Nevada Provider News

July 2020 Anthem Provider News and Important Updates -- Nevada

Medicare:

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 of Anthem's Provider News will be effective August 1. 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-CONV

URL: https://providernews.anthem.com/nevada/article/update-new-go-live-date-for-level-of-care-medical-necessity-review-of-upper-and-lower-endoscopy-procedures-2

Anthem prior authorization updates for specialty pharmacy are available (MAC)

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

Material Adverse Change (MAC)

Anthem prior authorization updates for specialty pharmacy are available

540-0720-PN-CONV

Article Attachments

20200701-540-0720-PN-CONV_MAC - Anthem Prior Auth Update for Specialty Rx - NV rv 20200620 final.pdf
application/pdf - 607.42 KB

URL: https://providernews.anthem.com/nevada/article/anthem-prior-authorization-updates-for-specialty-pharmacy-are-available-mac-7

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-CONV

URL: https://providernews.anthem.com/nevada/article/updated-coverage-for-hiv-prep-medications-3

Drug fee schedule update

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

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

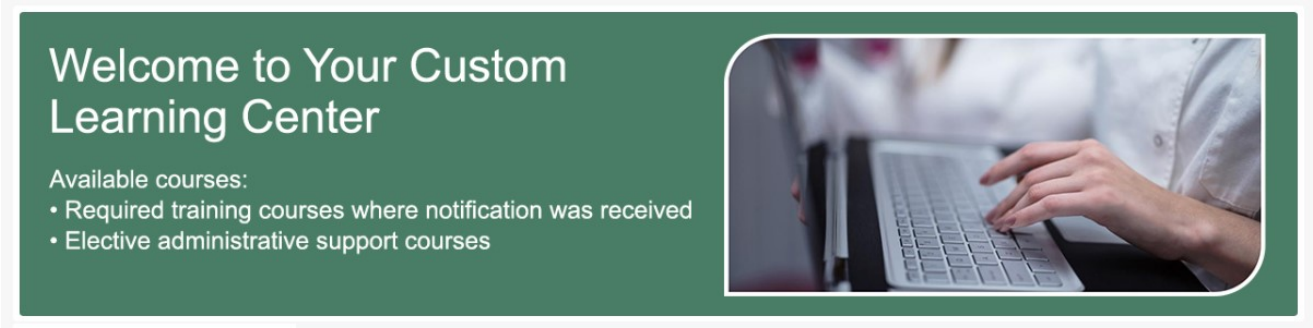
510-0720-PN-CONV

URL: https://providernews.anthem.com/nevada/article/drug-fee-schedule-update-7

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 **Payer Spaces** > **Applications** > **Access Your Custom Learning Center**.

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.

Article Attachments

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-CONV

URL: https://providernews.anthem.com/nevada/article/welcome-to-the-custom-learning-center-in-availity-2

Commercial Risk Adjustment (CRA) 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'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 (HCC's), 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 at Socorro.Carrasco@anthem.com.

527-0720-PN-CONV

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

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UPDATE: Notice of changes to the AIM Musculoskeletal Program prior authorization requirements and Setting determinations (MAC)

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

Material Adverse Change (MAC)

Transition to AIM Clinical Appropriateness Guidelines -- Rehabilitative Services

553-0720-PN-CONV

Article Attachments

20200701-553-0720-PN-CONV_MAC - AIM MSK Prior Auth - NV rv 20200620 final.pdf
application/pdf - 720.76 KB

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

URL: https://providernews.anthem.com/nevada/article/new-mcg-24th-edition-guidelines-4

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 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 work 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 800-860-2156.

517-0720-PN-CONV

URL: https://providernews.anthem.com/nevada/article/admission-review-process-for-anthem-blue-cross-and-blue-shield-federal-employee-program-fep-members-2

Medical drug benefit Clinical Criteria updates

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

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 Healthcare Solutions (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.

If you have questions or would like additional information, use this **email**.

ANV-NU-0133-20 May 2020

URL: https://providernews.anthem.com/nevada/article/medical-drug-benefit-clinical-criteria-updates-27

Complex Case Management program

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

Managing illness can be a daunting task for our members. It is not always easy to understand test results, how to obtain essential resources for treatment, or whom to contact with questions and concerns.

Anthem Blue Cross and Blue Shield Healthcare Solutions is available to offer assistance in these difficult moments with our complex care management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals there to support members, families, primary care physicians and caregivers. The complex care management process uses the experience and expertise of the Care Coordination team to educate and empower our members by increasing self-management skills. The complex care management process can help members understand their illnesses and learn about care choices to ensure they have access to quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the Customer Service number located on their ID card. They will be transferred to a team member based on the immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about health care decisions and goals.

You can contact us by phone at **1-844-396-2330**. Case Management business hours are Monday to Friday from 8 a.m. to 5p.m. Pacific time.

ANV-NU-0129-20 May2020

URL: https://providernews.anthem.com/nevada/article/complex-case-management-program-14

Important information about utilization management

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

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor do we make decisions about hiring, promoting or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in underutilization. Our medical policies are available on our provider website at **https://mediproviders.anthem.com/nv/pages/medical-policies.aspx**.

You can request a free copy of our UM criteria from Provider Services at **1-844-396-2330** . Providers can discuss a UM denial decision with a physician reviewer by calling us toll free at the number listed below. To access UM criteria online, go to **https://mediproviders.anthem.com/nv/pages/medical-policies.aspx**.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
You can submit precertification requests by:

- Faxing to:
  - For DME, PT/OT/ST, pain management, home care, home infusion, hyperbaric treatment or wound care: **1-866-920-8362**
  - All other, including elective IP and OP services: **1-800-964-3627**
- Calling us at **1-844-396-2330**
- The Availity Portal at **https://www.availity.com***

Have questions about utilization decisions or the UM process?
Call our clinical team at **1-844-396-2330** Monday through Friday from 8 a.m. to 5 p.m. Pacific time.

ANV-NU-0130-20 May 2020

URL: https://providernews.anthem.com/nevada/article/important-information-about-utilization-management-34

Members' Rights and Responsibilities Statement

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

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

If you need a physical copy of the statement, call Provider Services at 1-844-396-2330.

ANV-NU-0131-20 May 2020

URL: https://providernews.anthem.com/nevada/article/members-rights-and-responsibilities-statement-10

Coding spotlight: Provider's guide to code social determinants of health

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

What are social determinants of health (SDOH)?

The World Health Organization (WHO) defines SDOH as "conditions in which people are born, grow, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequalities." Capturing SDOH is becoming a necessary element of documentation.

Official coding guidelines for SDOH — new update
For 2019, the *ICD-10-CM Official Guidelines for Coding and Reporting* has been updated to allow reporting SDOH using the documentation of clinicians other than the patient's provider. Most of the patient-specific SDOH information is captured by ancillary staff supporting the physicians.

Do SDOH affect everyone?
The SDOH codes are very powerful tools in capturing the complexity of patient populations and allowing application of more accurate care. These conditions affect patient care. This publicly reported data will also improve capture of conditions that impact readmission reduction and mortality metrics.

SDOH diagnosis codes are one of the few tools that are shared collectively to measure and evaluate SDOH on a national scale.

How can providers address SDOH issues for the members?

- Using the CMS Screening Tool, which can be found at:
- **https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf**
- Submitting ICD-10-CM codes from *Chapter 21 (Z00 to Z99)* to identify issues that may impact member health via claims

Coding SDOH

SDOH codes are represented in ICD-10-CM code categories Z55 to Z65 — persons with potential health hazards related to socioeconomic and psychosocial circumstances. Codes in the Z55 to Z65 groupings include the following:

Code grouping	Examples
Z55 — Problems related to education and literacy	Illiteracy/low level of literacy, schooling unavailable
Z56 — Problems related to employment and unemployment	Unemployment, change of job, threat of j military deployment status, sexual harass on the job
Z57 — Occupational exposure to risk factors	Occupational exposure to noise, radiation tobacco, toxic agents in agriculture, extre temperature
Z59 — Problems related to housing and economic circumstances	Homelessness, inadequate housing, disc with neighbors, extreme poverty, low incc
Z60 — Problems related to social environment	Adjustment to lifestyle transition, problem alone, acculturation difficulty, social exclu and rejection
Z62 — Problems related to upbringing	Inadequate parental supervisions and co parental overprotection, institutional upbr
Z63 — Other problems related to primary support group, including family circumstances	Problems with spousal or other relationsh absence of a family member, alcoholism addiction in family
Z64 — Problems related to certain psychosocial circumstances	Problems with unwanted pregnancy, prob related to multiparity, discord with counse
Z65 — Problems related to other psychosocial circumstances	Conviction, imprisonment, victim of crime terrorism

SDOH diagnosis code reference

View the **SDOH diagnosis code reference** for additional coding details.

Resources

World Health Organization, About social determinants of health, found online at: **https://www.who.int/social_determinants/sdh_definition/en**.

ICD-10-CM Expert for Physicians, the complete official code set, Optum360, LLC. 2020.

ANV-NU-0126-20 April 2020

Article Attachments

SDOH Coding Reference ANV-NU-0126-20.pdf
application/pdf - 300.84 KB

URL: https://providernews.anthem.com/nevada/article/coding-spotlight-providers-guide-to-code-social-determinants-of-health-6

Coding spotlight: Provider's guide to coding for cardiovascular conditions

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

In this coding spotlight, we will focus on several cardiovascular conditions; codes from Chapter 9 of the
ICD-10-CM are listed in the table below.

Diseases of the circulatory system	Category codes
Acute rheumatic fever	I00-I02
Chronic rheumatic heart diseases	I05-I09
Hypertensive diseases	I10-I16
Ischemic heart diseases	I20-I25
Pulmonary heart disease and diseases of pulmonary circulation	I26-I28
Other forms of heart disease	I30-I52
Cerebrovascular diseases	I60-I69
Diseases of arteries, arterioles and capillaries	I70-I79
Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified	I80-I89
Other and unspecified disorders of the circulatory system	I95-I99

Hypertension

ICD-10-CM classifies hypertension by type as essential or primary (categories I10 to I13) and secondary (category I15).

Categories I10 to I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), chronic kidney disease (I12), or heart and chronic kidney disease combined (I13).[1]

Elevated blood pressure versus hypertension
A diagnosis of elevated blood pressure reading, without a diagnosis of hypertension, is assigned code R03.0. This code is never assigned on the basis of a blood pressure reading documented in the medical record; the physician must have specifically documented a diagnosis of elevated blood pressure.

The postoperative hypertension is classified as a complication of surgery, and code **I97.3, postprocedural hypertension**, is assigned. When the surgical patient has pre-existing hypertension, only codes from categories I10 to I13 are assigned.

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 the ICD-10-CM. These conditions should be coded as related even in the absence of provider documentation linking them. First, code **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, then the heart condition (I50.-, II51.4-I51.9) and hypertension are coded separately.[1]

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, 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.

Hypertensive crisis

A code from category I16, hypertensive crisis, is assigned for any documented hypertensive urgency (I16.0), hypertensive emergency (I16.1), or unspecified hypertensive crisis (I16.9). Report two codes, at a minimum, for hypertensive crisis. The crisis code is reported in addition to the underlying hypertension code (I10-I15).[1]

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]

Ischemic heart disease

Category I25, chronic ischemic heart disease, includes coronary atherosclerosis, old myocardial infarction, coronary artery dissection, chronic coronary insufficiency, myocardial ischemia, and aneurysm of the heart.

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are **I25.11, atherosclerotic heart disease with angina pectoris** and **I25.7, atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris**.

When using one of these combination codes, it is not necessary to use an additional code for angina pectoris. **A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates that angina is due to a condition other than atherosclerosis.[2]**

Heart failure

Systolic heart failure is coded as I50.2 and diastolic heart failure is coded as I50.3-; combined systolic and diastolic heart failure is assigned code I50.4. Fifth characters further specify whether the heart failure is unspecified, acute, chronic or acute on chronic.

Other classifications of heart failure include:

- Right heart failure, unspecified (I50.810)
- Acute right heart failure (I50.811)
- Chronic right heart failure (I50.812)
- Acute on chronic right heart failure (I50.813)

- Right heart failure due to left heart failure (I50.814)
- Biventricular heart failure (I50.82)
- High output heart failure (I50.83)
- End-stage heart failure (I50.84)
- Other heart failure (I50.89)
- Unspecified (I50.9)

For a diagnosis of left ventricular, biventricular and end-stage heart failure, two codes are required to completely describe the condition: one to report the left, biventricular or end-stage heart failure, and one to identify the type of heart failure.

Cardiomyopathy
Cardiomyopathy is coded as I42- with the third character describing:

- I42.0 Dilated cardiomyopathy, which includes congestive cardiomyopathy
- I42.1 Obstructive hypertrophic cardiomyopathy, including idiopathic hypertrophic subaortic stenosis
- I42.2 Other hypertrophic cardiomyopathy, including nonobstructive hypertrophic cardiomyopathy
- I42.3 Endomyocardial (eosinophilic) disease, including endomyocardial (tropical) fibrosis and Loffler's endocarditis
- I42.4 Endocardial fibroelastosis, including congenital cardiomyopathy and elastomyofibrosis
- I42.5 Other restrictive cardiomyopathy, including constrictive cardiomyopathy not otherwise specified
- I42.6 Alcoholic cardiomyopathy due to alcohol consumption: a code for alcoholism (F10.-) is also assigned if present
- I42.7 Cardiomyopathy due to drug and external agent: code first the poisoning due to drug or toxin; if applicable (T36-T65 with fifth or sixth character 1-4 or 6); if the condition is caused by an adverse effect, use an additional code, if applicable, to identify the drug (T35-T50 with fifth or sixth character)
- I42.8 Other cardiomyopathies
- I42.9 Unspecified

Two codes may be required for cardiomyopathy due to other underlying conditions; for example, cardiomyopathy due to amyloidosis is coded E85.4, organ-limited amyloidosis, and I43, cardiomyopathy in diseases classified elsewhere. The underlying disease, amyloidosis, is sequenced first.[2]

Status Z codes
ICD-10-CM provides several Z codes to indicate that the patient has a health status related to the circulatory system, such as the following:

- Z94.1 Heart transplant status
- Z95.0 Presence of cardiac pacemaker
- Z95.1 Presence of aortocoronary bypass graft
- Z95.810 Presence of automatic (implantable) cardiac defibrillator
- Z95.811 Presence of heart assist device
- Z95.828 Presence of other vascular implants and grafts

These codes are assigned only as additional codes and are reportable only when the status affects the patient's care for a given episode.

Resources
1 ICD-10-CM Expert for Physicians. The complete official code set. Optum360, LLC. 2020.
2 ICD-10-CM/PCS Coding. Theory and practice. 2019/2020 Edition. Elsevier

ANV-NU-0135-20 May 2020

URL: https://providernews.anthem.com/nevada/article/coding-spotlight-providers-guide-to-coding-for-cardiovascular-conditions-2

Keep up with Medicaid news

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

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

- Medical Policies and Clinical Utilization Management Guidelines update
- InterQual 2020 update
- Modifier use reminders

ANV-NU-0134-20
ANV-NU-0136-20
ANV-NU-0113-20

URL: https://providernews.anthem.com/nevada/article/keep-up-with-medicaid-news-33

2020 Special Needs Plans

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

Introduction

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 and transportation to medical appointments. Some SNP plans include a card or catalog for purchasing over-the-counter items. SNPs do not charge premiums.

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 **https://www.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.

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.

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URL: https://providernews.anthem.com/nevada/article/2020-special-needs-plans-3

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, 2020, the following codes will require prior authorization with Anthem Blue Cross and Blue Shield (Anthem) rather than with AIM.

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

E0470	Respiratory assist device, bilevel pressure capability, without back-up rate featu used with noninvasive interface, such as a nasal or facial mask (intermittent ass 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 ass 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

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URL: https://providernews.anthem.com/nevada/article/prior-authorization-codes-moving-from-aim-specialty-health-to-anthem-blue-cross-and-blue-shield-2

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**.

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URL: https://providernews.anthem.com/nevada/article/medical-drug-benefit-clinical-criteria-updates-28

Keep up with Medicare news

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

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

- Modifier use reminders
- 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
- 2020 affirmative statement concerning utilization management decisions

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ABSCRNU-0142-20
ABSCRNU-0143-20
ABSCRNU-0148-20
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