Wisconsin Provider News

March 2020 Anthem Provider News - Wisconsin

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

Published: Mar 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.

- Level of Care medical necessity reviews for upper and lower endoscopy procedures begin June 1, 2020*
- National Drug Code requirement on outpatient claims*

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

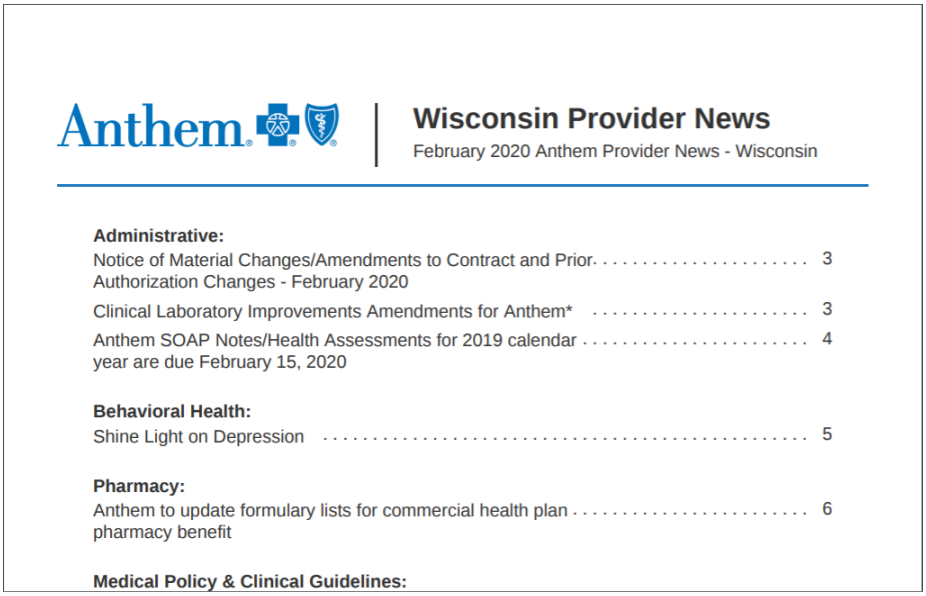
Provider News site enhancements

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

Great news! Commercial Provider Communications would like to share some recent enhancements to the Commercial Provider News site:

- Article categories are now appearing directly under the article title in both the website and PDFs.

- PDFs for Individual Articles and Publications have been improved with a new look & feel for better readability and easier printing.



Anthem | **Wisconsin Provider News**
February 2020 Anthem Provider News - Wisconsin

Article Attachments

March-2020_article_WI.png
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URL: https://providernews.anthem.com/wisconsin/article/provider-news-site-enhancements-6

Anthem Commercial Risk Adjustment (CRA) Program Update: Medical chart collection for ACA members due March 31, 2020

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

Each year, Anthem Blue Cross and Blue Shield (Anthem) requests your assistance in our Commercial Risk Adjustment (CRA) Program. There are **two distinct programs (Retrospective and Prospective) that work to improve risk adjustment accuracy** and focus on performing appropriate interventions and chart reviews **for patients with undocumented Hierarchical Condition Categories (HCC)**, **in order to document and close the coding gaps.**

The CRA Program is specific to our Affordable Care Act (ACA) Members who have purchased our individual and small group health insurance plans on or off the Health Insurance Marketplace (commonly referred to as the exchange).

With our **Retrospective Program** we focus on medical chart collection. We continue to request members' medical records to obtain information required by the Centers for Medicare & Medicaid Services (CMS). This particular effort is part of Anthem's compliance with provisions of the ACA that require our company to collect and report diagnosis code data for our ACA membership. The members' medical record documentation helps support this data requirement.

Analytics are performed internally on claims which do not have the ICD10 code for which we suspect a chronic condition. These medical records will be requested, reviewed and any additional codes abstracted can be submitted to CMS to increase our risk score values.

Anthem network providers -- **may be PCPs, specialists, facilities, behavioral health, ancillary, etc.** -- may receive letters from vendors such as Inovalon, Verscend, Ciox, Sharecare, and Episource requesting access to medical records for chart review. These vendors are independent companies that provide secure, clinical documentation services and contact providers on our behalf.

We ask that our network providers provide the medical record information to the designated vendor **within 30 days of the request *(by March 31, 2020)***. While faxing remains our primary method for record retrieval, we offer many other electronic ways for providers to submit information.

Electronic options that may make medical chart collection easier for providers:

- EMR Interoperability
  - Allscripts (Opt in -- signature required to allow for remote review)
  - NextGen (Opt out -- auto-enrolled)
  - Athenahealth (Opt out -- auto-enrolled)
  - MEDENT
- Remote/Direct Anthem access
- Vendor virtual or onsite visit
- Secure FTP

The goal of these electronic options is to both improve the medical record data extraction and the experience for Anthem's network-participating hospitals, clinics and physician offices. If you are interested in this type of set up or any other remote access options, please contact our Commercial Risk Adjustment Network Education Representative: Mary.Swanson@anthem.com

Thank you for your continued efforts with our CRA Program, and expediting these medical chart collection requests.

URL: https://providernews.anthem.com/wisconsin/article/anthem-commercial-risk-adjustment-cra-program-update-medical-chart-collection-for-aca-members-due-march-31-2020-1

Patient360 enhancement for medical providers

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

Patient360 is a real time dashboard you can access through the Availity Portal that gives you a robust picture of your Anthem Blue Cross and Blue Shield (Anthem) patient's health and treatment history and will help you facilitate care coordination.

If an Anthem patient has a Care Gap Alert your medical practice can locate Active Alerts on the Member Summary page of the Patient360 application.

What's new: Medical providers now have the option available on Patient360 to include feedback for each gap in care that is listed on the patient's active alerts.

However, to be able to access the Care Gap Alert Feedback you will need to provide an individual NPI. If you select an NPI from Express Entry menu, the feedback options will not be available.

Article Attachments

Patent360.png
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Once you have completed all the required fields you will land on the Member Summary page of the application. To provide feedback, select the **Resolution Health Index (RHI)** within the **Active Alerts** section. This will open the **Care Gap Alert Feedback Entry** screen. You can choose the feedback menu option that applies to your patient's care gap.

Are you using Patient360 for the first time? You can easily access Patient360 on the Availity Portal. First, you need to be assigned to the Patient360 Role which your Availity Administrators can locate within the Clinical Roles options.

Once you have the Availity role assignment, navigate to Patient360 through the Availity Portal by selecting the application on Anthem Payer Spaces or by choosing the Patient360 link located on the patient's benefits screen.

URL: https://providernews.anthem.com/wisconsin/article/patient360-enhancement-for-medical-providers-1

Modifier use reminders

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

Billing of patient treatment can be complex, particularly when determining whether modifiers

are required for proper payment. Anthem Blue Cross and Blue Shield reimbursement policy and correct coding guidelines establish the appropriate use of coding modifiers. We would like to highlight the appropriate use of some commonly used modifiers.

Things to remember…

- Review the “CPT Surgical Package Definition” found in the current year’s CPT Professional Edition. Use modifiers such as 25 and 59 only when the services are not included in the surgical package.
- Review the current year’s CPT Professional Edition Appendix A – Modifiers for the appropriate use of modifiers 25, 57 and 59.
- When an evaluation and management (E/M) code is reported on the same date of service as a procedure, the use of the modifier 25 should be limited to situations where the E/M service is “above and beyond” or “separate and significant” from any procedures performed the same day.
- When appropriate, assign anatomical modifiers (Level II HCPCS modifiers) to identify different areas of the body that were treated. Proper application of the anatomical modifiers helps ensure the highest level of specificity on the claim and can help show that different anatomic sites received treatment.
- Use modifier 59 to indicate that a procedure or service was distinct or independent of other “non E/M services” performed on the same date of service. The modifier 59 represents services not **normally** performed together but which may be reported together under the circumstances.

If you feel that you have received a denial after applying a modifier appropriately under correct coding guidelines, please follow the normal claims dispute process and include medical records that support the usage of the modifiers when submitting claims for consideration.

We will be publishing additional articles on correct coding in upcoming newsletters.

URL: https://providernews.anthem.com/wisconsin/article/modifier-use-reminders-2

Important coding reminder for walk-in retail health clinics

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

Some professional (837P / HCFA-1500) claims for services rendered to non-Anthem Blue plan members at retail health locations are being reported with a Place of Service that does not reflect a retail health clinic location. Specifically, for services rendered at a retail health location, some providers are submitting values for Office (11) or Urgent Care Facility (20) instead of the value of Walk-in Retail Health Clinic (17). Reporting Place of Service as 11 or 20 can cause claims to process incorrectly, and thus result in the need for claim adjustments and rework for providers.

If your practice is a Walk-in Retail Health Clinic, please remind your coding staff to report the most accurate Place of Service, Walk-in Retail Health Clinic (17), for professional claims when submitting claims for non-Anthem members.

URL: https://providernews.anthem.com/wisconsin/article/important-coding-reminder-for-walk-in-retail-health-clinics-1

Level of Care medical necessity reviews for upper and lower endoscopy procedures begin June 1, 2020*

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

Anthem Blue Cross and Blue Shield (Anthem) is committed to being a valued health care partner in identifying ways to achieve better health outcomes, lower costs and deliver access to a better healthcare experience for consumers.

Effective with dates of service on or after June 1, 2020, members with commercial plans covered by Anthem will require a medical necessity review of the hospital outpatient level of care for certain upper endoscopy and colonoscopy procedures. The clinical guideline, *Level of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services, CG-SURG-52*, will apply to the review process. The review will be administered by AIM Specialty Health® (AIM).

AIM will evaluate the clinical information in the request against CG-SURG-52, to determine if the hospital-based outpatient setting is the appropriate level of care for the endoscopy service. Your office may contact AIM to request a peer-to-peer discussion before or after the determination.

The level of care medical necessity review only applies to procedures performed in an outpatient hospital setting. This does not apply to requests for review of endoscopy performed in a non-hospital setting or as part of an inpatient stay. Reviews also do not apply when Anthem is the secondary payer.

For a complete list of procedures subject to the medical necessity level of care review, and additional information, such as Frequently Asked Questions, visit aimproviders.com/surgicalprocedures.

Submit a request for review
Starting May 18, 2020, ordering providers may submit prior authorization requests for the hospital outpatient level of care for these procedures for dates of service on or after June 1, 2020 to AIM in one of the following ways:

- Access AIM ***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.

AIM will offer **webinars**, beginning in May, to provide information on navigating the AIM ***Provider****Portal*SM. To register for a webinar visit aimproviders.com/surgicalprocedures.

Please note, this review does not apply to the following plans: BlueCard®, Federal Employee Program® (FEP®), Medicaid, Medicare Advantage, Medicare Supplemental plans. Providers can view prior authorization requirements for Anthem members on the Medical Policy & Clinical UM Guidelines page at anthem.com.

Providers should continue to verify eligibility and benefits for all members prior to rendering services.

If you have questions, please call the Provider Service phone number on the back of the member's ID card.

Note: In some plans “site of service” or another term such as “setting” or “place of service” may be the term used in benefit plans, provider contracts or other materials instead of or in addition to “level of care” and in some plans, these terms may be used interchangeably. For simplicity, we will use “level of care.”

URL: https://providernews.anthem.com/wisconsin/article/level-of-care-medical-necessity-reviews-for-upper-and-lower-endoscopy-procedures-begin-june-1-2020

National Drug Code requirement on outpatient claims*

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

Anthem Blue Cross and Blue Shield (Anthem) values the quality and commitment with which you serve your patients and our members. In this edition of *Provider News*, we are notifying you about a National Drug Code (NDC) requirement for drugs administered in a physician’s office or outpatient facility setting for Local Plan and BlueCard member claims only. This notice EXCLUDES claims for members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP) and Coordination of Benefits/secondary claims.

For dates of service on and after June 15, 2020, all providers are required to supply the 11-digit NDC – along with the information below – when billing for injections and other drug items on the CMS-1500 and UB-04 claim forms as well as on 837 electronic transactions.

1. The applicable HCPCS code or CPT code
2. Number of HCPCS code or CPT code units
3. The 11-digit NDC(s), including the **N4 qualifier**
4. Dosage Unit of Measurement (F2, GR, ML, UN, ME)
5. Number of NDC Units dispensed (must be greater than 0)

To ensure accurate and timely claims payments, it is important that you provide the NDC information as outlined above when filing claims to us. **Anthem will reject any line items on claims with dates of service on and after June 15, 2020, when the above information is not included regarding drugs.**

If you have further questions, please contact Provider Services.

URL: https://providernews.anthem.com/wisconsin/article/national-drug-code-requirement-on-outpatient-claims-1

Pharmacy information available at anthem.com

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

Visit anthem.com/pharmacyinformation for more information on:

- Copayment/coinsurance requirements and their applicable drug classes
- Drug lists and changes
- Prior authorization criteria
- Procedures for generic substitution
- Therapeutic interchange
- Step therapy or other management methods subject to prescribing decisions
- Any other requirements, restrictions, or limitations that apply to using certain drugs

The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October).

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

URL: https://providernews.anthem.com/wisconsin/article/pharmacy-information-available-at-anthemcom-21

Medicare News - March 2020

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

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

- Benefits update for special supplemental benefits for the chronically ill

- Prior authorization requirements for CardioMEMS

URL: https://providernews.anthem.com/wisconsin/article/medicare-news-march-2020

Outpatient Rehabilitation Program transition: new prior authorization requirements

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

Effective April 1, 2020, Anthem Blue Cross and Blue Shield (Anthem) will transition the utilization management of our Outpatient Rehabilitation Program 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.

This relationship with AIM will enable Anthem to expand and optimize this program, further ensuring that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Anthem for medical necessity determination. Anthem makes coverage determinations based on guidance from CMS, including national coverage determinations, local coverage determinations, other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Anthem clinical guidelines *CG.REHAB.04*, *CG.REHAB.05* and *CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed online at https://medicalpolicies.amerigroup.com/am_search.html.

Detailed prior authorization requirements are available online https://www.availity.com by accessing the Precertification Lookup Tool under *Payer Spaces*. Contracted and non-contracted providers should call Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Prior authorization review requirements

For services to be rendered for dates of service from October 1, 2019, through March 31, 2020, no prior authorization is required for outpatient rehabilitation services. For these service dates, in addition to all other rights Anthem has under our provider contract and law, Anthem and AIM will continue to monitor claims history and utilization trends and will validate provider and member information.

AIM will facilitate training sessions to provide an overview of the program and demonstrate the AIM ***Provider****Portal*$_{SM}$. Please access the AIM Rehabilitation Provider Portal to register for an upcoming session.

For services that are scheduled on or after April 1, 2020, providers must contact AIM to obtain prior authorization. Beginning March 19, 2020, providers will be able to contact AIM for prior authorization of services to take place on or after April 1, 2020. Providers are strongly encouraged to verify that they have obtained prior authorization before scheduling and performing services.

How to place a review request
You may place a prior authorization request online via the AIM ***Provider****Portal*. This service is available 24/7 to process requests in real time using clinical criteria. Go to www.providerportal.com to register. You can also call AIM at **1-800-714-0040**, Monday through Friday 7 a.m. to 7 p.m. Central time.

For more information
For resources to help your practice get started with the Outpatient Rehabilitation Program, go to www.aimproviders.com/rehabilitation. For portal login Issues, call **1-800-252-2021**.

The AIM website provides access to useful information and tools, such as order entry checklists, clinical guidelines and an FAQ.

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URL: https://providernews.anthem.com/wisconsin/article/outpatient-rehabilitation-program-transition-new-prior-authorization-requirements-1

Complex discharge planning

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

As we begin 2020, we are adding utilization management complex discharge planning and case management complex discharge planning roles to our teams. We are excited to offer members, their families and caregivers someone to work with them while the member is inpatient and after discharge.

This team member will work with the facility to understand the member's needs, discharge plan and possible home needs. If your patient is sent to a post-acute setting, we will also work with that facility to understand any barriers to discharge and referrals to other Medicare programs.

If the member requires assistance after discharge, we will offer a team member to help the member receive necessary referrals to identified programs, help the member follow their discharge plan and assist in making any necessary appointments to see their doctors.

This is a collaborative program; we need your help to understand what your patients need to be successful upon discharge and to reach our common goal – avoidance of readmissions and ER utilization.

We look forward to working with you, and the acute and post-acute facilities that offer this value added program to our Medicare Advantage population.

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URL: https://providernews.anthem.com/wisconsin/article/complex-discharge-planning

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Personal Home Helper benefit

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

Your patient's current supplemental benefit for Personal Home Helper has been reauthorized for 2020. For billing in 2020, use the new authorization number. For more information or to view the new authorization number, sign into the Availity Portal or call Provider Services at **1-800-499-9554**.

Submit claims electronically through Availity

Availity is well known as a web portal and claims clearinghouse, but they are much more. Availity also functions as an electronic data interchange (EDI) gateway for multiple payers and is the single EDI connection for all of Anthem, Inc. It will allow you to submit claims electronically, verify pre-authorization and member information, check claims status, and much more.

To get started, go to https://www11.anthem.com/edi and select your state.

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URL: https://providernews.anthem.com/wisconsin/article/personal-home-helper-benefit-1

Reminder: Mid-level practitioners are required to file using their NPI

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

Anthem Blue Cross and Blue Shield (Anthem) provides benefits for covered services rendered by nurse practitioners (NPs) and physician assistants (PAs) when operating within the scope of their license. Our policy states that these mid-level practitioners are required to file claims using their specific NPI number — not that of the medical doctor.

We will continue to monitor this area of concern through medical chart review and data analysis. Billing non-compliance can be considered a contract breach.

Anthem recognizes the quality of care delivered to our members can be improved by the proper use of NPs and PAs. This notice is in no way intended to discourage their proper use, but rather to clearly define how services should be appropriately billed.

Thank you for your continued participation. Should you have any questions, please call the Provider Services number located on the back of the member's card.

507411MUPENMUB

URL: https://providernews.anthem.com/wisconsin/article/reminder-mid-level-practitioners-are-required-to-file-using-their-npi-1

Non-preferred products and corresponding preferred alternatives

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

Beginning January 1, 2020, patients using non-preferred products with a high patient cost share are now contacted about the availability of lower patient cost share preferred alternatives. If the patient is interested in switching, we will call or fax their provider who can determine whether the preferred alternative is clinically appropriate. This is strictly informational and not a substitute for physician-directed medical evaluations or treatments.

A list of the included non-preferred products and corresponding preferred alternatives are listed here.

Non-preferred products	Preferred alternative(s)
Aciphex DR	omeprazole pantoprazole
Actos	pioglitazone HCL
Advair Diskus	fluticasone-salmeterol Wixela Inhub
Aggrenox	aspirin-dipyridamole ER
Ampyra ER	dalfampridine ER
Breo Ellipta	fluticasone-salmeterol Wixela Inhub
Cambia	diclofenac sumatriptan
chlorzoxazone	cyclobenzaprine
Coumadin	warfarin
Crestor	rosuvastatin
Dexilant	omeprazole pantoprazole
Dilantin	phenytoin
Diovan HCT	valsartan/hydrochlorothiazide
Duexis	ibuprofen & famotidine
Dymista	fluticasone & azelastine
Epzicom	abacavir-lamivudine
Evzio	naloxone HCL
Farxiga	Jardiance
Gleevec	imatinib
Glumetza	metformin ER (generic Glucophage XR)
Incruse Ellipta	Spiriva
Invega	paliperidone ER
Invokana	Jardiance
Jublia	ciclopirox
Kerydin	ciclopirox
Kombiglyze	Janumet XR
Lamictal	lamotrigine
Lanoxin	digoxin
Lipitor	atorvastatin

Livalo	atorvastatin lovastatin pravastatin simvastatin
Lovaza	omega-3 acid ethyl esters
Mestinon	pyridostigmine
metformin ER (generic Glumetza)	metformin ER (generic Glucophage XR)
metformin ER OSM (generic Fortamet)	metformin ER (generic Glucophage XR)
Mirapex	pramipexole
Myrbetriq ER	oxybutynin
Nexium	omeprazole pantoprazole
Nilandron	nilutamide
Novolin N	Humulin N
Novolog	Humalog
omeprazole-bicarbonate	omeprazole pantoprazole
Onfi	clobazam
Onglyza	Januvia
Pennsaid	meloxicam
Protonix	omeprazole pantoprazole
Renvela	sevelamer
Requip	ropinirole
Restasis	Xiidra
Soolantra	metronidazole azelaic acid
Symbicort	fluticasone-salmeterol Wixela Inhub
Synthroid	levothyroxine
Tresiba	Basaglar Lantus Toujeo
Trokendi XR	topiramate
Tudorza Pressair	Spiriva
Vasotec	enalapril

Vimovo	naproxen & omeprazole
Wellbutrin XL	bupropion XL
Xalatan	latanoprost
Xenazine	tetrabenazine
Zestoretic	lisinopril/hydrochlorothiazide
Zestril	lisinopril
Zileuton ER	montelukast

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URL: https://providernews.anthem.com/wisconsin/article/non-preferred-products-and-corresponding-preferred-alternatives

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Reminder: Mid-level practitioners are required to file using their NPI

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

This communication applies to the Medicaid and Medicare Advantage programs for Anthem Blue Cross and Blue Shield (Anthem).
Anthem provides benefits for covered services rendered by nurse practitioners (NPs) and physician assistants (PAs) when operating within the scope of their license. Our policy states that these mid-level practitioners are required to file claims using their specific NPI number – not that of the medical doctor.

We will continue to monitor this area of concern through medical chart review and data analysis. Billing noncompliance can be considered a contract breach.

Anthem recognizes the quality of care delivered to our members can be improved by the proper use of NPs and PAs. This notice is in no way intended to discourage their proper use, but rather to clearly define how services should be appropriately billed.

Thank you for your continued participation. Should you have any questions, please call Provider Services:

- *Medicaid:* 1-855-558-1443
- *Medicare Advantage:* Call the number on the back of members' ID cards.

Coding tip for psychological and neuropsychological testing

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

A change to CPT® codes for psychological and neuropsychological test administration and evaluation services was effective January 1, 2019.* The new codes do not crosswalk on a one-to-one basis with the deleted codes.

These coding changes separate test administration from test evaluation, psychological testing evaluation from neuropsychological testing evaluation and define the testing performed by a professional or technician. The information below clarifies coding for these services.

Please note: Prior authorization (PA) requirements have not changed. Please check the Precertification Look Up Tool for PA requirements for each code.

Neurobehavioral status exams
Neurobehavioral status exams are clinical interview examinations performed by a psychologist or neuropsychologist to assess thinking, reasoning and judgment.

Providers should continue to use CPT code 96116 when billing for the first hour.

Test administration and scoring by a psychologist or neuropsychologist
Two or more tests using any method should now be billed using CPT code 96136 for the first 30 minutes and 96137 for each additional 30 minutes.

Test administration and scoring by a technician
Two or more tests using any method should now be billed using CPT code 96138 for the first 30 minutes and 96139 for each additional 30 minutes.

Testing evaluation services

Testing evaluation services include the selection of the appropriate tests to be administered; integration of patient data; interpretation of standardized test results and clinical data; clinical decision-making; treatment planning; and reporting and interactive feedback to the patient, family members, or caregivers (when performed). There are distinct testing evaluation service codes for psychological testing and for neuropsychological testing.

Providers should now use CPT code 96130 to bill for the first hour of psychological testing evaluation services and 96131 for each additional hour.

Neuropsychological evaluation services should now be billed using CPT code 96132 for the first hour and 96133 for each additional hour.

Single automated test administration
Single automated test administration should be reported with newly created code 96146 for a single automated psychological or neuropsychological instrument that is administered via electronic platform and formulates an automated result. Psychologists should not use this code if two or more electronic tests are administered and/or if administration is performed by the professional or technician. Instead, the psychologist should use the appropriate codes listed above for test administration and scoring. A single automated test as the only service is not considered appropriate for the many elements seen with test evaluation.

Screening and risk assessment (repetitive assessment after screening)
Screening and risk assessment (repetitive assessment after screening) includes brief emotional/behavioral assessment (for example, a depression inventory or ADHD scale) with scoring and documentation, per standardized instrument. This should be billed using CPT code 96127 separately from testing. Brief emotional/behavioral assessments should not be billed as psychological or neuropsychological testing.

For questions, please contact Provider Services at **1-855-558-1443**.

* American Psychological Association website: *2019 Psychological and Neuropsychological Testing Billing and Coding Guide*: https://www.apa.org

URL: https://providernews.anthem.com/wisconsin/article/coding-tip-for-psychological-and-neuropsychological-testing-6

Antibiotic dispensing guidelines

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

Overuse of antibiotics is directly linked to the prevalence of antibiotic resistance. Promoting judicious use of antibiotics is important for reducing the emergence of harmful bacteria that is unresponsive to treatment. The following HEDIS® measures assess appropriate antibiotic dispensing for pharyngitis, upper respiratory infection and bronchitis/bronchiolitis. Changes for HEDIS 2020 include expanded age range and additional stratifications.

Appropriate Testing for Pharyngitis (CWP)
Pediatric Clinical Practice Guidelines recommend only children with lab-confirmed group A strep or other bacteria-related ailments be treated with appropriate antibiotics. This measure reports the percentage of episodes for members 3 years of age and older where the member was diagnosed with pharyngitis, prescribed an antibiotic at an outpatient visit and received a group A strep test. A higher rate indicates better performance (in other words, appropriate testing).

Appropriate Treatment for Upper Respiratory Infection (URI)
This measure calculates the percentage of episodes for members 3 months of age and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event. Reducing unnecessary use of antibiotics is the goal of this measure. It is reported as an inverted rate. A higher rate indicates appropriate upper respiratory infection treatment (in other words, the proportion of episodes that did not result in an antibiotic dispensing event).

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
There is considerable evidence that prescribing antibiotics for uncomplicated acute bronchitis is not indicated unless it is associated with a comorbid diagnosis. This measure assesses the percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. It is reported as an inverted rate. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (in other words, the proportion of episodes that did not result in an antibiotic dispensing event).

Helpful tips:

- When patients present with symptoms of pharyngitis, ensure proper testing (for strep) is performed to avoid the unnecessary prescribing of antibiotics. Record the results of the strep test.

- If prescribing an antibiotic to members with acute bronchitis, be sure to use the diagnosis code for the bacterial infection and/or comorbid condition.
- Educate members on the difference between bacterial and viral infections. Refer to the illness as a common cold, sore throat or chest cold. Parents and caregivers tend to associate these labels with a less frequent need for antibiotics.
- Write a prescription for symptom relief, such as rest, fluids, cool mist vaporizers and over-the-counter medicine.
- If a patient insists on an antibiotic, consider using delayed prescribing. Refer to the CDC handout for patients titled *What is Delayed Prescribing?* available at the link below.

Resources:

1. CDC's Be Antibiotics Aware campaign: https://www.cdc.gov/antibiotic-use/index.html
2. CDC handouts for patients: https://www.cdc.gov/antibiotic-use/community/materials-references/index.html

URL: https://providernews.anthem.com/wisconsin/article/antibiotic-dispensing-guidelines-1

Coding spotlight: HIV and AIDS

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

Code only confirmed cases

According to ICD-10-CM coding guidelines for *Chapter One*, code, only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline *Section II*, *H*. In this context, "confirmation" does not require documentation of positive serology or culture for HIV. The provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient.

Status	ICD-10-CM code
Asymptomatic HIV	Assign code Z21 – Asymptomatic human immunodeficiency virus [HIV] infection status when the patient without any documentation of symptoms is listed as being 'HIV positive', 'known HIV', 'HIV test positive' or similar terminology. Assign code B20 – Human immunodeficiency virus [HIV] disease on the claim when the term AIDS is used, when the patient is being treated for HIV-related illness or when the patient is described as having any active HIV-related condition.
Patients with inconclusive HIV serology	Assign code R75 – Inconclusive laboratory evidence of human immunodeficiency virus [HIV] when the patient's record is documented with inconclusive HIV serology, but there is no definitive diagnosis or manifestations of the illness.
Previously diagnosed HIV-related illness	Code B20 if you document a patient as having had any known prior diagnosis of an HIV-related illness – Z21 is no longer reported. If the patient develops an HIV-related illness, they should be assigned code B20 on every subsequent admission/encounter.
HIV infection in pregnancy, childbirth and the puerperium	Assign code O98.7 – Human immunodeficiency virus [HIV] disease complicating pregnancy, childbirth and the puerperium first when a patient presents for treatment of an HIV-related illness during pregnancy, childbirth or the puerperium followed by code B20. Also assign additional code(s) for HIV-related illness(es). Keep in mind that codes from *Chapter 16* take priority when sequencing codes on the claim. If a patient with asymptomatic HIV infection status presents for a routine visit during pregnancy, childbirth or the puerperium, the correct code assignment would be O98.7 followed by code Z21.

Assign code B20 for all types of HIV infections, which may be described by a variety of terms including:

- AIDS.
- Acquired immune deficiency syndrome.
- Acquired immunodeficiency syndrome.
- AIDS-related complex (ARC).
- AIDS-related conditions.
- HIV infection, symptomatic.

Testing for HIV:

- Assign code Z11.4 – Encounter for screening for human immunodeficiency virus [HIV] when seeing a patient with no prior diagnosis of HIV infection or positive HIV-status to determine their HIV-status.
- Code the signs and symptoms when seeing a patient with signs or symptoms for HIV testing. If you provide counseling during the encounter, assign additional code

Z71.7 – Human immunodeficiency virus [HIV] counseling.

- Assign code Z71.7 if a patient's test results are negative for HIV.
- Assign code Z72.8 if a patient is known to be in a high-risk group for HIV infection. Other problems related to lifestyle can be assigned as an additional code.

Major HIV-related conditions

HIV-related condition	ICD-10-CM code
Pneumonia, unspecified organism	J18.9
Tuberculosis of other sites	A18.89
Sepsis, unspecified organism	A41.9
Candida stomatitis (thrush)	B37.0
Herpes zoster (any site)	B02.9
Encephalopathy, unspecified	G93.40

Other HIV-related conditions	ICD-10-CM code
Tinea cruris	B35.6
Anemia, unspecified	D64.9
Underweight	R63.6
Acute lymphadenitis	L04.9
Arthropathy, unspecified	M12.9
Splenomegaly, not elsewhere classified	R16.1
Weakness	R53.1

HIV/AIDS prevention

The CDC works with other federal agencies, state and local health departments, national organizations, and other entities to reduce the spread of HIV in the United States. This work covers several components:

- Behavioral interventions – These interventions ensure people have the information, motivation and skills necessary to reduce the risk of infection.
- HIV testing – Testing is critical to prevent the spread of HIV.
- Treatment and care – Treatment and care enable individuals with HIV to live longer, healthier lives.

The CDC remains on the forefront of pursuing high-impact prevention. This approach is designed to maximize the impact of prevention efforts for all Americans at risk for HIV infections and the CDC is aligning its efforts with the first National HIV/AIDS Strategy for the United States (NHAS). The Division of HIV/AIDS Prevention has developed a strategic three-year plan for 2017-2020 with the goal of one day achieving a future free of HIV.

Resources:

1. *ICD-10-CM Expert for Physicians.* The complete official code set. Optum360, LLC. 2019.
2. http://www.cdc.gov: HIV/AIDS.

URL: https://providernews.anthem.com/wisconsin/article/coding-spotlight-hiv-and-aids-1