California Provider News

July 2019 Anthem Blue Cross Provider News - California

Medi-Cal Managed Care:

Cal MediConnect:

Updates to AIM Advanced Imaging clinical appropriates guidelines

Published: Jul 1, 2019 - **Products & Programs**

Effective for dates of service on and after September 28, 2019, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines.

Brain Imaging Guideline contains updates to the following:
Infection, Multiple sclerosis and other white matter diseases, Movement disorders (Adult only), Neurocognitive disorders (Adult only), Trauma, Pituitary adenoma, Tumor, Hematoma or hemorrhage – intracranial or extracranial, Hydrocephalus/ventricular assessment, Pseudotumor cerebri, Spontaneous intracranial hypotension, Abnormality on neurologic exam, Ataxia, Dizziness or Vertigo, Headache, Hearing loss and Tinnitus.

Extremity Imaging Guideline contains updates to the following:
Congenital or development anomalies of the extremity (Pediatric only), Discoid meniscus (Pediatric only), Soft tissue infection, Osteomyelitis, Septic arthritis, Bursitis, Capitellar osteochondritis, Fracture, Patellar dislocation, patellar sleeve avulsion, Trauma complications, Bone lesions, Soft tissue mass – not otherwise specified, Lisfranc injury, Labral tear – hip, Labral tear – shoulder, Meniscal tear and ligament tear of the knee, Rotator cuff tear (Adult only), Avascular necrosis, Lipohemarthrosis (Pediatric only), Paget's disease – new multimodality indication and General Perioperative Imaging (including delayed hardware failure), not otherwise specified.

Spine Imaging Guideline contains updates to the following:
Multiple sclerosis or other white matter disease, Spinal infection, Cervical injury, Thoracic or lumbar injury, Paget's disease, Spontaneous (idiopathic) intracranial hypotension (SIH), Perioperative Imaging, including delayed hardware failure, not otherwise specified, Neck pain (cervical), Mid-back pain (thoracic).

- Access AIM's ***Provider****Portall*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: **1-877-291-0360**, Monday – Friday, 7:00 a.m. 5:00 p.m. PT.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

URL: https://providernews.anthem.com/california/article/stronger-together

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Stronger together!

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

Anthem collaborated with national organizations to create the *Stronger Together* website. The site is a collection of innovative resources that help people where they live, learn, work, and play.

These resources are free and available to everyone. Have a look!

Resources accessible through the website include:

- **Cancer** – interactive apps that bring together several resources for people touched by cancer. Patients, survivors, caregivers, providers, and even employers all will find valuable resources that can help during all phases of cancer, from diagnosis to survivorship, and everything in between.

- **Mental Health / Substance Abuse** – these resources focus on caring for the whole person, body and mind.

- **Vaccinations –** provides tools to address vaccination disparities, and a vehicle to connect providers to their state immunization program or local immunization coalition.

- **Health Equity –** resources designed to help reduce health care disparities.

URL: https://providernews.anthem.com/california/article/stronger-together-1

Make the move to the Availity EDI Gateway today

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

If you currently submit claims directly to the Anthem EDI Gateway, now is the time to make the move. **It is mandatory that, all trading partners must transition to the Availity EDI Gateway to avoid future disablement**.

Do you already have an Availity User ID and Login? You can use the same login for your Anthem Blue Cross (Anthem) EDI transactions.

- Log in to the Availity Portal and select **Help & Training | Get Trained**. In the Availity Learning Center, search the Catalog by key word "**SONG"** for live and on-demand resources created especially for you.

If you wish to become a direct a trading partner with Availity, the setup is easy.

- Use the **Availity Welcome Application** to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions.

Do you use a clearinghouse or vendor today?

- Check out Availity's preferred vendors list to see if your vendor has already made the transition.
    - o Go to com *(**prior** to logging in to your User account)*, select **Vendors** from the top menu bar. Then see the **Preferred Vendors** or **Supported Systems** lists to view those that are already in a preferred status with Availity.

- If you don't see your vendor on the list, we encourage you to contact your vendor to ensure they have made the move.

Need Assistance?

The Availity Quick Start Guide will assist you with any EDI connection questions you may have.

If you need additional assistance, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 5 a.m. to 4:30 p.m. PT.

URL: https://providernews.anthem.com/california/article/make-the-move-to-the-availity-edi-gateway-today-5

Anthem Blue Cross Commercial Risk Adjustment reporting update: 2019 program year progression, what's in it for you and your patients?

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

Continuing our 2019 Commercial Risk Adjustment (CRA) reporting updates, Anthem Blue Cross (Anthem) requests your assistance with respect to our CRA reporting processes.

As we reported in the May and June newsletters, we are completing our prospective and retrospective reviews for 2019. Prospectively, we intervene to encourage the participation of the members we have identified as appropriate for clinical assessments. Retrospectively, certified coders review medical charts to determine if there are diagnosis codes that have not been reported.

What's in it for you?
First, monthly you will receive lists of our members who are your patients to help you reach out to those who may have gaps in care, so they can come in for office visits earlier.

Second, we've heard resoundingly from providers that participation in these programs helps them better evaluate their patients (who are our members) and, as a result, perform more strongly in population health management and gain sharing programs. Many cite that they ask different questions today that allow them to better manage their patients end to end.

Finally, when you see Anthem members and submit assessments, **we pay incentives of $50 for a paper submission and $100 for an electronic submission**. For additional details on how to earn these incentives and the options available, please contact our CRA

Network Education Representative listed below.

What's in it for your patients?
Anthem has completed monthly postcard campaigns to members with Affordable Care Act (ACA) compliant coverage when we suspect a high risk condition with messaging to encourage the member to call his or her Primary Care Provider (PCP) and schedule an annual checkup. The goal is to get the members in to see their PCPs, so the PCPs have an overall picture of their patients' health and schedule any screenings that may be needed. We will continue these monthly postcard mailings throughout all of 2019 to continue to encourage the members to be seen in your office, which supplements any patient outreach you may be doing as well.
If you have any questions regarding our reporting processes, please contact our CRA Network Education Representative: Socorro.Carrasco@anthem.com

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-commercial-risk-adjustment-reporting-update-2019-program-year-progression-whats-in-it-for-you-and-your-patients

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Workers' Compensation acknowledgments required

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

As a reminder, the Workers' Compensation Physicians Acknowledgments is required by California Code of Regulations §9767.5.1, "Medical Provider Networks" (MPN). The "MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment
in which the physician affirmatively elects to be a member of the MPN."

To maintain and affirm your participation in all MPNs that you have been selected for and have subscribed to Anthem's Provider Affirmation Portal, go to Availity and login. Once in, click on the Payer Spaces drop down menu in the top right hand corner, and select Anthem Blue Cross from the options available to you. On the next page click on "Resources" in the middle of the page and look for "MPN Provider Affirmation Portal."

Availity>Payer Spaces>Anthem Blue Cross>Resources>MPN Provider Affirmation Portal
If you cannot go online, call Anthem Workers' Compensation at **1-866-700-2168** and we can take action on your behalf in the Provider Affirmation Portal. Please also keep an eye out for email notifications from "Anthem MPN Admin."

Please also be advised the Provider Affirmation Portal will also notify participating medical providers when an MPN is terminating its relationship with Anthem and/or the Division of Workers Compensation.

URL: https://providernews.anthem.com/california/article/workers-compensation-acknowledgments-required-1

Medical treatment utilization schedule updates for Workers' Compensation

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

The Department Workers' Compensation (DWC) posted an Order adopting updates to the California Medical Treatment Utilization Schedule (MTUS) that are applicable as of April 18, 2019. These include:

- Ankle and Foot Disorders Guideline (ACOEM July 16, 2018)

- Cervical and Thoracic Spine Disorders Guideline (ACOEM October 17, 2018)
- Elbow Disorders Guideline (ACOEM August 23, 2018)
- Hand, Wrist, and Forearm Disorders Guideline (ACOEM January 7, 2019)
- Workplace Mental Health: Post-traumatic Stress Disorder and Acute Stress Disorder Guideline (ACOEM December 18, 2018)

These are most current evidence-based recommendations drawn from the current ACOEM Guidelines.
Reminder
Free Access to the California MTUS Available to Providers in California

Arrangements by the DIR/DWC and The Reed Group, publisher of the "ACOEM Guidelines", allows for free access to the MTUS for Providers involved in the California Workers' Compensation System by signing up with the Reed Group at: www.mdguidelines.com/mtus. Additional tools are available, the Guidelines are clear, relatively concise, and expedites treatment requests and enhances knowledge of accepted evidence-based care.

URL: https://providernews.anthem.com/california/article/medical-treatment-utilization-schedule-updates-for-workers-compensation-1

Contracted provider claim escalation process

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

In an effort to better service our contracted providers right the first time, Anthem Blue Cross has improved our provider claim escalation process. Just click, Provider Claim Escalation Process to read, print, download and share the improved process with your office staff.

Our Network Relations Team is available by email at CAContractSupport@anthem.com to answer questions you have about the process.

URL: https://providernews.anthem.com/california/article/contracted-provider-claim-escalation-process-9

Provider Education seminars, webinars, workshops and more!

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

Our Provider Network Education team offers quality complimentary educational programs and materials specially designed for our providers. For a complete listing of our workshops, seminars, webinars and job aids, log on to the Anthem Blue Cross website: www.anthem..com/ca. Scroll down the page to ***Partners in Health*** > Tools for Providers. In the middle of the page select the box ***Find Resources for California***. From the **Answers@Anthem** page, select the link titled Provider Education Seminars and Webinars link.

URL: https://providernews.anthem.com/california/article/provider-education-seminars-webinars-workshops-and-more-9

Anthem Blue Cross provider directory and provider data updates

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

It is extremely important that we have accurate and up-to-date information about your practice in our

directories. Senate Bill 137 (SB 137), which went into effect on July 1, 2016, requires that Anthem Blue Cross (Anthem) provide our members accurate and up-to-date provider directory data. As a result, Anthem will be conducting ongoing outreaches to all practices to confirm the information we have on file is accurate. Without verification from you that our Provider Directory information is accurate, we will be required to remove your practice from the directories we make available to our members. We appreciate your attention to this matter.

URL: https://providernews.anthem.com/california/article/anthem-blue-cross-provider-directory-and-provider-data-updates-9

Easily update provider demographics with the online Provider Maintenance Form

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

Anthem Blue Cross (Anthem) providers should now submit changes to their practice profile using our online Provider Maintenance Form.

Online update options include: add an address location, name change, tax ID changes, provider leaving a group or a single location, phone/fax numbers, closing a practice location, etc. Visit the Anthem.com/ca form page to review more.

The new online form can be found on **www.anthem.com/ca/provider/ > *Find Resources for California >*** *Answers@Anthem tab>Provider Forms bullet>Provider Change Forms> Provider Maintenance Form*. In addition, the **Provider Maintenance Form** can be found on the **Availity Web Portal** by selecting *California> Payer Spaces-Anthem Blue Cross> Resources tab >Provider Maintenance Form.*

Important information about updating your practice profile:

- **Change request should be submitted using the online Provider Maintenance Form**
- Submit the change request online. No need to print, complete and mail, fax or email demographic updates
- You will receive an auto-reply e-mail acknowledging receipt of your request and another email when your submission has been processed
- For change(s) that require submission of an updated IRS Form w-9 or other documentation, attach them to the form online prior to submitting
- Change request should be submitted with advance notice

- Contractual agreement guidelines may supersede effective date of request

You can check your directory listing on the *Anthem Blue Cross: "Find a Doctor tool".* The Find a Doctor tool at Anthem is used by consumers, members, brokers, and providers to identify in-network physicians and other health care providers supporting member health plans. To ensure Anthem has the most current and accurate information, please take a moment to access the Find A Doctor tool (www.anthem.com/ca) and review how you and your practice are being displayed.

URL: https://providernews.anthem.com/california/article/easily-update-provider-demographics-with-the-online-provider-maintenance-form-9

Network leasing arrangements

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

Anthem Blue Cross (Anthem) has network leasing arrangements with a variety of organizations, which we call *Other Payors*. Other payors and affiliates use the Anthem network.

Under the terms of your provider agreement, members of other payors and affiliates are treated like Anthem members. As such, they're entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. You can obtain the *Other Payors* list on the Availity web portal, at www.Availity.com. From the Availity site, select Home > Anthem California > Education and Reference Center, or email us at CAContractSupport@Anthem.com.

URL: https://providernews.anthem.com/california/article/network-leasing-arrangements-9

Changes to timely filing requirements coming in October

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

In the effort to simplify our processes, align with industry standards, and better support coordination of care, Anthem Blue Cross (Anthem) is changing professional agreements to

adopt a common time frame for the submission of claims. **Notification was sent June 21, 2019, to providers of applicable networks and contracts.**

Effective **for all claims received by Anthem on or after October 1, 2019**, all impacted contracts will require the submission of all professional claims within ninety (90) days of the date of service. This means claims **submitted on or after October 1, 2019** will be subject to a ninety (90) day timely filing requirement, and Blue Cross will refuse payment if submitted more than ninety (90) days after the date of service1.

If you have any questions, email our Network Relations staff at CAContractSupport@anthem.com.

[1]If Plan is the secondary payor, the ninety (90) day period will not begin until Provider receives notification of primary payor's responsibility.

URL: https://providernews.anthem.com/california/article/changes-to-timely-filing-requirements-coming-in-october

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Modifier 79 reminder (professional)

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

A recent review of our claim trends has identified that many providers are not billing appropriately for modifier 79. According to Appendix A in the *CPT Professional Edition,* modifier 79 is used to indicate that a procedure or service is an "…*unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period*". If the current procedure or service does not fall within the postoperative period of a previously performed 0, (same day), 10 or 90 day postoperative period, by the same provider or a provider in the same group practice, please carefully consider the definition of modifier 79 when adding the modifier to a procedure or service.

URL: https://providernews.anthem.com/california/article/modifier-79-reminder-professional-5

Modifier 63 reminder (professional)

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

According to Appendix A of the CPT Professional Edition codebook, modifier 63 is only used when an invasive procedure is performed on neonates or infants up to a present body weight of 4 kg to indicate significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. Unless otherwise designated, this modifier should only be appended to the procedures/services identified in the modifier description.

Additionally, based on the modifier description, modifier 63 is not valid for use with evaluation and management, anesthesia, radiology, pathology/laboratory, or medicine codes. Furthermore, many procedures performed on infants for correction of congenital abnormalities include additional difficulty or complexity that are inherent to the procedure and are identified by the code nomenclature and the CPT parenthetical "do not use modifier 63 in conjunction with…" These codes are also identified in Appendix F of the CPT Professional Edition codebook. Please note, incorrect reporting of modifier 63 may result in claim denials.

URL: https://providernews.anthem.com/california/article/modifier-63-reminder-professional-5

ICD-10-CM coding guidelines and Laterality (professional)

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

With the adoption of ICD-10-CM code set, we were introduced to diagnosis codes that now indicate the laterality of a condition. At present, diagnosis code descriptions indicate whether the condition is present on the left, right or exists bilaterally. A recent review of our claim denial trends has identified that many providers are not billing appropriately in regards to laterality.

As a reminder, if a condition currently exists on both sides, please refer to the *ICD-10-CM Official Guidelines for Coding and Reporting FY 2019*, specifically, the General Coding Guidelines Section and the Chapter Specific Sections; for specific guidance for reporting a diagnosis that designates a condition on the left and right versus a bilateral diagnosis. Please carefully consider the information contained in the ICD-10-CM Coding Guidelines when trying to decide between reporting a condition using left diagnosis and right diagnosis codes versus a bilateral diagnosis code.

URL: https://providernews.anthem.com/california/article/icd-10-cm-coding-guidelines-and-laterality-professional-5

Sepsis diagnosis coding and billing reminder

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

To help ensure compliance with the coding and billing of Sepsis, Anthem Blue Cross reviews clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for Sepsis applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent Sepsis-3 clinical criteria published in the **Journal of the American Medical Association, February 2016**. At discharge, clinicians and facilities should apply the Sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of Sepsis. The claim may be subject to an adjustment in reimbursement when Sepsis is not supported based on the Sepsis-3 definition and criteria.
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URL: https://providernews.anthem.com/california/article/sepsis-diagnosis-coding-and-billing-reminder-6

Home health billing guidelines for contracted providers

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

*This information is intended for home health agencies that **do not** submit their claims to MyNexus and are contracted with Anthem Blue Cross and Blue Shield (Anthem) to be compensated based on the original Medicare Home Health Prospective Payment System. This information is not intended for home health agencies that are contracted to be compensated based on per visit rates.*

Use this guideline information for recommendation about home health provider billing. Read the full article: Home health billing guidelines for contracted providers.
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URL: https://providernews.anthem.com/california/article/home-health-billing-guidelines-for-contracted-providers-6

Outpatient rehabilitation program transitioning to AIM

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

Effective October 1, 2019, Anthem Blue Cross (Anthem) will transition utilization management of our Outpatient Rehabilitation Program for Medicare Advantage from OrthoNet LLC to AIM Specialty Health® (AIM). AIM is a specialty health benefits company. The Outpatient Rehabilitation Program includes physical, occupational and speech therapy services. Anthem has an existing relationship with AIM in the administration of other programs. Read the full article about the AIM transition.

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URL: https://providernews.anthem.com/california/article/outpatient-rehabilitation-program-transitioning-to-aim-5

LAPRA to offer Medicare Advantage from Anthem Blue Cross

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

Beginning July 1, 2019, the Los Angeles Police Relief Association, Inc. (LAPRA) will offer Medicare Advantage under the Anthem Blue Cross Senior Secure HMO plan. Retirees with Medicare Parts A and B who reside in select counties are eligible to enroll in the plan. This Medicare Advantage plan offers the same hospital and medical benefits as Original Medicare, as well as additional benefits such as an annual routine physical exam; hearing, vision and chiropractic care; acupuncture; LiveHealth Online and SilverSneakers®.

You will be able to recognize these members by their member ID cards. The prefix on LAPRA member ID cards will be MHG, and the cards will show the LAPRA logo.

Providers may submit claims electronically using the electronic payer ID or submit a *UB-04* or *CMS-1500* form to Anthem Blue Cross. Providers should not file claims with Original Medicare. Contracted and noncontracted providers may call the Provider Services number on the back of the member ID card for benefit eligibility, prior authorization requirements, and questions about LAPRA member benefits or coverage.

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

ABCCRNU-0028-19
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URL: https://providernews.anthem.com/california/article/lapra-to-offer-medicare-advantage-from-anthem-blue-cross

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Keep up with Medicare news

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

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

- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus

ABCCRNU-0032-19
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URL: https://providernews.anthem.com/california/article/keep-up-with-medicare-news-72

Coding spotlight: Hypertension

Published: Jul 1, 2019 - **State & Federal** / Medi-Cal Managed Care

A Providers' guide for coding

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 I51.9) 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.

HEDISâ 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 codes4	
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

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

The codes and measure tips listed are informational only, not clinical guidelines or standards medical care, and do not guarantee reimbursement. All member care and related decisions o treatment are the sole responsibility of the provider. This information does not dictate or contr your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimburseme for the applicable codes. Proper coding and providing appropriate care decrease the need fo high volume of medical record review requests and provider audits. It also helps us review yo performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS 2019 technical specifications and is subject to chang based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer t the appropriate agency for additional guidance.

URL: https://providernews.anthem.com/california/article/coding-spotlight-hypertension-2

New service types added to Availity

Published: Jul 1, 2019 - **State & Federal** / Medi-Cal Managed Care

Enhancements have been made to the Availity Portal that will now allow you to access more service types when using the Eligibility and Benefits Inquiry tool and will also allow us to share even more valuable information with you electronically.

You may have already noticed new additions to service types, including:

- Medically related transportation.
- Long-term care.

- Acupuncture.
- Respite care.
- Dermatology.
- Sleep study therapy (found under diagnostic medical).
- Allergy testing.

Note, although there is an extensive list of available benefit types available when submitting an eligibility and benefits request, these types do vary by payer.

Here are some important points to remember when selecting service types:

- The benefit/service type field is populated with the last benefit type you selected. If you don't see a specific benefit in the results, submit a new request and select the specific benefit type/service code.
- You have the ability to inquire about 50 patients at one time using the Add Multiple Patients feature.

URL: https://providernews.anthem.com/california/article/new-service-types-added-to-availity-3

Referring patients to California Smokers' Helpline

Published: Jul 1, 2019 - **State & Federal** / Medi-Cal Managed Care

The California Smokers' Helpline DIRECT messaging service is an efficient way for providers to refer their patients for tobacco cessation counseling. This referral method is built

into the electronic health record (EHR) and requires no manual entry; it's automatic! If this option is not of interest, providers can also refer patients by submitting either a web-based form or a peer-to-peer form through **www.nobutts.org**.

For more details about programming DIRECT messaging into your EHR system or any questions about the other two referral methods, please contact Carrie Kirby at ckirby@ucsd.edu.

URL: https://providernews.anthem.com/california/article/referring-patients-to-california-smokers-helpline

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Home health billing guidelines for contracted providers

Published: Jul 1, 2019 - **State & Federal** / Cal MediConnect

*This information is intended for providers who **do not** submit their claims to MyNexus.*

Below are some billing guidelines we recommend home health providers use when billing a Request for Anticipated Payment (RAP) and final claim to Anthem Blue Cross (Anthem). This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract.

- Anthem should receive the final bill within 120 days after the start date of the episode or 60 days after the paid date of the RAP claim — whichever is greater. If the final bill is not received within this time frame, the RAP payment will be canceled/recouped — This is a **Medicare billing requirement**.
- Bill the full Medicare allowed amount for the episode as the billed charges. Do not bill only the expected additional payment on the final claim as the billed charges. When this happens, the Lesser of Logic term in your contract affects the final payment made for the services. If the billed charges are less than the final allowed, the payment will be reduced to only pay up to the billed charges. The billed charges on the final claim should be for at least the full Medicare allowed amount for the services rendered. This will allow the claim to process correctly according to Medicare guidelines.

- Example: RAP claim paid $500. The final claim is submitted with billed charges in the amount of $1,000. The Medicare allowed amount is $1,500. Since the billed charges on the final claim are only $1,000, Anthem would only pay an additional $500 for the final allowed according to the Lesser of Logic term in the contract. If the provider would have

billed charges in the amount of at least $1,500, then an additional payment of $1,000 would have been paid.

Please contact your Provider Relations representative with any questions.

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URL: https://providernews.anthem.com/california/article/home-health-billing-guidelines-for-contracted-providers-7

Sepsis diagnosis coding and billing reminder

Published: Jul 1, 2019 - **State & Federal** / Cal MediConnect

To help ensure compliance with the coding and billing of Sepsis, Anthem Blue Cross reviews clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for Sepsis applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent Sepsis-3 clinical criteria published in the **Journal of the American Medical Association, February 2016**. At discharge, clinicians and facilities should apply the Sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of Sepsis. The claim may be subject to an adjustment in reimbursement when Sepsis is not supported based on the Sepsis-3 definition and criteria.

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URL: https://providernews.anthem.com/california/article/sepsis-diagnosis-coding-and-billing-reminder-7
