Virginia Provider News

January 2021 Anthem Provider News - Virginia

Medicare:

IngenioRx introduces new pharmacy network in 2021

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

Starting **January 1, 2021**, IngenioRx, the pharmacy benefit manager for our affiliated health plans, will make its new standard pharmacy network available to your patients. The standard network will be made up of about 58,000 pharmacies nationwide, including well-known national chains like Costco, CVS, Kroger, Sam's Club, Target and Walmart.

With robust access, your patients can use any participating pharmacy across the country in the standard network to fill their prescriptions.

Network Notification Plan

Some of your patients covered by an Anthem Blue Cross and Blue Shield health plan may currently use pharmacies that are not in this new network. They'll need to transfer their active prescription(s) to a network pharmacy to ensure there is no interruption of their coverage.

Prior to the network effective date, we'll notify your patients by letter outlining the easy steps about transferring their prescriptions to another pharmacy in the network.

In addition, to help you easily send prescriptions to a participating pharmacy, upon the member's effective date, we'll include messaging via your patients' electronic medical record. This message will appear if you attempt to submit a prescription to a pharmacy that's not included in the standard network. This will ensure your patients' prescriptions are properly routed to a network pharmacy and will help them continue to receive their medications worry-free.

If your patients would like to search for a network pharmacy prior to the new network effective date, they can log in to anthem.com where instructions will appear with a helpful link to our online pharmacy search tool. They can enter their address/city/state or their zip code to begin searching.

Questions?

Please refer to our helpful **Frequently Asked Questions** for more details about the new standard network.

887-0121-PN-VA

Prior authorization updates for specialty pharmacy are available

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

Prior authorization updates

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

Please note, inclusion of National Drug Code (NDC) code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code. The Health Plan requires that claims for injection services performed in the office setting must include the applicable HCPCS J-code, Q-code, or S-code, with the corresponding National Drug Code, for the injected substance. This requirement is consistent with CMS guidelines. A covered drug will not be eligible for reimbursement when the NDC is not reported on the same claim

Access the **Clinical Criteria information**.

For Anthem Blue Cross and Blue Shield along with our affiliate HealthKeepers, Inc., prior authorization clinical review of these specialty pharmacy drugs will be managed by Anthem. Drugs used for the treatment of Oncology will still require pre-service clinical review by AIM Specialty Health® (AIM), a separate company and *are shown in italics in the table below.*

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

Clinical Criteria	HCPCS or CPT Code(s)	Drug
*ING-CC-0095	J9041	Velcade (Bortezomib)
*ING-CC-0095	J9044	Bortezomib
*ING-CC-0093	J9171	Docetaxel
*ING-CC-0181	J3490	Veklury

***** Non-oncology use is managed by Anthem's medical specialty drug review team. O*ncology use is managed by AIM.*

Step therapy updates

Update on Ocrevus step therapy notification

Ocrevus will still be non-preferred as noted below, but please note that the step therapy criteria have been updated since the last publication.

Effective for dates of service on and after **February 1, 2021**, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process.

Access the **step therapy drug list**.

For Anthem Blue Cross and Blue Shield and HealthKeepers, Inc., prior authorization clinical review of these specialty pharmacy drugs will be managed by Anthem. Drugs used for the treatment of Oncology will still require pre-service clinical review by AIM Specialty Health® (AIM), a separate company and are *shown in italics in the table below*.

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

Clinical Criteria	Status	Drug(s)	HCPCS Codes
ING-CC-0011	Non-preferred	Ocrevus	J2350

Correction to a prior authorization update

In the October 2020 edition of *Provider News,* we published a prior authorization update regarding clinical criteria **ING-CC-0174** on the drug Kesimpta.

- The NOC codes, J3490, J3590 and C9399 are valid codes for Kesimpta. The code J9302 is not a valid code for the drug Kesimpta.

915-0120-PN-VA

URL: https://providernews.anthem.com/virginia/article/prior-authorization-updates-for-specialty-pharmacy-are-available-9

Procedure searches in Find Care: New sort option

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

Find Care, the doctor finder and transparency tool in Anthem Blue Cross and Blue Shield's online directory, provides many Anthem members with the ability to search and compare cost and quality measures for in-network providers using the secure member portal at anthem.com. This tool currently offers multiple sorting options, such as sorting providers based on distance, name, or personalized match.

Beginning **March 1, 2021**, the personalized match sorting option will be available for searches by procedure type. This sorting option is based on algorithms which will use a combination of member and provider features to intelligently sort and display results for a member's search. The sorting results will take into account member factors such as the member's medical conditions and demographics. Provider factors such as surgeon-facility pairing (an individual provider who performs a procedure at a specific facility), cost efficiency measures, volumes of patients treated across various disease conditions, and outcome-based quality measures.

These member and provider features will be combined to generate a unique ranking of surgeon-facility pairings or facility providers for each member conducting the procedure search. Surgeon-facility pairings with the highest overall ranking within the search radius will be displayed first with other pairings displayed in descending order based on overall rank and proximity to the center of the search radius.

The personalized match methodology for specialty-based searches remains unchanged. Members continue to have the ability to sort from a variety of sorting orders (such as distance), and this enhancement in sorting methodology has no impact on member benefits.

- Providers may review a copy of the new sorting methodology which has been posted on Availity – our secure Web-based provider tool – using the following navigation: Go to Availity > Payer Spaces > Anthem > Education & Reference Center > Administrative Support > Personalized Provider Procedure Search Methodology.pdf.

- If you have general questions about the Find Care tool or this new sorting option, please contact Provider Customer Service.

- If you would like detailed information about quality or cost factors used as part of this unique sorting or you would like to request reconsideration of those factors, you may do so by emailing personalizedmatchsorting@anthem.com or by calling 833-292-2601.

Going forward, Anthem will continue to focus and expand our consumer tools and content to assist members in making more informed and personalized health care decisions.

924-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/procedure-searches-in-find-care-new-sort-option-4

New Blue HPN® plans in effect

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

When you understand your patients' health coverage and local health plan networks, you can help maximize your patients' benefits and boost your own success. Here are some details you should know about new Blue HPN products and the high performance network in Virginia:

Blue HPN® plans offer access to a select set of providers with a record of delivering high-quality, efficient care. Blue HPN networks are live, effective **January 1, 2021**, in more than 50 cities across the country.

In Virginia, Blue HPN networks are in place in the Richmond and the Washington, D.C-Arlington-Alexandria metro areas. Virginia-based employers of all sizes may offer plans with access to the local HPN, referred to as the Blue Connection network.

The Virginia Blue Connection network is a closed narrow network by design. If you are a participating professional provider, please note that only those provider offices that are physically located within the designated metro areas (as determined by ZIP code) will be considered in network. If your organization has multiple office locations, only those locations in the Blue Connection ZIP codes will be considered in-network. Certain exceptions may apply for Ancillary providers (for example Ambulance, Dialysis, Infusion Therapy and so on).

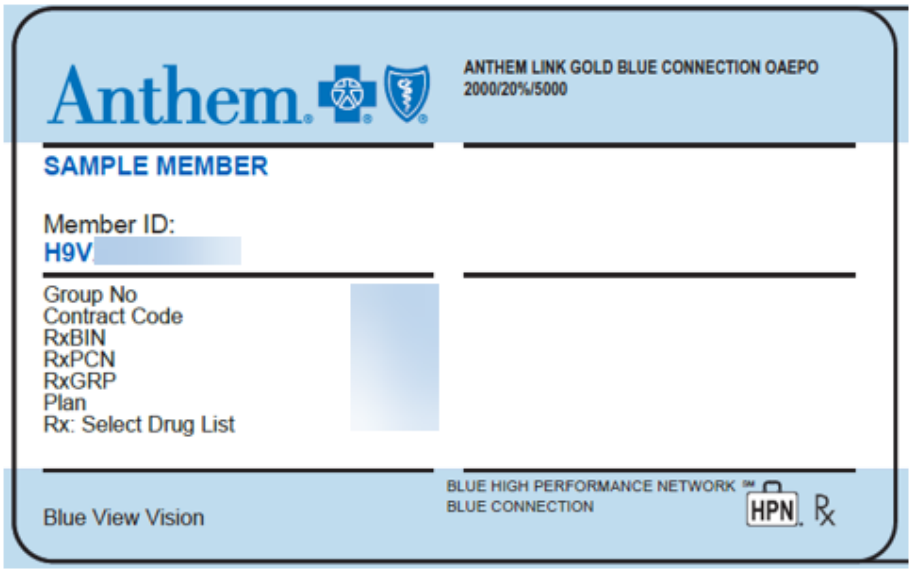
A **special note** for our professional providers located in the northern Virginia Anthem/CareFirst service area: Participation in the Anthem Blue Connection network is based on the physical office location's nine-digit ZIP code.

You can search our Find a Doctor/Find Care tool at www.anthem.com to find participating HPN providers effective January 2, 2021. If you have questions about your participation status, please contact your Anthem Network Manager.

You may see patients accessing this network through either a national employer plan, Blue HPN, or large or small group employer EPO plans and HSA plans with EPO network. Under EPO plans, out-of-network benefits are limited to emergency or urgent care. Members may be required to select a primary care provider (PCP), but PCP referrals are not required for specialty care.

Large group BlueHPN health plans sold in Virginia have a plan prefix of H8V, and small group plans prefixes include H9V and H5V. Keep in mind that other prefixes may be part of HPN plan member IDs. The new "Blue High Performance Network" logo and "HPN" indicator in the suitcase icon are the most reliable indicators that a member is enrolled in an HPN plan.

Article Attachments



The above SAMPLE Virginia ID card is for illustration purposes only.

913-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/new-blue-hpn-plans-in-effect-3

New features added to Interactive Care Reviewer

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

You no longer need to pick up the phone or head to the fax machine to check the status of an authorization request or update a case. Anthem Blue Cross and Blue Shield has added new features to Interactive Care Reviewer (ICR), our online medical and behavioral health authorization tool to improve your digital self-service experience.

- Do you need to update a case that was submitted by phone or fax? Now you can add clinical notes and make other updates to these authorization requests through ICR. To

make the update, you need to have the Authorization & Referral Request role assigned to you by your Availity Administrator.

To locate the case, log on to the Availity Portal and select **Patient Registration** | **Authorizations & Referrals**, then choose **Auth/Referral Inquiry**.
Search for the case in ICR by **Member**, **Reference/Authorization Request Number**, or by **Date Range**.
From the ICR **Case Overview** screen select **Update Case** to update service codes, provider information or clinical notes. If you only need to make changes or add to your notes, select **Update Clinical.** Select **Submit Update** to complete the request.

- We've removed the guesswork from the notes that are recommended for many standard authorization requests. ICR provides a check list of the supporting clinical information that will assist Anthem with completing the review. The list is located on the **Clinical Details** You can upload notes, images and photos directly through ICR. You can include the documentation immediately or you can submit your request then return to the case in ICR later and select **Update Clinical** to add the missing information.

- Check the status of a submitted case at a glance. The ICR ***UM tracker***, located on the ***Case Overview*** screen provides a quick view of where the case is in the review process. You can view when Anthem received the request, when the clinical review is underway and completed and the final decision.

If you don't have the role assignments required to access ICR and research a case, the **Chat with Payer** application accessed through Payer Spaces on Availity gives you an option to check the status of a submitted authorization request. Select **Topic for Chat** \| **Authorization Status** to conduct a live chat. Be sure you have the patient name, health plan member ID number and birth date.

922-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/new-features-added-to-interactive-care-reviewer-5

Find out in minutes why your claim denied; Introducing self-service claim denial review on our secure provider portal

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

Anthem Blue Cross and Blue Shield (Anthem) wants to make your job easier — and that includes real-time feedback to claim denials. Through predictive analytics, we now have insight into the reasons for claim denial. We have taken that information and streamlined the inquiries by reason codes. It is available to you digitally, through our secure provider portal.

Within minutes, you will know why a claim denied. We will also provide the steps needed so you can take action faster to correct the claim. There is less wait time and faster payment.

There is no need to call for updates or experience unnecessary delays waiting for the explanation of benefits (EOB).

With little more than a click:

- Review a complete list of claims, including claims with proactive insights
- Learn the reasons for claim denial
- Access the information you need to move the claim forward

Predictive analytics and self-service claim denial information is just another way Anthem is using digital technology to improve your healthcare experience.

From Anthem.com**, use the** Log In **button to access our secure provider portal** Availity.com**. Go to *Payer Spaces* to access *Claims Status Listing*.**

945-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/find-out-in-minutes-why-your-claim-denied-introducing-self-service-claim-denial-review-on-our-secure-provider-portal

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Self-service, digital transactions are fast and easy

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

Reduce the amount of time spent on transactional tasks by more than 50% when using our secure provider portal or electronic data interchange (EDI) submissions (via Availity) to:

- File claims
- Check statuses
- Verify eligibility and benefits
- Submit prior authorizations

The Provider Digital Engagement Supplement outlines Anthem provider expectations, processes and self-service tools across all electronic channels, including medical, dental, and vision benefits – all in one comprehensive resource. Find it on anthem.com>Providers>Forms & Guides>Digital Tools.

Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered, visit anthem.com and use the Log In button for access to our secure provider portal, or via the Availity EDI website.

Accept digital member ID cards

- Save time by accepting the digital member ID card when presented by the member via their App or email.

Register for EFT to get funds faster

- Electronic Funds Transfer (EFT) eliminate the need for paper checks. Safe, secure and faster, payments are deposited directly to your bank account. Register here.

Eliminate paper remittances

- Electronic remittance advice (ERA) is completely searchable and downloadable from the secure provider portal or the EDI 835 remittance. Meeting all mandates of the Health Insurance Portability and Accountability Act (HIPAA), ERAs eliminate the need for paper remittances.

We appreciate your healthcare team going digital with Anthem as of **January 1, 2021**, enabling us to realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration.

946-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/self-service-digital-transactions-are-fast-and-easy-5

MCG Care Guidelines 24th Edition Customization

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

Effective **April 1, 2021**, the following new customizations will be implemented:

- Gastrointestinal Bleeding, Upper (W0170, previously ORG M-180) – Customized the Clinical Indications for admission to inpatient care by revising the hemoglobin; systolic blood pressure; pulse; melena; orthostatic hypotension; and BUN criteria.

- Gastrointestinal Bleeding, Upper Observation Care (W0171, previously OCG OC-021) – Customized the Clinical Indications for observation care by revising the systolic blood pressure and hemoglobin criteria and adding melena or hematochezia and suspected history of bleeding.

View a **detailed summary of customizations,** and once on the Web page, scroll down to other criteria section and select Customizations to MCG Care Guidelines 24th Edition.

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

902-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/mcg-care-guidelines-24th-edition-customization-7

It is almost CAHPS survey time

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

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized survey conducted between February to May each year to assess consumers' experience with their provider and health plan. A random sample of your adult and child patients may receive the survey. Over half of the questions used for scoring are directly impacted by providers. The survey questions are:

- *When you needed care right way, how often did you get it?*
- *How often did you get an appointment for a check-up or routine care as soon as you needed?*
- *How often was it easy to get the care, tests, or treatment you needed?*
- *How often did you get an appointment to see a specialist as soon as you needed?*
- *How often did your personal doctor seem informed and up-to-date about the care you got from other health providers?*
- *How would you rate your personal doctor?*
- *How would you rate the specialist you see most often?*

To learn more about how you can improve the patient experience review *What Matters Most: Improving the Patient Experience*, an online course for providers and office staff. This course is available at no cost and is eligible for one CME credit by the American Academy of Family Physicians. The *What Matters Most* training can be accessed at: www.patientexptraining.com.

Your efforts to create an exceptional care experience for your patients will help to strengthen their healthcare journey.

916-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/it-is-almost-cahps-survey-time-4

Attachment tools for Anthem and affiliate payers: Live webinars

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

You're invited!

In this 60-minute webinar, you will learn how to use Availity's* Attachment tools to submit and track supporting documentation electronically to Anthem and affiliate payers.

We will explore **new** key workflow options to fit your organization's needs, including how to:

- Work a request in the inbox of your Attachments Dashboard.
- Enter and submit a web claim including supporting documentation.
- Use EDI batch options to trigger a request in your inbox.
- Track attachments you submitted using sent and history lists in your Attachments Dashboard.
- Get set up to use these tools.

As part of the session, we'll answer questions and provide handouts and a job aid for you to reference later.

Register for an upcoming webinar session:

1. In the Availity Portal, select **Help & Training** > **Get Trained**.
2. The **Availity Learning Center** opens in a new browser tab.
3. Search for and enroll in a session using one of these options:
    - In the **Catalog**, search by webinar title or keyword.
        - To find this specific live session quickly, use keyword ***medattach*.**
    - Select the **Sessions** tab to scroll the live session calendar.
4. After you enroll, you'll receive emails with instructions to join the session.

Webinar dates and times (PST):

DATE	DAY	TIME
January 8, 2021	Friday	10 a .m. to 11 a.m.
January 19, 2021	Tuesday	Noon to 1 p.m.

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

909-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/attachment-tools-for-anthem-and-affiliate-payers-live-webinars

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Coverage guidelines effective April 1, 2021

Published: Jan 1, 2021 - **Guideline Updates** / Coverage and Clinical Guidelines

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective ***April 1, 2021***. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage, the Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan, and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP). Furthermore, the guidelines were among those recently approved at the Medical Policy and Technology Assessment Committee meeting held on November 5, 2020.

The services addressed in these coverage guidelines here and in the attachment under "Article Attachments" on the right will require authorization for all of our HealthKeepers, Inc. products with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage, and the Anthem CCC Plus plan. Please note that FEP is excluded from these requirements as well. A pre-determination can be requested for our PPO products.

If applicable, services related to specialty pharmacy drugs (non-cancer related) require a medical necessity review, which includes site of care criteria, as outlined in the applicable coverage or clinical UM guideline.

The guidelines addressed in this edition of *Provider News* are:

- Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices (DME.00011)

- Genetic Testing and Biochemical Markers for the Diagnosis of Alzheimer's Disease (GENE.00003)

- Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity (GENE.00055)

- Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS) (LAB.00037)

- Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele (SURG.00062)

- Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain (SURG.00158)

- Molecular Marker Evaluation of Thyroid Nodules (CG-GENE-04)

- Sacral Nerve Stimulation and Percutaneous Tibial Nerve Stimulation for Urinary and Fecal Incontinence; Urinary Retention (CG-SURG-95)

920-0121-PN-VA

Article Attachments

Coverage guidelines effective April 1, 2021.pdf
application/pdf - 148.35 KB

Evaluation and Management changes 2021 (Professional)

Published: Jan 1, 2021 - **Guideline Updates** / Reimbursement Policies

Anthem recognizes all coding changes from both the American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) effective the date provided by the coding source. This includes the Evaluation and Management (E/M) changes effective **January 1, 2021**.

The following updates pertaining to Evaluation and Management services have been identified:

- CPT code 99201 (new patient E/M) will be a deleted code.

- CPT codes 99202 through 99215 (new/established E/M) definitions have changed. Selection of these E/M codes can now be based on either Medical Decision Making or Time.

- CPT code 99417 (prolonged services) and HCPCS Code G2212 (prolonged services) will be recognized as billable codes. These codes will be payable based on our existing Prolonged Services policy, which will be updated to reflect the new code along with the modifications to existing prolonged service codes CPT codes 99354 and 99355.

- HCPCS Code G2211 (complexity inherent to evaluation and management associated with primary medical care) will not be separately reimbursed for this service. We will be updating our Bundled Services and Supplies policy to reflect this position.

Additionally, we are in the process of updating reimbursement policies impacted by the E/M service changes such as the Documentation and Reporting Guidelines for Evaluation and Management Services.

936-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/evaluation-and-management-changes-2021-4

Professional system updates for 2021

Published: Jan 1, 2021 - **Guideline Updates** / Reimbursement Policies

As a reminder, Anthem Blue Cross and Blue Shield (Anthem) will update our claim editing software monthly for professional services throughout 2021 with the majority of maintenance updates occurring quarterly in February, May, August and November of 2021. 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 edits (NCCI) and medically unlikely edits (MUEs).

- 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, bundled services and global surgery preoperative and post-operative

periods assigned by The Centers for Medicare & Medicaid Services (CMS).

- Apply to any provider, provider group (tax identification number) and/or across providers and claim type (professional/facility) for the same member.

910-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/professional-system-updates-for-2021-4

Outpatient system updates for 2021 (Facility)

Published: Jan 1, 2021 - **Guideline Updates** / Reimbursement Policies

As a reminder, Anthem Blue Cross and Blue Shield (Anthem) will update our claim editing software monthly for outpatient facility services throughout 2021 with the majority of maintenance updates occurring quarterly in 2021. These updates will:

- Reflect the addition of new, and revised codes (for example CPT, HCPCS, ICD-10, modifiers, Revenue Codes) and their associated edits.

- Include appropriate use of various code combinations, which can include, but are not limited to, procedure code to revenue code, HCPCS to revenue code, type of bill to procedure code, type of bill to HCPCS code, procedure code to modifier, and HCPCS to modifier.

- Include updates to National Correct Coding Initiative edits (NCCI) and medically unlikely edits (MUEs).

- Include updates to reflect coding requirements as designated by industry standard sources such as The National Uniform Billing Committee (NUBC).

937-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/outpatient-system-updates-for-2021-facility-4

2021 FEP® benefit information available online

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

To view the 2021 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 Tools & Resources>Brochure & Resources>Plan Brochures. Here you will find the Service Benefit Plan Brochure and Benefit Plan Summary information for year 2021. For questions, please contact FEP Customer Service toll free at **800-552-6989**.

907-0121-PN-VA

URL: https://providernews.anthem.com/virginia/article/2021-fep-benefit-information-available-online-8

Updates to AIM Clinical Appropriateness Guidelines for Advanced Imaging

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

Please note, this communication applies to Anthem HealthKeepers Plus offered by HealthKeepers, Inc.

The following updates will apply to the *AIM Clinical Appropriateness Guidelines for Advanced Imaging* for claims with dates of service on and after March 14, 2021.

Chest imaging, and head and neck imaging

Hoarseness, dysphonia and vocal cord weakness/paralysis — primary voice complaint:

- Required laryngoscopy for the initial evaluation of all patients with primary voice complaint

Brain imaging, and head and neck imaging

Hearing loss:

- Added CT temporal bone for evaluation of sensorineural hearing loss in any pediatric patients or in adults for whom MRI is non-diagnostic or unable to be performed

- Higher allowed threshold for consecutive frequencies to establish sensorineural hearing loss

- Removed CT brain as an alternative to evaluating hearing loss based on ACR guidance

Tinnitus:

- Removed sudden onset symmetric tinnitus as an indication for advanced imaging

Head and neck imaging

Sinusitis/rhinosinusitis:

- Added more flexibility for the method of conservative treatment in chronic sinusitis

- Required conservative management prior to repeat imaging for patients with prior sinus CT

Temporomandibular joint dysfunction:

- Removed requirement for radiographs/ultrasound

Cerebrospinal fluid (CSF) leak of the skull base:

- Added scenario for management of known leak with change in clinical condition

Brain imaging

Ataxia, congenital or hereditary:

- Combined with congenital cerebral anomalies to create one section

Acoustic neuroma:

- More frequent imaging for a watch and wait or incomplete resection

- New indication for neurofibromatosis type 2 (NF 2)**Neurofibromatosis type 2**

- More frequent imaging when MRI shows findings suspicious for recurrence

- Single post-operative MRI following gross total resection

- Included pediatrics with known acoustics (rare but NF 2)

Tumor — not otherwise specified:

- Repurposed for surveillance imaging of low grade neoplasms

Seizure disorder and epilepsy:

- Limited imaging for the management of established generalized epilepsy

- Required optimal medical management (aligning adult and pediatric language) prior to imaging for management in epilepsy

Headache:

- Removed response to treatment as a primary headache red flag

- Include pregnancy as a red flag risk factor

Mental status change and encephalopathy:

- Added requirement for initial clinical and lab evaluation to assess for a more specific cause

Oncologic imaging

General enhancements — Updates to Scope/Definitions, general language standardization

General content enhancements — Overall alignment with current National Comprehensive Cancer Network (NCCN) recommendations, resulting in:

- Removal of indications/parameters not addressed by NCCN

- Average risk inclusion criteria for CT colonography

- New allowances for MRI abdomen and/or MRI pelvis by tumor type, liver metastatic disease

- New indications for acute leukemia (CT, PET/CT), multiple myeloma (MRI, PET/CT), ovarian cancer surveillance (CT), bone sarcoma (PET/CT)

- Updated standard imaging prerequisites prior to PET/CT for bladder/renal pelvis/ureter, ectal, esophageal/GE junction, gastric and non-small cell lung cancers

- Additional PET/CT management scenarios for cervical cancer, Hodgkin Lymphoma

Other content enhancements by section

Cancer screening: New indication for pancreatic cancer screening

Breast cancer: New PET/CT indication for restaging/treatment response for bone-only metastatic disease and limitation of post-treatment breast MRI after breast conserving therapy or unilateral mastectomy

Prostate cancer: MRI pelvis: removal of TRUS biopsy requirement, allowance if persistent/unexplained elevation in PSA or suspicious DRE

Axumin PET/CT: Updated inclusion criteria (removal of general MRI pelvis requirement, additional allowance for rising PSA with non-diagnostic mpMRI)

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM Specialty Health®* (AIM) in one of several ways:

- Access the AIM ***Provider****Portal*℠ directly at **https://aimspecialtyhealth.com/providerportal**. (Online access is available 24/7 to process orders and is the fastest and most convenient way to request authorization.)

- Access AIM via the Availity* Portal at **https://availity.com**.

- Call the AIM Contact Center toll-free number at **1-800-714-0040** from 7 a.m. to 7 p.m. CT.

If you have questions related to guidelines, please contact AIM by email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of HealthKeepers, Inc. Availity, LLC is an independent company providing administrative support services on behalf of HealthKeepers, Inc.

AVA-NU-0305-20

URL: https://providernews.anthem.com/virginia/article/updates-to-aim-clinical-appropriateness-guidelines-for-advanced-imaging-7

FDA approvals and expedited pathways used: New molecular entities (NMEs)

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

Please note, this communication applies to Anthem HealthKeepers Plus offered by HealthKeepers, Inc.

HealthKeepers, Inc. reviews the activities of the Food and Drug Administration (FDA)'s approval of drugs and biologics on a regular basis to understand the potential effects for our providers and members.

The FDA approves new drugs and biologics using various pathways. Recent studies on the effectiveness of drugs and biologics going through different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Here is a list of the approval pathways the FDA uses for drugs/biologics:

- **Standard review** — The standard review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public; watches for problems once drugs and biologics are available to the public; monitors drug/biologic information and advertising; and protects drug/biologic quality. Follow this **link** to learn more about the standard review process.

- **Fast track** — Fast track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. Follow this **link** to learn more about the fast track process.

- **Priority review** —A priority review designation means FDA's goal is to take action on an application within six months. Follow this **link** to learn more about the priority review process.

- **Breakthrough therapy** — This process is designed to expedite the development and review of drugs/biologics which may demonstrate substantial improvement over available therapy. Follow this **link** to learn more about the breakthrough therapy review process.

- **Orphan review** — This refers to the review of drugs that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. Follow this **link** to learn more about the orphan drug review process.

- **Accelerated approval** — These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. To learn more about the accelerated approval process, follow this **link**.

New molecular entities approvals: January 2020 through August 2020

Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

HealthKeepers, Inc. reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, we are providing a list of NMEs approved from January to August 2020 along with the FDA approval pathway utilized.

Note: This information has no impact on our standard prior authorization/pre-certification process.

Generic name	Trade name	Standard review	Fast track	Priority	Break-through therapy	Orphan review	Accelerated approval	Approval date

Indication									
Abametapir	Xeglyze	X						7/24/2020	Head lice
Amisulpride	Barhemys	X						2/26/2020	Postoperative nausea and vomiting
Avapritinib	Ayvakit		X	X	X	X		1/9/2020	PDGFRa exon 18 mutant gastrointestinal stromal tumor
Belantamab mafodotin	Blenrep			X	X	X	X	8/05/2020	Multiple myeloma
Bempedoic acid	Nexletol	X						2/21/2020	Dyslipidemia
Brexucabtagene autoleucel	Tecartus			X	X	X	X	7/24/2020	Mantle cell lymphoma
Capmatinib	Tabrecta			X	X	X	X	5/6/2020	Non-small cell lung cancer (NSCLC)
Decitabine/ cedazuridine	Inqovi			X		X		7/07/2020	Myelodysplastic syndromes
Eptinezumab-jjmr	Vyepti	X						2/21/2020	Migraine prevention
Fostemsavir	Rukobia		X	X	X			7/02/2020	Human immunodeficiency virus (HIV) treatment
Inebilizumab	Uplizna	X			X	X		6/11/2020	Neuromyelitis optica spectrum disorder
Isatuximab	Sarclisa	X				X		3/2/2020	Multiple myeloma
Lurbinectedin	Zepzelca			X		X	X	6/15/2020	NSCLC
Nifurtimox	Lampit			X		X	X	8/06/2020	Chagas disease
Oliceridine	Olinvyk	X	X					8/07/2020	Moderate to severe acute pain
Opicapone	Ongentys	X						4/24/2020	Parkinson’s disease
Osilodrostat	Isturisa	X				X		3/6/2020	Cushing’s disease
Ozanimod	Zeposia	X						3/25/2020	Multiple sclerosis

Peanut (Arachis hypogaea) allergen powder-dnfp	Palforzia	X	X		X			1/31/2020	Peanut allergy
Pemigatinib	Pemazyre			X	X	X	X	4/17/2020	Cholangiocarcinoma
Remimazolam	Byfavo	X						7/02/2020	Sedation for procedures
Rimegepant	Nurtec ODT			X				2/27/2020	Migraine treatment
Risdiplam	Evrysdi		X	X	X	X		8/07/2020	Spinal muscular atrophy
Ripretinib	Qinlock		X	X	X	X		5/15/2020	Gastrointestinal stromal tumor
Sacituzumab-hziy	Trodelvy		X	X	X	X	X	4/22/2020	Triple negative breast cancer
Selpercatinib	Retevmo			X	X	X	X	5/8/2020	NSCLC and thyroid cancers
Selumetinib	Koselugo		X	X	X	X		4/10/2020	Neurofibromatosis type 1
Tafasitamab	Monjuvi	X	X		X	X	X	7/31/2020	Large B-cell lymphoma
Tazemetostat	Tazverik			X		X	X	1/23/2020	Epithelioid sarcoma
Teprotumumab-trbw	Tepezza		X	X	X	X		1/21/2020	Thyroid eye disease
Triheptanoin	Dojolvi	X	X			X		6/30/2020	Long-chain fatty acid oxidation disorders
Tucatinib	Tukysa		X	X	X	X		4/17/2020	Breast cancer
Viltolarsen	Viltepso		X	X		X	X	8/12/2020	Duchenne muscular dystrophy

Source: www.fda.gov

AVA-NU-0309-20

URL: https://providernews.anthem.com/virginia/article/fda-approvals-and-expedited-pathways-used-new-molecular-entities-nmes-10

Medical drug benefit Clinical Criteria updates

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

Please note, this communication applies to Anthem HealthKeepers Plus offered by HealthKeepers, Inc.

On August 21, 2020, 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 websites, and the effective dates will be reflected in the ***Clinical Criteria Web Posting August 2020***. Visit ***Clinical Criteria*** to search for specific policies.
If you have questions or would like additional information, use this **email**.

AVA-NU-0310-20

URL: https://providernews.anthem.com/virginia/article/medical-drug-benefit-clinical-criteria-updates-85

Coding spotlight: HEDIS MY 2021

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

Please note, this communication applies to Anthem HealthKeepers Plus offered by HealthKeepers, Inc.

HEDIS overview

The National Committee for Quality Assurance (NCQA) is a non-profit organization that accredits and certifies health care organizations. The NCQA establishes and maintains the Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is a tool comprised of standardized performance measures used to compare managed care plans. The overall goal is to measure the value of health care based on compliance with HEDIS measures. HEDIS also allows stakeholders to evaluate physicians based on health care value rather than cost. This article will outline specific changes to the HEDIS measures as outlined by the NCQA. The changes are effective for the measurement year (MY) 2020 to 2021. It is important to note that the state health agency has the authority to determine which measures and rates managed care organizations should capture.

HEDIS data helps calculate national performance statistics and benchmarks and sets standards for measures in NCQA Accreditation.

Health plans use HEDIS performance results to:

- Evaluate the quality of care and services.
- Evaluate provider performance.
- Develop performance improvement initiatives.
- Perform outreach to providers and members.
- Compare performance with other health plans.

HEDIS MY 2020 new measures:

- Follow-up After High-Intensity Care for Substance Use Disorder (FUI)
- Pharmacotherapy for Opioid Use Disorder (POD)
- Breast Cancer Screening (BCS-E)
- Follow-up Care for Children Prescribed ADHD Medication (ADD-E)
- Prenatal Depression Screening and Follow-up (PND)
- Postpartum Depression Screening and Follow-up (PDS)

HEDIS MY 2020 retired measures:

- Annual Monitoring for Patients on Persistent Medications (MPM)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
- Standardized Healthcare-Associated Infection Ratio (HAI).

Retired measures are no longer maintained by NCQA or included in the HEDIS measurement set. NCQA has determined that specific measures are clinically inappropriate and are no longer in use. Once retired, the measures are not used in any product, program or service, and all use must stop.

HEDIS MY 2020 revised hybrid measures:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Childhood Immunization Status (CIS)
- Immunizations for Adolescents (IMA)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL)
- Care for Older Adults (COA)
- Controlling High Blood Pressure (CBP)
- Medication Reconciliation Post-Discharge (MRP)
- Transitions of Care (TRC)
- Prenatal and Postpartum Care (PPC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)

HEDIS MY 2020 revised administrative measures:

- Appropriate Testing for Children with Pharyngitis (CWP)
- Statin Therapy for Patient’s with Cardiovascular Disease (SPC)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Osteoporosis Management in Women Who Had a Fracture (OMW)

- Follow-Up After Hospitalization for Mental Illness (FUH)
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP).

HEDIS and telehealth

HEDIS measures include synchronous telehealth (which requires real-time interactive audio and video telecommunications), telephone visits and online assessments, as appropriate. A measure specification will indicate when telephone visits or online assessments are eligible for use in reporting.

A measure specification that is silent about telehealth is assumed to include telehealth. Correct coding requires billing telehealth services using standard CPT® and HCPCS codes for professional services in conjunction with a telehealth modifier and a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A measure specification will indicate when telehealth is not eligible for use and is excluded.

The future of HEDIS

The future of HEDIS focuses on six core ideas:

- **Allowable adjustments:** New flexibility lets users modify measures without changing their clinical intent.

- **Licensing and certification:** Updated requirements ensure the accuracy of the results.

- **Digital measures:** HEDIS specifications that download directly into users' data systems bring new ease of use.

- **Electronic clinical data systems (ECDS):** This new reporting method helps clinical data create insight for managing the health of individuals and groups.

- **Schedule change:** A new schedule gives users more time by providing the complete measure specifications sooner – 11 months earlier than the traditional timeline.

- **Telehealth:** The access to care that telehealth has brought during COVID-19 is vital to quality now after the pandemic.

Resources:

HEDIS® Measures and Technical Resources. **https://www.ncqa.org/HEDIS®/measures**

If you have any questions about this communication, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**.

AVA-NU-0313-20

URL: https://providernews.anthem.com/virginia/article/coding-spotlight-hedis-my-2021-3

Disease Management/Population Health program

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

Please note, this communication applies to Anthem HealthKeepers Plus offered by

Disease Management/Population Health is designed to support providers in caring for patients with chronic health care needs. HealthKeepers, Inc. provides members enrolled in the program with continuous education on self-management, assistance in connecting to community resources, and coordination of care by a team of highly qualified professionals whose goal is to create a system of seamless health care interventions and communications.

Who is eligible?

Disease Management/Population Health case managers provide support to members with:

- Asthma.
- Bipolar disorder.
- COPD.
- Diabetes.
- Congestive heart failure.
- Coronary artery disease.
- HIV/AIDS.
- Hypertension.
- Major depressive disorder — adults.
- Major depressive disorder — children and adolescents.
- Schizophrenia.
- Substance use disorder.

Our case managers use member-centric motivational interviewing to identify and address health risks, such as tobacco use and obesity, to improve condition-specific outcomes. Interventions are rooted in evidence-based clinical practice guidelines from recognized sources. We implement continuous improvement strategies to increase evaluation, management and health outcomes.

For more information on our program and how to refer a HealthKeepers, Inc. member for this program, please visit our website at **https://mediproviders.anthem.com/va**.

Your input and partnership is valued. Once your patient is enrolled in the Disease Management/Population Health program, you will be notified by the case manager assigned.

We look forward to working with you.

If you have any questions about this communication, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1 855 323 4687**.

AVA-NU-0315-20

URL: https://providernews.anthem.com/virginia/article/disease-managementpopulation-health-program-3

New state legislation prompts changes in reimbursement of services during credential process: Medicaid clarification

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

Please note, this communication applies to Anthem HealthKeepers Plus and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

HealthKeepers, Inc. has implemented necessary requirements to comply with Virginia legislative House Bill (HB) 822 that became effective July 1, 2020. If you are a new provider applicant under credentialing review for participation in provider networks offered by HealthKeepers, Inc., HB 822 will allow you to see Anthem HealthKeepers Plus members and Anthem CCC Plus members and retroactively receive payments if you are ultimately credentialed.

This means that as of July 1, 2020, if you are a provider who submits a completed credentialing application to us, HealthKeepers, Inc. will adhere to the requirements specified in HB 822. Requirements in the bill do not apply to credentialing applications submitted **before** July 1, 2020, but only to applications that are still in the credentialing review process after the July effective date.

Under the new law, we are required to establish protocols and procedures for reimbursing new provider applicants at the contracted in-network rate for approved, covered services provided during the period in which a provider's credentialing application is pending. Effective July 1, 2020, under HB 822, the credentialing period begins with the receipt of a completed credentialing application. Incomplete credentialing applications and denied applications are excluded.

What lines of our business are impacted?

Members enrolled in the following health benefit plans are impacted by the new state legislation:

- Anthem's PAR/PPO health benefit plans.
- HealthKeepers, Inc. (including commercial **and Medicaid**) health benefit plans. This includes health plans members purchase on or off the Health Insurance Marketplace (commonly referred to as the exchange).
- Commonwealth of Virginia COVA Care and COVA HDHP health benefit plans, the Local Choice (TLC) health benefit plans, and the Line of Duty (LODA) health benefit plans.
- Medicare Supplement health benefit plans.

The lines of business **not** impacted are:

- Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP).
- Administrative services only (ASO) health plans.
- Medicare Advantage health plans.

Impact to providers – call to action

Once the effective date is determined, the effective date will apply to all lines of business; however, based on the line of business, claims will process differently.

Hold claims for Anthem HealthKeepers Plus members:

During the credentialing period, providers **are required to hold claims** for our members until HealthKeepers, Inc. sends a final notification of a credentialing decision. If you submit claims to HealthKeepers, Inc. during the credentialing period before receiving a credentialing decision, claims for the impacted lines of business noted above will be rejected or denied indicating that the claims must be resubmitted upon a final credentialing decision. Members will be protected from inappropriate billing and held harmless during this period.

Patient financial responsibility:

Except for the Anthem HealthKeepers Plus program with Medallion and Anthem CCC Plus program, upon receiving notice of HealthKeepers, Inc.'s final credentialing approval, providers may collect any applicable member cost shares based on members' health benefit plans as appropriate. Providers with approved credentialing applications are required to submit claims under their contract with HealthKeepers, Inc. For denied applications, no claims will be paid for services rendered on behalf of Anthem HealthKeepers Plus members, and providers may not bill any Anthem HealthKeepers Plus members for any outstanding balances.

Notify Anthem HealthKeepers Plus members as required by HB 822:

In order to submit claims pursuant to HB 822, providers are required to take the following actions regarding members enrolled in health benefit plans offered by HealthKeepers, Inc.:

- Notify members – either in writing or electronically – stating that the provider’s credentialing application has been submitted to HealthKeepers, Inc. and is under review.
- Provide the notice in advance of providing treatment to members.
- Include in the notice to members certain credentialing information as outlined in HB 822. Please refer to the legislation for actual requirements and how they impact you.

Questions

If you have questions about the status of your credentialing application, please email our credentialing area at credentialing@anthem.com. All other questions about the credentialing process should be directed to your Anthem HealthKeepers Plus network manager.

Please forward this information to those in your practice who may need this information.

If you have any questions about this communication, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**.

* Availity, LLC is an independent company providing administrative support services on behalf of HealthKeepers, Inc.

AVA-NU-0317-20

URL: https://providernews.anthem.com/virginia/article/new-state-legislation-prompts-changes-in-reimbursement-of-services-during-credential-process-medicaid-clarification

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Discharge planning

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

Please note, this communication applies to Anthem HealthKeepers Plus offered by HealthKeepers, Inc.

Discharge planning is the process of identifying and preparing for a patient's anticipated health care needs after they have transitioned from the hospital to home. It is a process that involves the engagement of the Anthem HealthKeepers Plus patient, family, and healthcare team. If done correctly, effective discharge planning improves patient safety, patient quality and cost outcomes.

Statistical data

Health disparities are known to contribute to readmission risks. Medicaid readmissions are considered significant; meaning, they can be widespread and costly. Statistical data is shown below:

- Medicaid all-cause 30-day readmission rates for patients ages 21 to 44 (19.2%) and 45 to 64 (21.6%) are higher than Medicare readmission rates (17.3%).
- Nearly 20% of members experience an adverse event within three weeks of discharge.
- Three-quarters of adverse events could be prevented with proper discharge planning.
- The most common complications post-discharge include adverse drug events, hospital acquired infections and procedural complications.
- Approximately 70% of surgical patients were re-hospitalized with a medical problem.

- The cost of unplanned hospitalization in 2004 was $17.4 billion.

Background

Under the *Affordable Care Act*, there are certain hospital readmissions that could lead to a penalty and cause lower reimbursements. In addition, the Commonwealth of Virginia has enacted legislation which requires that if a member is readmitted to the same hospital for a potentially preventable readmission then the payment for such cases will be paid at fifty (50) % of the normal rate, except an readmission within five (5) days of discharge will be considered a continuation of the same stay and will not be treated as a new case.

This specific requirement underscores the need to focus in on patient-centered care and a discharge plan that is all-inclusive and, therefore, limits the chance of unnecessary readmissions. Discharge planning can be a complex process; however, having safe transitions from the hospital to home is a top priority. The IDEAL discharge planning strategy seeks to engage the patient and family in the discharge planning process. Building effective relationships with the member and family will ensure patient quality and patient safety. Embracing a culture of open communication will optimally lead to positive patient outcomes and help to make the transition to home safe and effective.

The IDEAL discharge planning strategy

There are many ways to promote effective discharge planning. This article focuses on the IDEAL discharge planning strategy. The IDEAL discharge planning strategy is a strategic way to engage the patient and family in the discharge planning process. Its focus is on a culture of inclusivity:

- **Include** the patient and the family in the complete discharge planning process. This is a process that carries on throughout the entire hospitalization. Determine who will provide care for the patient at home and be sure to include this individual in the team meetings and conversations.

- **Discuss** with the patient and family five areas to prevent problems when they return home. These five areas include home life, medication reconciliation, potential warning signs and concerns, test results with thorough instructions, and follow-up appointments with providers.

- **Educate** the patient and family in layman's terms about his/her condition and the discharge process. Complete education throughout the entire hospital stay. Address patient and family goals at admission and throughout the hospital stay.

- **Assess** how well the information has been provided to the patient by the doctors, nurses and other health care professionals and use the teach-back method to ensure understanding. Avoid overloading the patient with too much information.

- **Listen** to and respect the patient and family's goals, preferences, observations and concerns. Use motivational interviewing such as open-ended questions to spark questions and concerns. Schedule a meeting prior to discharge with patient, family and interdisciplinary team.

Challenges to discharge planning:

- Fragmented care due to multiple providers and inability to keep scheduled appointments
- Medication reconciliation discrepancy (complex or high-risk medications)
- Inadequate discharge preparation
- Miscommunication between provider, patient and family
- Communication and education not properly completed
- Information or educational offerings not provided in layman's terms
- Appropriate teachings based on how the patient best learns not utilized (verbal, audiovisual)
- Inability to have patient self-manage his/her condition

Evidence-based practices to improve discharge planning:

- Come up with your own discharge planning sheets or checklists and follow them per your facility policies and procedures.

- Provide trainings on effective discharge planning with nursing staff and allow staff to feel a part of the process.

- Empower patients through educational activities throughout the stay to help them better understand their conditions, manage their diet, manage activities, manage medications, manage care regimens and manage follow-up care.

- Provide attention to discharge planning on the first day of admission and throughout the entire stay, providing a multidisciplinary approach.

- Develop a plan for care coordination after discharge and complete any follow-up appointments prior to the patient leaving the facility.

- Always implement practices or set aims to improve discharge planning in your facility.

References

- Agency for Healthcare Research and Quality (2017, December). Strategy 4: Care transitions from hospital to home: IDEAL discharge planning. Retrieved from **https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html**

- Barrett, M.L., Weir, L.M., Jiang J. H., Steiner, C.A. (2015). Cup statistical brief #199: All-cause readmissions by payer and age, 2009–2013. *AHRQ Healthcare Cost and*

Utilization Project. Retrieved from **http://www.hcup-us.ahrq.gov/reports/statbriefs/sb199-Readmissions-Payer-Age.pdf**. Accessed April 13, 2020.

If you have any questions about this communication, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**.

AVA-NU-0321-20

URL: https://providernews.anthem.com/virginia/article/discharge-planning-1

Keep up with Medicaid news

Published: Jan 1, 2021 - **State & Federal** / 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 are the topics we're addressing in this edition:

New specialty pharmacy medical step therapy requirements
AVA-NU-0298-20

AIM Clinical Appropriateness Guidelines for Radiation Oncology.
AVA-NU-0303-20

Updates to AIM Specialty Health Cardiac Clinical Appropriateness Guidelines.
AVA-NU-0306-20

August 2020 Coverage Guidelines and Clinical Utilization Management Guidelines update
AVA-NU-0311-20

Signing up to receive email from HealthKeepers, Inc.
AVA-NU-0318-20

URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicaid-news-52

Medical drug benefit Clinical Criteria updates

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

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

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the ***Clinical Criteria Web Posting August 2020***. Visit ***Clinical Criteria*** to search for specific policies.
If you have questions or would like additional information, use this **email**.

ABSCRNU-0187-20 515073MUPENMUB

URL: https://providernews.anthem.com/virginia/article/medical-drug-benefit-clinical-criteria-updates-86

2020 Medicare risk adjustment provider trainings

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

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

Medicare risk adjustment and documentation guidance (General):

- Series: Offered the first Wednesday of each month from 1 to 2 p.m. (ET).*

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

- Credits: This live activity, Medicare risk adjustment and documentation guidance, from January 8, 2020 to December 2, 2020, has been reviewed and is acceptable for up to 1.00 prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To learn how providers play a critical role in facilitating the risk adjustment process, register for one of the monthly training sessions at the link below:

https://bit.ly/2TYMgbn
** Note: Dates may be modified due to holiday scheduling*

Medicare risk adjustment, documentation and coding guidance (Condition specific)

- **Series:** Offered the third Wednesday of each month from 1 to 2 p.m. (ET).

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

- **Credits:** This live series activity, Medicare risk adjustment documentation and coding guidance, from January 15, 2020 to November 18, 2020, has been reviewed and is acceptable for credit by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity

For those interested in the following training topics, please register at the link below.

https://bit.ly/2IgxDO9

** Note: Enter the password provided, and the recording will play upon registration.*

- Red flag HCCs
- Neoplasms
- Acute, chronic and status conditions
- Diabetes mellitus and other metabolic disorders
- Coinciding conditions in risk adjustment models

Please note that the original training events have been modified due to a transition within WebEx as of August 1, 2020. The date and time of the events have not changed but the program link and invitation detail have been updated. Previously registered participants will need to re-register for a training event using the updated registration link(s) provided in this announcement.

ABSCRNU-0192-20 515074MUPENMUB

URL: https://providernews.anthem.com/virginia/article/2020-medicare-risk-adjustment-provider-trainings-27

Keep up with Medicare news

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

Please continue to read news and updates at **anthem.com/medicareprovider** for the latest Medicare Advantage information, including:

Medicare Advantage Group Retiree Quick Reference Guide and FAQ
ABSCRNU-0195-20 515396MUPENMUB

Medicare Advantage Group Retiree Member Eligibility, Alpha Prefix FAQ
ABSCRNU-0183-20 514595MUPENMUB

SNF admission reporting requirements for D-SNP plans
ABSCRNU-0196-20 515362MUPENMUB

Policy Update — Nurse Practitioner and Physician Assistant Services, Professional

ABSCRNU-0169-20 513546MUPENMUB

URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicare-news-182