# Indiana Provider News

May 2020 Anthem Provider News - Indiana


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# Anthem prior authorization updates for specialty pharmacy are available - May 2020*

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

### Prior authorization updates

Effective for dates of service on and after August 1, 2020, 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 NDC code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

To access Clinical Criteria information please click here.

Anthem's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

*Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company and are in italics in the table below.*

| Clinical Criteria | HCPCS or CPT Code(s) | Drug |
|---|---|---|
| ING-CC-0156 | J3490 | Reblozyl |
| ING-CC-0156 | J3590 | Reblozyl |
| ING-CC-0156 | C9399 | Reblozyl |
| *ING-CC-0157* | *C9399* | *Padcev* |
| *ING-CC-0157* | *J9309* | *Padcev* |
| *ING-CC-0158* | *J3490* | *Enhertu* |
| *ING-CC-0158* | *J3590* | *Enhertu* |
| *ING-CC-0158* | *C9399* | *Enhertu* |
| *ING-CC-0158* | *J9999* | *Enhertu* |
| ING-CC-0159 | J3490 | Scenesse |
| ING-CC-0159 | J3590 | Scenesse |
| *ING-CC-0155* | *J0207* | *Ethyol* |
| ING-CC-0160 | J3490 | Vyepti |
| ING-CC-0160 | J3590 | Vyepti |
| **ING-CC-0002* | *J3590* | *Ziextenzo* |
| **ING-CC-0002* | *C9399* | *Ziextenzo* |
| ING-CC-0062 | J3590 | Avsola |
| ING-CC-0062 | J3590 | Abrilada |
| ING-CC-0062 | C9399 | Abrilada |
| ING-CC-0065 | J7192 | Esperoct |

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

**Site of care updates**

Effective for dates of service on and after August 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing prior authorization site of care review process.

To access the site of care drug list, please click here.

Anthem's prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

| Clinical Criteria | HCPCS or CPT Code(s) | Drug |
|---|---|---|
| ING-CC-0082 | J0222 | Onpattro |
| ING-CC-0043 | J0517 | Fasenra |
| ING-CC-0049 | J1301 | Radicava |
| ING-CC-0041 | J1303 | Ultomiris |
| ING-CC-0003 | J1599 | Asceniv |
| ING-CC-0047 | J1746 | Trogarzo |
| ING-CC-0050 | J3245 | Ilumya |
| ING-CC-0013 | J3397 | Mepsevii |
| ING-CC-0002 | Q5110 | Nivestym |
| ING-CC-0002 | Q5111 | Udenyca |

**Step therapy updates**

Effective for dates of service on and after August 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process.

To access the step therapy drug list, please click here.

Anthem's prior authorization clinical review of these specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

| Clinical Criteria | Status | Drug(s) | HCPCS Code(s) |
|---|---|---|---|
| ING-CC-0062 | Non-preferred | Avsola | J3590 |

432-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/anthem-prior-authorization-updates-for-specialty-pharmacy-are-available-may-2020

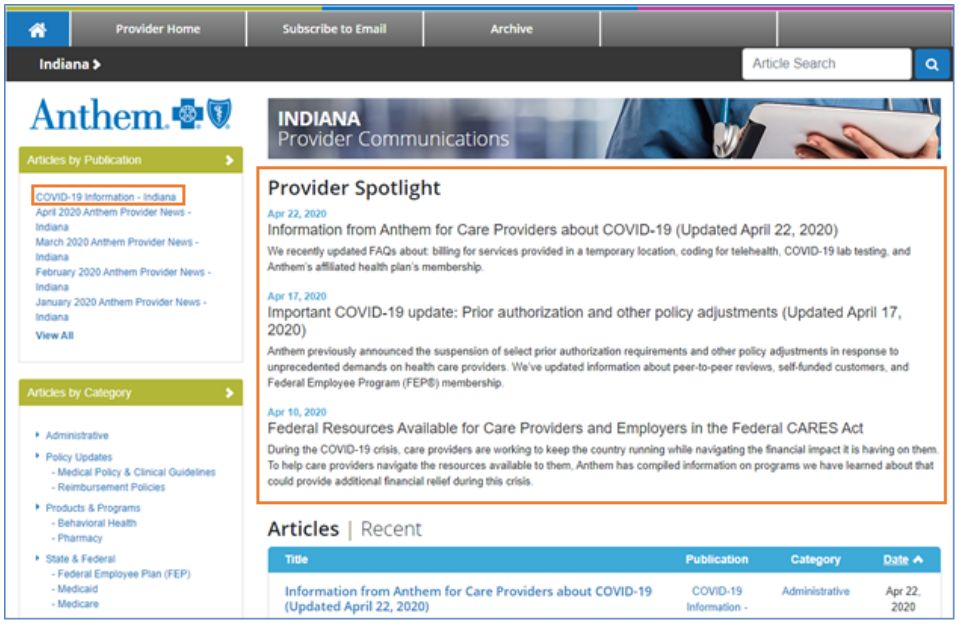
# COVID-19 information repository for Anthem Care Providers

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

Article Attachments

For the most up-to-date information from Anthem Blue Cross and Blue Shield about COVID-19, please bookmark/add to favorites **Provider News Home** and check back often. The most recent articles will be displayed in the *Provider Spotlight* section.

For a repository of all COVID-19 related articles in one location, please reference **COVID-19 Information – Indiana** under *Articles by Publication*.




444-0520-PN-IN

**URL:** https://providernews.anthem.com/indiana/article/covid-19-information-repository-for-anthem-care-providers-1

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# Notice of Changes to Prior Authorization Requirements - May 2020

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

**COVID-19**

- COVID-19 Information repository for Anthem Care Providers

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

- Anthem prior authorization updates for specialty pharmacy are available – May 2020*
- Updates to AIM Advanced Imaging Clinical Appropriateness Guideline*
- Updates to AIM Sleep Disorder Management Clinical Appropriateness Guideline*
- Updates to AIM MSK Interventional Pain Management Clinical Appropriateness Guideline*
- Updates to AIM Musculoskeletal Program Joint Surgery Clinical Appropriateness Guidelines*
- Reimbursement Policy Update: Claims requiring additional documentation (Facility)*

**Other Important Updates**

- Medicare and Medicaid News

**URL:** https://providernews.anthem.com/indiana/article/notice-of-changes-to-prior-authorization-requirements-may-2020

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## Anthem Commercial Risk Adjustment (CRA) Prospective Program Update: Assessing Your Patients for Risk Adjustable Conditions

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

We understand the increased risk and strain on the health care system during the fight against COVID-19, and we support you in the response and treatment of your patients. Telehealth is now an option to assess your patients with risk adjustable conditions. Anthem's Prospective Risk Adjustment program works to improve risk adjustment accuracy and focus on performing appropriate interventions for patients with undocumented Hierarchical Condition Categories (HCC) in order to help you close your patients' gaps in care. This program involves:

- **Member outreach encouraging primary care physicians (PCP) in-person or telehealth visits.** Refer to Anthem's notice *Information from Anthem for Care Providers about COVID-19* in Provider News for updates about *telehealth* reimbursement guidance.

- **Provider outreach sharing previously coded and suspected conditions, and encouraging member visits**

- **PCP alternatives to complete Health Assessments**

**Inovalon Requests**

Consistent with 2019, we have again engaged a vendor, Inovalon – an independent company that provides secure, clinical documentation services – to help us comply with the provisions of the Affordable Care Act that require us to assess members' relative health risk levels. In the coming weeks and months, Inovalon will begin sending letters to providers as part of a new risk adjustment cycle, asking for your help with completing Health Assessments for some of our members.

If you worked with Inovalon in 2019, many thanks for your help. This year will bring a new round of assessments because chronic conditions must be assessed and coded each and every year. As always, if you have questions about the requests you receive, you can reach Inovalon directly at 1-877-448-8125.

**Prospective Program ask of Providers:**

**Anthem network providers – usually PCPs – receive letters from Inovalon, requesting that they:**

- **Schedule a comprehensive in-person or telehealth visit** with patients identified by Inovalon to confirm or deny if previously coded or suspected diagnoses exists, and;

- **Submit a Health Assessment** documenting the previously coded or suspected diagnoses (also called SOAP Notes - *Subjective, Objective, Assessment* and *Plan*).

Incentives for properly submitted Health Assessments (these incentives are in addition to the office visit reimbursement):

- $100 for each Health Assessment properly submitted electronically
- $50 for each Health Assessment properly submitted via fax

Submit electronically via Inovalon's ePASS tool:

- *Inovalon ePASS® Training Webinars:* Every Wednesday, 3:00 – 4:00 pm ET
- *Join an ePASS webinar:* Register by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

**Alternative Engagement**

ePASS® is our preferred method for submission. However to improve engagement and collaborate with our providers who are not submitting via ePASS®, we have identified other tools which may be helpful. If in 2019 your practice utilized some of these alternative options for prospective member outreach, we thank you for continuing on these alternative forms of program participation into 2020.

For those providers not familiar with our alternative options, they are listed here. Telehealth visits are also an acceptable form of a patient visit for these alternative engagement options. Any questions your office has on these can be directed to either your local Provider Representative, or the Anthem CRA Network Education Representative listed below.

- **EPHC Providers using PCMS** - Providers participating in our Enhanced Personal Health Care (EPHC) program can use member reports from our PCMS tool to schedule members for comprehensive visits. PCMS does have a link to take you directly to the Inovalon ePASS® tool where completed Health Assessments will result in a $100 incentive payment per submitted Health Assessment.

- **List of Members to be scheduled** - Anthem CRA provides member/patient reports for providers to schedule members for comprehensive visits. Providers use normal gap closure through claims submission.  No Health Assessment needed. Not eligible for additional incentive.

- **EPIC Patient Assessment Form (PAF)** - Providers with EPIC as their electronic medical record (EMR) system can fax the EPIC PAF to Inovalon at 1-866-682-6680 with a coversheet indicating "see attached Anthem Progress Note," which is eligible for a $50 incentive payment.

- **Providers Existing Patient Assessment Form (PAF)** - Utilize providers existing EMR system and applicable PAF. Must be submitted to Inovalon at 1-866-682-6680 with coversheet indicating, "see attached Anthem Progress Note," which is eligible for a $50 incentive payment.

Please contact our Commercial Risk Adjustment Network Education Representative if you have any questions: Mary.Swanson@anthem.com

Thank you for your continued efforts with our CRA Program.

416-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/anthem-commercial-risk-adjustment-cra-prospective-program-update-assessing-your-patients-for-risk-adjustable-conditions-2

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## Quality Corner: Diabetes HbA1c<8 HEDIS Guidance

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

Diabetes is a complex chronic illness requiring ongoing patient monitoring. NCQA includes diabetes in its HEDIS® measures on which providers are rated annually. Since diabetes HbA1c testing is a key measure to assess for future medical conditions related to complications of undiagnosed diabetes, the National Committee for Quality Assurance (NCQA) requires health plans to review claims for diabetes in patient health records.  The findings contribute to health plan stars ratings for Commercial and Medicare plans and the

Quality Rating System (QRS) measurement for Marketplace plans. A systematic sample of patient records is pulled annually as part of the HEDIS® medical record review to assess for documentation.

**Which HEDIS measures are diabetes measures?**

The diabetes measures focus on members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following assessments:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Dilated Retinal exam
- Medical attention for nephropathy

The American College of Physicians' guidelines for people with type 2 diabetes recommend the desired A1c blood sugar control levels remain between 7 to 8 percent.[1]

In order to meet the HEDIS measure "HbA1c control <8", you must document the date the test was performed and the corresponding result. For this reason, report one of the four Category II codes and use the date of service as the date of the test, not the date of the reporting of the Category II code.

| To report most recent hemoglobin A1c level | Use |
|---|---|
| HbA1c level less than 7.0% | 3044F |
| HbA1c level greater than or equal to 7.0% and less than 8.0% | 3051F |
| HbA1c level greater than or equal to 8.0% and less than or equal to 9.0% | 3052F |
| HbA1c level greater than 9.0% | 3046F |
| HbA1c level ≤9.0% | 3044F, 3051F, 3052F[2] |

*NOTE: Multiple dates of service may be associated with a single lab test (e.g., a collection date, a reported date and a claim date). For a laboratory test CPT II code to count toward HEDIS, the Category II date of service and the test result date must be no more than seven days apart.*

Continued management and diverse pathways to care are essential in controlling blood glucose and reducing the risk of complications. While it is extremely beneficial for the patient to have continuous management, it also benefits our providers. As HEDIS rates increase, there is potential for the provider to earn maximum or additional revenue through Pay for Quality, Value Based Services, and other pay-for-performance models.[3]

*Sources include:*
− Diabetes Prevalence: 2015 state diagnosed diabetes prevalence, cdc.gov/diabetes/data; 2012 state undiagnosed diabetes prevalence, Dall et al., ”The Economic Burden of Elevated Blood Glucose Levels in 2012”, *Diabetes Care*, December 2014, vol. 37.
− Diabetes Incidence: 2015 state diabetes incidence rates, cdc.gov/diabetes/data
− Cost: American Diabetes Association, “Economic Costs of Diabetes in the U.S. in 2017”, Diabetes Care, May 2018.
− Research expenditures: 2017 NIDDK funding, projectreporter.nih.gov; 2017 CDC diabetes funding, www.cdc.gov/fundingprofiles

[1] https://www.medicalnewstoday.com/articles/321123#An-A1C-of-7-to-8-percent-is-recommended
[2] https://www.ama-assn.org/system/files/2020-01/cpt-cat2-codes-alpha-listing-clinical-topics.pdf
[3] https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/value-based-programs.html

402-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/quality-corner-diabetes-hba1c8-hedis-guidance

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## Updates to AIM Advanced Imaging Clinical Appropriateness Guideline*

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

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Advanced Imaging of the Chest and AIM Oncologic Imaging Clinical Appropriateness Guidelines.

**Advanced Imaging of the Chest updates by section:**
Tumor or Neoplasm

- Allowed follow up of nodules less than 6 mm in size seen on incomplete thoracic CT, in alignment with follow up recommendations for nodules of the same size seen on complete thoracic CT
- Added new criteria for which follow up is indicated for mediastinal and hilar lymphadenopathy
- Separated mediastinal/hilar mass from lymphadenopathy, which now has its own entry

Parenchymal Lung Disease – not otherwise specified

- Removed as it is covered elsewhere in the document (parenchymal disease in Occupational lung diseases and pleural disease in Other thoracic mass lesions)

Interstitial lung disease (ILD), non-occupational including idiopathic pulmonary fibrosis (IPF)

- Defined criteria warranting advanced imaging for both diagnosis and management

Occupational lung disease (Adult only)

- Moved parenchymal component of asbestosis into this indication
- Added Berylliosis

Chest Wall and Diaphragmatic Conditions

- Removed screening indication for implant rupture due to lack of evidence indicating that outcomes are improved
- Limited evaluation of clinically suspected rupture to patients with silicone implants

**Oncologic Imaging updates by section:**
MRI breast

- New indication for BIA-ALCL
- New indication for pathologic nipple discharge

- Further define the population of patients most likely to benefit from preoperative MRI

Breast cancer screening

- Added new high risk genetic mutations appropriate for annual breast MRI screening

Lung cancer screening

- Added asbestos-related lung disease as a risk factor

As a reminder, ordering and servicing 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 Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday – Friday, 8:30 a.m. – 7:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

426-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/updates-to-aim-advanced-imaging-clinical-appropriateness-guideline-1

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## Updates to AIM Sleep Disorder Management Clinical Appropriateness Guideline*

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

Effective for dates of service on and after August 16, 2020, the following updates will apply to the AIM Sleep Disorder Management Clinical Appropriateness Guideline.

**Sleep Disorder Management updates by section:**

Bi-Level Positive Airway Pressure Devices

- Change in BPAP FiO2 from 45 to 52 mmHg based on strong evidence and aligns with Medicare requirements for use of BPAP.

Multiple Sleep Latency Testing and/or Maintenance of Wakefulness Testing

- Style change for clarity
- Code Changes:  None

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

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- Access AIM via the Availity Web Portal at availity.com
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For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

427-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/updates-to-aim-sleep-disorder-management-clinical-appropriateness-guideline-9

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## Updates to AIM MSK Interventional Pain Management Clinical Appropriateness Guideline*

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

**Musculoskeletal Program: Interventional Pain Management Guideline updates by section:**

General Requirements – Conservative Management

- Addition of physical therapy or home therapy requirement and one complementary modality based on preponderance of benefit over harm to conservative care
- Align with approach to conservative management defined in spine and joint surgery guidelines

Epidural Injection Procedures and Diagnostic Selective Nerve Root Blocks

- Addition of statement about adherence to ESI procedural best practices established by FDA Safe Use Initiative. Recommendations are intended for provider education and will not be used for adjudication.
- Clarification of intent around requirement for advanced imaging for repeat injections

Paravertebral Facet Injection/Nerve Block/Neurolysis

- Remove indication for 4 unilateral medial branch blocks per session based on panel consensus

Paravertebral Facet Injection/Nerve Block/Neurolysis continued

- Procedural clarification restricting use of corticosteroids for diagnostic MBB based on panel consensus
- Limit use of intra-articular steroid injection to mechanical disruption of a facet synovial cyst
- Remove indication for intra-articular steroid injections based on new evidence for lack of efficacy
- Increase duration of initial RFN efficacy needed to avoid a MBB to 6 months based on panel consensus
- Clarification that MBB or RFN is not medically necessary after spinal fusion

Spinal Cord and Nerve Root Stimulators

- Clarify inclusion of different stimulation methods for spinal cord stimulation
- Add new indication for dorsal root ganglion stimulation
- Clarify exclusions for spinal cord and dorsal root ganglion stimulation

As a reminder, ordering and servicing 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 Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday – Friday, 8:30 a.m. – 7:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

428-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/updates-to-aim-msk-interventional-pain-management-clinical-appropriateness-guideline-1

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## Updates to AIM Musculoskeletal Program Joint Surgery Clinical Appropriateness Guidelines*

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

As recently communicated in the February 2020 edition of Anthem's *Provider News*, effective for dates of service on and after May 17, 2020, updates will apply to the AIM Musculoskeletal Program: Joint Surgery Clinical Appropriateness Guidelines.

**These updates relate to the criteria in the following sections:**

- Hip arthroplasty

- Knee arthroscopy and open procedures
- Shoulder arthroplasty including the removal of the  indication for subacromial impingement with rotator cuff tear

As a reminder, ordering and servicing 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 Web Portal at availity.com.
- Call the AIM Contact Center toll-free number: 800-554-0580, Monday – Friday, 8:30 a.m. – 7:00 p.m. ET.

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines here.

438-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/updates-to-aim-musculoskeletal-program-joint-surgery-clinical-appropriateness-guidelines-1

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## Reimbursement Policy Update: Claims requiring additional documentation (Facility)*

Published: May 1, 2020 - **Policy Updates** / Reimbursement Policies

Anthem Blue Cross and Blue Shield (Anthem) continues to take steps to improve the payment accuracy of provider claims and reduce post-payment recoveries. To this end, beginning with dates of service on or after August 1, 2020, Anthem will update its claims requiring additional documentation policy to include the following requirement:

Outpatient facility claims reimbursed at a percent of charge with billed charges above $20,000 require an itemized bill to be submitted with the claim.

For more information about this policy, visit the Reimbursement Policies page on the anthem.com provider website for your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

433-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/reimbursement-policy-update-claims-requiring-additional-documentation-facility-10

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## Reminder about system updates

Published: May 1, 2020 - **Policy Updates** / Reimbursement Policies

As a reminder, we are continuing to update our claim editing software for outpatient claims on a monthly basis throughout 2020. These updates will:

- Reflect the addition of new, and revised codes (e.g. CPT, HCPCS, ICD-10, modifiers) and their associated edits
- Include updates to National Correct Coding Initiative (NCCI) edits
- Include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- Include assistant surgeon eligibility in accordance with the policy
- Include edits associated with reimbursement policies including, but not limited to, frequency edits, medically unlikely edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)
- Apply to any provider or provider group (tax identification number) and may apply to both institutional and professional claim types including looking across claim types to determine where conflicts may exist between professional (CMS-1500) claims and institutional (CMS-1450) claims.

413-0520-PN-CNT

**URL:** https://providernews.anthem.com/indiana/article/reminder-about-system-updates-1

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# Normal newborn diagnosis-related group (DRG) claims processing update

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

Effective July 1, 2020, Anthem Blue Cross and Blue Shield (Anthem) will update the claims processing system to ensure accurate payment of newborn claims in accordance with Indiana normal newborn diagnosis-related group (DRG) requirements and the Anthem inpatient authorization requirements for patients enrolled in Hoosier Healthwise, Healthy Indiana Plan and Hoosier Care Connect.

All newborn inpatient stays must have sufficient documentation provided to support admission to an area beyond the newborn nursery, such as a neonatal intensive care unit (NICU), or for the higher level of care associated with the more complex newborn DRG. Documentation to support the higher-level admission includes authorization or medical records.

Failure to provide the appropriate documentation will result in claims processing at the standard newborn rate. Please note that current authorization guidelines for standard newborn and higher level of care baby inpatient stays will be applied.

**What is the impact of this change?**

- Newborn claims billed with higher level of care newborn DRG codes (tables A and B) must have the required documentation on file. If the required documentation is not on file, the claim will be processed based on the standard well-newborn DRG rate.
- Documentation is required for reimbursement of non-normal newborn care or an inpatient stay beyond the standard well-newborn period or admission to NICU.
- Newborn claims submitted with only newborn care revenue codes (170 and 171) and no authorization for services provided for a higher level of care to support the higher level of care DRG will result in claims paid at the standard rate.

***Explanation of Payment* code**

Based on the information provided above, we have implemented a new explanation (EX) code: A 59 (DRG billed does not match the revenue code submitted). This code will appear on your *Explanation of Payment* when a claim is billed with a higher level of care newborn DRG code and the required authorization for the higher level of care is not on file. You may appeal your request for payment of the higher acuity DRG by submitting the appropriate supporting clinical documentation. Please follow the normal appeal process detailed in our provider manual, which is available online at www.anthem.com/inmedicaiddoc.

Article Attachments

**Please click here to view the affected DRG codes.**

If you have questions, please call Provider Services:

- Hoosier Healthwise – **1-866-408-6132**
- Healthy Indiana Plan – **1-844-533-1995**
- Hoosier Care Connect – **1-844-284-1798**

**URL:** https://providernews.anthem.com/indiana/article/normal-newborn-diagnosis-related-group-drg-claims-processing-update

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## Reimbursement Policy Update: Unlisted, Unspecified or Miscellaneous Codes

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

Anthem Blue Cross and Blue Shield (Anthem) allows reimbursement for unlisted, unspecified or miscellaneous codes for psychiatric services with an applicable revenue code without documentation of a written description, office notes or operative report. Unlisted, unspecified or miscellaneous codes should only be used when an established code does not exist to describe the service, procedure or item rendered. Reimbursement is based on review of the unlisted, unspecified or miscellaneous codes on an individual claim basis.

Effective August 1, 2020, Anthem will allow reimbursement for the billing of intensive outpatient programs with unlisted psychiatric services or procedure code with an applicable revenue code without documentation of a written description, office notes or operative report.

For additional information, please review the *Unlisted, Unspecified or Miscellaneous Codes* reimbursement policy here.

**URL:** https://providernews.anthem.com/indiana/article/reimbursement-policy-update-unlisted-unspecified-or-miscellaneous-codes-1

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## Medical drug benefit Clinical Criteria updates - November 2019

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

On November 15, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem Blue Cross and Blue Shield. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the *Clinical Criteria Web Posting November 2019*. Visit *Clinical* Criteria to search for specific policies.

For questions or additional information, use this email.*

***** IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross and Blue Shield.

**URL:** https://providernews.anthem.com/indiana/article/medical-drug-benefit-clinical-criteria-updates-november-2019-8

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## Medical drug benefit Clinical Criteria updates - December 2019

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

On December 18, 2019, and December 23, 2019, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the **medical drug benefit** for Anthem

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the *Clinical Criteria Web Posting December 2019*. Visit *Clinical Criteria* to search for specific policies.

For questions or additional information, use this email.*

***** IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem Blue Cross and Blue Shield.

**URL:** https://providernews.anthem.com/indiana/article/medical-drug-benefit-clinical-criteria-updates-december-2019-7

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## Disease Management can help you care for patients with chronic health care needs

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Disease Management programs are designed to assist PMPs and specialists in caring for members with chronic health care needs. Anthem Blue Cross and Blue Shield provides members 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 for members.

**Who is eligible?**
Disease Management case managers provide support to members with:

- Behavioral health conditions such as depression, schizophrenia, bipolar disorder and substance use disorder.
- Diabetes.
- Heart conditions such as congestive heart failure, coronary artery disease and hypertension.
- HIV/AIDS.
- Pulmonary conditions such as asthma and chronic obstructive pulmonary disease.

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.

We welcome your referrals. To refer a member to Disease Management:

- Call **1-888-830-4300** to speak directly to one of our team members.
- Fill out the *Disease Management Referral Form* located on the provider website and fax it to **1-888-762-3199** or submit electronically via the Availity Portal.

Your input and partnership are valued. Once your patient is enrolled, you will be notified by the assigned Disease Management case manager. You can also access your patient's Disease Management care plan, goals and progress at any time via the Availity Portal through Patient360.

We are happy to answer any questions. Our registered nurse case managers are available Monday to Friday from 8:30 a.m. to 5:30 p.m. local time, and our confidential voicemail is available 24 hours a day, 7 days a week.

**URL:** https://providernews.anthem.com/indiana/article/disease-management-can-help-you-care-for-patients-with-chronic-health-care-needs-4

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## Right Choices Program update

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Anthem Blue Cross and Blue Shield (Anthem) would like to inform you that a change has been made to the Right Choices Program (RCP) requirements. Effective April 29, 2020, members are no longer required to be locked into a single hospital for non-emergent visits.

RCP is a program for Indiana Medicaid recipients who may need assistance learning how to properly use their health insurance. The program provides members a lock-in provider who acts as a safeguard against the unnecessary or inappropriate use of benefits.

Though members in RCP will no longer be locked into one hospital, members will still be locked into one primary medical provider, who will coordinate member health care, and one pharmacy to fill prescriptions.

This information applies to members in the Hoosier Healthwise, Healthy Indiana Plan (HIP) and Hoosier Care Connect programs. Anthem will update the provider manual to reflect this program change.

**Questions?**
To discuss your patient's panel or add to it, call **1-866-902-1690**, **option 1**. You can also fax requests to **1-866-387-2959**.

If you have questions about this communication or any other topic, please contact your Network Relations consultant or call Provider Services:

- Hoosier Healthwise – **1-866-408-6132**
- Healthy Indiana Plan – **1-844-533-1995**
- Hoosier Care Connect – **1-844-284-1798**

**URL:** https://providernews.anthem.com/indiana/article/right-choices-program-update

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## Specialty pharmacy level of care

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Click here for more information about the Specialty pharmacy level of care

**URL:** https://providernews.anthem.com/indiana/article/specialty-pharmacy-level-of-care

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## Use of Imaging Studies for Low Back Pain (LBP)

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

The HEDIS® measure, Use of Imaging Studies for Low Back Pain (LBP), analyzes the

Clinical guidelines for treating patients with acute low back pain recommend against the use of imaging in the absence of red flags (in other words, indications of a serious underlying pathology such as a fracture or tumor). Unnecessary or routine imaging is problematic because it is not associated with improved outcomes and exposes patients to unnecessary harms such as radiation exposure and further unnecessary treatment.

**Measure exclusions:**

- Cancer
- Recent trauma
- Intravenous drug abuse
- Neurological impairment
- HIV
- Spinal infection
- Major organ transplant
- Prolonged use of corticosteroids

**Helpful tips:**
Hold off on doing imaging for low back pain within the first six weeks, unless red flags are present.

**Consider alternative treatment options prior to ordering diagnostic imaging studies, such as:**

- Nonsteroidal anti-inflammatory drugs.
- Non-pharmacologic treatment, such as heat and massage.
- Exercise to strengthen the core and low back or physical therapy.

**Other available resources:**

- National Committee for Quality Assurance – NCQA.org
- Choosing Wisely – Choosingwisely.org
- American Academy of Family Physicians –org

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

**URL:** https://providernews.anthem.com/indiana/article/use-of-imaging-studies-for-low-back-pain-lbp-5

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## Medicare News - May 2020

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Please continue to check Important Medicare Advantage Updates for the latest Medicare Advantage information, including:

- Prior Authorization requirements
- New behavioral health Medicare Advantage individual and Group Retiree Solutions provider fax

**URL:** https://providernews.anthem.com/indiana/article/medicare-news-may-2020

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## Reimbursement Policy Update: Unlisted, Unspecified or Miscellaneous Codes

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Effective August 1, 2020, Anthem Blue Cross and Blue Shield will continue to allow reimbursement for unlisted, unspecified or miscellaneous codes. Unlisted, unspecified or miscellaneous codes should only be used when an established code does not exist to describe the service, procedure or item rendered. Reimbursement is based on review of the unlisted, unspecified or miscellaneous codes on an individual claim basis. Claims submitted with unlisted, unspecified or miscellaneous codes must contain specific information and/or documentation for consideration during review.

For additional information, please review the *Unlisted, Unspecified or Miscellaneous Codes* reimbursement policy here.

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**URL:** https://providernews.anthem.com/indiana/article/reimbursement-policy-update-unlisted-unspecified-or-miscellaneous-codes

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# Multi-dose packaging

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

Anthem Blue Cross and Blue Shield wants to make multi-dose packaging available to your patients to help support medication adherence. It’s a simpler, safer way for your patients to manage their medications. Multi-dose packaging is a free service available to members at select network pharmacies.

**What is multi-dose packaging?**
Multi-dose packaging (MDP) involves organizing prescription and over-the-counter products to provide ease to patients when taking their routine medications. Each MDP dispenser provides patients with a personalized roll of pre-sorted medication packs, labeled with the date and time of the patient's next scheduled dose. MDP helps reduce the stress of determining which medications to take, when to take them and how much of them to take.

**Who provides these services?**
MDPs can be shipped to the CVS* retail pharmacy of choice or directly to a patient’s home at no additional charge. The MDP Care team is available 24/7 to address patient questions and concerns. The team also coordinates mid-month prescription changes with local CVS pharmacies. CVS MDP is licensed in all states and the District of Columbia.

If CVS isn't the right fit based on geography, PillPack* can provide MDP services for your patients. Packages can include prescription medication, over-the-counter medication and vitamins, and will include a date and time stamp on each packet to help your patients remember to take their medications. Patient copays should be the same; in some cases, it may be cheaper.

**How do I refer my patients to MDP providers?**

**For CVS:** Patients can enroll online at https://www.CVS.com/multidose or call **1-800-753-0596**. Patients residing in the District of Columbia, Georgia or South Carolina should call **1-844-650-1637** (due to remote practice restrictions). Members may also enroll at their local CVS pharmacy.

**For PillPack:** Patients interested in PillPack can enroll online at https://www.pillpack.com/blue or via phone by calling **1-866-282-9462**.

* CVS is an independent company providing pharmacy services on behalf of Anthem Blue Cross and Blue Shield. PillPack is an independent company providing pharmacy services on behalf of Anthem Blue Cross and Blue Shield.

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**URL:** https://providernews.anthem.com/indiana/article/multi-dose-packaging-1