Connecticut Provider News

March 2021 Anthem Connecticut Provider News

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UPDATE: Notice of changes to the AIM Small Joint Surgery Guideline

Published: Mar 1, 2021 - **Products & Programs**

On November 1, 2020, AIM Specialty Health® (AIM) began administering the AIM Musculoskeletal program to perform medical necessity reviews for certain elective surgeries of the small joints using AIM clinical guidelines for Anthem fully-insured members and certain ASO groups.

Effective March 14, 2021, the AIM Small Joint Surgery Guideline will be updated with the following:

- Clarified requirements for imaging reports
- Removed radiographic requirement for confirmation of lesser toe deformities
- Added ankle arthrodesis and total ankle arthroplasty as new indications for revision of failed previous reconstructions
- Removed total ankle arthroplasty requirements for adjacent joint or inflammatory arthritis
- Clarified contraindications only apply to total ankle arthroplasty

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

- Access AIM's ***Provider****Portal*SM directly at www.providerportal.com. Real-time, online access is available 24/7 to process orders, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at www.availity.com.
- Call the AIM toll-free number at 866-714-1107, Monday through Friday 8:30 a.m. – 7:00 p.m.

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

993-0321-PN-NE

Site of care medical necessity reviews for long-acting colony-stimulating factors begin June 1, 2021

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

We are 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, 2021, medical necessity review of the site of care will be required for the following long-acting, colony-stimulating factors for oncology indications for Anthem Commercial plan members:

- Neulasta® & Neulasta Onpro® (pegfilgrastim)
- Fulphila® (pegfilgrastim-jmdb)
- Udenyca® (pegfilgrastim-cbqv)
- Ziextenzo® (pegfilgrastim-bmez)
- Nyvepria™ (pegfilgrastim-apgf)

The review will be administered by AIM Specialty Health® (AIM), a separate company.

AIM will evaluate the clinical information in the request to the *CG-MED-083 Site of Care: Specialty Pharmaceuticals* policy to determine if the hospital-based outpatient setting is medically necessary for the medication administration. To see the clinical guideline and what clinical considerations are taken into account for determination, visit our Medical Policy and Clinical Guidelines webpage. You may contact AIM to request a peer-to-peer discussion before or after the determination.

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

Submit a request for review
Starting May 16, 2021, ordering providers may submit prior authorization requests for the hospital outpatient site of care for these medications for dates of service on or after June 1, 2021 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: 866-714-1107, Monday - Friday, 8:00 a.m. - 5:00 p.m.

Please note, this review does not apply to the following plans: BlueCard®, Federal Employee Program® (FEP®), Medicaid, Medicare Advantage and Medicare Supplemental plans. Providers can view prior authorization requirements for Anthem members on the Clinical Criteria webpage.

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 member’s ID card.

1019-0321-PN-NE

URL: https://providernews.anthem.com/connecticut/article/site-of-care-medical-necessity-reviews-for-long-acting-colony-stimulating-factors-begin-june-1-2021-5

Certain HIV medication combinations may require prior authorization

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

Effective May 1, 2021, we will implement a new prior authorization requirement for HIV medications to help ensure patients are not receiving therapeutic duplications when taking

In order for members to continue to receive coverage for the drug combination, providers must submit a separate prior authorization form for each drug and provide the medical necessity rationale for why the drug combination is clinically necessary.

Combinations that are considered clinical duplicates are based on drug mechanism of action (MOA) and developed in accordance with the U.S. Department of Health and Human Services HIV Guidelines.

The duplicate therapy policy may be initiated as a result of one of the following drug combinations:

Duplicate Name	Duplicate Description	Example
Integrase stand transfer inhibitors (INSTI)	Two drug products each containing a drug with an INSTI mechanism of action	Isentress (**raltegravir**) and Dovato (**dolutegravir**/ lamivudine)
Non-nucleoside reverse transcriptase inhibitors (NNRTI)	Two drug products each containing a drug with an NNRTI mechanism of action.	Edurant (**rilpivirine**) and Symfi (**efavirenz**/lamivudine/TDF)
Protease inhibitors (PI)	Two drug products each containing a drug with a PI mechanism of action	Prezcobix (**darunavir**/cobicistat) and Reyataz (**atazanavir**)
Nucleoside reverse transcriptase inhibitors (NRTI)	Two drug products that together result in four NRTI active ingredients	Truvada (**emtricitabine/TDF**) and Biktarvy (bictegravir/ **emtricitabine/TAF**)
Boosters	Two drug products that result in a combination of the protease inhibitor boosters, ritonavir and cobicistat	Prezcobix (darunavir/**cobicistat**) and Kaletra (lopinavir/**ritonavir**)

As a reminder, prior authorizations may be submitted via phone, fax, or online (through www.CoverMyMeds.com). If you have questions, please call the Provider Service phone number on the member’s ID card.

1002-0321-PN-NE

URL: https://providernews.anthem.com/connecticut/article/certain-hiv-medication-combinations-may-require-prior-authorization

Specialty pharmacy updates

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

Prior authorization updates

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

Please note, inclusion of national drug code (NDC) code on your claim will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Visit our website to access the clinical criteria information.

Clinical Criteria	HCPCS or CPT Code(s)	Drug
*ING-CC-0185	J3490, C9399	Oxlumo
**ING-CC-0184	J3490, J3590, J9999	Danyelza

*Prior authorization clinical review of **non-oncology** use of specialty pharmacy drugs is managed by the medical specialty drug review team.
Review of specialty pharmacy drugs for **oncology use is managed by AIM Specialty Health® (AIM).

Prior authorization update – change in effective date

Please note the change in date for the implementation of prior authorization for the injectable iron deficiency anemia products listed below. The effective date previously communicated was March 1, 2021.

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

Please note, inclusion of national drug code (NDC) code on your claim will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Visit our website to access the clinical criteria information.

Clinical Criteria	HCPCS or CPT Code	Drug
*ING-CC-0182	J1756	Venofer
*ING-CC-0182	J2916	Ferrlecit
*ING-CC-0182	J1750	Infed
*ING-CC-0182	J1439	Injectafer
*ING-CC-0182	Q0138	Feraheme
*ING-CC-0182	J1437	Monoferric

*Prior authorization clinical review of **non-oncology** use of specialty pharmacy drugs is managed by the medical specialty drug review team.

Step therapy update – change in effective date

Please note the change in date for the implementation of step therapy for the injectable iron deficiency anemia products listed below. The effective date previously communicated was March 1, 2021.

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

Please note, inclusion of national drug code (NDC) code on your claim will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Visit our website to access the clinical criteria information.

Clinical Criteria	Status	Drug	HCPCS Codes
*ING-CC-0182	Preferred	Venofer	J1756
*ING-CC-0182	Preferred	Ferrlecit	J2916
*ING-CC-0182	Preferred	Infed	J1750
*ING-CC-0182	Non-preferred	Injectafer	J1439
*ING-CC-0182	Non-preferred	Feraheme	Q0138
*ING-CC-0182	Non-preferred	Monoferric	J1437

*Prior authorization clinical review of **non-oncology** specialty pharmacy drugs will be managed by the medical specialty drug review team.

Prior authorization update - codes removed from prior authorization requirement

In a recent notification, we shared that effective April 1, 2021, the following codes would be included in our prior authorization review process. Please be advised that these codes **will NOT be included in our prior authorization review process at this time.**

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

Medical specialty pharmacy update – removal of prior authorization requirement for certain drugs used to treat ocular conditions

In an effort to help simplify care and support our providers, effective **May 1, 2021**, we have **removed the prior authorization requirement** for the use of the drugs listed below used to treat ocular conditions.

Drug	Code(s)	Code description
Avastin	C9257, J9035	Intravitreal bevacizumab
Mvasi	Q5107	Bevacizumab-awwb
Zirabev	Q5118	Bevacizumab-bvzr

1007-0321-PN-NE

URL: https://providernews.anthem.com/connecticut/article/specialty-pharmacy-updates

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New utilization management tool now available on Availity Payer Spaces: Authorization Rules Lookup tool

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

In February, we introduced our new Authorization Rules Lookup tool that you can access through Availity Payer Spaces. This new self-service application displays prior authorization rules so you can quickly verify if the outpatient services require prior authorization for members enrolled in Anthem's commercial plans.

In addition to verifying whether an outpatient authorization is needed, the tool provides the following details that apply to the procedure code:

- Medical Policies and Clinical Guidelines
- Third Party Guidelines, if applicable (such as AIM Specialty Health, IngenioRx)

Access the Authorization Lookup application through Availity Payer Spaces

Access to the tool does not require an Availity role assignment.

1. Select **Payer Spaces**
2. Select the **Anthem Blue Cross Blue Shield** tile from the Payer Spaces menu
3. Select the **Applications** tab
4. Select the **Authorization Rules Lookup** tile

Once you are in the tool, you will need to provide the following information to display the service’s prior authorization rules:

- Tax ID
- National Provider Identifier (NPI)
- Member ID and birth date
- Member’s group number or contract code

(This information can be found on the member’s ID card or through the Eligibility & Benefits return on the Patient Information tab)

- CPT/HCPCS code

Give this new tool a try and discover how much this will improve the efficiency of your authorization process.

Please note: If a prior authorization is required for outpatient services, you may submit the case through Interactive Care Reviewer, Anthem’s online authorization tool that is also accessible through the Availity Portal.

1005-0321-PN-NE

URL: https://providernews.anthem.com/connecticut/article/new-utilization-management-tool-now-available-on-availity-payer-spaces-authorization-rules-lookup-tool-3

Medical attachment capability now includes itemized bills and more

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

To help ensure accuracy and eliminate delays in the adjudication of your claims, the itemized bill must be included with qualifying claim submissions. Submitting an itemized bill (unsolicited* medical attachment) for a high dollar claim just got easier!

To submit an itemized bill (unsolicited medical attachment):

1. Log in to Availity Portal
2. Select **Claims & Payments | Attachments – New**
3. Select **Send Attachment**
4. Under **Request for Information**, select **No, if you are including the supplemental information/attachment for an 837 claim PWK.** (see example below)

Request for Information

Select Yes, if you are responding to a request from the health plan or need to submit documentation for a specific claim number.

Select No, if you are including the supplemental information/attachment for an 837 claim PWK.

Yes No

1. Include provider, patient and claim information
2. Attach supporting documentation and reason (example shown below)
3. Send attachment(s)

Attach Supporting Documentation

ADDING ATTACHMENTS:
- This Health Plan supports file types including .jpeg, .jpg, .pdf, .tiff and .tif.
- File names cannot contain spaces or special characters with the exception of "_" and "-".

Reason

Choose one ...

Add File

11503-0 - Medical Records

48768-6 - Itemized Bills

Add Attachment

Clear Values

Send Attachment(s)

Providers may also submit a claim attachment using the Availity Portal for solicited** medical attachments.

To submit supporting documentation in response to a formal (solicited) request from the payer:

- Log in to Availity Portal
- Select **Claims & Payments | Attachments – New**
- Select **Send Attachment**
- Under the **Request for Information**, select **Yes, if you are responding to a request from the health plan or need to submit documentation for a specific claim number** (see example below)
- Add supporting documentation and reason
- Submit

Request for Information

Select Yes, if you are responding to a request from the health plan or need to submit documentation for a specific claim number.

Select No, if you are including the supplemental information/attachment for an 837 claim PWK.

Yes No

Documentation Type

Select...

Other Claim Documentation Request

Quality Claims Review (QCR)

Special Investigations Unit (SIU)

Additionally, if you attended a previous webinar, we have updated information on submitting an EDI 837 batch that includes a PWK segment in loops 2300/2400. The update is regarding the linkage between the electronic claim and your supplemental documentation that can be submitted through the Availity portal.

What does this mean for you?
You may now submit attachments electronically (EDI) using the PWK segment to specify that documents are being submitted in support of the claim and no additional face sheet or coversheet is needed.

Here are the steps:

- Log in to Availity Portal
- Select **Claims & Payments I Attachments - New**
- From the **Inbox** tab, select the appropriate claim or open the request in your work queue
- Add files with supporting documentation
- Submit

Get trained

- Attend an Availity-hosted webinar to learn more about all capabilities. You can register for an upcoming live webinar hosted by Availity here, ***or***
- Log into Availity.com and select **Help & Training | Get Trained** to open the Availity Learning Center in a new tab (it is your dedicated ALC account).

- Search by keyword (**Medattach**) to find on-demand and live training options
- Click Enroll to enroll for a course and then go to your Dashboard to access it any time

Get started today with these wide-ranging capability enhancements to transform your business operations to a quick, secure, paperless and simple process to fulfill medical records requests electronically through Availity.

*Unsolicited attachment: Documentation submitted without a formal request from the payer
**Solicited attachment: Documentation submitted in response to a specific request from payer

Article Attachments

1017-0321-PN-NE

URL: https://providernews.anthem.com/connecticut/article/medical-attachment-capability-now-includes-itemized-bills-and-more-2

Updates to Use of a Non-Participating Provider Advance Patient Notice Policy

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

Effective April 1, 2021, several updates to the Advance Notice Policy will be implemented. If a member is scheduled to receive a service or procedure from a non-participating provider, the referring participating provider must provide advance notification to the member so the member may choose whether to oppose or approve the use of a non-participating provider for the service or procedure. The notice must be provided, completed, and dated by the member, and retained in the member's medical file a minimum of seven (7) days in advance of the procedure or service. In addition, providers or facilities who are instructed to provide copies of signed advance notice policies as the result of an audit will now be required to respond with the required information within fifteen (15) days.

This policy will continue to apply to both facilities and professional providers. The updated policy in its entirety may be viewed on anthem.com/provider > Connecticut > Scroll down and select Find Forms > Use of a Non-Participating Provider Advance Patient Notice Policy.

995-0321-PN-CT

URL: https://providernews.anthem.com/connecticut/article/updates-to-use-of-a-non-participating-provider-advance-patient-notice-policy

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2021 appointment access standards for PCPs, specialty care practitioners, and behavioral health practitioners

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

As a participating provider, please remember your contractual obligation to help ensure our members have prompt access to services. Please visit anthem.com to access our Provider Manual for our guidelines on access to care for primary care practitioners (PCPs), specialty care practitioners (SCPs) and behavioral health practitioners (BHPs). We use the following methods to monitor adherence to these access standards:

1. Assessing the availability of appointments via phone calls by our staff or designated vendor to the provider's office
2. Analysis of member complaint data
3. Analysis of member satisfaction surveys.

The following information is excerpted from the Provider Manual for your review:

Physician/Provider Access Goals and Calendar Requirements
One of our goals is to make accessing medical care easy for members by assuring a comprehensive network of physicians and providers close to their homes. As a result, we have implemented the following plan-wide geographic access goals as guidelines for our network. It is our goal to provide members with access to the following within our defined service areas:

- Two (2) PCPs within five (5) miles of each member
- Two (2) OB/GYNs within eight (8) miles of each member
- Full range of specialists (including non-MD allied providers) within 15 miles of each member

Calendar Access Requirements

Primary Care Providers:

- **Preventive care** - members scheduling periodic routine exams (well care/preventive visits), appointments should be available within 45 calendar days of a member's call. Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears.

- **Urgent care appointment with acute symptoms** - appointments should be available within 24 hours of the member's call. Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.

- **Routine care with symptoms -** must have access to care within five (5) days of the member's call.

- **Routine check-up** - must have access to care within 10 business days of the member's call. This consists of care provided for non-symptomatic visits or follow-up.

Though it is important for members to have the continuity of receiving care from their PCPs, there are occasions when you may not be available at a time that meets their scheduling needs. As a reminder, we now contract with walk-in centers and urgent care facilities that are listed in our directory.

Specialists:

- **Urgent care appointment with acute symptoms** - appointments should be available within 24 hours of the member's call. Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.

- **Routine check-up** - must have access to care within 15 calendar days of the member's call. Care provided for non-symptomatic visits for health check.

Behavioral Health Providers:

- **Non-life threatening emergency needs** - must be seen, or have appropriate coverage directing the member, within six (6) hours. Emergent behavioral health care provided when a member is in crisis, experiencing acute distress and/or other symptoms and needs immediate attention; no risk of loss of life.

- **Urgent needs** - must be seen, or have appropriate coverage directing the member, within 48 hours. Non-emergent behavioral health illness that requires immediate care; member is experiencing significant psychological distress with symptoms that impairs daily functioning; no risk of loss of life.

- **Initial routine office visit** - must be seen within 10 business days. New patient non-urgent appointment scheduled after intake assessment or a direct referral from a treating practitioner.

- **Follow-up routine visit** - must be seen within 30 calendar days. Non-urgent behavioral health care; member has been scheduled for a non-urgent consultation or requires services including, but not limited to, follow-up and existing medication management.

After-hours coverage

- After-hours coverage, which is required by the Provider Agreement, consists of an attendant or recording assisting the member in accessing urgent services outside of regular office hours. *Note that telephone answering machines and voice mail are not acceptable means of providing access for members if the answering machine or voice mail message only refers members to the emergency room or to call 911. The recording or live person must refer the patient to urgent care center, 911, or emergency room, and also provide the option to contact a live health care practitioner (via cell, pager, beeper, transfer system), get a call back for urgent instructions, or be transferred directly to the available practitioner or on-call practitioner.*

Timely access to physicians is a major priority of our members and employer groups. The requirements adopted reflect not only their expectations, but market norms. We will be assessing physicians against these requirements through our customer satisfaction surveys and provider surveys as well as follow-up on any members' complaints received. However, we are sensitive to problems related to seasonal services, the varying nature of practice specialties, and the challenges faced by busy practices. If your office routinely fails to meet these access and after-hours standards, it is important that you document and we understand the reasons that the requirements are not met.

996-0321-PN-CT

URL: https://providernews.anthem.com/connecticut/article/2021-appointment-access-standards-for-pcps-specialty-care-practitioners-and-behavioral-health-practitioners

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New provider directory indicator for telehealth services

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

We will begin publishing a new indicator in our online provider directories to help members easily identify professional providers who offer telehealth services.

We encourage providers who offer telehealth services to use the online Provider Maintenance Form to notify us, and we will add a telehealth indicator to your online provider directory profile.

Please contact Provider Services with any questions.

ABSCRNU-0203-20

URL: https://providernews.anthem.com/connecticut/article/new-provider-directory-indicator-for-telehealth-services-19

Medical policies and clinical utilization management guidelines update

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

The medical policies, clinical utilization management (UM) guidelines and third party criteria

Please share this notice with other members of your practice and office staff.

Visit our website to view our medical policies and clinical UM guidelines.

Notes/updates:
Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

- ***GENE.00055** – Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity
    - Gene expression profiling for risk stratification of inflammatory bowel disease (IBD) severity, including use of PredictSURE IBD, is considered investigational and not medically necessary for all indications
- ***LAB.00037** – Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)
    - Serological testing for biomarkers of irritable bowel syndrome (for example, CdtB and anti-vinculin), using tests such as, IBSDetex, ibs-smart or IBSchek, is considered investigational and not medically necessary for screening, diagnosis or management of irritable bowel syndrome, and for all other indications
- ***DME.00011** – Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices
    - Revised scope to only include non-implantable devices and moved content addressing implantable devices to SURG.00158
    - Added “non-implantable” to bullet point on percutaneous neuromodulation therapy
    - Added percutaneous electrical nerve field stimulation (PENFS) as investigational and not medically necessary for all indications
- ***SURG.00062** – Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele
    - Expanded scope to include percutaneous testicular vein embolization for varicocele and added embolization of the testicular (spermatic) veins as investigational and not medically necessary as a treatment of testicular varicocele

- ***CG-LAB-15** – Red Blood Cell Folic Acid Testing
    - RBC folic acid testing is considered not medically necessary in all cases
- ***CG-LAB-16** – Serum Amylase Testing
    - Serum amylase testing is considered not medically necessary for acute and chronic pancreatitis and all other conditions
- ***CG-GENE-04** – Molecular Marker Evaluation of Thyroid Nodules
- Added the Afirma Xpression Atlas as not medically necessary
- **00158** – Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain
    - A new medical policy was created from content contained in DME.00011.
    - There are no changes to the policy content.
    - Publish date is December 16, 2020.
- **CG-GENE-21** – Cell-Free Fetal DNA-Based Prenatal Testing
    - A new clinical guideline was created from content contained in GENE.00026.
    - There are no changes to the guideline content.
    - Publish date is December 16, 2020.

Medical policies
On November 5, 2020, the medical policy and technology assessment committee (MPTAC) approved the following medical policies applicable to Anthem. These guidelines take effect March 8, 2021.

Publish date	Medical Policy number	Medical Policy title	New or revised
12/16/2020	*GENE.00055	Gene Expression Profiling for Risk Stratification of Inflammatory Bowel Disease (IBD) Severity	New
12/16/2020	*LAB.00037	Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)	New
11/12/2020	ANC.00009	Cosmetic and Reconstructive Services of the Trunk and Groin	Revised
12/16/2020	*DME.00011	Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices	Revised
11/12/2020	GENE.00052	Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	Revised
11/12/2020	MED.00129	Gene Therapy for Spinal Muscular Atrophy	Revised
12/16/2020	SURG.00011	Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
12/16/2020	*SURG.00062	Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele	Revised

Clinical UM guidelines

On November 5, 2020, the MPTAC approved the following clinical UM guidelines applicable to Anthem. These guidelines were adopted by the medical operations committee for Anthem members on November 19, 2020. These guidelines take effect March 8, 2021.

Publish date	Clinical UM Guideline number	Clinical UM Guideline title	New or revised
12/16/2020	*CG-LAB-15	Red Blood Cell Folic Acid Testing	New
12/16/2020	*CG-LAB-16	Serum Amylase Testing	New
11/12/2020	CG-DME-42	Non-implantable Insulin Infusion and Blood Glucose Monitoring Devices	Revised
12/16/2020	*CG-GENE-04	Molecular Marker Evaluation of Thyroid Nodules	Revised
12/16/2020	CG-GENE-18	Genetic Testing for TP53 Mutations	Revised
12/16/2020	CG-GENE-20	Epidermal Growth Factor Receptor (EGFR) Testing	Revised
11/12/2020	CG-MED-87	Single Photon Emission Computed Tomography Scans for Noncardiovascular Indications	Revised

ABSCRNU-0206-21

URL: https://providernews.anthem.com/connecticut/article/medical-policies-and-clinical-utilization-management-guidelines-update-me-only-for-anthem-and-amh-health-llc-1

Access to more claim denial information is now self-service

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Through predictive analytics, healthcare teams can now receive real-time solutions to claim denials.

Anthem is committed to providing digital first solutions. Healthcare teams can now use self-service tools to reduce the amount of time spent following up on claim denials. Through the application of predictive analytics, Anthem has the answers before you ask the questions. With an initial focus on claim-level insights, Anthem has streamlined claim denial inquiries by making the reasons for the claim denial digitally available. In addition to the reason for the denial, we supply you with the next steps needed to move the claim to payment. This eliminates the need to call for updates and experience any unnecessary delays waiting for the Explanation of Payment (EOP).

Access the *Claims Status Listing* on Payer Spaces from https://www.anthem.com/medicareprovider using the Log In button or through the secure provider portal via Availity*. We provide a complete list of claims, highlight those claims that have proactive insights, provide a reason for the denial, and the information needed to move the claim forward.

Claim resolution daily
Automated updates make it possible to refresh claims history daily. As you resolve claim denials, the claim
status changes, other claims needing resolution are added, and claims are resolved faster.

Anthem made it easier to update and supply additional information, too. While logged into the secure provider portal, you have the ability to revise your claim, add attachments, or eliminate it if filed in error. Even if you did not file the claim digitally, you can access the proactive insights. Predictive analytics supplies the needed claim denial information online — all in one place.

Predictive proactive issue resolution and near real-time digital claim denial information is another example of how Anthem is using digital technology to improve the healthcare experience. If you have questions, please reach out to your Provider Relations representative.

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URL: https://providernews.anthem.com/connecticut/article/access-to-more-claim-denial-information-is-now-self-service-12

Keep up with Medicare news

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

- MCG Care Guidelines 24th edition customization for Anthem
- DME checklist of information needed from providers for Anthem members

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