Connecticut Provider News

October 2021 Anthem Connecticut Provider News

Products & Programs:

Pharmacy:

Medicare:

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

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

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/connecticut/article/federal-price-transparency-and-consolidated-appropriations-act-phase-in-new-mandates-beginning-january-1-2022-8

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

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

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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URL: https://providernews.anthem.com/connecticut/article/clarification-anthems-enhanced-claim-edits-for-outpatient-facility-claims-9

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/connecticut/article/clinical-appeals-8

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

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

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

1362-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/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

1352-1021-PN-NE

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

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

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

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.

1359-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/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

Published: Oct 1, 2021 - **Administrative** / Digital Tools

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 our Commercial lines of business**.

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:

1. provide documentation that the claim was submitted within the timely filing requirements or
2. demonstrate good cause exists

Reminder on how the Anthem provider claim payment dispute process works
The provider claim payment dispute process consists of two steps:

1. **Claim payment reconsideration:** As the first step, the reconsideration represents providers' initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step. Providers may submit the claim dispute via customer service (refer to the phone number on the back of the member's ID card), in writing, **or effective October 19, 2021 - via Availity.**Providers are encouraged to submit all reconsiderations via Availity. Providers are only allowed one claim payment reconsideration per claim.

We will make every effort to resolve the claims payment reconsideration within 30 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 30 additional calendar days. We will mail you a written extension letter before the expiration of the initial 30 calendar days.

1. **Claim payment appeal:** In this second step, providers who disagree with the outcome of the reconsideration may request an additional review as a claim payment appeal; however, we cannot process an appeal without a reconsideration on file. Providers may submit the claim dispute in writing **or effective October 19, 2021 - via Availity**; providers are encouraged to submit all appeals via Availity.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate Anthem clinical professionals.

We will make every effort to resolve the claim payment appeal within 60 calendar days of receipt. If additional information is required to make a determination, the determination date may be extended by 60 additional calendar days. We will mail you a written extension letter before the expiration of the initial 60 calendar days.

Submitting claim payment disputes in writing
When submitting a claim payment dispute in writing, providers must include the Claim Information/ Adjustment Request Form and submit to:

Anthem Blue Cross and Blue Shield
Provider Payment Disputes
PO Box 533
North Haven, CT 06473

Submitting claim payment disputes via Availity - preferred method as of October 19, 2021
For step-by-step instructions to submit a claim payment dispute through Availity:

- Log into Availity at availity.com
- Select Help & Training | Find Help
- Under Contents, select Overpayments and Appeals
- Select Dispute a Claim

Through Availity, you can upload supporting documentation and receive immediate acknowledgement of your submission.

Anthem's review and providers' other options
We will review the claim payment dispute once received and communicate an outcome in writing or through the Availity Portal. Providers can check the status of a claim payment dispute on the Availity portal at any time.

If a provider still disagrees with the reconsideration, the provider can then choose to submit the claim payment appeal. Once the claim payment appeal is submitted, the decision is final. A claim payment dispute may not be submitted again. Providers can contact their state regulatory agency for additional assistance.

Anthem requires providers to use our claims payment reconsideration process if providers feel a claim was not processed correctly.

Once providers complete both the Reconsideration and Appeal processes, providers can contact their Provider Experience Consultant for further assistance. However, providers are required to complete both the Reconsideration and Appeal processes before contacting their Provider Experience Representative.

Webinars available
To learn more about the claim dispute tool, register for a live webinar:

- Log in to Availity and select Help & Training | Get Trained
- Select Sessions and go to Your Calendar to locate a webinar
- Select View Course and then select Enroll
- The Availity Learning Center will email you with instructions to attend

As always, providers can refer to the Provider Manual, as the manual includes additional information about inquiries, the provider claim dispute process, reconsiderations and appeals.

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URL: https://providernews.anthem.com/connecticut/article/submit-provider-claim-payment-disputes-for-anthems-commercial-lines-of-business-via-availity-beginning-october-19-2021-3

Reminder: EnrollSafe replacing CAQH Enrollhub effective November 1, 2021

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As a reminder, effective **November 1, 2021**, EnrollSafe will replace CAQH Enrollhub as the electronic funds transfer (EFT) enrollment portal for Anthem providers. As of November 1, 2021, CAQH Enrollhub will no longer offer EFT enrollment to new users. **CAQH Enrollhub is the only CAQH tool being decommissioned. No other CAQH tools will be impacted.**

Benefits of EFT

Not only is receiving your payment more convenient, so is signing up for EFT. When you sign up for EFT through EnrollSafe, the new enrollment portal, you'll receive your payments up to seven days sooner than through the paper check method. What's more, it's easier to reconcile your direct deposits.

Secure and available 24-hours a day – EnrollSafe
Beginning November 1, 2021, if you need to make changes to an existing EFT enrollment or create a new first-time account, log onto the EnrollSafe enrollment hub at https://enrollsafe.payeehub.org to enroll in EFT. Once you have completed registration, you'll be directed through the EnrollSafe secure portal to the enrollment page, where you'll provide the required information to receive direct payment deposits.

Already enrolled in EFT through CAQH Enrollhub?
Please note if you're already enrolled in EFT through CAQH Enrollhub, no action is needed unless making changes. Your EFT enrollment information will not change as a result of the new enrollment hub.

If you have changes to make, after October 31, 2021, use EnrollSafe to update your account.

Electronic remittance advice (ERA) makes reconciling your EFT payments easy and paper-free
Now that you are enrolled in EFT, using the digital ERA is the very best way to reconcile your deposits – securely and safely. You'll be issued a trace number with your EFT deposit that matches up with your ERA on Availity.

ERAs can be retrieved directly from Availity. Log onto Availity and select **Claims and Payments** > **Send and Receive EDI Files** > **Received Files** folder. When using a clearinghouse or billing service, they will supply the 835 ERA for you. You also have the option to view or download a copy of the **Remittance Advice** under **Payer Spaces** > **Remittance Inquiry tool**.

ERA and EFT registration and contact information

Type of transaction	How to register, update, or cancel	For registration related questions	To resolve issues after registration
EFT only	Use EnrollSafe	EnrollSafe help desk at **877-882-0384**	EnrollSafe help desk at **877-882-0384**
ERA (835) only	Use Availity	Availity Support **800-282-4548**	Availity at **800-282-4548** *Note: Providers should allow up to 10 business days for ERA enrollment processing.*

1343-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/reminder-enrollsafe-replacing-caqh-enrollhub-effective-november-1-2021-1

Procedure searches in Find Care

Published: Oct 1, 2021 - **Administrative** / Digital Tools

Find Care, the doctor finder and transparency tool in Anthem's online directory, allows Anthem members to search and compare cost and quality measures for in-network providers. This tool allows members to sort providers based on distance, name, or personalized match. Additionally, as communicated earlier this year, the enhanced personalized match sorting option is now available to search by procedure type in addition to providers.

The algorithms used to sort procedure type use a combination of member and provider features to sort and display the results for a member's search. The sorting results take into account member factors such as the member's medical conditions and demographics. Provider factors such as surgeon-facility pairing (an individual provider who performs a procedure at a specific facility), cost efficiency measures, volumes of patients treated across various disease conditions, and outcome-based quality measures.

Combined member and provider features generate a unique ranking of surgeon-facility pairings or facility providers for each member conducting the procedure search. Displayed first are surgeon-facility pairings with the highest overall ranking within the search radius. Remaining pairings are displayed in descending order based on overall rank and proximity to the center of the search radius.

We are expanding personalized match procedure searches to include additional procedures on or after November 19, 2021. We will use an updated episode of care methodology for these new procedures. The episode of care methodology for procedure searches that became available earlier this year will remain unchanged. The personalized match methodology for specialty-based provider searches remains unchanged. Members continue to have the ability to sort from a variety of orders such as distance. This enhancement in sorting methodology has no impact on member benefits.

You may review a copy of the procedure sorting methodologies, including the updated episode of care methodology for procedures added on or after November 19, 2021, by going to Availity and then using the following navigation: Payer Spaces > Anthem > Information Center > Administrative Support > Personalized Provider Procedure Search Methodology.

If you have general questions about the Find Care tool or the change to the quality measures for procedure searches, please contact your local Anthem consultant.

If you would like detailed information about quality or cost factors used as part of this unique sorting or you would like to request reconsideration of those factors, you may do so by emailing personalizedmatchsorting@anthem.com or by calling 833-292-2601.

1328-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/procedure-searches-in-find-care-6

Good news! Non-payment remittance advice enhancements coming soon

Published: Oct 1, 2021 - **Administrative** / Digital Tools

In the coming months, we will be enhancing your ability to search, review and download a copy of the remittance advice on Availity when there is no associated payment. For

What's changing?

- Non-payment number display in the Check Number and Check/EFT Number fields:
  - **Current** - Today, there are two sets of numbers for the same remittance advice. The paper remittance displays 10 bytes (9999999999 or 99########) and the corresponding 835 (ERA) displays 27 bytes (9999999999 – [year] ##############).
  - **Enhancement** - The updated numbering sequence for the paper remittance and corresponding 835 (ERA) will contain the same ten-digit number beginning with 9 (9XXXXXXXXX). Each non-payment remittance issued will be assigned a unique number.

- Searching for non-payment remittance:
  - **Current** - When using Remit Inquiry, the search field requires a date range and tax ID to locate a specific remittance due to same number scenario being used for every non-payment remittance.
  - **Enhancement** - Once the unique ERA non-payment remittance number is available, it can be entered in the check number field in Remit Inquiry. This new way of assigning check numbers will provide a faster and simplified process to find the specific remittance.

The way your organization receives remittances and payments is not changing; we have simply enhanced the numbering for the non-pay remittances. These changes will not impact previously issued non-payment remittance advices. We'll provide further information before this change is implemented.

1355-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/good-news-non-payment-remittance-advice-enhancements-coming-soon-8

Reimbursement policy clarification: Claims Requiring Additional Documentation - facility

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

In the May 2021 issue of *Provider News*, we communicated the thresholds for the itemized bill requirement for claims reimbursed at a percent of charge:

- The threshold for requiring an itemized bill for inpatient claims is $100,000.
- The threshold for requiring an itemized bill for outpatient claims is $50,000.

We subsequently communicated in the August 2021 *Provider News* that the wording of the policy was updated to remove the threshold language from the policy; however, the removal of the language from the policy DOES NOT change the thresholds in place. The communicated thresholds remain at $100,000 for inpatient and $50,000 for outpatient. We will communicate any future changes in thresholds via *Provider News.*

1353-1021-PN-CT

URL: https://providernews.anthem.com/connecticut/article/reimbursement-policy-clarification-claims-requiring-additional-documentation-facility-13

New reimbursement policy: Multiple and Bilateral Surgery Processing - facility

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

Beginning with dates of service on or after January 1, 2022, Anthem will implement a new facility reimbursement policy titled, Multiple and Bilateral Surgery Processing.

We allow reimbursement for only the primary, or highest valued, procedure when multiple or bilateral procedures are performed on the same day or same session, and at the same place of treatment when billed by a facility. A single surgical procedure is subject to multiple procedure reduction guidelines when submitted with multiple units.

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

1369-1021-PN-CTME

Article Attachments

Mult Bilat Surg Fac BCBS 041421.pdf
application/pdf - 216.52 KB

URL: https://providernews.anthem.com/connecticut/article/new-reimbursement-policy-multiple-and-bilateral-surgery-processing-facility-4

Medical policy and clinical guideline updates are available on anthem.com

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

The following new and revised medical policies and clinical guidelines were endorsed at the August 12, 2021 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies and clinical guidelines, are available at anthem.com/provider > select state > scroll down and select ‘See Policies and Guidelines.'

To view medical policies and utilization management guidelines applicable to members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (commonly referred to as the Federal Employee Program® (FEP®)), please visit www.fepblue.org > Policies & Guidelines.

Medical policy updates

Revised medical policies effective August 19, 2021

The following policies were revised to expand medical necessity indications or criteria.

- 00032 - Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
- 00077 - Uterine Fibroid Ablation: Laparoscopic, Percutaneous or Transcervical Image Guided Techniques
- 00119 - Endobronchial Valve Devices
- 00121 - Transcatheter Heart Valve Procedures

Coding update effective October 1, 2021
The following policies were updated with new procedure and/or diagnosis codes.

- 00011 - Electrical Stimulation as a Treatment for Pain and Other Conditions: Surface and Percutaneous Devices
- 00052 - Whole Genome Sequencing, Exome Sequencing, Gene Panels, and Molecular Profiling
- 00117 - Autologous Cell Therapy for the Treatment of Damaged Myocardium
- 00011 - Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
- 00023 - Breast Procedures; including Reconstructive Surgery, Implants and Other Breast Procedures
- 00016 - Umbilical Cord Blood Progenitor Cell Transplant
- 00023 - Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias
- 00024 - Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome
- 00027 - Hematopoietic Stem Transplant for Pediatric Solid Tumors
- 00028 - Hematopoietic Stem Cell Transplant for Hodgkin's Disease and Non-Hodgkin’s Lymphoma
- 00029 - Hematopoietic Stem Cell Transplant for Genetic Diseases and Acquired Anemias
- 00030 - Hematopoietic Stem Cell Transplant for Germ Cell Tumors
- 00031 - Hematopoietic Stem Cell Transplant for Autoimmune Disease and Miscellaneous Solid Tumors
- 00034 - Hematopoietic Stem Cell Transplantation for Diabetes Mellitus
- 00035 - Other Stem Cell Therapy

Reviewed medical policies effective October 6, 2021
The following policies were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.

- 00006 - Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
- 00025 - Self-Operated Spinal Unloading Devices
- 00018 - Gene Expression Profiling for Cancers of Unknown Primary Site

- 00020 - Gene Expression Profile Tests for Multiple Myeloma
- 00023 - Gene Expression Profiling of Melanomas
- 00033 - Genetic Testing for Inherited Peripheral Neuropathies
- 00034 - SensiGene® Fetal RhD Genotyping Test
- 00047 - Methylenetetrahydrofolate Reductase Mutation Testing
- 00011 - Analysis of Proteomic Patterns
- 00019 - Serum Markers for Liver Fibrosis in the Evaluation and Monitoring of Patients with Chronic Liver Disease
- 00028 - Serum Biomarkers for Multiple Sclerosis
- 00029 - Rupture of Membranes Testing in Pregnancy
- 00030 - Measurement of Serum Concentrations of Monoclonal Antibody Drugs and Antibodies to Monoclonal Antibody Drugs
- 00036 - Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus
- 00055 - Wearable Cardioverter Defibrillators
- 00082 - Quantitative Sensory Testing
- 00089 - Quantitative Muscle Testing Devices
- 00095 - Anterior Segment Optical Coherence Tomography
- 00096 - Low-Frequency Ultrasound Therapy for Wound Management
- 00099 - Electromagnetic Navigational Bronchoscopy
- 00103 - Automated Evacuation of Meibomian Gland
- 00134 - Non-invasive Heart Failure and Arrhythmia Management and Monitoring System
- 00057 - Near-Infrared Coronary Imaging and Near- Infrared Intravascular Ultrasound Coronary Imaging
- 00061 - PET/MRI
- 00064 - Myocardial Sympathetic Innervation Imaging with or without Single-Photon Emission Computed Tomography (SPECT)
- 00008 - Mechanized Spinal Distraction Therapy
- 00052 - Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- 00082 - Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- 00088 - Coblation® Therapies for Musculoskeletal Conditions
- 00092 - Implanted Devices for Spinal Stenosis
- 00101 - Suprachoroidal Injection of a Pharmocoligc Agent

- 00104 - Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- 00107 - Prostate Saturation Biopsy
- 00114 - Facet Joint Allograft Implants for Facet Disease
- 00128 - Implantable Left Atrial Hemodynamic Monitor
- 00131 - Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- 00135 - Radiofrequency Ablation of the Renal Sympathetic Nerves
- 00144 - Occipital Nerve Block Therapy for the Treatment of Headache and Occipital Neuralgia
- 00153 - Cardiac Contractility Modulation Therapy
- 00156 - Implanted Artificial Iris Devices
- 00157 - Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis
- 00004 - Cell Transplantation (Adrenal-Brain, Fetal Mesencephalic, and Fetal Xenograft)

Archived medical policies effective October 6, 2021
The following medical policies have been archived.

- 00024 - DNA-Based Testing for Adolescent Idiopathic Scoliosis
- 00085 - Antineoplaston Therapy
- 00037 - Whole Body Computed Tomography Scanning

New medical policies effective January 1, 2022
The following policies are new and may result in services previously covered now being considered either not medically necessary and/or investigational.

- 00043 - Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring
- 00058 - TruGraf Blood Gene Expression Test for Transplant Monitoring
- 00040 - Biomarker Tests for Risk of Preeclampsia
- 00042 - Molecular Signature Test for Predicting Response to Tumor Necrosis Factor Inhibitor Therapy
- OR-PR.00007 - Microprocessor Controlled Knee-Ankle-Foot Orthosis

Revised medical policy effective January 1, 2022
The following policy listed below was revised and might result in services previously covered, but now being considered either not medically necessary and/or investigational.

- 00003 - In Vitro Chemosensitivity Assays and In Vitro Chemoresistance Assays

Clinical guideline updates

Revised clinical guideline effective August 19, 2021
The following adopted guidelines were revised to expand medical necessity indications or criteria.

- CG-GENE-22 - Gene Expression Profiling for Managing Breast Cancer Treatment
- CG-MED-55 - Site of Care: Advanced Radiologic Imaging
- CG-SURG-82 - Bone-Anchored and Bone Conduction Hearing Aids

Reviewed clinical guidelines effective October 6, 2021
The following adopted guidelines were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.

- CG-BEH-02 - Adaptive Behavioral Treatment
- CG-DME-10 - Durable Medical Equipment
- CG-DME-41 - Ultraviolet Light Therapy Delivery Devices for Home Use
- CG-MED-63 - Treatment of Hyperhidrosis
- CG-MED-64 - Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- CG-MED-65 - Manipulation Under Anesthesia
- CG-MED-66 - Cryopreservation of Oocytes or Ovarian Tissue
- CG-MED-69 - Inhaled Nitric Oxide
- CG-MED-83 - Site of Care: Specialty Pharmaceuticals
- CG-REHAB-07 - Skilled Nursing and Skilled Rehabilitation Services (Outpatient)
- CG-REHAB-08 - Private Duty Nursing in the Home Setting
- CG-SURG-28 - Transcatheter Uterine Artery Embolization
- CG-SURG-49 - Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities

- CG-SURG-52 - Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services
- CG-SURG-55 - Cardiac Electrophysiological Studies (EPS) and Catheter Ablation
- CG-SURG-63 - Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure
- CG-SURG-79 - Implantable Infusion Pumps
- CG-SURG-83 - Bariatric Surgery and Other Treatments for Clinically Severe Obesity

Revised clinical guidelines effective January 1, 2022
The following adopted guidelines were revised and might result in services previously covered, but now being considered not medically necessary.

- CG-DME-44 - Electric Tumor Treatment Field (TTF)
- CG-SURG-63 - Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure

1340-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/medical-policy-and-clinical-guideline-updates-are-available-on-anthemcom-7

Updated AIM Musculoskeletal Program site of care reviews delayed

Published: Oct 1, 2021 - **Products & Programs**

In the August 2021 edition of *Provider News*, we announced an expansion to the AIM Musculoskeletal program for medical necessity review of the requested site of service for certain joint and interventional pain procedures for Anthem fully-insured members. Please note the program expansion has been delayed. We may announce a new launch date in a future issue of *Provider News*.

1363-1021-PN-CT

URL: https://providernews.anthem.com/connecticut/article/updated-aim-musculoskeletal-program-site-of-care-reviews-delayed-1

Update on requirement to obtain certain specialty drugs from CVS Specialty Pharmacy effective January 1, 2022

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

As we previously communicated, Anthem implemented a policy requiring hospitals to acquire certain select specialty pharmacy medications administered in the hospital outpatient setting through CVS Specialty Pharmacy.

This update is to advise of the following changes:

Effective for dates of service on and after January 1, 2022, the following specialty pharmacy medications will be **added** to the Designated Medical Specialty Pharmacy drug list and must be procured from CVS Specialty Pharmacy pursuant to the policy.

HCPCS	Description	Brand name
J1554	Injection, immune globulin (asceniv), 500 mg	Asceniv
J7204	Injection, factor viii, antihemophilic factor (recombinant), (esperoct), glycopegylated-exei, per iu	Esperoct
J7208	Injection, factor viii, (antihemophilic factor, recombinant), pegylated-aucl, (jivi), 1 i.u.	Jivi
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	Sevenfact
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj	Darzalex Faspro

The Designated Medical Specialty Pharmacy drug list may be updated periodically by Anthem.

To access the current Designated Medical Specialty Pharmacy Drug List, visit anthem.com, select *Providers*, select the state Connecticut (top right of page), select *Forms and Guides* (under the *Provider Resources* column). Scroll down and select *Pharmacy* in the Category drop down. The Designated Medical Specialty Pharmacy drug list may be updated periodically by Anthem.

If you have questions or would like to discuss the terms and conditions for providing certain specialty medications, please contact your Anthem Contract Manager. Thank you for your continued participation in the Anthem networks and the services you provide to our members.

1348-1021-PN-CT

URL: https://providernews.anthem.com/connecticut/article/update-on-requirement-to-obtain-certain-specialty-drugs-from-cvs-specialty-pharmacy-effective-january-1-2022

Clinical criteria updates for specialty pharmacy

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

The following clinical criteria documents were endorsed at the August 20, 2021 Clinical Criteria meeting. Visit our website to access the clinical criteria information.

Revised clinical criteria effective September 1, 2021
The following criteria were revised to expand medical necessity indications or criteria.

- ING-CC-0020: Tysabri (natalizumab)
- ING-CC-0062: Tumor Necrosis Factor Antagonists
- ING-CC-0124: Keytruda (pembrolizumab)

Revised clinical criteria effective September 1, 2021
The following criteria were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.

- ING-CC-0007: Synagis (palivizumab)

Revised clinical criteria effective September 20, 2021
The following criteria were reviewed and may have word changes or clarifications, but had no significant changes to the policy position or criteria.

- ING-CC-0004: H.P. Acthar Gel (repository corticotropin injection)

- ING-CC-0011: Ocrevus (ocrelizumab)
- ING-CC-0014: Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis
- ING-CC-0030: Implantable and ER Buprenorphine Containing Agents
- ING-CC-0035: Duopa (carbidopa and levodopa enteral suspension)
- ING-CC-0036: Naltrexone Implantable Pellets
- ING-CC-0044: Exondys 51 (eteplirsen)
- ING-CC-0058: Octreotide Agents
- ING-CC-0082: Onpattro (patisiran)
- ING-CC-0100: Istodax (romidepsin)
- ING-CC-0139: Evenity (romosozumab-aqqg)
- ING-CC-0144: Lumoxiti (moxetumomab pasudotox-tdfk)
- ING-CC-0152: Vyondys 53 (golodirsen)
- ING-CC-0167: Rituximab Agents for Oncologic Indications Step Therapy
- ING-CC-0172: Viltepso (viltolarsen)
- ING-CC-0174: Kesimpta (ofatumumab)
- ING-CC-0176: Beleodaq (belinostat)
- ING-CC-0179: Blenrep (belantamab mafodotin-blmf)
- ING-CC-0180: Monjuvi (tafasitamab-cxix)
- ING-CC-0181: Veklury (remdesivir)
- ING-CC-0189: Amondys 45 (casimersen)
- ING-CC-0191: Pepaxto (melphalan flufenamide; melflufen)

Revised clinical criteria effective September 20, 2021
The following criteria were revised to expand medical necessity indications or criteria.

- ING-CC-0001: Erythropoiesis Stimulating Agents
- ING-CC-0010: Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors
- ING-CC-0038: Human Parathyroid Hormone Agents
- ING-CC-0075: Rituximab Agents for Non-Oncologic Indications
- ING-CC-0104: Levoleucovorin Agents
- ING-CC-0169: Phesgo (pertuzumab/trastuzumab/hyaluronidase-zzxf)
- ING-CC-0193: Evkeeza (evinacumab)

Revised clinical criteria effective October 1, 2021
The following criteria were updated with new procedure and/or diagnosis codes.

- ING-CC-0100: Istodax (romidepsin)
- ING-CC-0126: Blincyto (blinatumomab)
- ING-CC-0150: Kymriah (tisagenlecleucel)
- ING-CC-0151: Yescarta (axicabtagene ciloleucel)
- ING-CC-0168: Tecartus (brexucabtagene autoleucel)
- ING-CC-0171: Zepzelca (lurbinectedin)
- ING-CC-0173: Enspryng (satralizumab-mwge)
- ING-CC-0182: Iron Agents
- ING-CC-0187: Breyanzi (lisocabtagene maraleucel)
- ING-CC-0189: Amondys 45 (casimersen)
- ING-CC-0191: Pepaxto (melphalan flufenamide; melflufen)
- ING-CC-0192: Cosela (trilaciclib)
- ING-CC-0193: Evkeeza (evinacumab)
- ING-CC-0194: Cabenuva (cabotegravir extended-release; rilpivirine extended-release) Injection
- ING-CC-0195: Abecma (idecabtagene vicleucel)
- ING-CC-0196: Zynlonta (loncastuximab tesirine-lpyl)
- ING-CC-0197: Jemperli (dostarlimab)
- ING-CC-0201: Rybrevant (amivantamab-ymjw)

New clinical criteria effective January 1, 2022
The following clinical criteria are new.

- ING-CC-0202: Saphnelo (anifrolumab-fnia)
- ING-CC-0203: Breyanzi Ryplazim (plasminogen, human-tvmh)

Revised clinical criteria effective January 1, 2022
The following criteria listed below might result in services that were previously covered, but now being considered not medically necessary.

- ING-CC-0001: Erythropoiesis Stimulating Agents

- ING-CC-0009: Lemtrada (alemtuzumab) for the Treatment of Multiple Sclerosis
- ING-CC-0010: Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors
- ING-CC-0027: Denosumab Agents
- ING-CC-0029: Dupixent (dupilumab)
- ING-CC-0034: Hereditary Angioedema Agents
- ING-CC-0038: Human Parathyroid Hormone Agents
- ING-CC-0081: Crysvita (burosumab-twza)
- ING-CC-0096: Asparagine Specific Enzymes
- ING-CC-0104: Levoleucovorin Agents
- ING-CC-0156: Reblozyl (luspatercept)
- ING-CC-0182: Agents for Iron Deficiency Anemia

1339-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/clinical-criteria-updates-for-specialty-pharmacy-65

Specialty pharmacy updates - October 2021

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

Specialty pharmacy updates for Anthem are listed below.

Prior authorization clinical review of *non-oncology* use of specialty pharmacy drugs is managed by Anthem's medical specialty drug review team. Review of specialty pharmacy drugs for *oncology* use is managed by AIM Specialty Health® (AIM), a separate company.

Please note that inclusion of the national drug code (NDC) code on your claim will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Site of care updates

Effective for dates of service on and after January 1, 2022, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our site of care review process.

Access our Clinical Criteria to view the complete information for these site of care updates.

Clinical Criteria	HCPCS or CPT Code	Drug
*ING-CC-0062	Q5121	Avsola
*ING-CC-0081	J0584	Crysvita
*ING-CC-0162	J3241	Tepezza

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

Quantity limit updates

Effective for dates of service on and after January 1, 2022, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our quantity limit review process.

Access our Clinical Criteria to view the complete information for these quantity limit updates.

Clinical Criteria	Drug	HCPCS or CPT Code(s)
ING-CC-0009	Lemtrada	J0202
ING-CC-0011	Ocrevus	J2350
ING-CC-0014	Avonex	J1826
		Q3027
	Betaseron	J1830
	Copaxone	J1595
	Extavia	J1830
	Glatopa	J1595
	Plegridy	J3590
		C9399
	Rebif	J1826
		Q3028
ING-CC-0020	Tysabri	J2323
ING-CC-0029	Dupixent	J3490
		J3590
ING-CC-0038	Bonsity	J3110
	Forteo	J3110
	Tymlos	C9399
		J3490
ING-CC-0042	Siliq	C9399
		J3490
		J3590
	Taltz	C9399
		J3490
		J3590
ING-CC-0048	Spinraza	J2326
ING-CC-0062	Avsola	Q5121
	Erelzi	J3590
	Eticovo	J3590
ING-CC-0066	Kevzara	C9399
		J3590

J3490		
ING-CC-0075	Riabni	Q5123
ING-CC-0077	Palynziq	C9399
		J3590
ING-CC-0082	Onpattro	J0222
ING-CC-0156	Reblozyl	J0896
ING-CC-0159	Scenesse	J7352
ING-CC-0160	Vyepti	J3032
ING-CC-0162	Tepezza	J3241
ING-CC-0163	Durysta	J7351
ING-CC-0170	Uplizna	J1823
ING-CC-0172	Viltepso	J1427
ING-CC-0173	Enspryng	J3490
		J3590
ING-CC-0174	Kesimpta	C9399
		J3490
		J3590
ING-CC-0177	Zilretta	J3304
ING-CC-0181	Veklury	J3490
ING-CC-0183	Sogroya	J3590
ING-CC-0185	Oxlumo	J0224
ING-CC-0188	Imcivree	J3490
		J3590
ING-CC-0193	Evkeeza	J3490
		C9079
ING-CC-0194	Cabenuva	J3490
		C9077

1338-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/specialty-pharmacy-updates-october-2021-1

Pharmacy information available on anthem.com

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

Visit Pharmacy Information for Providers on anthem.com for more information on:

- Copayment/coinsurance requirements and their applicable drug classes
- Drug lists and changes
- Prior authorization criteria
- Procedures for generic substitution
- Therapeutic interchange
- Step therapy or other management methods subject to prescribing decisions
- Any other requirements, restrictions, or limitations that apply to using certain drugs

The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate “Marketplace Select Formulary” and pharmacy information, scroll down to “Select Drug Lists.” This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

1333-1021-PN-NE

URL: https://providernews.anthem.com/connecticut/article/pharmacy-information-available-on-anthemcom-111

Information about 2021 Special Needs Plans

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

Introduction

Anthem is offering Special Needs Plans (SNPs) to people eligible for both Medicare and Medicaid benefits or who are qualified Medicare Advantage beneficiaries. Some SNPs provide enhanced benefits to people eligible for both Medicare and Medicaid, which include supplemental benefits such as hearing, dental, vision, and transportation to medical appointments. Some SNP plans include a card or catalog for purchasing over-the-counter items, but SNPs do not charge premiums.

SNP members benefit from a model of care (MOC) that is used by Anthem to assess needs and coordinate care. Each member receives a comprehensive health risk assessment (HRA) within 90 days of enrollment and annually thereafter, which covers physical, behavioral, and functional needs, along with a comprehensive medication review. The HRA is then used to create a member care plan. Members with multiple or complex conditions are assigned a health plan case manager.

SNP HRAs, care plans, and case managers support members and their providers by helping identify and escalate potential problems for early intervention, ensuring appropriate and timely follow-up appointments plus providing navigation and coordination of services across the Medicare and Medicaid programs.

Provider training required
Providers contracted for SNP plans are required to complete an annual training to keep up-to-date with plan benefits and requirements, including details on coordination of care and MOC elements. Every provider contracted for SNP is required to complete an attestation stating they have completed their annual training. These attestations are located at the end of the self-paced training document.

To take the self-paced training, please go to the MOC Provider Training link at https://www.availity.com.

How to access the *Custom Learning Center* on the Availity Portal:*

1. Log in to the Availity Portal at https://www.availity.com.

    1. At the top of the Availity Portal, select **Payer Spaces** and select the appropriate payer.

2. On the *Payer Spaces* landing page, select **Access Your Custom Learning Center** from *Applications*.
3. In the *Custom Learning Center*, select **Required Training**.
4. Select **Special Needs Plan and Model of Care Overview**.
5. Select **Enroll**.
6. Select **Start**.
7. Once the course is completed, select **Attestation** and complete.

Not registered for the Availity Portal?
Have your organization's designated administrator register your organization for the Availity Portal.

1. Visit https://www.availity.com to register.
2. Select **Register**.
3. Select your organization type.
4. In the *Registration* wizard, follow the prompts to complete the registration for your organization.

Questions & Answers

What does it mean to be dual-eligible? What is a D-SNP?
The term *dual-eligible* refers to people with Medicare coverage who also qualify for some type of state Medicaid benefit — meaning that these members are eligible for both Medicaid and Medicare. These individuals may have higher incidence of chronic conditions, cognitive impairments, and functional limitations. D-SNPs are special Medicare Advantage plans that enroll only dual-eligible people, providing them with more intensive coordination of care and services than those offered by traditional Medicare and Medicare Advantage plans.

What is a SNP Model of Care?
The Centers for Medicare & Medicaid Services (CMS) requires Special Needs Plans (SNPs) to have a model of care (MOC) that describes how the SNP will administer key components of care management programs, including assessments and training. The MOC describes the unique needs of the population being served and how Anthem will meet those needs. Each SNP MOC is evaluated and scored by the NCQA and approved by CMS.

How does the MOC help physicians?
The three major components of the MOC — 1) the health risk assessment (HRA), 2) *Care Plan,* and 3) case manager — support providers in serving D-SNP members. Each member receives a comprehensive HRA that covers physical, behavioral, and functional needs, along with a comprehensive medication review. Anthem staff use the HRA information to create a *Care Plan*. Members with multiple or complex conditions may be assigned to a case manager.

These key MOC components identify and escalate potential problems for early intervention, ensure appropriate and timely follow-up, and help coordinate services across Medicare and Medicaid programs. Through the provider website, providers have access to review the *Care Plan*, the results of the HRA, and other information to help manage care.

How are transitions of care managed?
Anthem case managers are involved in transitions of care (for example, discharge from hospital to home for those at high-risk of readmission). Such transitions may trigger a reassessment and updates to the member's *Care Plan* as needed. Following a discharge, case managers help ensure that D-SNP members see their PCP within a week and work through barriers that members experience in adhering to post discharge medication regimens.

Who makes up the Interdisciplinary Care Team (ICT)?
Members of the ICT include any of the following: nurses, physicians, social workers, pharmacists, the member and/or the member's caregiver, behavioral health specialists, or other participants as determined by the member, the member's caregiver, or a relative of the member.

Providers who care for Anthem members are considered participants in the ICT and may be contacted by a case manager to discuss the member's needs. The case manager may present recommendations concerning care coordination or other needs. The goal of the ICT is to assist providers in managing and coordinating patient care.

Do I have to become a Medicaid provider?
You are not required to become a Medicaid provider, but we recommend that you do. Even if you are only providing services covered by Medicare Part A or Part B to SNP members, we recommend that you attain a Medicaid ID because the state Medicaid agency may require this for the Medicare cost share.

How do I file claims for SNP members?
Claims for services to SNP members are filed the same way claims are filed for Anthem members enrolled in Medicare Advantage who are not part of SNP. Providers should ensure that the claim has the correct member ID (including the prefix).

How is the SNP member's cost-sharing handled?

SNP benefits are administered similarly to Medicare fee-for-service benefits. Upon receiving the Explanation of Payment (EOP) from Anthem, you should bill the state Medicaid agency or the applicable Medicaid managed care organization (MCO) contracted with the state for processing of any Medicare cost-sharing applied.

Medicare cost-sharing is paid according to each state's Medicaid reimbursement logic. Some states do not reimburse for Medicare cost sharing if the payment has already met or exceeded Medicaid reimbursement methodology.

Do I have to file claims twice for SNP members?
Yes, when you treat Anthem members enrolled in a SNP, you will file the initial claim with Anthem and then bill the state Medicaid agency or the applicable Medicaid MCO contracted with the state for Medicare cost sharing processing. Please use the same electronic claim submission or address you currently use for Anthem claims filing.

Do SNP members have access to the same prescription drug formulary as other Anthem members enrolled in Medicare Advantage?
Yes, SNP members have coverage for the same prescription drugs listed on the Anthem prescription drug formulary for Medicare Advantage.

Please note that in California, the tier placement may vary. Be sure to review the plan's specific formulary for details on California SNPs, as the formulary depends on the market.

What are SNP benefits for Anthem members?
The SNP for Anthem members covers all Medicare Part A and Part B services and includes full Part D prescription coverage. Anthem also covers a range of preventive services with no-cost sharing for the member. In addition, the SNP includes coverage for supplemental benefits that may include routine dental, vision, and nonemergency medical transportation. A summary of the SNP benefits is posted on the provider website for Anthem members.

Any Medicaid benefits available to the member will be processed under their Medicaid coverage directly with the state or the Medicaid organization in which the member is enrolled.

Does the SNP use the same procedure codes and electronic data interchange (EDI) payer codes?
Yes, the SNP uses the same procedure and payer codes and electronic filing procedures as other Medicare Advantage plans through Anthem.

Is the EDI payer ID for this product the same as others?
Yes, all the claim submission information will be the same (this applies to EDI and paper). Providers must submit this information with the correct ID. Please check the EDI section of the provider website for the correct payer codes to use for your market.

* Availity, LLC is an independent company providing administrative support services on behalf of AMH Health, LLC.

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URL: https://providernews.anthem.com/connecticut/article/information-about-2021-special-needs-plans-10

HEDIS® medical record submission made easier with our Remote EMR Access Service

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

Instead of faxing multiple pages of medical records for HEDIS® studies, use Anthem's Remote EMR Access Service we offer to providers that allows us to access your EMR system directly to pull the documentation we need. Our Remote EMR Access Service helps reduce the time and costs associated with medical record retrieval while improving efficiency and lessening the impact on your office staff.

We have a centralized EMR team experienced with multiple EMR systems and extensively trained annually on HIPAA, EMR systems, and HEDIS® measure updates. We complete medical record retrieval based on minimum necessary guidelines:

- We only access medical records of members pulled into the HEDIS® sample using specific demographic data.
- We only retrieve the medical records that have evidence related to the HEDIS® measures.
- We only view face sheets when there are demographic discrepancies.
- We exclude data related to hospice, long-term care, inpatient, and palliative care.

Let us help you! Getting started with Remote EMR Access is just one click away.
Download and complete this registration form and email it to us at Centralized_EMR_Team@anthem.com.

To learn more about our Remote EMR Access Service, view the Frequently Asked Questions below.

How do you retrieve our medical records?
We access your EMR using a secure portal and retrieve only the necessary documentation by printing to an electronic file we store internally, on our secure network drives.

Is printing necessary?
Yes. The NCQA audit requires print-to-file access.

Is this process secure?
Yes. We only use secure internal resources to access your EMR systems. All retrieved records are stored on Anthem secure network drives.

Why does Anthem need full access to the entire medical record?
There are several reasons we need to look at the entire medical record of a member:

- HEDIS® measures can include up to a 10-year look back at a member's information.
- Medical record data for HEDIS® compliance may come from several different areas of the EMR system, including labs, radiology, surgeries, inpatient stays, outpatient visits, and case management.
- Compliant data may be documented or housed in a non-standard format, such as an in-office lab slip scanned into miscellaneous documents

What information do I need to submit to use your Remote EMR Access Service?
Complete the registration form that requests the following information:

- Practice/facility demographic information (e.g., address, National Provider ID, taxpayer identification numbers, etc.)
- EMR system information (e.g., type of EMR system, required access forms, access type – web based or VPN-to-VPN connection, special requirements needed for access, etc.)
- List of current providers/locations or a website for accessing this list. Also, if applicable, a list of providers affiliated with the group that are not in the EMR System.

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URL: https://providernews.anthem.com/connecticut/article/hedis-medical-record-submission-made-easier-with-our-remote-emr-access-service-17

New medical step therapy requirements

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

Effective November 1, 2021, the Clinical Criteria ING-CC-0005 will include a trial and inadequate response or intolerance to two preferred hyaluronan agents in the Part B medical step therapy precertification review. Step therapy review will apply upon precertification initiation, in addition to the current medical necessity review (as-is current procedure). Step therapy will not apply for members who are actively receiving non-preferred medications listed below.

Clinical Criteria are publicly available on the provider website. Visit the **Clinical Criteria page** to search for specific criteria.

Clinical Criteria	Preferred drug(s)	Nonpreferred drug(s)
ING-CC-0005	Euflexxa (J7323) Supartz FX (J7321) Durolane (J7318) Gelsyn-3 (J7328)	Including but not limited to: · Gel-One (J7326) · GenVisc 850 (J7320) · Hymovis (J7322) · Monovisc (J7327) · Orthovisc (J7324) · Synvisc/Synvisc One (J7325) · TriVisc (J7329) · Hyalgan/Visco-3 (J7321) · Triluron (J7332)

ABSCARE-1058-21

URL: https://providernews.anthem.com/connecticut/article/new-medical-step-therapy-requirements-10

New reimbursement policy effective January 1, 2022 - Sexually Transmitted Infections Testing - professional

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

Anthem allows reimbursement of sexually transmitted infection (STI) tests unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise. We consider certain STI testing CPT® codes to be part of a laboratory panel grouping. When Anthem receives a claim with two or more single tests laboratory procedure codes reported, we will bundle those two or more single tests into the comprehensive laboratory procedure code listed below.

Applicable single STI CPT codes:

- 87491: Infectious agent detection by nucleic acid (DNA or RNA); chlamydia trachomatis, amplified probe technique
- 87591: Infectious agent detection by nucleic acid (DNA or RNA); neisseria gonorrhoeae, amplified probe technique
- 87661: Infectious agent detection by nucleic acid (DNA or RNA); trichomonas vaginalis, amplified probe technique

Applicable comprehensive code:

- 87801: Infectious agent detection by nucleic acid (DNA or RNA), multiple organisms; amplified probe(s) technique

Anthem will reimburse the more comprehensive, multiple organism code for infectious agent detection by nucleic acid, amplified probe technique (CPT code 87801), when two or more single test CPT codes are billed separately by the same provider on the same date of service. Reimbursement will be made based on a single unit of CPT code 87801 regardless of the units billed for a single code. No modifiers will override the edit.

For additional information, please review the Sexually Transmitted Infections Testing - professional reimbursement policy at https://www.anthem.com/medicareprovider.

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Get your payments faster when you sign up for electronic funds transfer

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

Effective November 1, 2021, EnrollSafe will replace CAQH Enrollhub® as the electronic funds transfer (EFT) enrollment website for Anthem providers. As of November 1, 2021, CAQH Enrollhub will no longer offer EFT enrollment to new users.

When you sign up for EFT through https://enrollsafe.payeehub.org, the new enrollment website, you'll receive your payments up to seven days sooner than through the paper check method. Not only is receiving your payment more convenient, so is signing up for EFT. What's more, it's easier to reconcile your direct deposits.

EnrollSafe is secure and available 24-hours a day

Beginning November 1, 2021, log onto the EnrollSafe enrollment hub at https://enrollsafe.payeehub.org to enroll in EFT. You'll be directed through the EnrollSafe secure portal to the enrollment page, where you'll provide the required information to receive direct payment deposits.

Already enrolled in EFT through CAQH Enrollhub?

If you're already enrolled in EFT through CAQH Enrollhub, no action is needed unless you are making changes. Your EFT enrollment information will not change as a result of the new enrollment hub.

If you have changes to make, after October 31, 2021, use https://enrollsafe.payeehub.org to update your account.

Electronic remittance advice (ERA) makes reconciling your EFT payment easy and paper-free

Now that you are enrolled in EFT, using the digital ERA is the very best way to reconcile your deposit. You'll be issued a trace number with your EFT deposit that matches up with your ERA on the Availity* Portal. To access the ERA, log onto https://www.availity.com and use the **Claims and Payments** tab. Select **Send and Receive EDI Files**, then select **Received Files Folder**. When using a clearinghouse or billing service, they will supply the 835 ERA for you. You also have the option to view or download a copy of the *Remittance Advice* through the Remittance Inquiry app.

* Availity, LLC is an independent company providing administrative support services on behalf of AMH Health, LLC.

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URL: https://providernews.anthem.com/connecticut/article/get-your-payments-faster-when-you-sign-up-for-electronic-funds-transfer-23

Town of Manchester and Manchester BOE, CT moves to Anthem Medicare Advantage Plan

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

Effective October 1, 2021, Town of Manchester and Manchester BOE in Connecticut will offer an Anthem Medicare Preferred (PPO) plan. Anthem will provide medical benefits for Town of Manchester retirees through the Anthem Local Preferred Provider Organization (LPPO) product, which includes the National Access Plus benefit. The LPPO plan allows members to receive services from any provider, as long as the provider is eligible to receive payments from Medicare.

Town of Manchester members' copay or coinsurance percentage will be the same whether their provider is in- or out-of-network. **Locally or nationwide, doctors or hospitals, member share-of-cost (SOC) doesn't change.**

Non-contracted providers may continue treating Town of Manchester members and will be reimbursed 100% of Medicare's allowed amount for covered services, less any member SOC.

The Medicare Advantage plan offers the same hospital and medical benefits that Medicare covers, while covering additional benefits that Medicare does not, such as LiveHealth Online* and SilverSneakers.*

The prefix on the Medicare Advantage ID cards is **ZDX**.

Detailed prior authorization requirements are also available to contracted providers by accessing the *Provider Self-Service Tool* on the Availity Portal* at https://www.availity.com.

Providers will follow their normal claim filing procedures for Town of Manchester member claims.

Providers may call Provider Services at 833-848-8730 for eligibility, prior authorization requirements, and any questions about the Town of Manchester member benefits or coverage.

* Availity is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield. LiveHealth Online is the trade name of Health Management Corporation, an independent company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield. Tivity Health Inc. is an independent company providing the SilverSneakers fitness program on behalf of Anthem Blue Cross and Blue Shield.

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URL: https://providernews.anthem.com/connecticut/article/town-of-manchester-and-manchester-boe-ct-moves-to-anthem-medicare-advantage-plan-1

Keep up with Medicare news

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

Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- 2021 affirmative statement concerning utilization management decisions
- May 2021 Medical Policies and Utilization Management Guidelines update

URL: https://providernews.anthem.com/connecticut/article/keep-up-with-medicare-news-229
