15

Direct contracting for nurse practitioners and physician assistants in 2019

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

Catergory: Medicare

Earlier in the year, we notified you of our plans to begin direct contracting and credentialing of nurse practitioners (NPs) and physician assistants (PAs) in Virginia. Once contracted and

credentialed, NPs and PAs can begin billing services under their own 10-digit NPI. In addition to Medicare Advantage plans under Anthem Blue Cross and Blue Shield (Anthem), this effort will impact other health plans in Virginia.

As you may know, Virginia legislation went into effect on July 1, 2018, allowing NPs who meet certain work history requirements to begin practicing independently. Before this legislation took effect, licensed NPs and PAs could only bill for covered services under the supervision of the participating physician using that physician's name and NPI. With this change, NPs and PAs must bill Anthem directly and the "incident to" guidelines will no longer apply.

CMS defines "incident to" services as services billed by physicians and nonphysician practitioners that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home. **Please note that the new participation agreement will not apply to certified nurse midwives as they are contracted under a separate participation agreement.**

How the contracting process will work

We began the direct contracting effort for NPs and PAs in the second quarter of 2019. We will be reaching out to participating providers who we know currently employ NPs and PAs.

Other than the provider type description, the participation agreement will contain the same provisions and obligations as our standard physician agreements. For Medicare Advantage, we will reimburse NP and PA services at 100% of the Medicare rate for these provider types.

Credentialing process

NPs and PAs are required to be credentialed through Anthem in Virginia. Therefore, NPs and PAs must complete the online application process through the Council for Affordable Quality Healthcare, Inc. (CAQH). To contact CAQH, call **1-888-599-1771** Monday through Thursday, 7 a.m. to 9 p.m. Eastern time or Friday, 7 a.m. to 7 p.m. Eastern time. You may also visit the CAQH website at: **http://www.caqh.org/ucd_physician_register.php**.

Benefits of direct contracting for NPs and PAs

This direct contracting and credentialing approach will allow us to include NPs and PAs in our provider directories as independent providers. Our members can easily search our provider finder tool for participating NPs and PAs.

In addition, direct contracting with NPs and PAs will allow for simplified handling of Medicare crossover claims. Medicare crossover claims for services provided by NPs and PAs to members holding a secondary group coverage policy will process under the participating NP or PA record — without rebilling by the group under the supervising physician's NPI.

Looking ahead

Going forward, we will keep you informed of details and the date contracted NPs and PAs can begin billing directly for their services. Please refer to our provider newsletter for further details.

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URL: https://providernews.anthem.com/virginia/article/direct-contracting-for-nurse-practitioners-and-physician-assistants-in-2019-2

Medical drug Clinical Criteria updates

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

Category: ***Medicare***

On June 20, 2019, the Pharmacy and Therapeutic (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* are publicly available on the provider website, and the effective dates will be reflected in the Medical drug Clinical Criteria updates. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.

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URL: https://providernews.anthem.com/virginia/article/medical-drug-clinical-criteria-updates-24

Blue Cross and Blue Shield Association mandate about Medicare Advantage care management and provider engagement (APM ID 0037943)

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

Category: ***Medicare***

The Blue Cross and Blue Shield Association (BCBSA) has issued a mandate with the goal of improving health outcomes and care management for Medicare Advantage members living outside of a control/home plan service area. This mandate will require a change in the way we process the following requests for Medicare Advantage out-of-area (OOA) membership:

- Stars care gap requests
- HEDIS® requests
- Risk adjustment requests
- Medical record requests

This change in process applies to all Blue plans and will go into effect on **January 1, 2020.**

The current process

The current process for the above-mentioned requests involves the control/home plan sending requests to providers via Inovalon/vendor for medical records and supplemental data to address and/or close an identified or suspected HEDIS measure, care gap or risk adjustment. Providers receive requests and submit the requested information to the home plan. The home plan receives the information and uses this information, medical records and supplemental data to complete and/or close the request.

The new process

The new process is specific for Medicare Advantage OOA (PPO) members only. These members will be split out from all other members.

For Medicare Advantage OOA members whose home plan is Anthem Blue Cross and Blue Shield (Anthem), the Stars care gap, risk adjustment, HEDIS and medical record requests will be processed via the new BCBSA Provider Engagement Data Exchange (PEX) platform. Anthem as control/home plan will submit these requests to BCBSA via the PEX system. BCBSA will then route the request to the health plan with which the provider is contracted (host plan). The host plan will initiate the provider engagement and gather the requested information (for example, medical records). Providers contracted by the host plan will submit the requested documentation to the plan. The host plan will then submit the documentation via the PEX system to BCBSA. BCBSA will sort the responses and documentation and send to the requesting home plan (member's home plan).

When Anthem is the host plan, Anthem will receive requests for Stars care gap, risk adjustment, HEDIS and medical record requests from the member's home plan via the PEX system. Anthem will process the requests, engage providers, and submit requests for medical records and/or supplemental data to the provider. When the provider supplies a response (medical records, supplemental data or additional requests for information), Anthem will send the responses/documentation to the control/home plan via the PEX system. BCBSA will route the responses/documentation to the requesting home plan.

Provider role in new process

Each provider has a key role in the new process. In order to improve the overall care and health outcomes for members, the provider must:

- Respond to requests for medical records and/or supplemental data in a timely manner.

- Request additional information from the provider's contracted plan, if needed, to complete requests.

- Follow the standard HEDIS, Stars care gap, risk adjustment and medical records requests processes as outlined in the current process.

As a control/home plan, Anthem is taking steps to ensure that providers have the resources needed to complete this new process with little or no impact to the provider's current operations. Additional provider education resources will be communicated as they become available.

For additional information, please refer to the service numbers on the back of the Member ID Card.

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URL: https://providernews.anthem.com/virginia/article/blue-cross-and-blue-shield-association-mandate-about-medicare-advantage-care-management-and-provider-engagement-apm-id-0037943-4

Reminder to Medicare Advantage providers: Refer patients to contracted network specialists

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

Category: Medicare

As a reminder, primary care physicians (PCPs) may only refer Anthem Blue Cross and Blue Shield (Anthem) members to in-network Medicare Advantage providers.

Anthem has contracted with specialists to ensure adequate care of our members. The use of contracted network specialists will ensure continuity of appropriate clinical background data and coordination of care with the PCP.

Should there be a need to refer the member outside the contracted network, contact Anthem directly for prior authorization (PA). Referring a Medicare Advantage member out-of-network, who does not have out-of-network benefits, could result in claim denials with member liability unless the service is urgent, emergent, out-of-area dialysis or if PA was approved by the plan.

Although not required, PA is encouraged for preferred provider organization (PPO) members who want to receive notification of advanced coverage when utilizing an out-of-network provider for services.

As a reminder to all providers, the referring physician name and NPI must be reported on the claim when the PCP does not provide the service rendered. This will reduce the number of rejections issued during initial claim processing.

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URL: https://providernews.anthem.com/virginia/article/reminder-to-medicare-advantage-providers-refer-patients-to-contracted-network-specialists

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Keep up with Medicare news

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

Category: ***Medicare***

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

- View additional information about the Group Retiree PPO plans

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- View more information about the CMS reminder: expedited/urgent requests

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- Check out additional information about the Prior authorization requirements for E0784, K0553 and K0554

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- Visit us on the Web for more information about the Global 3M19 Medical Policy and Technology Assessment Committee prior authorization requirement updates

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- Review additional information online about the 2020 Medicare Advantage individual benefits and formularies

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URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicare-news-97
