Wisconsin Provider News

November 2020 Anthem Provider News - Wisconsin

Medicare:

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

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

Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements starred (*) below.

- Prior authorization updates for specialty pharmacy are available*
- Medical policy and clinical guideline updates*
- Correction to Prior Authorization Update for Commercial business*
- New reimbursement policy: Documentation Standards for Episodes of Care (Professional)*
- Reimbursement policy update: Modifier rules (Professional)*
- Reimbursement policy update: Bundled Services and Supplies (Professional)*

URL: https://providernews.anthem.com/wisconsin/article/notice-of-material-changesamendments-to-contract-and-prior-authorization-changes-november-2020-1

IngenioRx Introduces new pharmacy network in 2021

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

Starting **January 1, 2021**, IngenioRx, the pharmacy benefit manager for our affiliated health plans, will make its new standard pharmacy network available to your patients. The standard network will be made up of about 58,000 pharmacies nationwide, including well-known national chains like Costco, CVS, Kroger, Sam's Club, Target and Walmart.

With robust access, your patients can use any participating pharmacy across the country in the standard network to fill their prescriptions.

Network Notification Plan

Some of your patients covered by an Anthem Blue Cross and Blue Shield health plan may currently use pharmacies that are not in this new network. They'll need to transfer their active prescription(s) to a network pharmacy to ensure there is no interruption of their coverage.

Prior to the network effective date, we'll notify your patients by letter outlining the easy steps about transferring their prescriptions to another pharmacy in the network.

In addition, to help you easily send prescriptions to a participating pharmacy, we'll include messaging via your patients' electronic medical record. This message will appear if you attempt to submit a prescription to a pharmacy that's not included in the standard network. This will ensure your patients' prescriptions are properly routed to a network pharmacy and will help them continue to receive their medications worry-free.

If your patients would like to search for a network pharmacy prior to the new network effective date, they can log in to anthem.com, where instructions will appear with a helpful link to our online pharmacy search tool. They can enter their address/city/state or their zip code to begin searching.

Questions? Please refer to our helpful Frequently Asked Questions below for more details about the new standard network.

Frequently Asked Questions

Q: What is the standard pharmacy network?
A: The standard pharmacy network is being added to the IngenioRx network portfolio, beginning **January 1, 2021**. The standard pharmacy network will be made up of approximately 58,000 pharmacies nationwide, including well-known national retailers and big-box stores. These include Costco, CVS, Kroger, Sam's Club, Target and Walmart.

Q: How will my patients who have used a non-network pharmacy and are moving to the standard pharmacy network be notified?
A: Prior to January 1, we'll notify your patients who are currently utilizing a pharmacy that will not be part of the standard network on the effective date via letter. The information will help patients easily transfer their prescriptions to a participating network pharmacy with no interruption when they need to fill their prescriptions.

Q: How will I be notified if an ePrescription is routed to a non-network pharmacy?

A: An alert will be provided to you via your patients' electronic medical records if you attempt to forward a prescription to a pharmacy that doesn't participate in the standard network. This will ensure your patients' prescriptions are properly routed to a network pharmacy and this will help them seamlessly receive their medications.

Q: If I'm alerted through my patients' electronic medical record that a pharmacy will not be part of the standard network, how can my patient move their prescription to another participating pharmacy?
A: You can choose another pharmacy in the patient's EMR where the ePrescription will be routed, or your patient can **take a printed copy of your prescription to the new pharmacy of their choosing and ask the new pharmacy to contact the non-network pharmacy to make arrangements for the transfer.**

Q: How can my patients search for a pharmacy that participates in the standard pharmacy network?
A: Starting in November 2020, your patients can log in to anthem.com, where information about their new pharmacy network will appear. The information will also outline how to transfer prescriptions to a network pharmacy with a helpful link to our online pharmacy search tool. They can enter their address/city/state or their zip code to begin searching.

Q: Can my patients obtain maintenance medications at a standard network pharmacy?
A: While pharmacies in the standard network often fill prescriptions for both acute and maintenance medications, we encourage your patients who will be moving to the standard network in 2021 to use home delivery or their 90-day retail benefit after January 1, 2021, such as Retail 90 or Rx Maintenance 90, depending on their benefit design, to fill prescriptions for maintenance medications and possibly save on their out-of-pocket cost.

Q: If my patients have questions about the new standard pharmacy network or need help with having their prescriptions transferred, whom should they contact?
A: If your patients have questions, they can call Pharmacy Member Services at the phone number on their member ID card.

750-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/ingeniorx-introduces-new-pharmacy-network-in-2021-3

Prior authorization updates for specialty pharmacy are available - November 2020*

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

Prior authorization updates

Effective for dates of service on and after February 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.

Anthem Blue Cross and Blue Shield (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 shown in italics in the table below.*

Clinical Criteria	HCPCS or CPT Code(s)	Drug
**ING-CC-0127*	*J9999, C9399*	*Darzalex Faspro*

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

Step therapy updates

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

To access the Clinical Criteria information related to Step Therapy, 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 shown in italics in the table below.*

Clinical Criteria	Status	Drug(s)	HCPCS Codes
ING-CC-0160	Non-preferred	Vyepti	J3032
ING-CC-0160	Non-preferred	Vyepti	C9063
ING-CC-0011	Non-preferred	Ocrevus	J2350

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

Correction to a prior authorization update

In the October 2020 edition of *Provider News,* we published a prior authorization update regarding clinical criteria **ING-CC-0174** on the drug Kesimpta.

- One HCPCS code has been added, J9302. This is the valid code for the drug Kesimpta.

743-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/prior-authorization-updates-for-specialty-pharmacy-are-available-november-2020

Availity attachment tools for Anthem and affiliate payers - Live Webinars

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

In this 60-minute webinar, you will learn how to use Availity's* attachment tools to submit and track supporting documentation electronically to Anthem and affiliate payers.

We will explore key workflow options to fit your organization's needs, including how to:

- Work a request in the inbox of your Attachments Dashboard.

- Enter and submit a web claim including supporting documentation.
- Use EDI batch options to trigger a request in your inbox.
- Track attachments you submitted using sent and history lists in your Attachments Dashboard.
- Get set up to use these tools.

As part of the session, we'll answer questions and provide handouts and a job aid for you to reference later.

Register for an upcoming webinar session:

1. In the Availity Portal, select **Help & Training** > **Get Trained**.
2. The Availity Learning Center opens in a new browser tab.
3. Search for and enroll in a session using one of these options:

- In the Catalog, search by webinar title or keyword.
  - To find this specific live session quickly, use keyword ***medattach***.
  - Select the Sessions tab to scroll the live session calendar.

1. After you enroll, you'll receive emails with instructions to join the session.

Webinar Dates

Date	Day	Time
November 4, 2020	Wednesday	12 noon to 1 p.m. ET
November 17, 2020	Tuesday	2 p.m. to 3 p.m. ET
December 4, 2020	Friday	3 p.m. to 4 p.m. ET
December 15, 2020	Tuesday	3 p.m. to 4 p.m. ET

762-1120-PN-CNT

Clinical Laboratory Improvement Amendments (CLIA) Number - Additional Information

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

The purpose of this article is to provide additional information regarding submission of the CLIA number on claims for laboratory services that include QW or 90 modifiers. As a reminder, claims filed without the CLIA number are considered incomplete and will reject.

Both paper and electronic claim formats accommodate the CLIA number.

- On the CMS-1500 form, Box 23 (Prior Authorization) is reserved for the CLIA number.
- On the 837P, REF segments are available: REF (X4) in loops 2300 and 2400, and REF (F4) in loop 2400.

Note: The CLIA number for the Referring Clinical Laboratory should be included in REF (F4)

The following examples illustrate how the CLIA number as well as procedure code modifiers QW and 90 should be filed:

Claim Format	Location(s) Reserved for Procedure Modifier and CLIA #		
Modifier QW – diagnostic lab service is a CLIA waived test			
CLIA Waived Tests - simple laboratory examinations and procedures that have an insignificant risk of an erroneous result			
CMS-1500	Procedure modifier ‘QW’: Box 24d	CLIA #: Box 23 Prior Authorization	
837P	Procedure modifier ‘QW’: Loop 2400 SV101-3 (1st position)	CLIA #: Loop 2300 or 2400 REF X4	
Modifier 90 – Reference (Outside) Laboratory			
Referring laboratory – refers a specimen to another laboratory for testing Reference laboratory – receives a specimen from another laboratory and performs one or more tests on that specimen			
CMS-1500	Procedure modifier ‘90’: Box 24d	CLIA #: Box 23 Prior Authorization	
837P	Procedure modifier ‘90’: Loop 2400 SV101-3 – SV101-6	CLIA #: Loop 2300 or 2400 REF X4	CLIA # - Referring Facility Identification: Loop 2400 REF F4

Additional information regarding CLIA is available on the CMS website.

If you have additional questions, please call the telephone number on the back of the member’s identification card.

733-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/clinical-laboratory-improvement-amendments-clia-number-additional-information-2

Digital transactions cut administrative tasks in half

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

Introducing the Anthem Blue Cross and Blue Shield (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 percent 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, please visit the **Availity EDI website** or the **secure provider portal via 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 you can receive payments faster. Electronic remittance advice (ERA) is completely searchable and downloadable from the secure provider portal or the EDI 835 remittance, which meets all HIPAA mandates – eliminating the need for paper remittances.

Member IDs go digital

Anthem members are transitioning to digital member identification cards making it 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 identification cards to EDI transactions, APIs to Direct Data Entry, we cover it all in our **Provider Digital Engagement Supplement** to the provider manual and on the secure **Availity Provider Portal**. The Supplement outlines Anthem provider expectations, processes and self-service tools across all electronic channels, 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 and go digital with Anthem.

774-1120-PN-CNT

Get the full picture of your patient's health through their smartphone

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

Anthem Blue Cross and Blue Shield (Anthem) is committed to creating innovative tools that help simplify health care. In pursuit of that commitment, we recently enhanced our digital tool that enables members to share their personal health data with physicians and hospitals. This tool, referred to as My Health Records, merges patient health records from providers who may have cared for an individual member and stores the data in one secure place that is accessible to the member via the Sydney Health mobile app and anthem.com. My Health Records provides a new way for members to access their personal health information from multiple providers' databases then view, download and share their health data and medical records with doctors via their smartphone or computer.

My Health Records allows members to share important health information with physicians, such as:

- Lab results and historical insights with visualizations
- Medications, Conditions, Immunizations, Vaccinations
- Health records
- Health records of dependents (14 years and under)
- Easy access to provider information
- Personalized health data tracking over time
- Integration for member authorization to more health record data

The enhanced digital tool gives physicians and hospitals a holistic view of a member's up-to-date health data. This complete health data in one trusted place enables providers and members to feel more confident in making important life decisions easily and quickly.

*This tool is now available to Anthem members in our Medicare, Individual, Small Group and Fully Insured Large Group business segments and will be available to members in our Large Group ASO and Anthem National Account business segments in early 2021.

763-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/get-the-full-picture-of-your-patients-health-through-their-smartphone-3

US Antibiotic Awareness Week

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

US Antibiotic Awareness Week is November 18-24, 2020!

This is a one week observance that gives organizations and providers an opportunity to raise awareness on the appropriate use of antibiotics and reduce the threat of antibiotic resistance. The Centers for Disease Control and Prevention (CDC) has over 10 hours of **free Continuing Education** available for providers at https://www.cdc.gov/antibiotic-use/community/for-hcp/continuing-education.html.

The CDC promotes *Be Antibiotics Aware*, an educational effort to raise awareness encouraging safe antibiotic prescribing practices and use. *Be Antibiotics Aware* has many resources for health care professionals (in outpatient and inpatient settings) including videos such as *The Right Tool* and *Antibiotics Aren't Always the Answer* that can be utilized in provider's waiting rooms.

722-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/us-antibiotic-awareness-week-3

Medical policy and clinical guideline updates - November 2020*

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

Medical policy updates

The following Anthem Blue Cross and Blue Shield new medical polices were reviewed on August 13, 2020 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

*NOTE *Precertification required*

Title	Information	Effective date
MED.00134 Non-invasive Heart Failure and Arrhythmia Management and Monitoring System	• The use of a non-invasive heart failure and arrhythmia management and monitoring system (for example, µ-Cor™ Heart Failure and Arrhythmia Management System) is considered Investigational and Not Medically Necessary (INV&NMN) for all indications. - Existing codes 0607T, 0608T (which were effective 07/01/2020) will be considered INV&NMN for all indications	2/1/2021
SURG.00156 Implanted Artificial Iris Devices	• The use of implanted artificial iris devices is considered INV&NMN for all indications, including as a treatment of congenital or traumatic aniridia -Existing codes 0616T, 0617T, 0618T (effective 07/01/20), C1839, 08RC3JZ, and 08RD3JZ will be considered INV&NMN for all indications	2/1/2021
*SURG.00157 Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis	• Minimally invasive treatment of the posterior nasal nerve area, such as cryotherapy or radiofrequency therapy, to decrease the symptoms of allergic or nonallergic rhinitis is considered INV&NMN in all cases - No specific code for cryotherapy or RF treatment of nasal tissue for rhinitis; listed 30999 (NOC) and 30117 if billed for this diagnosis, considered INV&NMN	2/1/2021

Clinical guideline updates

The following clinical guideline has been adopted by Anthem Blue Cross and Blue Shield for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

*NOTE *Precertification required*

Title	Information	Effective date
* CG-SURG-104 Intraoperative Neurophysiological Monitoring	This Clinical Guideline addresses the various types of evoked response studies and their use in intraoperative neurophysiological monitoring when the monitoring is not provided by a member of the operating team. The use of neural evoked response studies for purposes other than assistance during a surgical procedure is not addressed in this document. Applicable Codes: - CPT codes: 95829, 95940, 95941 - HCPCS: G0453 - ICD10 procedure codes: 4A1004G-4A10X4G, 4A1104G-4A11X4G	2/1/2021

737-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/medical-policy-and-clinical-guideline-updates-november-2020

Correction to Prior Authorization Update for Commercial business*

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

In the October 2020 edition of *Provider News*, we announced updates to prior authorizations that applied to Commercial Individual business effective January 1, 2021. **Please be advised that the prior authorization updates apply to all Commercial local business, including individual and group business. Also, the effective date of these updates is now February 1, 2021.**

Please see below for the complete updated notice.

Anthem Blue Cross and Blue Shield in Indiana, Kentucky, Missouri, Ohio and Wisconsin is committed to reducing costs that are not medically necessary while improving health outcomes. To that end, **effective February 1, 2021** Anthem Blue Cross and Blue Shield in Indiana, Kentucky, Missouri, Ohio and Wisconsin will require prior authorization for **all of our commercial local business.**

The following codes will require prior authorization with a date of service on or after **February 1, 2021** for **all of our commercial local business**:

Medical Policy or Clinical Guideline	Code(s)
CG-SURG-70 SURG.00026 SURG.00007	C1767

The following Clinical Guidelines have been adopted for **all of our Commercial local business** in Indiana, Kentucky, Missouri, Ohio and Wisconsin and will require prior authorization on or after **February 1, 2021**.

Clinical Guideline	Code
CG-DME-13	L5987
CG-DME-42	A9274, E0784, E0787, S1034
CG-DME-47	E0466, E0467
CG-OR-PR-04	S1040, L0112
CG-SURG-86	34705, 34841, 34842, 34843, 34844, 34845, 34846, 34847, 34848

The following Medical Policies have been reviewed and will require prior authorization for **all of our Commercial local business** in Indiana, Kentucky, Missouri, Ohio and Wisconsin**,** on or after **February 1, 2021**.

Medical Policy or Clinical Guideline	Code
GENE.00054	0157U, 0158U, 0159U, 0160U, 0161U,
SURG.00121	33477
SURG.00010	53445, 53447
LAB.00016	81599
GENE.00011	81599
GENE.00037	81599
GENE.00020	81599
GENE.00016	81599
GENE.00018	81599
LAB.00019	81599
GENE.00023	81599
GENE.00009	81599
GENE.00026	81599
GENE.00052	81599
SURG.00007	C1767
CG-DME-44	E0766, A4555
GENE.00054	0157U, 0158U, 0159U, 0160U, 0161U
CG-SURG-95	C1767
SURG.00121	33477

776-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/correction-to-prior-authorization-update-for-commercial-business

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Reminder: Post-service reviews using AIM

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

As previously communicated in the October 2017 Network Update, Anthem Blue Cross and

Provider*Portal*$_{SM}$. If documentation/post-service review request is submitted to Anthem, providers are notified via another letter or remit message to submit to AIM.

To help prevent delays in claim processing and post-service reviews, ordering providers submit pre-service request to AIM in one of the following ways:

- Access AIM ***Provider****Portal* directly at **providerportal.com** available 24/7 to process orders in real-time
- Access AIM via the Availity web portal at **availity.com**

As a reminder, AIM reviews the following services for clinical appropriateness:

- Advanced diagnostic imaging
- Cardiology tests and procedures (e.g. MPI, echocardiography, PCI, cardiac catheterization)
- Medical oncology treatments through the Cancer Care Quality Program
- Radiation oncology treatments (e.g. IMRT, brachytherapy)
- Sleep testing, treatment and supplies
- Genetic testing
- Musculoskeletal (e.g., spine and joint surgeries, pain management)
- Rehabilitative services (physical, speech and occupational therapy)
- Surgical Site of Care (e.g., gastroenterology, other surgeries will be implemented which will be communicated via provider newsletter)

Services performed in an emergency or inpatient setting are excluded from AIM programs.

This update applies to local fully-insured Anthem members and members who are covered under a self-insured (ASO) benefit plan, with services medically managed by AIM. It does not apply to BlueCard, Medicare Advantage, Medicaid, Medicare Supplement, Federal Employee Program (FEP).

For more information please contact the phone number on the back of the member ID card.

711-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/reminder-post-service-reviews-using-aim-4

New reimbursement policy: Documentation standards for episodes of care (Professional)*

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

The new professional reimbursement policy for Documentation Standards for Episodes of Care will be effective February 1, 2021. This policy will replace the current Documentation Guidelines for Adaptive Behavior Assessments and Treatment for Autism Spectrum Disorder and Documentation Guidelines for Central Nervous System Assessments and Tests policies. Those policies will be retired as of February 1, 2021. The Documentation Standards for Episodes of Care policy will be considered an administrative policy and will serve as an overarching documentation standards policy.

For more information about this policy, visit the Reimbursement Policies webpage for your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

748-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/new-reimbursement-policy-documentation-standards-for-episodes-of-care-professional-1

Reimbursement policy update: Modifier rules (Professional)*

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

Beginning with dates of service on or after February 1, 2021, Anthem Blue Cross and Blue Shield (Anthem) policy language has been updated to add Modifier FB to the related coding section and indicate that when used in the adjudication of a claim reimbursement may be affected.

Modifier FB is defined as an item provided without cost to provider, supplier or practitioner, or full credit received for replaced device.

For more information about this policy, visit the Reimbursement Policies webpage for your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

751-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/reimbursement-policy-update-modifier-rules-professional-1

Reimbursement policy update: Bundled services and supplies (Professional)*

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

Beginning with dates of service on or after February 1, 2021, Anthem Blue Cross and Blue Shield (Anthem) will update Bundled Services and Supplies Section 2 Coding list to indicate that the following codes:

- 43281 - laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh,
- 43282 - laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh or other prosthesis,
- 43283 - laparoscopy, surgical, esophageal lengthening procedure,
- 43332 - repair paraesophageal hiatal hernia, via laparotomy, except neonatal; without implantation of mesh or other prosthesis, and
- 43333 - repair paraesophageal hiatal hernia, via laparotomy, except neonatal; with implantation of mesh or other prosthesis,

are *not eligible for separate reimbursement* when reported with bariatric procedure codes 43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43886, 43887 and 43888.

Additionally, the Bundled Services Section 2 coding list will be updated to include the telehealth originating site facility fee HCPCS code (Q3014) when reported with an E&M code in place of service 11.

For more information about this policy, visit the Reimbursement Policies webpage for your state: Indiana, Kentucky, Missouri, Ohio, Wisconsin.

754-1120-PN-CNT

URL: https://providernews.anthem.com/wisconsin/article/reimbursement-policy-update-bundled-services-and-supplies-professional-1

Medicaid News - November 2020

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

Please continue to check **Provider Communications & Updates** on the **provider website** for the latest BadgerCare Plus information, including:

- Evaluation and management services correct coding
- New specialty pharmacy medical step therapy requirements
- Provider Chat: A fast, easy way to get your questions answered
- New specialty pharmacy medical step therapy requirements
- Update: Notice of changes to the AIM Musculoskeletal Program prior authorization requirements and setting determinations
- Electronic visit verification notification

URL: https://providernews.anthem.com/wisconsin/article/medicaid-news-november-2020

Digital transactions cut administrative tasks in half

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

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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 *Digital Provider 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 *Digital Provider Engagement Supplement* to the provider manual, available by going to **https://mediproviders.anthem.com/WI/Pages/manuals-directories-training.aspx** > Manuals, Training, Directories & More > Tutorials, Reference Guides & Other Resources > 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, including medical, dental and vision benefits.

The *Digital Provider 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 **https://mediproviders.anthem.com/WI/Pages/manuals-directories-training.aspx** > Manuals, Training, Directories & More > Tutorials, Reference Guides & Other Resources > Provider Digital Engagement. Go digital with Anthem.

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

URL: https://providernews.anthem.com/wisconsin/article/digital-transactions-cut-administrative-tasks-in-half-11

Medical drug benefit clinical criteria updates

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

On February 21, 2020, May 15, 2020, and June 18, 2020, 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 website, and the effective dates will be reflected in the ***Clinical Criteria Web Posting June 2020***. Visit ***Clinical Criteria*** to search for specific policies.
If you have questions or would like additional information, use this **email**.

URL: https://providernews.anthem.com/wisconsin/article/medical-drug-benefit-clinical-criteria-updates-70

Prior authorization requirements for HCPCS code 55899

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

Effective **December 1, 2020**, prior authorization (PA) requirements will change 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**: **1-800-964-3627**

- **Phone**: **1-855-558-1443**

Not all PA requirements are listed here. PA requirements are available to contracted providers by accessing the Provider Self-Service Tool at **availity.com** by visiting **https://mediproviders.anthem.com/wi** > Login. Contracted and non-contracted providers who are unable to access Availity* may call Provider Services at **1-855-558-1443** for PA requirements.

* 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/prior-authorization-requirements-for-hcpcs-code-55899

Inhaled nitric oxide reviews for diagnosis-related group admissions

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

This is a notification regarding inhaled nitric oxide.

The purpose of this notification is to inform participating hospitals that the use of inhaled nitric oxide (iNO) during an inpatient stay will be reviewed for medical necessity using our *Clinical Utilization Management (UM) Guideline for Inhaled Nitric Oxide*, CG-MED-69. iNO is a covered service for eligible members when the use of iNO meets medical necessity criteria. To view the *Clinical UM Guideline* for iNO, visit **mediproviders.anthem.com/wi**.

This also requires that the facility notify Anthem Blue Cross and Blue Shield (Anthem) of the use of iNO during the course of an inpatient review, and it must be reviewed and approved at some point prior to discharge to avoid exclusion of charges for iNO from the claim payment. If we are not alerted to the use of iNO and, therefore, medical necessity cannot be determined, and charges for iNO are included in the claim submission, the charges for iNO will not be considered in calculation of reimbursement for the stay.

When iNO is used, providers are required to submit an itemized list of charges with the claim for the inpatient stay.

Impact on the diagnosis-related group (DRG) payment

The charges for iNO that are determined to be not medically necessary will not be considered and could impact the DRG outlier payment, as the stay may not reach outlier status as soon as it would with inclusion of these charges. If the case reaches the outlier threshold, we will adjudicate the claim consistent with the financial terms of the contract for outliers, without inclusion of charges for iNO that are not medically necessary or the use of which was not disclosed.

Providers should direct questions regarding this guideline or in relation to the Utilization Management review process to the health plan numbers listed below:

- **1-855-558-1443**

Providers should fax new prior authorization requests for physical health inpatient services to **1-800-964-3627**.

Fax submissions of clinical documentation as requested by the Anthem Inpatient Utilization Management department supporting medical necessity reviews for inpatient concurrent reviews to **1-877-279-2418**.

URL: https://providernews.anthem.com/wisconsin/article/inhaled-nitric-oxide-reviews-for-diagnosis-related-group-admissions

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Transition to AIM Rehabilitative Service Clinical Appropriateness Guidelines

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

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

Anthem previously communicated that AIM Specialty Health®* (AIM) would transition the clinical criteria for medical necessity review of certain rehabilitative services to *AIM Rehabilitative Service Clinical Appropriateness Guidelines* as part of the AIM Rehabilitation Program beginning October 1, 2020. Please be aware that this transition has been delayed. The new transition date will be in December 1, 2020.

URL: https://providernews.anthem.com/wisconsin/article/transition-to-aim-rehabilitative-service-clinical-appropriateness-guidelines-5

Provider transparency update

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

A key goal of the provider transparency initiatives of Anthem Blue Cross and Blue Shield (Anthem) is to improve quality while managing health care costs. One of the ways this is accomplished is through our value-based programs (for example, the Provider Quality Incentive Program, the Provider Quality Incentive Program Essentials, Risk and Shared Savings, etc.), known as *the Programs*.

Value-Based Program Providers (also known as Payment Innovation Providers) in our various value-based programs receive quality, utilization and/or cost data, reports and information about other health care providers (Referral Providers). The Value-Based Program Providers can use that information in selecting Referral Providers for their patients covered under the Programs. If a Referral Provider is higher quality and/or lower cost, this component of the Programs should result in the provider getting more referrals from Value-Based Program Providers. If Referral Providers are lower quality and/or higher cost, the converse should be true.

Providing this type of data, including comparative cost information, to Value-Based Program Providers helps them make more informed decisions about managing health care costs, and maintaining and improving quality of care. It also helps them succeed under the terms of the Programs.

Anthem will share data on which we relied in making these quality/cost/utilization evaluations upon request, and will discuss it with Referral Providers, including any opportunities for improvement. If you have questions or need support, please refer to your local market representative or care consultant.

URL: https://providernews.anthem.com/wisconsin/article/provider-transparency-update-36

Coding spotlight: Tips and best practices for compliance

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

Need for coding compliance
Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes.

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Medical records documentation
All medical records entries should be complete and legible, and should include the legible identity of the provider and date of service.

Each encounter in the medical record must include the patient's full name and date of birth. Documentation integrity is at risk when there is wrong information on the wrong patient health record because it can affect clinical decision-making and patient safety.

Providers' signatures and credentials are of the utmost importance in all documentation efforts. The signature is an attestation from the treating and documenting provider that certifies the written document as reflecting the provider's intentions regarding the services performed during the encounter, and the reason(s).

Specific information is required to describe the patient encounter each time he or she presents for medical services.

Each encounter generally will need to contain the following:

- The chief complaint

- The history of present illness
- The physical examination
- Assessment and care plan.

Common coding and billing risk areas
The following billing risks are commonly subject to Office of Inspector General (OIG) investigations and audits:

- Billing for items or services not rendered or not provided as claimed
- Double billing, resulting in duplicate payment
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary
- Billing for non-covered services
- Knowingly misusing provider identification numbers, which results in improper billing
- Unbundling
- Failure to properly use modifiers
- Upcoding the level of service.

Evaluation and Management (E&M) claims are typically denied for two reasons:

- Incorrect coding, such as the code not matching the documentation, and insufficient documentation, which can include a lack of a provider signature or no record of the extent and amount of time spent in counseling.
- Coordination of care when it is used to qualify for a particular level of E&M service.

There are several strategies on how to prevent E&M claims being denied:

- In addition to the individual requirements for billing a selected E&M code, providers should also consider whether the service is reasonable and necessary (for example, a level 5 office visit for a patient with a common cold and no comorbidities will not be reasonable and necessary).
- Remember the following when selecting codes for E&M services:
    - Patient type (new or established)
    - Setting/place of service

- The level of service provided based on the extent of the history, the extent of the examination, and the complexity of the medical decision making (for example, the number and type of the key components performed).

Best practices to avoid common documentation mistakes

Providers need to formulate a complete and accurate description of the patient's condition with a detailed plan of care for each encounter. Listing problems without a corresponding plan of care does not confirm physician management of that problem and could cause a downgrade of complexity. Listing problems with a brief, generalized comment (for example, diabetes management (DM), chronic kidney disease (CKD), congestive heart failure (CHF): Continue current treatment plan) equally diminishes the complexity and effort put forth by the physician.

The care plan needs to be documented clearly. The care plan represents problems the physician personally manages, along with those that must also be considered when he or she formulates the management options, even if another provider is primarily managing the problem. For example, one provider can monitor the patient's diabetic management while the nephrologist oversees the chronic kidney disease (CKD).

Pathology service, laboratory testing, radiology and medicine-based diagnostic testing contributes to diagnosing or managing patient problems.

Documentation tips:

- Specify tests ordered and document rationale in the medical record
- Document test review by including a description in the note (for example, elevated glucose levels)
- Indicate when images, tracings, or specimens are personally reviewed; be sure to include a comment on the findings
- Summarize any discussions of unexpected or contradictory test results with the provider performing the procedure or diagnostic study.

Patient risk in E&M is categorized as minimal, low, moderate or high based on the presenting problem, diagnostic procedures ordered and management options selected. Chronic conditions with exacerbations and invasive procedures offer more patient risk than acute, uncomplicated illnesses or noninvasive procedures. Stable or improving problems are considered less risky than progressing problems; conditions that pose a threat to life/bodily function outweigh undiagnosed problems where it is difficult to determine the patient's prognosis.

To determine the right complexity of the patient's problems, providers should:

- Document the status for all problems in the plan of care and identify them as stable, worsening, or progressing (mild or severe), when applicable; do not assume that the auditor or coder can infer this from the documentation details.
- Document all diagnostic or therapeutic procedures considered.
- Identify surgical risk factors involving co-morbid conditions that place the patient at greater risk than the average patient, when appropriate.

Frequent auditing is key to medical coding compliance

To ensure your organization's E&M services are coded appropriately, it is important to periodically review your charts to check for insufficient documentation, miscoding, upcoding and downcoding. Conducting audits of your medical coding process and procedures can help give you an understanding of recurring risk areas and key improvement opportunities. Using these insights, you can then incorporate best practices and address any bad habits, lessening the chances of negative consequences.

Resources

- *CPT® Professional Edition, 2020*. AMA
- *Compliance Guidance*. Office of Inspector General. **https://oig.hhs.gov/compliance/compliance-guidance/index.asp**
- *Risk Adjustment Documentation & Coding, 2nd edition*. American Medical Association

URL: https://providernews.anthem.com/wisconsin/article/coding-spotlight-tips-and-best-practices-for-compliance-2

Medicare News - November 2020

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

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

- AIM rehabilitation prior authorizations suspended for Group Retiree Solutions members until December 31, 2020
- Transition to AIM Rehabilitative Service Clinical Appropriateness Guidelines
- AIM Musculoskeletal program expansion postponed

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

Provider Chat: A fast, easy way to get your questions answered

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

You now have a new option to have questions answered quickly and easily. With Anthem Blue Cross and Blue Shield (Anthem) and AMH Health, LLC Chat, providers can have a real-time, online discussion through a new digital service, **available through Payer Spaces on Availity**.* Provider Chat offers:

- Faster access to Provider Services for all questions.
- Real-time answers to your questions about prior authorization and appeals status, claims, benefits, eligibility, and more.
- An easy to use platform that makes it simple to receive help.
- The same high level of safety and security you have come to expect with Anthem and AMH Health.

Chat is one example of how Anthem and AMH Health are using digital technology to improve the health care experience, with the goal of saving valuable time. To get started, access the service through Payer Services on **Availity**.

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

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URL: https://providernews.anthem.com/wisconsin/article/provider-chat-a-fast-easy-way-to-get-your-questions-answered-5

Digital transactions cut administrative tasks in half

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

Introducing the Anthem Blue Cross and Blue Shield (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 percent 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, please visit the **Availity EDI website** or the **secure provider portal via 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 at **https://www.anthem.com/medicareprovider** > select your state > Providers > Policies, Guidelines & Manuals, 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 **https://www.anthem.com/medicareprovider** > select your state > Providers > Policies, Guidelines & Manuals. Go digital with Anthem.

* 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/digital-transactions-cut-administrative-tasks-in-half-12

FDA approvals and expedited pathways used - new molecular entities

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

Anthem Blue Cross and Blue Shield (Anthem) reviews the activities of the FDA's approval of drugs and biologics on a regular basis to understand the potential effects for both our providers and members.

The FDA approves new drugs/biologics using various pathways of approval. Recent studies on the effectiveness of drugs/biologics going through these different FDA pathways illustrates the importance of clinicians being aware of the clinical data behind a drug or biologic approval in making informed decisions.

Here is a list of the approval pathways the FDA uses for drugs/biologics:

- **Standard Review:** The Standard Review process follows well-established paths to make sure drugs/biologics are safe and effective when they reach the public. From concept to approval and beyond, FDA performs these steps: reviews research data and information about drugs and biologics before they become available to the public, watches for problems once drugs and biologics are available to the public, monitors drug/biologic information and advertising, and protects drug/biologic quality. Click here to learn more about the Standard Review process.
- **Fast Track:** Fast Track is a process designed to facilitate the development and expedite the review of drugs/biologics to treat serious conditions and fill an unmet medical need. Click here to learn more about the Fast Track process.
- **Priority Review:** A Priority Review designation means FDA's goal is to take action on an application within six months. Click here to learn more about the Priority Review process.
- **Breakthrough Therapy:** A process designed to expedite the development and review of drugs/biologics that may demonstrate substantial improvement over available therapy. Click here to learn more about the Breakthrough Therapy process.
- **Orphan Review:** Orphan Review is the evaluation and development of drugs/biologics that demonstrate promise for the diagnosis and/or treatment of rare diseases or conditions. Click here to learn more about the Orphan Review process.
- **Accelerated Approval:** These regulations allowed drugs/biologics for serious conditions that filled an unmet medical need to be approved based on a surrogate endpoint. Click here to learn more about the Accelerated Approval process.

New molecular entities approvals — January to August 2020

Certain drugs/biologics are classified as new molecular entities (NMEs) for purposes of FDA review. Many of these products contain active ingredients that have not been approved by FDA previously, either as a single ingredient drug or as part of a combination product; these products frequently provide important new therapies for patients.

Anthem reviews the FDA-approved NMEs on a regular basis. To facilitate the decision-making process, we are providing a list of NMEs approved from January to August 2020, along with the FDA approval pathway utilized.

Generic name	Trade name	Standard Review	Fast Track	Priority Review	Break-through Therapy	Orphan Review	Accelerated Approval	Approval date

Indication									
Abametapir	Xeglyze	X						July 24, 2020	Head lice
Amisulpride	Barhemys	X						February 26, 2020	Postoperative nausea and vomiting
Avapritinib	Ayvakit		X	X	X	X		January 9, 2020	PDGFRa exon 18 mutant gastrointestinal stromal tumor
Belantamab mafodotin	Blenrep			X	X	X	X	August 5, 2020	Multiple myeloma
Bempedoic acid	Nexletol	X						February 21, 2020	Dyslipidemia
Brexucabtagene autoleucel	Tecartus			X	X	X	X	July 24, 2020	Mantle cell lymphoma
Capmatinib	Tabrecta			X	X	X	X	May 6, 2020	Non-small cell lung cancer (NSCLC)
Decitabine/ cedazuridine	Inqovi			X		X		July 7, 2020	Myelodysplastic syndromes
Eptinezumab-jjmr	Vyepti	X						February 21, 2020	Migraine prevention
Fostemsavir	Rukobia		X	X	X			July 2, 20202	HIV treatment
Inebilizumab	Uplizna	X			X	X		June 11, 2020	Neuromyelitis optica spectrum disorder
Isatuximab	Sarclisa	X				X		March 2, 2020	Multiple myeloma
Lurbinectedin	Zepzelca			X		X	X	June 15, 2020	NSCLC
Nifurtimox	Lampit			X		X	X	August 6, 2020	Chagas disease
Oliceridine	Olinvyk	X	X					August 7, 2020	Moderate to severe acute pain

Opicapone	Ongentys	X						April 24, 2020	Parkinson’s disease
Osilodrostat	Isturisa	X				X		March 6, 2020	Cushing’s disease
Ozanimod	Zeposia	X						March 25, 2020	Multiple sclerosis
Peanut (Arachis hypogaea) allergen powder-dnfp	Palforzia	X	X		X			January 31, 2020	Peanut allergy
Pemigatinib	Pemazyre			X	X	X	X	April 17, 2020	Cholangiocarcinoma
Remimazolam	Byfavo	X						April 2, 20202	Sedation for procedures
Rimegepant	Nurtec ODT			X				February 27, 2020	Migraine treatment
Risdiplam	Evrysdi		X	X	X	X		August 7, 2020	Spinal muscular atrophy
Ripretinib	Qinlock		X	X	X	X		May 15, 2020	Gastrointestinal stromal tumor
Sacituzumab-hziy	Trodelvy		X	X	X	X	X	April 22, 2020	Triple negative breast cancer
Selpercatinib	Retevmo			X	X	X	X	May 8, 2020	NSCLC and thyroid cancers
Selumetinib	Koselugo		X	X	X	X		April 10, 2020	Neurofibromatosis type 1
Tafasitamab	Monjuvi	X	X		X	X	X	July 31, 2020	Large B-cell lymphoma
Tazemetostat	Tazverik			X		X	X	January 23, 2020	Epithelioid sarcoma
Teprotumumab-trbw	Tepezza		X	X	X	X		January 21, 2020	Thyroid eye disease
Triheptanoin	Dojolvi	X	X			X		June 30, 2020	Long-chain fatty acid oxidation disorders
Tucatinib	Tukysa		X	X	X	X		April 17, 2020	Breast cancer

Viltolarsen	Viltepso		X	X		X	X	August 12, 2020	Duchenne muscular dystrophy

Source: fda.gov

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URL: https://providernews.anthem.com/wisconsin/article/fda-approvals-and-expedited-pathways-used-new-molecular-entities-3