Indiana Provider News

March 2021 Anthem Provider News - Indiana

Medicare:

Notice of Changes to Prior Authorization Requirements - March 2021

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

New prior authorization requirements for providers may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements.

Changes to Prior Authorization Requirements

- Site of Care medical necessity reviews for long-acting colony-stimulating factors begin June 1, 2021
- Updates for specialty pharmacy are available – March 2021
- Some HIV medication combinations may require prior authorization
- Anthem clarifies guidance on prior authorization requirements for admissions to in-network skilled nursing facilities (SNF) facilities
- New reimbursement policy update: Place of Service Evaluation and Management – Facility
- Update: Notice of changes to the AIM Small Joint Surgery guideline

URL: https://providernews.anthem.com/indiana/article/notice-of-changes-to-prior-authorization-requirements-march-2021

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

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

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, 2021, medical necessity review of the site of care is 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).

AIM will evaluate the clinical information in the request to the CG-MED-083 policy, or *Site of Care: Specialty Pharmaceuticals*, to determine if the hospital-based outpatient setting is medically necessary for the medication administration. To see the policy and what clinical considerations are taken into account for determination, visit **Clinical Criteria page** and type *Specialty* in the search field. 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: 800-554-0580, Monday through Friday, 8:30 a.m. to 7:00 p.m. Eastern time.

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 **Clinical Criteria page**.

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.

Note: In some plans "level of care" 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 "site of care" and in some plans, these terms may be used interchangeably. For simplicity, we will hereafter use "site of care."

1019-0321-PN-CNT

URL: https://providernews.anthem.com/indiana/article/site-of-care-medical-necessity-reviews-for-long-acting-colony-stimulating-factors-begin-june-1-2021-2

Updates for specialty pharmacy are available - March 2021*

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

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.

To access the Clinical Criteria information, **click here**.

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).

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

***** Non-oncology use is managed by the medical specialty drug review team.
** Oncology use is managed by AIM.

Prior authorization update – change in effective date

Please note the change in effective date of prior authorization for injectable iron deficiency anemia products listed below.

The effective date has been changed to dates of service on and after May 1, 2021 for the following specialty pharmacy codes from current or new clinical criteria documents that will be included in our prior authorization review process. The previous effective date was March 1, 2021.

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.

To access the Clinical Criteria information, **click here**.

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).

Clinical Criteria	HCPCS or CPT Code(s)	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

***** Non-oncology use is managed by Anthem's medical specialty drug review team.

Step therapy update – change in effective date

Please note the change in the effective date of step therapy for injectable iron deficiency anemia products.

The effective date has been changed to dates of service on and after May 1, 2021 for the following specialty pharmacy codes from current or new clinical criteria documents that will be included in our existing specialty pharmacy medical step therapy review process. The previous effective date was March 1, 2021.

To access the Clinical Criteria information with step therapy drug lists, **click here.**

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).

Clinical Criteria	Status	Drug(s)	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

***** Non-oncology use is managed by Anthem's medical specialty drug review team.

Prior authorization update – change in code list

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 process at this time.**

To access the Clinical Criteria information, **click here**.

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).

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

*****Non-oncology use is managed by Anthem's medical specialty drug review team.
**Oncology use is managed by AIM.

Prior authorization update – medical specialty pharmacy update

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

Drug	Code	Code description
*Avastin	C9257 J9035	intravitreal bevacizumab
*Mvasi	Q5107	bevacizumab-awwb
*Zirabev	Q5118	bevacizumab-bvzr

*****Non-oncology use is managed by Anthem's medical specialty drug review team.

1007-0321-PN-CNT

URL: https://providernews.anthem.com/indiana/article/updates-for-specialty-pharmacy-are-available-march-2021-1

Some HIV medication combinations may require prior authorization*

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

Starting May 1, 2021, Anthem Blue Cross and Blue Shield (Anthem) will implement a new prior authorization for HIV medications to help ensure patients are not receiving therapeutic duplications when taking certain combinations. Providers and members expected to be impacted by this policy will receive advanced notice by mail.

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 needed.

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 trigger 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 CoverMyMeds.com).

If you have any questions regarding this policy, please contact Provider Services.

1002-0321-PN-CNT

URL: https://providernews.anthem.com/indiana/article/some-hiv-medication-combinations-may-require-prior-authorization-2

Medical attachment capability now includes itemized bills and more!

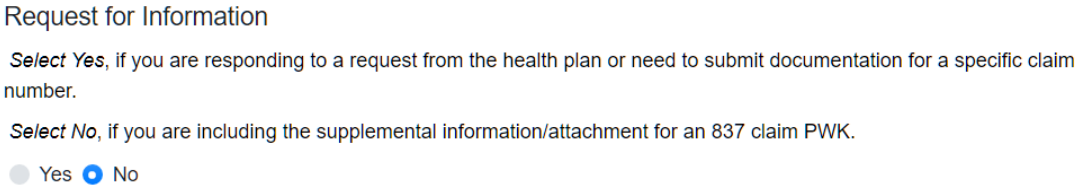
Published: Mar 1, 2021 - **Administrative**

Unsolicited medical attachments

To help ensure accuracy and eliminate delays in the adjudication of your claims, the itemized bill must be included with qualifying claim submissions. Including the itemized bill with the high dollar claim just got easier by submitting it as an **unsolicited medical attachment** (documentation submitted without a formal request from the payer).

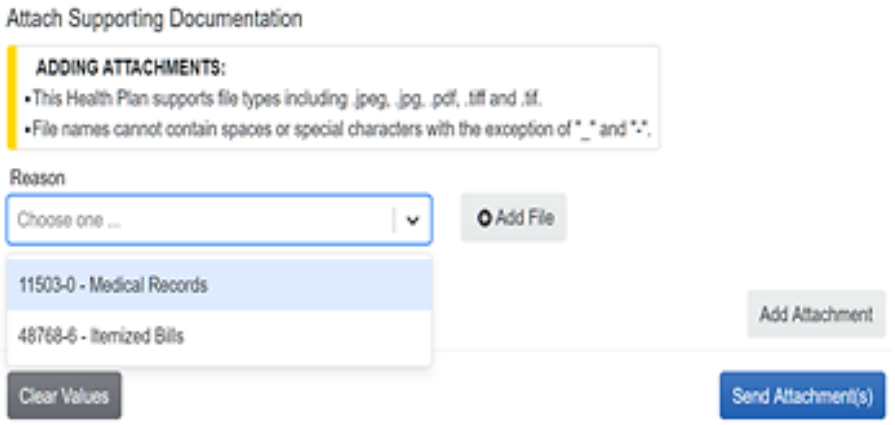
Did you know there is an **"itemized bill"** submission option under **Attachments – New!**

- Log in to Availity Portal
- Select **Claims & Payments** | **Attachments – New**
- Select **Send Attachment**
- Under the **Request for Information**, select **No, if you are including the supplemental information/attachment for an 837 claim PWK.**



- Provide provider, patient and claim information
- Attach Supporting Documentation and Reason

- Send Attachment(s)

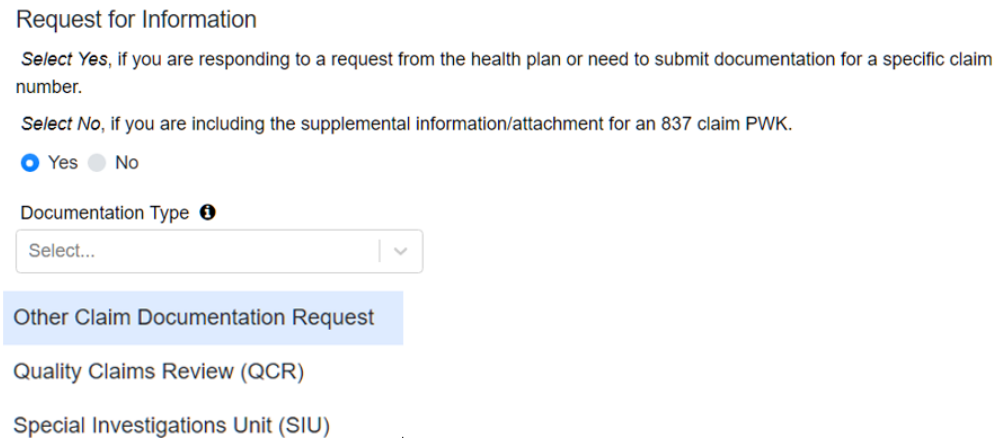


Solicited medical attachments

Also available to you is the option to submit a claim attachment using Availity Portal for **solicited medical attachments** (documentation submitted in response to a specific request from payer).

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**
- Add supporting documentation and Reason
- Submit



As an added bonus, if you attended a previous webinar there is updated information we want to share with you around submitting an EDI 837 batch, which includes a PWK segment in loops 2300/2400; this detail is 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

Article Attachments

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.

1017-0321-PN-CNT

URL: https://providernews.anthem.com/indiana/article/medical-attachment-capability-now-includes-itemized-bills-and-more-1

Update: Notice of changes to the AIM Small Joint Surgery guideline

Published: Mar 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

As of 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 Blue Cross fully insured members and some ASO groups.

Effective March 14, 2021, the **AIM Small Joint Surgery Guideline** has been updated with the following:

- Clarified requirements for imaging reports.
- Removed radiographic requirement for confirmation of lesser toe deformities.
- Ankle arthrodesis and total ankle arthroplasty added 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 prior authorization review requests to AIM using 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 Portal at **availity.com**
- Call the AIM toll-free number at 800-554-0580, Monday through Friday, 8:30 a.m. to 7 p.m. ET.

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

993-0321-PN-CNT

URL: https://providernews.anthem.com/indiana/article/update-notice-of-changes-to-the-aim-small-joint-surgery-guideline-2

Anthem clarifies guidance on prior authorization requirements for admissions to in-network skilled nursing facilities (SNFs)

Published: Mar 1, 2021 - **Policy Updates** / Medical Policy & Clinical Guidelines

Note that the following information applies to Anthem Blue Cross and Blue Shield (Anthem) local Commercial health plans in Indiana and Ohio only.

In the January 2021 newsletter, you were previously notified that effective November 1, 2020, Anthem will allow a 5-day initial length of stay upon notification of an admission to an in-network skilled nursing facility (SNF) facility for Indiana and Ohio members.

To clarify, this process only applies to hospital inpatient transfers to a skilled nursing facility (SNF).
It does not apply to transfers from acute inpatient rehab to SNF, LTAC to SNF, or SNF to SNF.

- Facility and physician must be in-network for the member.
- Anthem will require notification of the SNF admission, which includes sending demographics and verification of benefits via the usual channels to aid in our members' care coordination and management**.**
- Anthem will approve an initial 5-day length of stay without the need to provide clinical information.

- SNF providers will need to submit the clinical information within two business days after the admission to aid in our members' care coordination, discharge planning and member management. Note that prior authorization is still required but we allow the transfer to SNF, and then allow provider to send clinical within 2-days after the admission and prior to the last covered day for concurrent review.
- Concurrent review will be required starting on day 5 of the SNF stay.

- Anthem may apply monetary penalties, such as a reduction in payment, for failure to provide timely notice of admission.

- Indiana and Ohio will pilot this process through June 1, 2021 and will conduct random audits and monitor trends to evaluate the effectiveness of the pilot

***Note:** This process does not apply to admissions to out-of-network SNF facilities.

998-0321-PN-IN.OH

URL: https://providernews.anthem.com/indiana/article/anthem-clarifies-guidance-on-prior-authorization-requirements-for-admissions-to-in-network-skilled-nursing-facilities-snfs

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Claims editing update for ICD-10-CM Excludes 1 notes

Published: Mar 1, 2021 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after February 1, 2021 Anthem has implemented revised claims editing logic tied to Excludes 1 notes from ICD-10-CM 2020 coding guidelines. To help ensure the accurate processing of claims, use ICD-10-CM Coding Guidelines when selecting the most appropriate diagnosis for member encounters. Please remember to code to the highest level of specificity. For example, if there is an indication at the Category level that a code can be billed with another range of codes, it is imperative to look for Excludes 1 notes that may prohibit billing a specific code combination.

For assistance in determining proper coding guidance, the following site should be helpful: **https://www.cdc.gov/nchs/icd/icd10cm.htm**

One of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes 1 notes. An Excludes 1 note indicates that the excluded code identified in the note should not be billed with the code or code range listed above the Excludes 1 note. These notes appear below the affected codes – if the note appears under the Category (first three characters of a code), it applies to the entire series of codes within that category. If the Excludes 1 note appears beneath a specific code (3, 4, 5, 6 or 7 characters in length) then it applies only to that specific code

In ICD-10-CM, when a category includes an Excludes 1 note, it outlines what codes should NOT be billed together. Examples of this code scenario would include but are not limited to the following:

- Reporting Z01.419 with Z12.4
    - 41X (encounter GYN exam w/out abnormal findings) has an Excludes 1 note below that includes Z12.4 (encounter for screening malignant neoplasm cervix)
- Reporting Z79.891with F11.2X

- 891 (long-term use of Opiates) has an Excludes 1 note after it for F11.2X. F11.2X (Opioid dependence)

- Reporting M54.2 with M50.XX
  - 2 (Cervicalgia) has an Excludes 1 note below it for M50.XX (cervicalgia due to intervertebral disc disorder)

- Reporting M54.5 with S39.012X and/or M54.4x
  - 5 (low back pain) has an Excludes 1 note below it which includes; S93.012X (strain of muscle, fascia and tendon of lower back), M54.4X (low back pain) M51.2X (lumbago due to intervertebral disc disorder)

- Reporting J03.XX with J02.XX, J35.1, J36, J02.9
  - - (Acute tonsillitis) has an Excludes 1 note below it which includes; J02.- (acute sore throat), J35.1 (hypertrophy of tonsils), J36 (Peritonsillar abscess)

- Reporting N89 with R87.62X, D07.2, R87.623, N76.XX, N95.2, 00
  - N89 (Other inflammatory disorders of the vagina) has an Excludes 1 note below the category for R87.62X(abnormal results from vaginal cytological exam), D07.2 (vaginal intraepithelial neoplasia), R87.623(HGSIL of vagina), N76.XX inflammation of the vagina), N95.2 (senile [atrophic] vaginitis), A59.00 (trichomonal leukorrhea)

Finally, if you believe an Excludes1 note denial is incorrect, please consult the ICD-10-CM code book to verify appropriate use of the billed codes and provide supporting documentation through the normal dispute process as to why the billed diagnoses codes are appropriately used together.

990-0321-PN-CNT

URL: https://providernews.anthem.com/indiana/article/claims-editing-update-for-icd-10-cm-excludes-1-notes-2

New reimbursement policy update: Place of Service Evaluation and Management - Facility*

Published: Mar 1, 2021 - **Policy Updates** / Reimbursement Policies

A new facility reimbursement policy titled *Place of Service Evaluation and Management* will be implemented beginning with dates of service on, or after June 1, 2021.

The policy outlines where Evaluation and Management (E&M) services can be rendered by office, professional building, medical office building, clinic or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider.

E&M Services must be billed on a CMS-1500 claim form and are not reimbursable if they are billed on a UB-04 claim form.

For more information about this policy, visit the **Reimbursement policy** page at anthem.com.

991-0321-PN-IN

URL: https://providernews.anthem.com/indiana/article/new-reimbursement-policy-update-place-of-service-evaluation-and-management-facility

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New Hoosier Care Connect contract starting April 2021

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

The Hoosier Care Connect program coordinates benefits and services to address the physical, behavioral, medical and social needs of our members who have complex, chronic conditions, as well as preventive and comprehensive coordinated care with the goal of:

- Improving quality outcomes and consistency of care across delivery systems.
- Ensuring member choice, protections and access.
- Coordinating care across the care continuum.
- Providing flexible person-centered care.
- Increasing member engagement in the management and treatment of their conditions.

With our renewed contract to continue serving Hoosier Care Connect recipients beginning April 1, 2021, Anthem Blue Cross and Blue Shield (Anthem) is excited to introduce a number of enhancements in support of you, our dedicated providers, and our members, the patients you serve every day delivering quality healthcare and improving their health and well-being.

Member ID card

One of the changes you may notice is the new member ID card for Hoosier Care Connect members. We reissued new ID cards to all our Hoosier Care Connect members. The new ID card now only contains the State RID (Recipient Identification) beginning April 1, 2021. This will help streamline the method of identification and eligibility of our Hoosier Care Connect members. We have also added the alpha prefix to the front of the ID card. That prefix is YRH. When filing claims, please use the alpha prefix YRH immediately followed by the member's State RID. Do not use a space between YRH and the State RID.

We have also changed the Pharmacy Help Desk number, located on the back of your patients' ID card. The new number is **1-844-916-3653**. This is the number pharmacies will use if they need assistance with any of your patients' medications.

Provider incentives

In preparation for the launch of the new Hoosier Care Connect contract, we have also introduced several new incentive programs for our providers. The new incentive programs include:

- **Smoking Cessation Provider Incentive Program:** encourages providers to provide smoking cessation counseling to members who use tobacco, including referring them to Indiana's Tobacco Quitline.
- **Behavioral Health Provider Incentive Program:** rewards providers for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependency (FUA) and Follow-Up After Hospitalization for Mental Illness (FUH).
- **Obstetrics Prenatal Incentive Program:** incentivizes provider groups who meet certain benchmarks for deliveries and completion of prenatal visits.
- **Food Insecurity Provider Incentive Program:** incentivizes providers to identify and assist members with food insecurity needs.
- **Housing Insecurity Incentive Program:** incentivizes providers to identify and assist our members with housing insecurity needs.

Member programs
At Anthem, we know your primary focus is on taking care of your patients and making sure they get the care they need when they need it. That's why we have created new programs and benefits that support the important work you do, day in and day out. These services include:

- **Behavioral Health Crisis Line:** available 24/7
- **Suicide Prevention Outreach Team (SPOT):** for adolescent young adults at high risk for suicide

As part of the new Hoosier Care Connect program, we are also offering many new cost-free extra benefits to assist you in helping enhance the health of our members, your patients:

- $75 in Healthy Lifestyle Aid
- $75 in enhanced vision benefits
- Gym memberships or home fitness kits
- $50 in exercise equipment
- Youth and adult hygiene kit vouchers
- Asthma and COPD catalogue
- $100 in gas cards for eligible members in rural locations
- Job and skills training
- Savings account gift card
- Medical alert jewelry
- Caregiver toolkit

Most extra benefits are available through the Benefit Rewards Hub. Your patients can log in or register online at **anthem.com/inmedicaid.** They can also call Member Services at **1-844-284-1797**. Extra benefits offered by Anthem are limited to certain members and may change or end at any time.

Questions?
If you have questions about this communication or need assistance with any other item, contact your local Network Relations consultant or call Provider Services at:

- Hoosier Healthwise — **1-866-408-6132**
- Healthy Indiana Plan — **1-844-533-1995**

- Hoosier Care Connect — **1-844-284-1798**

Thank you for being dedicated to serving our members. We value our partnership with you and are grateful to you for providing our members with quality care.

URL: https://providernews.anthem.com/indiana/article/new-hoosier-care-connect-contract-starting-april-2021

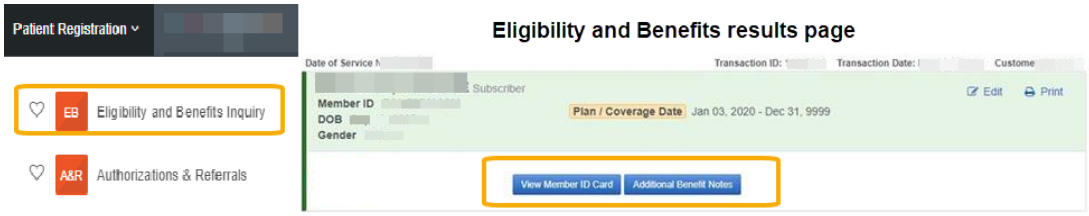
Availity Portal eligibility and benefits provides both additional benefit notes and digital member ID cards

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

New: Additional benefit detail

Now, you can select **Additional Benefit Notes**, on the **Availity portal*** *Eligibility and Benefits* results screen to find more descriptive benefit information.

Benefits are listed in alphabetical order, making it easier to search for specific benefits. Capabilities include full benefit descriptions, vendor information associated with the benefit and the option for the provider to print out the benefit information.



Digital member ID cards

The **digital member ID card** allows easy, low-touch access to view additional information or confirm basic membership details.

When conducting an eligibility and benefits inquiry for members, simply select **View Member ID Card** on the *Eligibility and Benefits results page.* **Note:** The Availity Portal requires you to enter the member's ID number, as well as a date of birth **or** the member's first and last name into the search options in order to submit an eligibility and benefits inquiry.

Try both of these valuable tools today!

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

Article Attachments

URL: https://providernews.anthem.com/indiana/article/availity-portal-eligibility-and-benefits-provides-both-additional-benefit-notes-and-digital-member-id-cards-4

Digital transactions cut administrative tasks in half

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

This communication applies to the Medicaid and Medicare Advantage programs for Anthem Blue Cross and Blue Shield (Anthem).

Introducing the Anthem Provider Digital Engagement Supplement to the provider manual

Using our secure provider portal or EDI submissions (via Availity*), administrative tasks can be reduced by more than 50% when filing claims with or without attachments, checking statuses, verifying eligibility, benefits and when submitting prior authorizations electronically. In addition, it could not be easier. Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered, just go **here** for EDI or **here** for the secure provider portal (Availity).

Get payments faster

By eliminating paper checks, electronic funds transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and will deliver payments to you faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the Availity Provider Portal or the *EDI 835* remittance, which meets all *HIPAA* mandates – eliminating the need for paper remittances.

Member ID cards go digital

Members who are transitioning to digital member ID cards, will find it is easier for them and you. The ID card is easily emailed directly to you for file upload, eliminating the need to scan or print. In addition, the new digital member ID card can be directly accessed through the secure provider portal via Availity. Providers should begin accepting the digital member ID cards when presented by the member.

Anthem makes going digital easy with the Provider Digital Engagement Supplement

From our digital member ID cards, EDI transactions, application programming interfaces and direct data entry, we cover everything you need to know in the *Provider Digital Engagement Supplement* to the provider manual, available by going to **mediproviders.anthem.com/in/pages/communications-updates.aspx** > Communications & Updates > Communications and Updates > 2021 > Provider Digital Engagement, and on the secure **Availity Provider Portal**. The supplement outlines our provider expectations, processes and self-service tools across all electronic channels Medicaid and Medicare, including medical, dental and vision benefits.

The *Provider Digital Engagement Supplement* to the provider manual is another example of how Anthem is using digital technology to improve the health care experience. We are asking providers to go digital with Anthem no later than January 1, 2021, so we can realize our mutual goals of reducing administrative burden and increasing provider satisfaction and collaboration. Read the *Provider Digital Engagement Supplement* now by going to **mediproviders.anthem.com/in/pages/communications-updates.aspx** > Communications & Updates > Communications and Updates > 2021 > Provider Digital Engagement, and go digital with Anthem.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

URL: https://providernews.anthem.com/indiana/article/digital-transactions-cut-administrative-tasks-in-half-36

Neulasta medical step therapy requirements

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

Effective for dates of service on and after March 1, 2021, certain specialty pharmacy drugs and corresponding codes from current Clinical Criteria will be included in our medical step therapy precertification review process. Step therapy review will apply upon precertification initiation or renewal, in addition to the current medical necessity review of all drugs noted below.

Click here for more information about the Neulasta Medical Step Therapy Notice.

URL: https://providernews.anthem.com/indiana/article/neulasta-medical-step-therapy-requirements

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Prior authorization requirements for HCPCS code 55899

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

Effective December 1, 2020, prior authorization (PA) requirements changed for HCPCS code 55899. This will be reviewed using MED.00132: Adipose-derived Regenerative Cell Therapy and Soft Tissue Augmentation Procedures. This code will require PA by Anthem Blue Cross and Blue Shield for members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

PA requirements will be added to the following:

- 55899 — Unlisted procedure, male genital system

To request PA, you may use one of the following methods:

- Web: availity.com*
- Fax:
  - Inpatient-new emergent: **1-866-406-2803**
  - Inpatient-concurrent emergent/new urgent: **1-844-765-5156**
  - Outpatient: **1-844-765-5157**
- Phone:
  - Hoosier Healthwise: **1-866-408-6132**
  - Healthy Indiana Plan (HIP): **1-844-533-1995**
  - Hoosier Care Connect: **1-844-284-1798**

Not all PA requirements are listed here. PA requirements are available to providers by accessing the Precertification Lookup Tool at **anthem.com/inmedicaiddoc** > Provider Resources & Documents > Quick Tools or for contracted providers at **availity.com**. Providers may also call Provider Services for assistance with PA requirements.

Provider Services:

- Hoosier Healthwise: **1-866-408-6132**
- HIP: **1-844-533-1995**
- Hoosier Care Connect: **1-844-284-1798**

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URL: https://providernews.anthem.com/indiana/article/prior-authorization-requirements-for-hcpcs-code-55899-2

Disease Management/Population Health program

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

Disease Management/Population Health is designed to support providers in caring for patients with chronic health care needs. Anthem Blue Cross and Blue Shield (Anthem) provides members enrolled in the program with continuous education on self-management, assistance in connecting to community resources, and coordination of care by a team of highly qualified professionals whose goal is to create a system of seamless health care interventions and communications.

Who is eligible?
Disease Management/Population Health case managers provide support to members with:

- ADHD
- Asthma
- Autism
- Bipolar disorder
- COPD
- Diabetes
- Chronic kidney disease
- Congestive heart failure
- Coronary artery disease
- HIV/AIDS
- Hypertension

- Major depressive disorder – adults
- Major depressive disorder – children and adolescents
- Schizophrenia
- Substance use disorder

Our case managers use member-centric motivational interviewing to identify and address health risks, such as tobacco use and obesity, to improve condition-specific outcomes. Interventions are rooted in evidence-based clinical practice guidelines from recognized sources. We implement continuous improvement strategies to increase evaluation, management and health outcomes.

For more information on our program and how to refer an Anthem member for this program, please visit our website at **anthem.com/inmedicaiddoc**.

Your input and partnership is valued. Once your patient is enrolled in the Disease Management/Population Health program, you will be notified by the case manager assigned.

We look forward to working with you.

URL: https://providernews.anthem.com/indiana/article/disease-managementpopulation-health-program-6

CAHPS® survey

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

CAHPS is an annual standardized survey conducted from January to May to assess consumers' experience with their provider and health plan. A random sample of your adult and child patients may get the survey. Providers directly impact the majority of questions used for scoring.

These questions are:

- When you needed care right way, how often did you get it?
- How often did you get an appointment for a check-up or routine care as soon as you needed it?
- How often was it easy to get the care, tests, or treatment you needed?

- How often did you get an appointment to see a specialist as soon as you needed it?
- How often did your personal doctor seem informed and up-to-date about the care you got from other health providers?
- How would you rate your primary care doctor?
- How would you rate the specialist you see most often?
- To learn more about CAHPS and how you can improve the patient experience, review the CAHPS Overview training by visiting **com/inmedicaiddoc**.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

URL: https://providernews.anthem.com/indiana/article/cahps-survey-7

HEDIS Measurement Year 2020: Medicaid summary of changes from NCQA

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

Revised measures

- The former Well-Child Visits in the First 15 Months of Life (W15) measure was revised to **Well Child Visits in the First 30 Months of Life (W30)**. It includes two indicators:
  - Well-child visits in the first 15 months – children who turned 15 months during the measurement year with six or more well-child visits
  - Well-child visits for ages 15 to 30 months – children who turn 30 months during the measurement year with two or more well-child visits

- The former Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) and Adolescent Well-Care Visits (AWC) measures have been combined into **Child and Adolescent Well-Care Visits (WCV):**
  - The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a PMP or an OB/GYN practitioner during the measurement year

Key measure changes

- **Controlling High Blood Pressure (CBP and CDC-CBP)** – Telephone visits, e-visits and virtual check-ins are now acceptable settings for blood pressure (BP) readings. Digital BP readings reported by the member are considered numerator compliant.
- **Telehealth updates** – NCQA has updated telehealth guidance in 40 HEDIS® measures for HEDIS measurement years 2020 and 2021. The purpose of these changes is to:
    - Support increased use of telehealth caused by the pandemic.
    - Align with guidance from Centers for Medicare & Medicaid Services and other stakeholders.

A list of the 40 measures can be found on the NCQA COVID-19 website at **ncqa.org/covid**.

New Medicaid measures

- **Kidney Health Evaluation for Patients With Diabetes (KED)** – The percentage of members 18 to 85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a uACR identified by both a quantitative urine albumin test and a urine creatinine test with service days four or less days apart during the measurement year
- **Cardiac Rehabilitation (CRE)** – The percentage of members 18 years and older who attended cardiac rehabilitation following a qualifying cardiac event, including myocardial infarction, percutaneous coronary intervention, coronary artery bypass grafting, heart and heart/lung transplantation, or heart valve repair/replacement; four rates are reported:
    - **Initiation** – The percentage of members who attended two or more sessions of cardiac rehabilitation within 30 days after a qualifying event
    - **Engagement 1** – The percentage of members who attended 12 or more sessions of cardiac rehabilitation within 90 days after a qualifying event
    - **Engagement 2** – The percentage of members who attended 24 or more sessions of cardiac rehabilitation within 180 days after a qualifying event
    - **Achievement** – The percentage of members who attended 36 or more sessions of cardiac rehabilitation within 180 days after a qualifying event

Retired Medicaid measures

- Comprehensive Diabetes Care (CDC) retired sub-measures –
  - Medical Attention for Nephropathy (retired for Commercial and Medicaid)
  - HbA1c control (< 7.0%) for a selected population
- Adult BMI Assessment (ABA)
- Medication Management for People With Asthma (MMA)
- Children's and Adolescents' Access to Primary Care Practitioners (CAP)

Measure change summary
For a complete summary, go to **tinyurl.com/NCQA-measures**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

URL: https://providernews.anthem.com/indiana/article/hedis-measurement-year-2020-medicaid-summary-of-changes-from-ncqa-4

Medicare News - March 2021

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

Please continue to read news and updates at **anthem.com/medicareprovider** for the latest Medicare Advantage information, including:

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

URL: https://providernews.anthem.com/indiana/article/medicare-news-march-2021

New provider directory indicator for telehealth services

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

Anthem Blue Cross and Blue Shield 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.

Visit **anthem.com** to locate the *Provider Maintenance Form*. Please contact Provider Services if you have any questions.

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URL: https://providernews.anthem.com/indiana/article/new-provider-directory-indicator-for-telehealth-services-16

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* below were developed and/or revised to support clinical coding edits. Note that several policies and guidelines were revised to provide clarification only and are not included. Existing precertification requirements have not changed. **Please note:** The *Medical Policies* and *Clinical UM Guidelines* below are followed in the absence of Medicare guidance.

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

To view a guideline, visit anthem.com/provider/policies/clinical-guidelines/search/

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 Blue Cross and Blue Shield (Anthem). These guidelines take effect March 8, 2021.

Policies marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

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.

Guidelines marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

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

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URL: https://providernews.anthem.com/indiana/article/medical-policies-and-clinical-utilization-management-guidelines-update-41

Digital transactions cut administrative tasks in half

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

This communication applies to the Medicaid and Medicare Advantage programs for Anthem Blue Cross and Blue Shield (Anthem).

Introducing the Anthem Provider Digital Engagement Supplement to the provider manual

Using our secure provider portal or EDI submissions (via Availity*), administrative tasks can be reduced by more than 50% when filing claims with or without attachments, checking statuses, verifying eligibility, benefits and when submitting prior authorizations electronically. In addition, it could not be easier. Through self-service functions, you can accomplish digital transactions all at one time, all in one place. If you are not already registered, just go **here** for EDI or **here** for the secure provider portal (Availity).

Get payments faster
By eliminating paper checks, electronic funds transfer (EFT) is a digital payment solution that deposits payments directly into your account. It is safe, secure and will deliver payments to you faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the Availity Provider Portal or the *EDI 835* remittance, which meets all *HIPAA* mandates – eliminating the need for paper remittances.

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URL: https://providernews.anthem.com/indiana/article/digital-transactions-cut-administrative-tasks-in-half-37
