Maine Provider News

October 2021 Anthem Maine Provider News

Pharmacy:

Medicare:

Federal Price Transparency and Consolidated Appropriations Act phase in new mandates beginning January 1, 2022

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In late 2020, the Price Transparency final rule and the Consolidated Appropriations Act (CAA) were enacted. By law, many of these provisions require that Anthem must disclose pricing and other information previously not available publicly. Below is a summary of provisions that may impact you. Some sections of these laws are pending further rulemaking/regulations.

Transparency in pricing regulation – Overview of changes and action Anthem is taking

Transparency requirements will be phased in over three years beginning July 2022 as follows:

Plan years that begin	Regulation requirements	Anthem's action
On or after January 1, 2022	Anthem must make three separate machine-readable files in a standardized format available to the public, including stakeholders such as consumers, researchers, employers, and third-party developers. The three files must be placed on a publicly available website and updated monthly. 1. Negotiated in-network provider rates for all covered items and services 2. Historical payments to, and billed charges from, out-of-network providers 3. In-network negotiated rates and historical net prices for all covered prescription drugs administered by Anthem at the pharmacy location level. 4. The rate information is required to include the provider's National Provider Identifier (NPI) and taxpayer identification number (TIN).	We are developing the files that will be available through our website for the data we administer and maintain. Machine Readable Files will be published beginning July 1, 2022, except those for prescription drugs, which are pending further rulemaking.
January 1, 2023	Anthem must make personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services – including prescription drugs – available to participants, beneficiaries, and enrollees.	As required, we are on track with making information available through an internet-based, self-service tool and in paper form upon request.
January 1, 2024	Anthem must expand our transparency tools to encompass all covered items and services.	We continue to review and assess guidance regarding the regulation and are working to comply with requirements.

Consolidated Appropriations Act (CAA)

As a part of the Consolidated Appropriations Act or CAA, there are significant new health plan requirements, including protections for patients from surprise medical bills and other significant health coverage related provisions. Most of these provisions are effective January 1, 2022.

Regulatory detail needed for full implementation is still pending in most cases. However, the Centers for Medicare & Medicaid Services (CMS) has indicated good faith compliance should be pursued pending regulatory implementation detail.

Some key provisions of the CAA, effective January 1, 2022, are listed below that may impact your business interactions with us.

Surprise billing and independent dispute resolution process
The CAA requires that patients be held responsible for only in-network cost sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). The provision also prohibits out-of-network providers from balance billing except in limited circumstances where the out-of-network provider has obtained a notice and consent from the patient. An independent dispute resolution (IDR) process is available when an out-of-network provider and Anthem cannot reach an agreement on payment.

In July 2021, an interim final rule (IFR) provided some of the regulatory detail around cost sharing calculations for surprise billing. Further regulatory guidance is expected in the coming months – including guidance regarding the IDR process.

Anthem is moving forward with changes in calculations and payment based on the guidance received to date. We will continue to monitor for additional regulatory guidance.

Increasing transparency by removing contract provisions known as gag clauses that may prohibit health plans from disclosing price and quality information

The CAA requires Anthem to provide access to provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become Anthem enrollees.

Due to the gag clause provision, we will no longer be able to allow suppression of price and quality data upon provider request.

Member identification card changes

Member ID cards issued for plan years on and after January 1, 2022, must include information to ensure that members know how to access current information regarding their deductibles and out-of-pocket limits. Additionally, member ID cards must include a telephone number and internet address for members to use for assistance should they have questions such as whether a provider participates in our networks. We encourage in-network providers to continue to use Availity for member cost share information.

Continuity of care

As a part of the Consolidated Appropriations Act, there is a continuity of care protection requirement that allows patients with serious or complex care needs (continuing care patients) to have up to a 90-day period of continued coverage at the same terms and conditions when a provider changes network status or an insured group contract terminates. This provides continued coverage at in-network cost sharing rates to allow for a transition of care to an in-network provider or until the patient is no longer a continuing care patient under the CAA.

Anthem must notify individuals who qualify as continuing care patients at the time of the provider's termination as an in-network provider of the option to continue care for the transitional period of up to 90 days. Providers subject to this provision must accept the continued in-network payment as payment in full and otherwise comply with all policies, procedures and quality standards Anthem imposes. If an insured group terminates with Anthem, continuing care patients also have up to a 90-day period of continued care at in-network cost sharing rates. Applicable contract rates will apply for providers.

Protecting patients and improving the accuracy of provider directory information

Anthem must maintain a provider directory available to consumers online that includes a list of the in-network providers and facilities. Anthem must verify provider/facility name, address, specialty, phone number and digital contact information at least every 90 days.

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URL: https://providernews.anthem.com/maine/article/federal-price-transparency-and-consolidated-appropriations-act-phase-in-new-mandates-beginning-january-1-2022-8

Clinical appeals

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The clinical appeal process is designed to provide appropriate and timely review when providers disagree with a decision made by Anthem. The procedures also meet requirements of state laws and accreditation agencies. Appeals can be made verbally, in writing, or by using Interactive Care Reviewer through the Availity portal.

Clinical appeals refer to a situation in which an **authorization or claim** for a service was denied as not medically necessary or experimental/investigational. Medical necessity and prior authorization appeals are different than claim payment disputes and should be submitted in accordance with the clinical appeal process.

To learn more about our appeals process in detail, we encourage you to go to Anthem's provider manual, available on our website at anthem.com.

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URL: https://providernews.anthem.com/maine/article/clinical-appeals-8

Clarification: Anthem's enhanced claim edits for outpatient facility claims

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In the June 2021 edition *of Provider News*, we announced additional enhancements to our claims editing systems to include an automated front end adjudication of claims edits.

To clarify, this enhancement *does not affect* any of our reimbursement policies. The enhanced edits update our claims editing process for outpatient facility claims.

These enhanced edits provide an opportunity to shift certain existing back-end reviews to front-end adjudication for outpatient facility claims including but not limited to scenarios with:

- Revenue code billing
- CPT/HCPCS code reporting
- Modifier usage

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Are you talking to ALL of your patients about breast cancer screenings?

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African American and Hispanic women have higher risk of death from breast cancer than their White counterparts.[1]

Race and ethnicity continue to be a factor influencing mammography use according to a National Library of Medicine.[2] While research and studies show that annual screenings greatly reduce breast cancer deaths, 35% of women still do not get an annual mammogram and the percentage is even higher in African American and Hispanic women.

While African American and White women get breast cancer at about the same rate, African American women have a higher rate of death from breast cancer, according to the Centers for Disease Control and Prevention. African American and Hispanic women are 20% more likely to be diagnosed with advanced stage breast cancer, and they have, respectively, up to 70% and 14% increased risk of death.[4]

A common theme stressed in all of the major breast screening guidelines has been for providers to talk with patients about mammography. But when? Knowing that younger African American and Hispanic women are already considered a “high-risk” group, the conversation can be confusing to your patient under 30.

Help your African American and Hispanic patients understand the importance of early screening by sharing information with them about their unique risks. Below we’ve included links to videos that address breast cancer screening in both African American and Hispanic women. We hope you will share these with your patients either in your waiting rooms, or by offering to play them during their visits.

Why mammograms matter for Black women.
Why mammograms matter for Hispanic women.

There are other resources available through the Center for Disease control and the American Cancer Society, to name a few. The American College of Radiology has a Talking to Patients about Breast Cancer Screening CME Toolkit that offers CME credits for completing the toolkit.

Talking to women about taking everyday steps to lower their risk for getting breast cancer is the first step in closing disparity gaps in care.

1 https://jamanetwork.com/journals/jamaoncology/article-abstract/2775169
2 https://pubmed.ncbi.nlm.nih.gov/8909641/
3 https://www.acr.org/Media-Center/ACR-News-Releases/2019/ACR-Offers-New-Talking-to-Patients-about-Breast-Cancer-Screening-CME-Toolkit
4 https://www.eurekalert.org/news-releases/475470

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URL: https://providernews.anthem.com/maine/article/are-you-talking-to-all-of-your-patients-about-breast-cancer-screenings-8

Your recommendation is key to encouraging cancer screenings for your female patients

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The American Cancer Society estimates there will be approximately 1,898,160 cancer cases diagnosed in 2021. That's the equivalent of 5,200 new cases each and every day.[1] The good news is, patients say they are more likely to get screened when you recommend it. What else can you do to influence cancer screenings?[2]

1. Understand the power of the physician recommendation.
    - Your recommendation is the most influential factor in whether a person decides to get screened.
    - Patients are 90% more likely to get a screening when they reported a physician recommendation.
    - "My doctor did not recommend it," is the primary reason for screening avoidance.

2. Recognize cultural barriers that may impact your diverse patients
    - Culturally sensitive conversations with your patients can help with fear, embarrassment, anxiety, and misconceptions about screenings.

- Go to mydiversepatients.com for information and resources.

3. Measure the screening rates in your practice; it may not be as high as you think.

   - Set goals to get screening rates up.
   - Follow the HEDIS guidelines included in this article to help accurately track your care gap closures.

4. More screening doesn't have to mean more work for you.

   - Reach out to us about available member data – we may be able to help identify or supply access to data for those members who are due screenings.
   - Develop a reminder system, which has been demonstrated to be effective, to remind you and staff that patients have screenings due.

5. Help members access benefit information about screenings to eliminate the cost barrier.

   - Log onto Availity.com and use the Patient Information tab to run an Eligibility and Benefits inquiry.
   - Members can access their benefit information by logging onto anthem.com, through Live Chat, or by downloading the Sydney Health App.
   - Blue Cross Blue Shield Service Benefit Plan members, also known as Federal Employee Program® members, can access their benefit information by logging onto www.fepblue.org, or by downloading the fepblue App from the Apple Store or on Google Play.

Measure up: HEDIS® measure specifications for cancer screenings for women

Cervical cancer screening

Organized and continuous screenings along with removal of precancerous lesions can lead to a 60% decrease in cervical cancer.[3]

Cervical cancer screening is measured by the percentage of women, 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.

- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

Description	CPT/HCPCS Code
Cervical cytology lab test	**CPT:** 88141–88143, 88147, 88148, 88150, 88152–88153, 88164–88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143, G0145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
hrHPV lab test	**CPT:** 87620–87622, 87624, 87625 **HCPCS:** G0476 **LOINC:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0
Absence of cervix diagnosis	**ICD-10-CM:** Q51.5, Z90.710, Z90.712
Hysterectomy with no residual cervix	**CPT:** 51925, 56308, 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290–58294, 58548, 58550, 58552, 58553, 58554, 58570–58573, 58575, 58951, 58953, 58954, 58956, 59135 **ICD-10-PCS:** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

Breast cancer screening

More women in the United States are surviving and thriving after breast cancer than ever before. In fact, in the last 30 years, the breast cancer death rate has dropped an astounding 40%. The decreases are believed to be the result of finding breast cancer earlier through screening, increased awareness, and better treatments.[4]

Breast cancer screening is measured by the percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Compliant members have one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.

Description	CPT/HCPCS Code
Mammography	**CPT:** 77057, 77061–76063, 77065–77067 **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0
Online assessments	**CPT:** 98970–98972, 99421–99423, 99457 **HCPCS:** G0071, G2010, G2012, G2061–G2063
Telephone visits	**CPT:** 98966–98968, 99441–99443

Chlamydia screening in women

Sexual health is an essential element of overall health and well-being. Many patients want to discuss their sexual health with you, but most of them want you to bring it up. The National Coalition for Sexual Health has published a guide to help physicians feel comfortable about the conversation. Get a copy of the Sexual Health and Your Patients: A Providers Guide by clicking on the title or through this website: ctcfp.org.

Chlamydia screening in women is measured by the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Description	CPT/HCPCS Code
Chlamydia tests	**CPT:** 87110, 87270, 87320, 87490–87492, 87810

1 CA: A Cancer Journal for Clinicians. Cancer Statistics, 2021 https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21654
2 http://thecanceryoucanprevent.org/wp-content/uploads/14893-80_2018-PROVIDER-PHYS-4-PAGER-11-10.pdf
3 National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/9253676/
4 Research to Help Women Prevent Breast Cancer or Live their best life with it. American Cancer Society. https://www.cancer.org/latest-news/research-to-help-women-prevent-breast-cancer-or-live-their-best-life-with-it.html

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URL: https://providernews.anthem.com/maine/article/your-recommendation-is-key-to-encouraging-cancer-screenings-for-your-female-patients-8

Looking to earn CME credits? Register for on-demand webinars

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If you missed our live continuing medical education (CME) webinars, you can still register for the recorded webinars and earn CME credits. Join our CME webinar series and learn best practices to overcoming barriers in achieving clinical quality goals, attaining better patient outcomes and improving STARs performance.

Program objectives:

- Learn strategies to help you and your care team improve your performance across a range of clinical areas.
- Apply the knowledge you gain from the webinars to improve your organization's quality and STARs ratings.

Attendees will receive one CME credit upon answering required questions at the conclusion of each webinar.

Register Here for our upcoming live and on-demand clinical quality webinars.

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URL: https://providernews.anthem.com/maine/article/looking-to-earn-cme-credits-register-for-on-demand-webinars-1

Submit provider claim payment disputes for Anthem's Commercial lines of business via Availity beginning October 19, 2021

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Some time ago, Anthem introduced the ability to submit claim payment disputes via Availity for members enrolled in Anthem Medicaid and Medicare Advantage benefit plans as part of our more streamlined provider claims payment dispute process. **Effective October 19, 2021**, **providers will now also be able to submit claim payment disputes via Availity for many members in our Commercial lines of business**. (Note: There will be limited exceptions for Commercial membership. In addition, this process will not apply to claims for members of the Federal Employee Program® (FEP®).)

As a reminder, unlike inquiries about claims status, provider clinical appeals, or requests for additional information, provider claim payment disputes occur after a claim is finalized, and a provider disagrees with the claim payments we have issued. Some examples include claim disputes regarding manual processing errors, contract interpretation, reduced payments, code editing issues, other health insurance denials, eligibility issues, timely filing issues*, and so forth.

Our streamlined provider claim dispute process utilizing Availity across all lines of business allows a more cohesive and efficient approach for providers when:

- Filing a claim payment dispute
- Sending supporting documentation to Anthem
- Checking the status of a claim payment dispute
- Viewing the history of a claim payment dispute

*Reminder: we will consider reimbursement of a claim that has been denied due to failure to meet timely filing if you can: