Nevada Provider News

January 2020 Anthem Provider News and Important Updates - Nevada

Administrative:

Western Pathology Consultants is no longer a Participating Provider . . . 3

Receive and respond to post pay audit medical record requests via Availity beginning February 10, 2020 . . . 3

New Musculoskeletal and Pain Management Solution Effective for Select National ASO Accounts January 1, 2020 . . . 5

Upcoming retirement planned for legacy Medical Attachment submission tool . . . 6

Let us help you accomplish your 2020 “To Do” list early – EDI Migration . . . 7

New Year brings new ID cards for many Anthem members . . . 9

Drug fee schedule update . . . 10

Medical Policy & Clinical Guidelines:

Important Update: Milliman Care Guideline (MCG), 23rd Edition, Pelvic Organ Prolapse Repair (MAC) . . . 10

Reimbursement Policies:

Outpatient facility edit implementation effective April 26, 2020 (MAC) . . . 11

Federal Employee Plan (FEP):

2020 FEP® Benefit information available online . . . 11

Medicare:

Reminder: Medicare claims for secondary payer must be submitted after the 30-day Medicare remittance period . . . 11

Help protect your patients by providing medical ID protection -- best practices . . . 12

Postponed -- Review of professional claims with emergency room level 5 E/M codes . . . 14

Medical drug benefit Clinical Criteria updates – October 2019 15
Medical drug benefit Clinical Criteria updates – November 2019 15
Healthcare Quality Patient Assessment Form and Patient Assessment Form 16
Barrick Gold offers Medicare Advantage option 17
Keep up with Medicare news 18

Medicaid:

Coding spotlight: provider's guide to coding behavioral and emotional disorders 18
Medical drug benefit Clinical Criteria updates 21
Medical Policies and Clinical Utilization Management Guidelines update 22
Precertification Lookup Tool -- easy access to prior authorization guidelines on the Availity Portal 27
Coding Spotlight: Hypertension -- A providers' guide for coding 28
Keep up with Medicaid news 34

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC; Compcare Health Services Insurance Corporation (Compcare) underwrites or administers the HMO policies and Wisconsin Collaborative Insurance Company (WCIC) underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Use of the Anthem websites constitutes your agreement with our Terms of Use.

Western Pathology Consultants is no longer a Participating Provider

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

Effective November 1, 2019, Western Pathology Consultants became a non-participating provider with Anthem. This is a reminder to ensure that you are referring Anthem members to participating labs. LabCorp is our preferred lab provider and offers a Single Source Solution to your testing needs. The relationship with LabCorp does not affect network hospital-based lab service providers, contracted pathologists, or contracted independent laboratories. Physicians may continue to refer to all participating providers as they have in the past.

Not only does your Anthem agreement obligate you to refer to participating labs where available, but members will only receive their full benefits from participating providers. As a result, referring your patient and our member to a non-participating lab may expose them to a greater financial responsibility.

For a listing of Anthem participating laboratories, please check our online directory. Go to **anthem.com**. Select **Providers**. Under the *Provider Resources* heading, select **Find a Doctor**. *[Select Nevada as your state if you have not done so already].*

Note: When searching for laboratory, pathology, or radiology services, under the field *"I am looking for a:"* select **Lab/Pathology/Radiology**; and then under the field *"Who specializes in:"*, select **Laboratories**, **Pathology**, or **Radiology** as appropriate for your inquiry.

URL: https://providernews.anthem.com/nevada/article/western-pathology-consultants-is-no-longer-a-participating-provider

---

Receive and respond to post pay audit medical record requests via Availity beginning February 10, 2020

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

We are launching the use of Availity's medical attachment functionality to begin requesting medical records and itemized bill information from providers electronically instead of paper requests. This change applies only to the process of requesting and receiving medical records; it is not a change to the audit program. We began transitioning providers to this new

process in an active limited launch in October 2019. We will complete the transition by February 10, 2020.

Important facts regarding this change:

- This change only affects providers who use Availity and who have opted into using the medical attachment functionality through the permissions in Availity's enrollment center.

- The new functionality is for medical record requests for post pay claims for the Payment Integrity Quality Claims Review (provider audit) department only.

- There will be no duplicate requests (both paper and electronic).

- In Availity, the request will come into the provider's Medical Attachment "inbox"
    - The original letter historically sent via paper is accessible through a hyperlink in the Availity system as a pdf electronic copy. The letter content is the same as it was in paper format.
    - Each electronic request letter will have a timeframe for responding to the request. After the timeframe has passed for that letter, you will not be able to respond to that electronic letter. If you wish to upload medical records after the response time has expired, please refer to the Availity training referenced below.
    - Providers can respond to the request by uploading records in Availity. The attachments are received in almost real time and are delivered electronically to the payer's systems through secure means - - nothing is stored in Availity.

- The following are not included or not impacted:
    - Vendor requests for medical records on behalf of the payer.
    - Providers that do not use Availity or have not turned on permissions for Medical Attachments within Availity.
    - The request timing or verbiage in the request letter.
    - At this time, the Program Integrity Special Investigations Unit (SIU) post pay review, but they will be included at a future date.

Resources

Training is available for this Availity tool by selecting this link: Availity Training on Electronic Medical Records for Program Integrity.

Can I start using the functionality earlier?

Yes. If you chose to opt in earlier, please ensure you are configured within Availity. You may request early access via this email address: dl-Prod-Availity-Provider-Support@anthem.com.

For additional information, see our Frequently Asked Questions.

URL: https://providernews.anthem.com/nevada/article/receive-and-respond-to-post-pay-audit-medical-record-requests-via-availity-beginning-february-10-2020-3

New Musculoskeletal and Pain Management Solution Effective for Select National ASO Accounts January 1, 2020

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

Musculoskeletal care and interventional pain management (MSK) pose substantial challenges for employers as costs rise, the population ages and physician practice patterns vary widely. With disorders affecting one in every two American adults1, the need for evidence-based care and proactive consumer engagement is essential to better managing care and cost.

With that in mind, we are pleased to announce that select National Accounts will utilize the comprehensive Musculoskeletal and Pain Management Solution, administered by AIM Specialty Health. The new MSK program reviews certain spine and joint surgeries, and interventional pain services against clinical appropriateness criteria to help ensure that care aligns with established evidence-based medicine.

Transition Period

To ensure continuity of care, we will have a 90 day transition of care for members in active treatment for pain management or for members that have received prior approval through

the Anthem precertification. Providers do not need to obtain authorization through AIM portal for services already in progress or where prior authorization has been obtained with Anthem.

Please contact anthem.com or call the number on the back of the member ID card for member eligibility.

[1] American Academy of Orthopedic Surgeons

URL: https://providernews.anthem.com/nevada/article/new-musculoskeletal-and-pain-management-solution-effective-for-select-national-aso-accounts-january-1-2020-5

Upcoming retirement planned for legacy Medical Attachment submission tool

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

The **Medical Attachment tool** makes the process of submitting electronic documentation in support of a claim, simple and streamlined. We are now in the final stages of migration from the *Medical Attachments* link to the *Attachments-New* option.

What is happening to the current attachment tool?

- The legacy tool will be retired soon* with access via **Attachments-New** option available now.
- The history of the information you have previously submitted is still available on the legacy tool for now*.
- Read only access to the history is in the final stages*

***Look for messaging on the legacy attachment tool for specific dates**

How to assign access to utilize submitting *solicited* Medical Attachments for your office

Availity Administrator, complete these steps:

From **My Account Dashboard**, select **Enrollments Center** > **Medical Attachments Setup**, and complete the following sections:

Select Application > choose **Medical Attachments Registration**
Provider Management > select **Organization** from the drop-down.

- Add NPIs and/or Tax IDs

Assign user access by checking the box in front of the user’s name

Using the Medical Attachments tool

Availity User, complete these steps:

Log in to availity.com
Select **Claims and Payments** > **Attachments-New** > **Send Attachment** Tab
Complete all required fields of the form
Attach supporting documentation
Submit
Need Training?

To access additional training for this Availity feature: Log into Availity. Select **Help & Training** > **Get Trained** to open the Availity Learning Center (ALC) Catalog in a new browser tab. Search the Catalog by keyword **(attachments)** to find training demo and on-demand courses. Select **Enroll** to enroll for a course and then go to your Dashboard to access it any time.

URL: https://providernews.anthem.com/nevada/article/upcoming-retirement-planned-for-legacy-medical-attachment-submission-tool-3

Let us help you accomplish your 2020 “To Do” list early – EDI Migration

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

The New Year always gives us an opportunity to set new goals. Starting in 2020, we want to help you check off a few “to do” items. As the Availity migration continues full speed ahead, let’s get you started on your first goals of the year:

Don’t delay and transition to Availity today!

All EDI transmissions currently sent or received today via the Anthem EDI 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

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.

Availity setup is simple and at no cost for you!

Use this “Welcome” link below to get started today:

Learn Something New!

Enroll in one of Availity’s free courses and training demos. 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 www.Availity.com:

Log in to the Availity Portal and select **Help & Training | Get Trained** to access the Availity Learning Center (ALC).
Select Sessions from the menu under the search catalog field.

Scroll Your Calendar to locate your webinar.
Select View Course and then Enroll. The ALC will email you instructions to attend.

If you and your clearinghouse have already migrated, you are a step ahead! If not, take action today to make the transition.

For questions contact Availity Client Services at 1-800-Availity (1-800-282-4548) for assistance Monday – Friday, 8:00 am – 7:00 pm ET.

URL: https://providernews.anthem.com/nevada/article/let-us-help-you-accomplish-your-2020-to-do-list-early-edi-migration-4

New Year brings new ID cards for many Anthem members

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

Now is the time to ask all of your patients to present their current ID card. Many members were assigned new identification numbers effective January 1, 2020 and new ID cards were provided digitally or mailed to all affected members in late December 2019. To ensure claims are processed appropriately, here is some helpful information.

Tips for Success: When Anthem members arrive at your office or facility, ask to see their current member identification card at each visit. Many of our members no longer receive a paper card so they will present you with their digital card on their mobile device. Requesting a copy of the most current ID card will help you:

- Identify the member's product
- Obtain health plan contact information
- Speed claims processing

Note: *Claims submitted with an incorrect ID number may be unable to be processed and may be returned for correction and resubmission with the correct ID.*

Tips for Success: When you contact a member about a claim returned for an invalid ID, and they do not recall receiving a new ID card or they misplaced their ID card, please ask the member to confirm their member ID using one of the following options:

- Log in to their member account on anthem.com
- Use Anthem mobile app called Sydney (formerly *Anthem Anywhere)* to access their electronic ID card
- Members can fax or email their most current card from anthem.com, or the Sydney mobile app, to your office if needed.
- Call their Anthem member services number

Following the tips above will result in a successful start to your New Year.

URL: https://providernews.anthem.com/nevada/article/new-year-brings-new-id-cards-for-many-anthem-members-2

Drug fee schedule update

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

CMS average sales price (ASP) first quarter fee schedule with an effective date of January 1, 2020 will go into effect with Anthem Blue Cross and Blue Shield (Anthem) on February 1, 2020. To view the ASP fee schedule, please visit the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

URL: https://providernews.anthem.com/nevada/article/drug-fee-schedule-update-5

Important Update: Milliman Care Guideline (MCG), 23rd Edition, Pelvic Organ Prolapse Repair (MAC)

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

Material Adverse Change (MAC)

Important Update: Milliman Care Guideline (MCG), 23rd Edition, Pelvic Organ Prolapse Repair

URL: https://providernews.anthem.com/nevada/article/important-update-milliman-care-guideline-mcg-23rd-edition-pelvic-organ-prolapse-repair-mac-1

Outpatient facility edit implementation effective April 26, 2020 (MAC)

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

Material Adverse Change (MAC)

Outpatient facility edit implementation effective April 26, 2020

URL: https://providernews.anthem.com/nevada/article/outpatient-facility-edit-implementation-effective-april-26-2020-mac-1

2020 FEP® Benefit information available online

Published: Jan 1, 2020 - **State & Federal** / Federal Employee Plan (FEP)

To view the 2020 benefits and changes for the Blue Cross Blue Shield Service Benefit Plan, also known as the Federal Employee Program® (FEP), go to www.fepblue.org > select Benefit Plans > Plan Brochure & Forms. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2020. For questions please contact FEP Customer Service at 800-727-4060.

URL: https://providernews.anthem.com/nevada/article/2020-fep-benefit-information-available-online-7

Reminder: Medicare claims for secondary payer must be submitted after the 30-day Medicare remittance period

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

Category: Medicare

Claims will deny when a provider submits a Medicare claim to Anthem Blue Cross and Blue Shield (Anthem) as a secondary payer if the claim has been received prior to the 30-day Medicare remittance period. Providers submitting a paper claim for Medicare claims that are filed with Medicare as the first payer must not file with Anthem as the secondary payer until the 30-day remittance period has expired.

These claims rejections are a result of improper timely filing by providers. To eliminate claims rejections when Anthem is the secondary payer, submit the claim 30 days after the Medicare Remittance period.

For additional information, call the number on the back of the member's ID card.

ABSCRNU-0094-19 November 2019 505847MUPENMUB

URL: https://providernews.anthem.com/nevada/article/reminder-medicare-claims-for-secondary-payer-must-be-submitted-after-the-30-day-medicare-remittance-period-5

Help protect your patients by providing medical ID protection -- best practices

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

Category: Medicare

Overview

Many of our members have reported that they received unsolicited calls (or emails) from an individual or company offering to provide durable equipment devices, such as back or leg braces, or items such as topical creams at little or no cost. While it may be tempting to want to receive something for free, members should know that there is a cost.

Although our members may not receive a bill for these devices or medications, the items are billed to the insurance companies, costing hundreds or even thousands of dollars each.

How does this impact members?

Members should also know that the cost may be more than monetary. Allergic reactions may occur when using medications that are not properly prescribed. Ill-fitting leg or back braces, or equipment that is not specifically intended for the pain experienced by the member, could do more harm than good.

This problem is prevalent throughout the country, so all of our members should be aware. Billions of unsolicited telemarketing calls are made each year, many of which are promoting health care services. Calls often spoof local phone numbers or numbers that appear familiar to trick the recipient into accepting the call.

How can I help protect my patients?

While the ultimate purpose of these telemarketing calls is to sell these items, the immediate goal of the person or company placing the call is to obtain valuable personally identifiable information (PII) from the member. Without this personal information, such as a social security number or insurance identification number, selling these devices and medications is much more difficult. Share this information with you patients to help them learn how to protect their PII.

You can help protect your patients and their personally identifiable information from scams by reminding them of the following:

- Don’t fall prey to scams!
- Take a few moments to review your *Explanation of Benefits (EOB)* and the services listed.
- When receiving robotic (robo) or telemarketing calls:
  - Simply hang up the phone.
  - Beware of threatening or urgent language used by the caller.
  - Do not provide any personally identifiable information such as your social security number or insurance identification number. The caller may imply that they have your information and ask you to provide it to confirm that they have the correct information. Do not provide the information or confirm it if they do happen to have any identification information.
- When receiving emails:
  - Do not open email attachments you weren’t expecting.
  - Check for spelling mistakes and poor grammar.
  - Do **not** click on the links you are sent. You can type the link into a new browser.
  - Online scams can come from anywhere. Take a few moments to review your *EOB* and confirm that you received the services listed on the *EOB*.
- Additional ways to protect yourself:
  - Shred or destroy obsolete documents that contain medical claims information or *EOBs*.
  - Do not use social media to share medical treatment information.

How to report when you receive what you suspect is a scam call or email:

To file a complaint with the Federal Trade Commission, you can go to:
https://ftc.gov/complaint or call **1-877-FTC-HELP**.
Members may contact their plan's Member Services department.

ABSCRNU-0086-19 November 2019 505755MUPENMUB

URL: https://providernews.anthem.com/nevada/article/help-protect-your-patients-by-providing-medical-id-protection-best-practices-4

Postponed -- Review of professional claims with emergency room level 5 E/M codes

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

Category: Medicare

Anthem Blue Cross and Blue Shield communicated to you on June 1, 2019, that we were initiating post-payment reviews for professional emergency room (ER) claims billed with level 5 ER evaluation and management (E/M) codes 99285 and G0384.

The implementation of this policy has been postponed.

This update relates only to the policy announced June 1, 2019. All other current policies applicable to you, including but not limited to other audit or reimbursement policies pertaining to ER claims, are unaffected by this update. We will keep you informed about the initiation of the review process; however, we require proper coding and billing to ensure prompt and accurate payment.

ABSCARE-0112-19 November 2019 506163MUPENMUB

URL: https://providernews.anthem.com/nevada/article/postponed-review-of-professional-claims-with-emergency-room-level-5-em-codes-8

Medical drug benefit Clinical Criteria updates – October 2019

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

Category: Medicare

On August 16, 2019, 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 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.

ABSCRNU-0085-19 October 2019 505536MUPENMUB

URL: https://providernews.anthem.com/nevada/article/medical-drug-benefit-clinical-criteria-updates-october-2019

Medical drug benefit Clinical Criteria updates – November 2019

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

Category: Medicare

On September 19, 2019, 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 website, and the effective dates will be reflected in the *Medicare Advantage Clinical Criteria Web Posting September 2019*. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.

ABSCRNU-0097-19 November 2019 505908MUPENMUB

Healthcare Quality Patient Assessment Form and Patient Assessment Form

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

Category: Medicare

Anthem Blue Cross and Blue Shield (Anthem) offers the *Healthcare Quality Patient Assessment Form (HQPAF)/Patient Assessment Form (PAF)*. This newsletter focuses on key tips that may help participating providers successfully close out their 2019 *HQPAF/PAF*.

Dates and tips to remember:

Anthem encourages you to review your patient population as soon as possible. You can help patients schedule an in-office visit. These appointments help the patient manage chronic conditions, which impact the health status of the patient.

At the conclusion of each office visit with the patient, providers who are participating in the *HQPAF/PAF* program are asked to complete and return a *HQPAF/PAF*. The form should be completed based on information collected during the visit. Participating providers may continue to use the 2019 version of the *HQPAF/PAF* for encounters taking place on or before December 31, 2019. Anthem will accept the 2019 version of the *HQPAF/PAF* for 2019 encounters **until midnight on January 31, 2020.**

Important note: *HQPAF/PAF* for 2019 dates of service that are rejected due to provider error and corrected by the provider may be submitted through March 31, 2020.

If not already submitted, participating providers are required to submit an *Account Setup Form (ASF)*, *W9* and a completed direct deposit enrollment by March 31, 2020. Participating providers should call **1-877-751-9207** if they have questions regarding this requirement. Failure by a participating provider to comply with this requirement will result in forfeiture of the provider payment for submitted 2019 *HQPAF/PAF* program, if applicable.

If you have any questions about the PAF or HQPAF programs, please call **1-877-751-9207** from 9:30 a.m. to 7:30 p.m. Eastern time, Monday to Friday.

ABSCRNU-0095-19 November 2019 506172MUPENMUB

URL: https://providernews.anthem.com/nevada/article/healthcare-quality-patient-assessment-form-and-patient-assessment-form-6

Barrick Gold offers Medicare Advantage option

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

Category: Medicare

Effective January 1, 2020, Barrick Gold retirees who are eligible for Medicare Parts A and B will be enrolled in a Medicare PPO plan with Senior Rx Plus (a Medicare Advantage Prescription Drug MAPD plan) under Anthem Blue Cross and Blue Shield (Anthem). The plan includes the National Access Plus benefit, which allows retirees the freedom of receiving services from any provider as long as the provider is eligible to receive payments from Medicare. In addition, Barrick Gold retirees will pay no cost share for both in-network and out-of-network covered services. The MAPD plan offers the same hospital and medical benefits that Medicare covers and also covers additional benefits that Medicare does not, such as an annual routine physical exam, LiveHealth Online and SilverSneakers.

The prefix on Barrick Gold ID cards will be AFJ. The cards will also show the National Access Plus icon.

Providers can submit claims electronically using the electronic payer ID for the Anthem plan in their state or submit a *UB-04* or *CMS-1500* form to the Anthem plan in their state. Claims should not be filed with original Medicare.

Detailed prior authorization requirements also are available to contracted providers by accessing the provider self-service tool at https://www.availity.com.

ABSCRNU-0093-19 November 2019 505959MUPENABS

URL: https://providernews.anthem.com/nevada/article/barrick-gold-offers-medicare-advantage-option

---

Keep up with Medicare news

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

Category: Medicare

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

- Nevada 2020 Medicare Advantage plan changes
- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- City of Marietta Offers Medicare Advantage Option
- Prior authorization requirements for E0784, K0553 and K0554
- Pharmacy benefit manager change to IngenioRx
- Medical Policies and Clinical Utilization Management Guidelines update

URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicare-news-105

Coding spotlight: provider’s guide to coding behavioral and emotional disorders

Published: Jan 1, 2020 - **State & Federal** / Medicaid

Category: Medicaid

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 Customer Service 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

ANV-NU-0087-19 November 2019

URL: https://providernews.anthem.com/nevada/article/coding-spotlight-providers-guide-to-coding-behavioral-and-emotional-disorders-6

Medical drug benefit Clinical Criteria updates

Published: Jan 1, 2020 - **State & Federal** / Medicaid

Category: Medicaid

This communication applies to Medicaid under Anthem Blue Cross and Blue Shield Healthcare Solutions and Medicare Advantage under Anthem Blue Cross and Blue Shield (Anthem).

On August 16, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem. 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.

ANV-NU-0094-19 November 2019 505536MUPENMUB

URL: https://providernews.anthem.com/nevada/article/medical-drug-benefit-clinical-criteria-updates-11

Medical Policies and Clinical Utilization Management Guidelines update

Published: Jan 1, 2020 - **State & Federal** / Medicaid

Category: Medicaid

The *Medical Policies*, *Clinical Utilization Management (UM) Guidelines* and *Third Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. For markets with carved-out pharmacy services, the applicable listings below are informational only.

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

To view a guideline, visit https://www11.anthem.com/search.html.

Notes/updates:

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

- ***GENE.00023** -- **Gene Expression Profiling of Melanomas**
  - Expanded Scope to include testing for the diagnosis of melanoma
  - Updated investigational and not medically necessary (**INV&NMN**) statement to include suspicion of melanoma

- ***GENE.00046** -- **Prothrombin G20210A (Factor II) Mutation Testing**
  - Revised title
  - Expanded scope and position statement to include all prothrombin (factor II) variations

- ***MED.00110 -- Growth Factors, Silver-based Products and Autologous Tissues for Wound Treatment and Soft Tissue Grafting**
  - Revised title
  - Added new **INV&NMN** statements addressing Autologous adipose-derived regenerative cell therapy and use of autologous protein solution

- ***SURG.00052 -- Intradiscal Annuloplasty Procedures (Percutaneous Intradiscal Electrothermal Therapy [IDET], Percutaneous Intradiscal Radiofrequency Thermocoagulation [PIRFT] and Intradiscal Biacuplasty [IDB])**
  - Revised title
  - Combined the three **INV&NMN** statements into a single statement
  - Added Intraosseous basivertebral nerve ablation to the **INV&NMN** statement

- ***TRANS.00035** -- **Mesenchymal Stem Cell Therapy for the Treatment of Joint and Ligament Disorders, Autoimmune, Inflammatory and Degenerative Diseases**
  - Revised title
  - Expanded Position Statement to include non-hematopoietic adult stem cell therapy

- ***CG-ANC-07 -- Inpatient Interfacility Transfers**
  - Added NMN statements regarding admission and subsequent care at the receiving facility

- ***CG-DME-46 -- Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities**
  - Revised title
  - Expanded Scope
  - Revised MN statement to include upper extremities

- The following **AIM Specialty Health® updates** were approved:
  - *Spine Surgery
  - *Radiation Oncology-Brachytherapy Brachytherapy, intensity modulated radiation therapy (IMRT), stereotactic body radiation therapy (SBRT) and stereotactic radiosurgery (SRS) treatment guidelines
  - Sleep Disorder Management Diagnostic & Treatment Guidelines
  - Advanced Imaging
    - Imaging of the Heart: Cardiac CT for Quantitative Evaluation of Coronary Calcification
    - *Imaging of the Abdomen and Pelvis
  - **MCG Customization** for Repair of Pelvic Organ Prolapse (W0163) -- Updated Coding Section

Medical Policies

On August 22, 2019, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem).

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised

9/25/2019	**MED.00130**	**Surface Electromyography Devices for Seizure Monitoring**	New
8/29/2019	**DRUG.00071**	**Pembrolizumab (Keytruda®)**	Revised
8/29/2019	**DRUG.00082**	**Daratumumab (DARZALEX®)**	Revised
9/25/2019	**GENE.00010**	**Panel Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status** *Previous title*: Genotype Panel Testing for Genetic Polymorphisms to Determine Drug-Metabolizer Status	Revised
9/25/2019	**GENE.00011**	**Gene Expression Profiling for Managing Breast Cancer Treatment**	Revised
9/25/2019	**GENE.00029**	**Genetic Testing for Breast and/or Ovarian Cancer Syndrome**	Revised
8/29/2019	**OR-PR.00003**	**Microprocessor Controlled Lower Limb Prosthesis**	Revised
8/29/2019	**RAD.00023**	**Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications**	Revised
9/25/2019	**SURG.00129**	**Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring**	Revised
7/30/2019	**MED.00129**	**Gene Therapy for Spinal Muscular Atrophy**	Revised

Clinical UM Guidelines

On August 22, 2019, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. These guidelines adopted by the medical operations committee for Anthem members on September 26, 2019.

Publish date	***Clinical UM Guideline* number**	***Clinical UM Guideline* title**	**New or revised**
8/29/2019	**CG-DME-47**	**Noninvasive Home Ventilator Therapy for Respiratory Failure**	New
9/25/2019	**CG-MED-84**	**Non-Obstetric Gynecologic Duplex Ultrasonography of the Abdomen and Pelvis in the Outpatient Setting**	New
9/25/2019	**CG-SURG-**		

103	**Male Circumcision**	New	
11/20/2019	**CG-GENE-12**	**PIK3CA Mutation Testing**	New
9/25/2019	**CG-GENE-02**	**Analysis of RAS Status** *Previous title*: Analysis of KRAS Status	Revised
11/20/2019	**CG-MED-39**	**Bone Mineral Density Testing Measurement** *Previous title*: Central (Hip or Spine) Bone Density Measurement and Screening for Vertebral Fractures Using Dual Energy X-Ray Absorptiometry	Revised
9/25/2019	**CG-MED-68**	**Therapeutic Apheresis**	Revised
9/25/2019	**CG-REHAB-08**	**Private Duty Nursing in the Home Setting**	Revised
9/25/2019	**CG-SURG-52**	**Level of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services**	Revised
9/25/2019	**CG-SURG-63**	**Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure**	Revised
11/20/2019	**CG-SURG-78**	**Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies** *Previous Title*: Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies	Revised
9/25/2019	**CG-SURG-79**	**Implantable Infusion Pumps**	Revised
9/25/2019	**CG-SURG-83**	**Bariatric Surgery and Other Treatments for Clinically Severe Obesity**	Revised

ANV-NU-0095-19 November 2019

Precertification Lookup Tool -- easy access to prior authorization guidelines on the Availity Portal

Published: Jan 1, 2020 - **State & Federal** / Medicaid

Category: Medicaid

Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem) has an online tool that displays prior authorization guidelines to help you quickly determine whether certain services for Anthem members require a prior authorization.

You can access the **Precertification Lookup Tool** through the Availity Portal. The Precertification Lookup Tool will let you know if clinical edits apply, information such as the medical necessity criteria used in making the authorization decision, and if a vendor is used -- without the need to make a phone call.

Where is the Precertification Lookup Tool located on Availity?

Navigate to the Precertification Lookup Tool on the Availity Portal by selecting either 1) **Payer Spaces** or 2) **Patient Registration** from Availity's homepage. You can also reach Availity via phone at **1-800-AVAILITY** (**1-800-282-4548**). Access to the information does not require an Availity role assignment, tax ID or NPI.

Through Availity **Payer Spaces**:

- Select Anthem from the *Payer Spaces* menu.
- Select the **Applications** tab.
- Select the **Precertification Lookup Tool** tile.

From the **Patient Registration** menu:

- Select **Authorizations and Referrals**.

- Select the **Precertification Lookup Tool** link located on the page below *Additional Authorizations & Referrals.*

Once you've accessed the Precertification Lookup Tool, choose a line of business from the menu selection offered, and then type the CPT®/HCPCS code or a code description to determine if a prior authorization is required.

Other ways to access: If you are currently accessing the Pre-certification / Pre-Authorization Requirements list through your health plan's public website, this option is still available for you.

ANV-NU-0090-19 November 2019

URL: https://providernews.anthem.com/nevada/article/precertification-lookup-tool-easy-access-to-prior-authorization-guidelines-on-the-availity-portal

---

Coding Spotlight: Hypertension -- A providers' guide for coding

Published: Jan 1, 2020 - **State & Federal** / Medicaid

Category: Medicaid

ICD-10-CM hypertension coding highlights:

- Hypertensive crisis can involve hypertensive urgency or emergency.
- Hypertension can occur with heart disease, chronic kidney disease (CKD) or both.
- ICD-10-CM classifies hypertension by type as essential or primary (categories I10-I13) and secondary (category I15).[1]
- Categories I10-I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), CKD (I12), or heart and CKD combined (I13).[1]

Hypertension categories:

Code	Description
I10	Essential (primary) hypertension
I11.0	Hypertensive heart disease with heart failure
I11.9	Hypertensive heart disease without heart failure
I12.0	Hypertensive CKD with stage 5 CKD or end-stage renal disease (ERSD)
I12.9	Hypertensive CKD with stage 1 through stage 4 CKD or unspecified CKD
I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD or unspecified CKD
I13.10	Hypertensive heart and CKD without heart failure with stage 1 through stage 4 CKD or unspecified CKD
I13.11	Hypertensive heart and CKD without heart failure with stage 5 CKD or ERSD
I13.2	Hypertensive heart and CKD with heart failure and with stage 5 CKD or ERSD
I15.-	Secondary hypertension
I16.-	Hypertensive crisis

Hypertensive heart disease

ICD-10-CM presumes a causal relationship between hypertension and heart involvement and classifies hypertension and heart conditions to category I11 (hypertensive heart disease) because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them. Code first I11.0 (hypertensive heart disease with heart failure) as instructed by the note at category I50 (heart failure). If the provider specifically documents different causes for the hypertension and the heart condition, the heart condition (I50.-, II51.4 to I51.x9) and hypertension are coded separately.[1]

Category I11 is subdivided to indicate whether heart failure is present. However, an additional code from category I50 is required to specify the type of heart failure, if known.

Documentation may vary, but coding instructions remain the same. For example:

- Congestive heart failure due to hypertension: I11.0 + I50.9
- Hypertensive heart disease with congestive heart failure: I11.0 + I50.9
- Congestive heart failure with hypertension: I11.0 + I50.9

Other heart conditions that have an assumed causal connection to hypertensive heart disease:

Code	Description
I51.4	Myocarditis, unspecified
I51.5	Myocardial degeneration
I51.7	Cardiomegaly
I51.81	Takotsubo syndrome
I51.89	Other ill-defined heart diseases
I51.9	Heart disease, unspecified

Hypertension and CKD

When the diagnostic statement includes both hypertension and CKD, ICD-10-CM assumes there is a cause-and-effect relationship. A code from category I12 (hypertensive CKD) is assigned because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them, unless the documentation clearly states the conditions are unrelated.[1]

A fourth character is used with category I12 to indicate the stage of the CKD. The appropriate code from category N18 should be used as a secondary code to identify the stage of CKD.

Hypertensive heart and CKD

Combination category I13 codes are assigned for hypertensive heart and CKD when there is hypertension with both heart and kidney involvement. If heart failure is present, an additional code from category I50 is assigned to identify the type of heart failure.[1]

The appropriate code from category N18 (CKD) should be used as secondary code with a code from category I13 to identify the stage of CKD.

Hypertensive cerebrovascular disease

For hypertensive cerebrovascular disease, first the appropriate code from categories I60 to I69 is assigned followed by the hypertension code.

Hypertensive retinopathy

Subcategory H35.0 (background retinopathy and retinal vascular changes) should be used with a code from category I10 to I15 (hypertensive disease to include the systemic hypertension).[2]

Hypertension, secondary

Two codes are required -- one to identify the underlying etiology and one from category I15 to identify the hypertension. For example:

- Hypertension due to systemic lupus erythematosus: M32.10 + I15.8
- Acromegaly with secondary hypertension seen for hypertension management: I15.2 + E22.0

Hypertension, transient

Code R03.0 (elevated blood pressure reading without diagnosis of hypertension) is assigned unless the patient has an established diagnosis of hypertension. For transient hypertension of pregnancy, code O13.- (gestational [pregnancy-induced] hypertension without significant proteinuria) or O14.- (pre-eclampsia).

Hypertensive crisis

A code from category I16 (hypertensive crisis) is assigned for any documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Report two codes, at a minimum, for hypertensive crisis. The crisis code is reported in addition to the underlying hypertension code (I10 to I15).[1]

- Hypertensive urgency: I16.0
- Hypertensive emergency: I16.1
- Hypertensive crisis, unspecified: I16.9

Pulmonary hypertension

Pulmonary hypertension is classified to category I27 (other pulmonary heart diseases). For secondary pulmonary hypertension (I27.1, I27.2-), any associated conditions or adverse effect of drugs or toxins should be coded.[2]

More coding tips

Blood pressure and medication management should be assessed at every encounter involving a hypertensive patient. Clarity is important in documenting hypertension. Ensure that the diagnosis is captured by noting it in the medical record documentation:

- Specify a pregnant patient with hypertension as having a pre-existing, gestational, pre-eclampsic or eclampsic hypertension.
- Document and code the smoking status of a patient with hypertension:
  - Current smoker: F17.
  - Personal history of tobacco dependence: Z87.891
  - Tobacco use: Z72.0
  - Exposure to environmental tobacco smoke: Z57.31
- Document any causal relationship between hypertension and background retinopathy or other condition in which the hypertension caused vascular changes and organ damage.

HEDIS Quality Measures for hypertension

The Controlling High Blood Pressure (CBP) measure looks at a sample of members ages 18 to 85 years of age who have a diagnosis of hypertension and whose blood pressure (BP) is regularly monitored and controlled.[3]
HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Record your efforts

Document blood pressure and diagnosis of hypertension. Patients whose BP is adequately controlled include patients ages 18 to 59 with less than 140/90 mm Hg.

Both systolic and diastolic values must be below the stated value. The most recent BP measurement during the year counts toward compliance.

What does not count?

- A BP measurement taken on the same day or one day before the test or procedure (fasting blood tests not included).
- Patient reported BP measurements.
- A BP measurement taken on the same day as a diagnostic test or procedure that requires a change in diet or medication regimen. For example:
    - Procedures that require a change in diet or medication regimen: colonoscopy, dialysis, infusions, chemotherapy, nebulizer treatment with albuterol and injection of lidocaine prior to mole removal
    - Procedures (low-intensity or preventive) that would not disqualify the BP reading: vaccinations, injections, TB test, intrauterine device insertion and eye exam with dilating agents

Codes to identify hypertension

ICD-10-CM	CPT Category II codes[4]
I10	3074F: systolic BP <130 3075F: systolic BP 130 to 139 3077F: systolic BP ≥140 3078F: diastolic BP <80 3079F: diastolic BP 80 to 89 3080F: diastolic BP ≥90

Strategies for success

- Improve the accuracy of BP measurements performed by your clinical staff by:
    - Providing training materials from the American Heart Association.
    - Conducting BP competency tests to validate the education of each clinical staff member.
    - Making a variety of cuff sizes available.

- Instruct your office staff to recheck BPs for all patients with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits; have your staff record the recheck in the patient’s medical records.

- Educate your patients (and their spouses, caregivers or guardians) about the elements of a healthy lifestyle, such as:
  - Heart-healthy eating and low-salt diet.
  - Smoking cessation and avoiding secondhand smoke.
  - Adding regular exercise to daily activities.
  - Home BP monitoring.
  - Ideal body mass index.
  - The importance of taking all prescribed medications as directed.
- Remember to include the applicable Category II reporting codes on the claim form to help reduce the burden of HEDIS medical record review.

Resources

"ICD-10-CM Expert for Physicians. The complete official code set," Optum360, LLC (2019).
Elsevier, "ICD-10-CM/PCS Coding, Theory and Practice — 2019/2020 Edition."
"HEDIS Measures and Technical Resources," NCQA, accessed April 15, 2019, https://www.ncqa.org/hedis/measures.
"CPT 2019 Professional Edition," American Medical Association (2019).
"HCPCS Level II," American Medical Association (2019).

ANV-NU-0055-19 October 2019

URL: https://providernews.anthem.com/nevada/article/coding-spotlight-hypertension-a-providers-guide-for-coding-1

Keep up with Medicaid news

Published: Jan 1, 2020 - **State & Federal** / Medicaid

Category: Medicaid

Please continue to check Medicaid Provider Communications & Updates at anthem.com/mediproviders for the latest Medicaid information.

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

URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicaid-news-17