Wisconsin Provider News

March 2021 Anthem Provider News - Wisconsin

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Notice of Material Changes/Amendments to Contract and Prior Authorization Changes - March 2021

Published: Mar 1, 2021 - **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.

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

URL: https://providernews.anthem.com/wisconsin/article/notice-of-material-changesamendments-to-contract-and-prior-authorization-changes-march-2021-1

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/wisconsin/article/site-of-care-medical-necessity-reviews-for-long-acting-colony-stimulating-factors-begin-june-1-2021-3

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/wisconsin/article/updates-for-specialty-pharmacy-are-available-march-2021-2

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/wisconsin/article/some-hiv-medication-combinations-may-require-prior-authorization-3

Medical attachment capability now includes itemized bills and more!

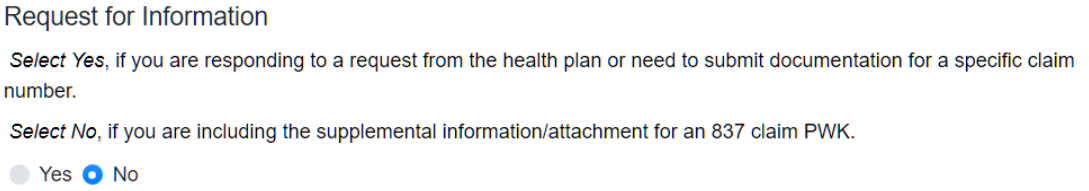
Published: Mar 1, 2021 - **Administrative**

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).

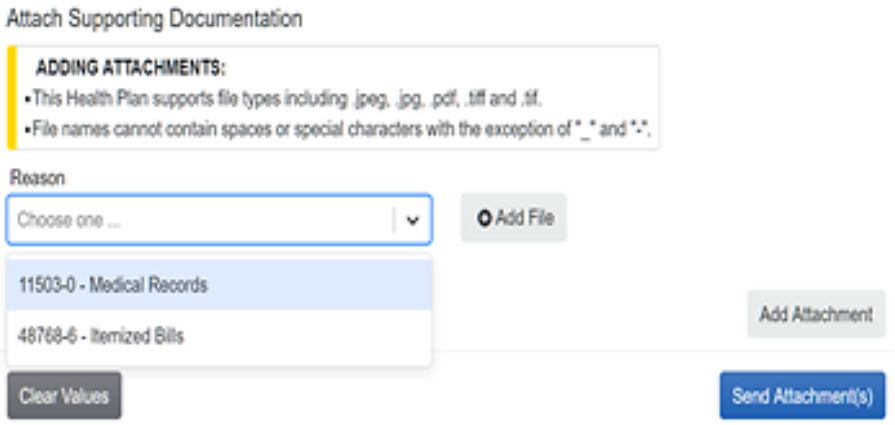
Did you know there is an **"itemized bill"** submission option under **Attachments – New!**

- 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)

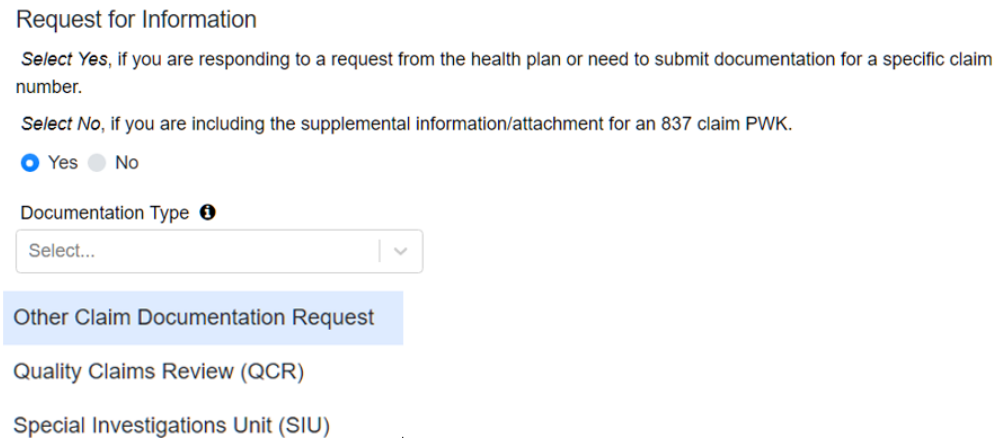


Solicited medical attachments

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/wisconsin/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/wisconsin/article/update-notice-of-changes-to-the-aim-small-joint-surgery-guideline-2

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/wisconsin/article/claims-editing-update-for-icd-10-cm-excludes-1-notes-2

Access to more claim denial information is now self-service

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).

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 *EOP*.

Access the *Claims Status Listing* on Payer Spaces from **mediproviders.anthem.com/wi** by 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.

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

URL: https://providernews.anthem.com/wisconsin/article/access-to-more-claim-denial-information-is-now-self-service-3

MCG Care Guidelines 24th edition customization

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

Effective June 1, 2021, new customizations will be implemented. **Click here for more information about the MCG Care Guidelines 24th edition customization.**

URL: https://providernews.anthem.com/wisconsin/article/mcg-care-guidelines-24th-edition-customization-9

Updated AIM Rehabilitative program effective August 1, 2021 - Site of Care reviews

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

We are committed to being a valued healthcare partner in identifying ways to achieve better health outcomes, lower costs and deliver access to a better healthcare experience for consumers.

Effective August 1, 2021, AIM Specialty Health® (AIM),* a separate company, will expand the AIM Rehabilitative program to perform medical necessity review evaluations for physical, occupational and speech therapy procedures and the requested site of care for Anthem Blue Cross and Blue Shield (Anthem) fully insured members, as further outlined below.

AIM will continue to manage physical therapy (PT), occupational therapy (OT) and speech therapy (ST) medical necessity reviews and will require prior authorization for all outpatient facility and office-based rehabilitative and habilitative services. Prior authorization will now also be required for the requested site of care. AIM will use the following Anthem clinical utilization management (UM) guideline: *CG.REHAB.10 Level of care: outpatient physical therapy, occupational therapy, and speech-language pathology services*. This clinical guideline can be reviewed online at **availity.com** by selecting **Clinical Resources** in the *Education and Reference Center* under *Payer Spaces*. Please note, this does not apply to procedures performed in an inpatient or observation setting, or on an emergent basis, services with diagnosis of autism, or the initial evaluation.

A complete list of CPT® codes requiring prior authorization for the AIM Rehabilitation program is available on the **AIM Rehabilitation microsite**. To determine if prior authorization is needed for an Anthem member on or after August 1, 2021, providers can contact Provider Services at **1-855-558-1443** for benefit information. They will be informed whether the AIM Rehabilitation program applies. AIM will also have a file upload from the health plan of the in-scope membership and will not provide prior authorization for members who are out of scope. If providers use the Interactive Care Reviewer (ICR) tool on the Availity Portal* to pre-certify an outpatient rehabilitative or habilitative service, ICR will produce a message referring the provider to AIM. (Note: ICR cannot accept prior authorization requests.)

AIM will be accepting authorizations on July 19, 2021, for services performed on or after August 1, 2021.

How to place a review request
Providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*$_{SM}$ directly at **providerportal.com**. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at **availity.com**.
- Call the AIM Contact Center toll-free number at **1-800-714-0040** from 7 a.m. to 7 p.m. ET.

Initiating a request on AIM's ***Provider****Portal* for PT/OT/ST and entering all the requested clinical questions will allow you to receive an immediate determination. If the request is approved, you will receive the order ID, the number of visits and valid time frame. **The AIM Rehabilitation Program microsite** on the AIM provider portal helps you learn more and access helpful information and tools such as order entry checklists.

AIM Rehabilitation training webinars
Anthem invites you to take advantage of a free informational webinar that will introduce you to the program and the robust capabilities of the AIM ***Provider****Portal*. Go to the **AIM Rehabilitation microsite** to register for an upcoming webinar. If you have previously registered for other services managed by AIM, there is no need to register again.

We value your participation in our network and look forward to working with you to help improve the health of our members.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

URL: https://providernews.anthem.com/wisconsin/article/updated-aim-rehabilitative-program-effective-august-1-2021-site-of-care-reviews

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Coding spotlight: Overview of the 2021 evaluation and management changes

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

Why are these changes necessary?

Changes are meant to simplify code selection criteria, make coding more clinically relevant and to reduce documentation overload for office-based evaluation and management (E/M) services, while continuing to differentiate payment based on complexity of care.

Key elements of major revisions for 2021:

- Physicians may choose their documentation based on medical decision making (MDM) or total time (including non-face-to-face services).
- History and exam are still important parts of the notes and may contribute to both time and MDM, but they will no longer be scored for determining the level of the E/M visit.
- MDM criteria has moved away from simply adding up tasks to instead focusing on tasks that affect the management of a patient's condition.
- Code 99201 was deleted.
- Codes 99202 to 99215 were revised.

Changes to time documentation

Time will now be defined as the total time spent by the provider (both face-to-face and time spent on non-face-to-face activities related to this patient's visit performed on the same day as the visit). This may include the services listed below but should not include time spent on separately billable services (such as X-ray interpretation). Effective January 1, 2021:

- The total time spent must be documented clearly by the provider for the E/M level to be determined by time and does not include ancillary staff time.

- Time will no longer need to be dominated by counseling.
- All time used for leveling the E/M must be on the same day as the face-to-face visit.

Services included in total time:

- Preparing for the visit (for example, reviewing test results)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering tests, medications, prescriptions or procedures after the visit
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the patient's medical record
- Independently interpreting results (not separately reportable) and communicating results to the patient/family/caregiver
- Care coordination (not separately reportable)

New patient E/M code	Typical time (2020)	Total time (2021)
99201	10 minutes	Code deleted
99202	20 minutes	15 to 29 minutes
99203	30 minutes	30 to 44 minutes
99204	45 minutes	45 to 59 minutes
99205	60 minutes	60 to 74 minutes

Established patient E/M code	Typical time (2020)	Total time (2021)
99211	5 minutes	Time component removed
99212	10 minutes	10 to 19 minutes
99213	15 minutes	20 to 29 minutes
99214	25 minutes	30 to 39 minutes
99215	40 minutes	40 to 54 minutes

Prolonged office services

2021 changes include addition of a new add-on code **(currently labeled 99417)** for prolonged office visits when time is used for code level selection, including face-to-face and non-face-to-face provider time of at least 15 additional minutes on the same date of service for level five office visits (99205, 99215).

Medical decision making (MDM)
Using the new MDM table, medical decision making for office/outpatient visits will be based on meeting (or exceeding) two out of three categories:

MDM must meet two out of three elements				
Code	**Level of MDM**	**Number and complexity of problems addressed**	**Amount and/or complexity of data to be reviewed and analyzed**	**Risk of complications and/ or morbidity or mortality of patient management**
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal	Minimal or none	Minimal
99203 99213	Low	Low	Limited	Low
99204 99214	Moderate	Moderate	Moderate	Moderate
99205 99215	High	High	Extensive	High

Number and complexity of problems addressed at the encounter:

- **Straightforward**: One self-limited or minor problem
- **Low**: Two or more self-limited or minor problems; one stable chronic illness, one acute, uncomplicated illness or injury
- **Moderate**: One or more chronic illnesses with exacerbation, progression or side effects of treatments; two or more stable chronic illnesses; one undiagnosed new problem with uncertain prognosis; one acute illness with systemic symptoms; one acute complicated injury
- **High**: One or more chronic illnesses with severe exacerbation, progression or side effects of treatment; one acute or chronic illness or injury that poses a threat to life or bodily function.

Amount and/or complexity of data to be reviewed and analyzed
The 2021 guidelines list three categories for data:

1. Tests, documents or independent historians.
2. Independent interpretation of tests
3. Discussion of management or test interpretation.

- **Straightforward**: Minimal or none
- **Low** (one category required):
  - Two tests/documents or independent historian
- **Moderate** (one category required):
  - Three tests, documents and/or independent historian
  - Independent interpretation of a test
  - Discussion of management or test interpretation
- **High** (two categories required):
  - Three items between documents and independent historian
  - Independent interpretation of a test
  - Discussion of management or test interpretation

Risk of complications and/or morbidity or mortality of patient management
For the purposes of MDM, level of risk is based upon the consequences of the problem(s) addressed at the encounter *when appropriately treated.* Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization:

- **Minimal:** Rest, gargle, elastic bandages, superficial dressings
- **Low:** OTC drugs, physical therapy, minor surgery with no identified risk factors, IV fluids without additives

- **Moderate:** Management of a prescription drug, minor surgery with identified risk factors, decision regarding major surgery without identified risk factors, diagnosis or treatment
- **High:** Need to discuss higher risk problems that could happen for which physician or other qualified health care professional will watch or monitor.

Tips to prepare your practice for E/M office visit changes:

- Identify project lead
- Schedule team preparation time
- Update practice protocols
- Consider coding support
- Review business liability coverage
- Guard against fraud/abuse
- Update compliance plan
- Check with your electronic health record (EHR)vendor
- Assess financial impact
- Understand medical liability coverage

Resources:

1. CPT® Professional Edition, 2021. AMA
2. AMA Elements of Medical Decision Making. https://www.ama-assn.org/system/files/2019-06/cpt-revised- mdm-grid.pdf
3. AMA Press Release 2021 CPT code set. https://www.ama-assn.org/press-center/press-releases/ama-releases- 2021-cpt-code-set
4. Major E/M Changes Coming Are you prepared? https://www.aapc.com/evaluation-management/em- codes-changes-2021.aspx

URL: https://providernews.anthem.com/wisconsin/article/coding-spotlight-overview-of-the-2021-evaluation-and-management-changes-1

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/wisconsin/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/wisconsin/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/wisconsin/article/medical-policies-and-clinical-utilization-management-guidelines-update-41

Access to more claim denial information is now self-service

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

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 *EOP*.

Access the *Claims Status Listing* on Payer Spaces from **https://mediproviders.anthem.com/wi** by 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.

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

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URL: https://providernews.anthem.com/wisconsin/article/access-to-more-claim-denial-information-is-now-self-service-5