Ohio Provider News

July 2020 Anthem Provider News - Ohio

Administrative:

Notice of Material Changes/Amendments to Contract and Prior Authorization Changes - July 2020 . . . 3

Important change to prior authorization requests for inpatient hospital admissions* . . . 6

Welcome to the Custom Learning Center in Availity . . . 7

Anthem Commercial Risk Adjustment (CRA) Reporting Update: 2020 Program Year Progression - What's in it for you and your patients? . . . 9

Products & Programs:

Update: New go-live date for level of care medical necessity review of upper and lower endoscopy procedures . . . 3

Pharmacy:

Updated coverage for HIV PrEP medications . . . 4

Anthem prior authorization updates for specialty pharmacy are available - July 2020* . . . 4

Medical Policy & Clinical Guidelines:

New MCG 24th Edition Guidelines . . . 10

Update: Notice of changes to the AIM Musculoskeletal Program prior authorization requirements and setting determinations* . . . 11

Federal Employee Plan (FEP):

Admission review process for Anthem Blue Cross and Blue Shield Federal Employee Program® (FEP) members . . . 13

Medicare:

Medicare News - July 2020 . . . 14

Prior authorization codes moving from AIM Specialty Health to Anthem Blue Cross and Blue Shield . . . 14

2020 affirmative statement concerning utilization management decisions 16
Medical drug benefit clinical criteria updates 17
In-Office Assessment Program 17
2020 Special Needs Plans 19

Notice of Material Changes/Amendments to Contract and Prior Authorization Changes - July 2020

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

Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements starred (*) below.

- Important change to prior authorization requests for inpatient hospital admissions*
- UPDATE: Notice of changes to the AIM Musculoskeletal Program prior authorization requirements and Setting determinations*
- Anthem prior authorization updates for specialty pharmacy are available - July 2020*
- New MCG 24th Edition Guidelines

URL: https://providernews.anthem.com/ohio/article/notice-of-material-changesamendments-to-contract-and-prior-authorization-changes-july-2020

Update: New go-live date for level of care medical necessity review of upper and lower endoscopy procedures

Published: Jul 1, 2020 - **Products & Programs**

Please be aware that the level of care medical necessity review of upper and lower endoscopy procedures that was previously announced in the March 2020 edition of Anthem Blue Cross and Blue Shield (Anthem) *Provider News* will be **effective August 1, 2020**.

Starting July 20, 2020, ordering providers may submit to AIM prior authorization requests for the hospital outpatient site of care for these procedures for dates of service on or after August 1, 2020.

Anthem invites you to take advantage of an informational webinar that will introduce you to the level of care review of upper and lower endoscopy procedures and the capabilities of the AIM **Provider***Portal*$_{SM.}$ Visit the AIM Surgical Procedures microsite to register for an upcoming training session.

525-0720-PN-IN.MO.OH.WI

URL: https://providernews.anthem.com/ohio/article/update-new-go-live-date-for-level-of-care-medical-necessity-review-of-upper-and-lower-endoscopy-procedures

---

Updated coverage for HIV PrEP medications

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

Beginning July 1, 2020, most of Anthem Blue Cross and Blue Shield (Anthem)'s ACA-complaint non-grandfathered health plans will cover pre-exposure prophylaxis (PrEP) medication at 100% with no member cost share, when used for prevention of HIV and dispensed at an in-network pharmacy with a prescription.

Since medications used for PrEP can also be used *to treat* HIV, Anthem will review medical and pharmacy claims data to determine if a member has been diagnosed and prescribed treatment for HIV or prescribed PrEP for preventive purposes. When prescribed for prevention of HIV, this drug is covered with no member cost share. When prescribed for treatment of HIV, member cost shares apply based on the member's benefit plan. Coverage includes Truvada (200-300 mg), and its generic components, Emtriva 200mg and tenofovir 300mg. When medically necessary, a prior authorization process is available for Descovy to be covered with no member cost share when used for prevention of HIV.

Providers can contact the Provider Service number on the back of the member ID card to determine if a member's plan includes this benefit.

515-0720-PN-CNT

URL: https://providernews.anthem.com/ohio/article/updated-coverage-for-hiv-prep-medications-1

Anthem prior authorization updates for specialty pharmacy are available - July 2020*

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

Prior authorization updates

Effective for dates of service on and after October 1, 2020, 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 NDC code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

To access the Clinical Criteria information, please click here.

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

Clinical Criteria	HCPCS or CPT Code(s)	Drug
ING-CC-0038	J3110	Bonsity
ING-CC-0162	J3490 J3590	Tepezza
ING-CC-0163	J3490 C9399	Durysta

Step therapy updates

Effective for dates of service on and after October 1, 2020, 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.

To access the Clinical Criteria information with step therapy(ies), please click here.

Anthem's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

Clinical Criteria	Status	Drug(s)	HCPCS Codes
ING-CC-0072	Preferred	Avastin	J9035, C9257
ING-CC-0072	Preferred	Mvasi	Q5107
ING-CC-0072	Preferred	Zirabev	Q5118
ING-CC-0072	Preferred	Eylea	J0178
ING-CC-0072	Non-preferred	Lucentis	J2778
ING-CC-0072	Non-preferred	Macugen	J2503
ING-CC-0072	Non-preferred	Beovu	J0179

CORRECTION: June 2020 step therapy update on clinical criteria ING-CC-0003

Panzyga has been non-preferred for ING-CC 0003 since 2018.

In the *June 2020 Provider News* edition, we published information regarding Panzyga to be effective 9/1/2020. This was published in error.

* Notice of Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements.

540-0720-PN-CNT

URL: https://providernews.anthem.com/ohio/article/anthem-prior-authorization-updates-for-specialty-pharmacy-are-available-july-2020

Important change to prior authorization requests for inpatient hospital admissions*

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

To help ensure clinical consistency and quality practices across all markets, Anthem Blue Cross and Blue Shield (Anthem) will change how we handle prior authorization requests for inpatient hospital admissions that do not meet Anthem's clinical guidelines and criteria. Beginning October 1, 2020, we will no longer apply a 30 percent penalty to these requests. Instead, these prior authorization requests that do not meet our clinical guidelines and criteria will be denied. All applicable appeal options remain available.

Please note, this change does not affect the penalty for late prior authorization requests. If applicable, Anthem will apply the standard penalty percentage for late prior authorization requests.

If you have questions, please contact Provider Services.

* Notice of Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements.

558-0720-PN-CNT

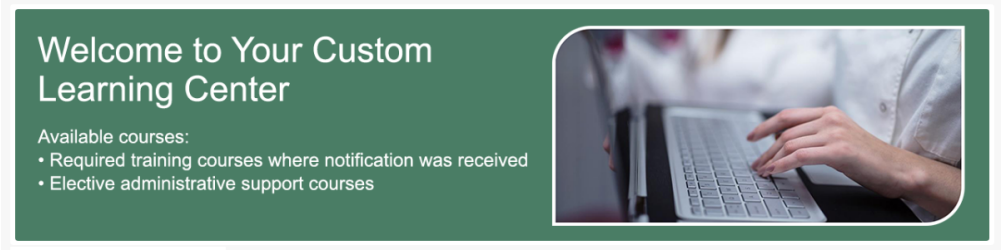
URL: https://providernews.anthem.com/ohio/article/important-change-to-prior-authorization-requests-for-inpatient-hospital-admissions

---

Welcome to the Custom Learning Center in Availity

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

The Custom Learning Center in the Availity portal offers an array of learning opportunities where you can access required training, recommended/elective trainings and view additional learning resources. Access to the Custom Learning Center is via **Payer Spaces** in the Availity Portal.



Highlights of the Custom Learning Center

- All the learning is in one place
- You can filter topics of interest
- View all your completed training
- Course resources may include links to a job aid

Your required courses are easily accessible and the available content is specific to your region. You may track your accomplishments, and view or download your training history via the Custom Learning Center **Dashboard**.

Select **Access Your Custom Learning Center** from the **Applications** tab in **Payer Spaces**.

Examples of trainings offered in the Custom Learning Center:

- Authorizations
- Coding and Documentation
- Claims and Payments
- Recommended administrative support courses

In addition, illustrated reference guides are located on Custom Learning Center – **Resources**. Select **Resources** from the menu located on the upper left corner of the screen. Usually, you may download or print reference guide materials.

Current Reference Guide topics include:

- Interactive Care Reviewer – Request Appeals Reference Guide
- Interactive Care Reviewer – Inquiries Reference Guide
- Patient 360 Navigation
- Remittance Inquiry Tips

Be sure to visit the Custom Learning Center in the Availity Portal often. New content is regularly added to the site.

For questions regarding the Availity Portal, please contact Availity Client Services at 1-800-282-4548.

526-0720-PN-CNT

Article Attachments

URL: https://providernews.anthem.com/ohio/article/welcome-to-the-custom-learning-center-in-availity-1

Anthem Commercial Risk Adjustment (CRA) Reporting Update: 2020 Program Year Progression - What's in it for you and your patients?

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

As a provider, we understand you are committed to providing the best care for our members, which now involves telehealth visits. Telehealth visits are an acceptable format for seeing your patients and assessing if they have risk adjustable conditions. As we reported in the May and June newsletters, we are completing our prospective and retrospective reviews for 2020 for Anthem Blue Cross and Blue Shield (Anthem)'s Commercial Risk Adjustment (CRA) program. The retrospective program focuses on medical chart collection. The prospective program focuses on member health assessments for patients with undocumented Hierarchical Condition Categories (HCCs), in order to help close patients' gaps in care.

What's in it for you?

First, monthly you will receive a list of your patients who are Anthem members enrolled in Affordable Care Act (ACA) compliant coverage who may have gaps in care to help you reach out to them, 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 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 ACA members and submit health 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 the CRA Network Education Representative listed below.

What's in it for your patients?

Anthem is completing monthly postcard campaigns to members with 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 to have a visit with their PCPs, so the PCPs have an overall picture of their patients' health and schedule any screenings that may be needed. Telehealth visits have become very flexible formats for patients and doctors to meet, so we encourage telehealth visits to be scheduled if that is what the patient is most comfortable with at this time.

We will continue these monthly postcard mailings throughout the remainder of 2020 to encourage the members to schedule an annual checkup, which supplements any patient outreach you may be doing.

If you have any questions regarding our reporting processes, please contact the CRA Network Education Representative: Mary.Swanson@anthem.com

527-0720-PN-CNT

URL: https://providernews.anthem.com/ohio/article/anthem-commercial-risk-adjustment-cra-reporting-update-2020-program-year-progression-whats-in-it-for-you-and-your-patients-1

New MCG 24th Edition Guidelines

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

Effective July 1, 2020, we will begin using the new acute viral illness guidelines that have been added to the 24th edition of MCG. Based on the presenting symptoms or required interventions driving the need for treatment or hospitalization, these guidelines are not a substantive or material change to existing MCG guidelines we use now, such as systemic or infectious condition, pulmonary disease, or adult or pediatric pneumonia guidelines.

Inpatient & Surgical Care (ISC)

- Viral Illness, Acute – Inpatient Adult (M-280)
- Viral Illness, Acute – Inpatient Pediatric (P-280)
- Viral Illness, Acute – Observation Care (OC-064)

Recovery Facility Care (RFC)

- Viral Illness, Acute – Recovery Facility Care (M-5280)

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

521-0720-PN-CNT

URL: https://providernews.anthem.com/ohio/article/new-mcg-24th-edition-guidelines-1

Update: Notice of changes to the AIM Musculoskeletal Program prior authorization requirements and setting determinations*

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

As you know, AIM Specialty Health® (AIM) administers the musculoskeletal program, which includes the medical necessity review of certain surgeries of the spine and joints and interventional pain treatment. For certain surgeries, the review also includes a consideration of the level of care for Commercial fully insured Anthem Blue Cross and Blue Shield (Anthem) members and some ASO groups.

According to the clinical criteria for level of care, which is based on clinical evidence as outlined in the AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures, it is generally appropriate to perform joint codes (CPT codes 27130, 29871, 29892) and four spine codes (CPT codes 22633, 22634, 63265 and 63267) in a hospital outpatient setting. To avoid additional clinical review for these procedures, providers requesting prior authorization, should either choose “hospital observation” admission as the site of service or hospital outpatient department (HOPD). If the provider determines that an inpatient stay is necessary due to post-operative care requirements, they can initiate a concurrent review request for inpatient admission with the health plan by contacting the number on the back of the member ID card.

Total hip arthroplasty (CPT code 27130) is currently reviewed for medical necessity and level of care. **Effective October 1, 2020, four spine codes (CPT codes 22633, 22634, 63265 and 63267) and two joint codes (29871 and 29892) will be incorporated into the AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures**. We will review requests for inpatient admission and will require the provider to substantiate the medical necessity of the inpatient setting with proper medical documentation that demonstrates one of the following:

- Current postoperative care requirements are of such an intensity and/or duration that they cannot be met in an observation or outpatient surgical setting.
- Anticipated postoperative care requirements cannot be met, even initially, in an observational surgical setting due to the complexity, duration, or extent of the planned procedure and/or substantial preoperative patient risk.

Peer-to-peer conversations are available to a provider at any time to discuss the applicable clinical criteria and to provide information about the circumstances of a specific member.

Providers should continue to submit pre-service review requests to AIM using one of the following ways:

- Access AIM's ***Provider****Portal*$_{SM}$ 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: 800-554-0580, Monday – Friday, 8:30 a.m. – 7:00 p.m. ET.

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

* Notice of Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements.

553-0720-PN-CNT

URL: https://providernews.anthem.com/ohio/article/update-notice-of-changes-to-the-aim-musculoskeletal-program-prior-authorization-requirements-and-setting-determinations-1

Admission review process for Anthem Blue Cross and Blue Shield Federal Employee Program® (FEP) members

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

We all want to reduce unnecessary contacts and coordinate excellent quality of care for your patients, our members. To help expedite claims payment, all FEP member days of care will need to be certified. We will also assist you in discharge planning/case management services in order to help provide optimal patient outcomes.

How do we accomplish those activities while minimizing your time involvement?

Initial admission review process

Contact us by phone at 1-800-860-2156 or electronically through Anthem's online inpatient review system for providers.

Whether you call us or electronically submit information to Anthem's FEP Medical Management Department to report an inpatient admission, once we certify the admission we'll provide an initial length of stay determination. At that time, we will also request the discharge planner's name and phone number to help facilitate discharge planning/case management.

Next steps after initial admission approval

After you receive initial admission approval, you will need to call:

- With a discharge date if it falls within the initial length of stay period ***OR***
- If the patient stays one or more days longer than the initial length of stay approved, we require updated clinical information for review and for approval of any subsequent length of stay decisions.
- We will also need an update on any discharge plans.

Working together

The Anthem FEP Medical Management Department is committed to working with you and look for opportunities to coordinate the patient's benefits and discharge plans. Please feel free to contact the Anthem FEP UM team members for assistance at 1-800-860-2156.

517-0720-PN-CNT

URL: https://providernews.anthem.com/ohio/article/admission-review-process-for-anthem-blue-cross-and-blue-shield-federal-employee-program-fep-members-1

Medicare News - July 2020

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

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

- New behavioral health discharge call-in line
- Medical policies and clinical utilization management guidelines update
- Updates to AIM Specialty Health advanced imaging clinical appropriateness guidelines
- Transition to AIM rehabilitative services clinical appropriateness guidelines
- Modifier use reminders

URL: https://providernews.anthem.com/ohio/article/medicare-news-july-2020

Prior authorization codes moving from AIM Specialty Health to Anthem Blue Cross and Blue Shield

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

AIM Specialty Health® (AIM) currently performs utilization management review for bilevel positive airway pressure (BiPAP) equipment and all associated supplies. Beginning July 1,

Line of business: Individual Medicare Advantage, Group Retiree Solutions, and Medicare-Medicaid Plans

E0470	Respiratory assist device, bilevel pressure capability, without back-up rate feature, used with noninvasive interface, such as a nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface, such as a nasal or facial mask (intermittent assist device with continuous positive airway pressure device)

AIM will continue to manage the supply codes for automatic positive airway pressure (APAP) and continuous positive airway pressure (CPAP) requests.

Anthem will continue to follow the COVID-19 Public Health Emergency orders from CMS until the waivers no longer apply. If the Public Health Emergency Orders are no longer in place beginning July 1, 2020, the following codes will require prior authorization with Anthem rather than with AIM when used in combination with the BiPAP codes above.

Precertification requests

Submit precertification requests via:

- Fax – **1-866-959-1537**
- Phone – Please dial the customer service number on the back of the member's card, identify yourself as a provider and follow the prompts to reach the correct precertification team. There are multiple prompts. Select the prompt that fits the description for the authorization you plan to request
- Web – Use the Availity Web Tool by following this link: https://apps.availity.com/availity/web/public.elegant.login

A4604	Tubing with heating element
A7046	Water chamber for humidifier, replacement, each
A7027	Combination Oral/Nasal Mask used with positive airway pressure device, each
A7030	Full Face Mask used with positive airway pressure device, each
A7031	Face Mask Cushion, Replacement for Full Face Mask
A7034	Nasal Interface (mask or cannula type), used with positive airway pressure device, with/without head strap
A7035	Headgear
A7036	Chinstrap
A7037	Tubing
A7039	Filter, non-disposable
A7044	Oral Interface for Positive Airway Pressure Therapy
A7045	Replacement Exhalation Port for PAP Therapy
A7028	Oral Cushion, Replacement for Combination Oral/Nasal Mask, each
A7029	Nasal Pillows, Replacement for Combination Oral/Nasal Mask, pair
A7032	Replacement Cushion for Nasal Application Device
A7033	Replacement Pillows for Nasal Application Device, pair
A7038	Filter, disposable

510502MUPENMUB

URL: https://providernews.anthem.com/ohio/article/prior-authorization-codes-moving-from-aim-specialty-health-to-anthem-blue-cross-and-blue-shield-1

2020 affirmative statement concerning utilization management decisions

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

All associates who make utilization management (UM) decisions are required to adhere to

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.

Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

509491MUPENMUB

URL: https://providernews.anthem.com/ohio/article/2020-affirmative-statement-concerning-utilization-management-decisions-4

Medical drug benefit clinical criteria updates

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

On November 15, 2019, and February 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 (Anthem). These policies were developed, revised or reviewed to support clinical coding edits.

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

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

509512MUPENMUB

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

In-Office Assessment Program

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

Anthem Blue Cross and Blue Shield (Anthem) is proud to offer the 2020 Optum* In-Office Assessment (IOA) Program, formerly known as the Healthcare Quality Patient Assessment Form/Patient Assessment Form (HQPAF/PAF) program. The name change reflects significant advancements in technology over the past few years, evolving from a paper form-based program to a program that securely exchanges clinical information digitally through multiple digital modalities.

If you are interested in learning about the electronic modalities available, please contact your Optum representative or the Optum Provider Support Center at **1-877-751-9207** from 8 a.m. to 7 p.m. ET, Monday through Friday.

The IOA Program is designed to help participating providers ensure chronic conditions are addressed and documented to the highest level of specificity at least once per calendar year for all of our participating Medicare Advantage plan members. The IOA Program is designed to help overall patient quality of care (preventive medicine screening, chronic illness management and trifurcation of prescriptions for monitoring of high-risk medications and medication adherence) and care for older adults when generated for a Special Needs Plan (SNP) member.

Success stories

Below are some achievements Optum has accomplished with provider groups through the IOA Program:

- As a result of incorporating technology and/or different types of resources offered under the IOA Program, numerous provider offices demonstrated an increase in productivity, documentation and coding accuracy.
- Providers have taken advantage of the IOA Program resources to help alleviate some of the burden for their staff and office resources.

COVID-19 update

Anthem knows this is a difficult time for everyone. We will continue to adapt and evolve our practices to fully address the changing dynamics of these unprecedented events. Anthem is following the CDC guidelines on social distancing; thus, all nonessential IOA Program personal are to work telephonically/electronically with the provider groups until further notice.

Dates and tips to remember:

- Anthem strongly encourages participating providers to review their patient population as soon as possible. This will help get patients scheduled for an appointment if they have not already scheduled an in-office visit. This will also help the provider manage chronic conditions, which impact the health status of the patient.
- At the conclusion of each office visit with a patient, providers participating in the IOA Program are asked to complete and return an *In-Office Assessment* The form should be completed based on information regarding the patient's health collected during the office visit. Participating providers may continue to use the **2020 version of the *In-Office Assessment* form for encounters that take place on or before December 31, 2020**. Anthem will accept the 2020 version of the form for 2020 encounters until midnight January 31, 2021.
- Participating providers **are required** to submit an *Account Setup Form*, *W9* and completed direct deposit enrollment by March 31, 2021. Participating providers should call **1-877-751-9207** if they have any questions regarding this requirement. Participating providers who fail to comply with this requirement will result in forfeiture of the provider payment for submitted *2020 In-Office Assessment* forms if applicable.

If you have any questions regarding the IOA Program, please call Optum at **1-877-751-9207**, Monday through Friday from 9:30 a.m. to 7:30 p.m. ET.

* Optum is an independent company providing medical chart review services on behalf of Anthem Blue Cross and Blue Shield.

509687MUPENMUB

URL: https://providernews.anthem.com/ohio/article/in-office-assessment-program-1

2020 Special Needs Plans

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

Anthem Blue Cross and Blue Shield (Anthem) is offering Special Needs Plans (SNPs) to people eligible for both Medicare and Medicaid benefits or who are qualified Medicare Advantage beneficiaries. SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid. These include supplemental benefits such as hearing, dental, vision

SNP members under Anthem benefit from a model of care that is used to assess needs and coordinate care. Within 90 days of enrollment and annually thereafter, each member receives a comprehensive health risk assessment (HRA) that covers physical, behavioral and functional needs, and a comprehensive medication review. The HRA is used to create a member *Care Plan*. Members with multiple or complex conditions are assigned a health plan case manager.

SNP HRAs, *Care Plans* and case managers support members and their providers by helping to identify and escalate potential problems for early intervention, ensuring appropriate and timely follow-up appointments, and providing navigation and coordination of services across Medicare and Medicaid programs.

Provider training required

Providers contracted for SNP plans are required to complete an annual training to stay up-to-date with plan benefits and requirements, including details on coordination of care and model of care elements. Every provider contracted for SNP is required to complete an attestation, which states they have completed their annual training. These attestations are located at the end of the self-paced training document.

To take the self-paced training, go to the *Model of Care Provider Training* link on the Availity Portal.*

How to access the *Custom Learning Center* on the Availity Portal

1. Log in to the **Availity Portal**.

1. At the top of Availity Portal, select **Payer Spaces** and select the appropriate payer.

2. On the *Payer Spaces* landing page, select **Access Your Custom Learning Center** from *Applications*.
3. In the *Custom Learning Center*, select **Required Training**.
4. Select **Special Needs Plan and Model of Care Overview**.
5. Select **Enroll**.
6. Select **Start**.
7. Once the course is completed, select **Attestation** and complete.

Not registered for Availity?
Have your organization's designated administrator register your organization for Availity.

1. Visit **Availity.com** to register.
2. Select **Register**.
3. Select your organization type.
4. In the *Registration* wizard, follow the prompts to complete the registration for your organization.

Questions and Answers (Q&A)

What does it mean to be dual-eligible? What is a D-SNP?
The term dual eligible refers to people with Medicare coverage who also qualify for some type of state Medicaid benefit – meaning that these members are eligible for both Medicaid and Medicare. These individuals may have higher incidence of chronic conditions, cognitive impairments and functional limitations. D-SNPs are special Medicare Advantage plans that enroll only dual-eligible people, providing them with more intensive coordination of care and services than those offered by traditional Medicare and Medicare Advantage plans.

What is a SNP model of care?
CMS requires Special needs plans (SNPs) to have a model of care that describes how the SNP will administer key components of care management programs, including assessments and training. The model of care describes the unique needs of the population being served and how Anthem will meet these needs. Each SNP model of care is evaluated and scored by the NCQA and approved by CMS.

How does the model of care help physicians?
The three major components of the model of care, 1) the HRA, 2) *Care Plan* and 3) case manager, support providers in serving D-SNP members. Each member receives a comprehensive HRA that covers physical, behavioral and functional needs, and a comprehensive medication review. Health plan staff use the HRA information to create a *Care Plan*. Members with multiple or complex conditions may be assigned to a case manager.

These key model of care components identify and escalate potential problems for early intervention, ensure appropriate and timely follow-up, and help coordinate services across Medicare and Medicaid programs. Through the provider website, providers have access to review the *Care Plan*, the results of the HRA and other information to help manage care.

How are transitions of care managed?
Anthem case managers are involved in transitions of care (for example, discharge from hospital to home for those at high risk of readmission). Such transitions may trigger a reassessment and updates to the member's *Care Plan* as needed. Following a discharge, case managers help ensure that D-SNP members see their PCP within a week and work through barriers that members experience in adhering to post-discharge medication regimens.

Who makes up the Interdisciplinary Care Team (ICT)?
Members of the ICT include any of the following: nurses, physicians, social workers, pharmacists, the member and/or the member's caregiver, behavioral health specialists, or other participants as determined by the member, the member's caregiver, or a relative of the member.

Providers who care for Anthem members are considered participants in the ICT and may be contacted by a case manager to discuss the member's needs. The case manager may present recommendations concerning care coordination or other needs. The goal of the ICT is to assist providers in managing and coordinating patient care.

Do I have to become a Medicaid provider?
You are not required to become a Medicaid provider, but we recommend that you do. Even if you are only providing services covered by Medicare Part A or Part B to SNP members, we recommend that you attain a Medicaid ID because the state Medicaid agency may require this for the Medicare cost share.

Do I need a separate agreement or contract to see SNP members under Anthem?
No, if you see Medicare Advantage HMO members under Anthem, you are considered contractually eligible to see SNP members under Anthem.

How do I file claims for SNP members?
Claims for services to SNP members are filed the same way claims are filed for Medicare Advantage members under Anthem who are not part of SNP. Providers should ensure that the claim has the correct member ID (including the prefix).

How is the SNP member's cost sharing handled?
SNP benefits are administered similarly to Medicare fee-for-service benefits. Upon receiving an *EOP* from Anthem, you should bill the state Medicaid agency or the applicable Medicaid MCO contracted with the state for processing of any Medicare cost sharing applied.

Medicare cost sharing is paid according to each state's Medicaid reimbursement logic. Some states do not reimburse for Medicare cost sharing if the payment has already met or exceeded Medicaid reimbursement methodology.

Do I have to file claims twice for SNP members?
Yes, when you treat SNP members under Anthem, you will file the initial claim with Anthem and then bill the state Medicaid agency or the applicable Medicaid MCO contracted with the state for Medicare cost sharing processing. Please use the same electronic claim submission or address you currently use for Anthem claims filing.

Do SNP members have access to the same prescription drug formulary as other Medicare Advantage members under Anthem?
Yes, SNP members have coverage for the same prescription drugs listed on the Medicare Advantage prescription drug formulary for Anthem.

Please note that in California the tier placement may vary. Be sure to review the plan's specific formulary for details on California SNPs as the formulary depends on the market.

What are SNP benefits for Anthem?
The SNP for Anthem members covers all Medicare Part A and Part B services and includes full Part D prescription coverage. Anthem also covers a range of preventive services with no cost sharing for the member. In addition, the SNP includes coverage for supplemental benefits that may include routine dental, vision and nonemergency medical transportation. A summary of the SNP benefits is posted on the provider website for Anthem members.

Any Medicaid benefits available to the member will be processed under their Medicaid coverage directly with the state or the Medicaid organization in which the member is enrolled.

Does the SNP use the same procedure codes and EDI payer codes?
Yes, the SNP uses the same procedure and payer codes and electronic filing procedures as other Medicare Advantage plans under Anthem.

Is the electronic data interchange (EDI) payer ID for this product the same as others?

Yes, all the claim submission information will be the same (this applies to EDI and paper). Providers must submit this information with the correct ID. Please check the EDI section of the provider website for the correct payer codes to use for your market.

510237MUPENMUB

URL: https://providernews.anthem.com/ohio/article/2020-special-needs-plans-1
