Kentucky Provider News

October 2021 Anthem Provider News - Kentucky

Medicaid:

Medicare:

Looking to earn CME credits? Register for these 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-CNT

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

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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 Blue Cross and Blue Shield (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. 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.

1341-1021-PN-CNT

URL: https://providernews.anthem.com/kentucky/article/federal-price-transparency-and-consolidated-appropriations-act-phase-in-new-mandates-beginning-january-1-2022-2

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

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

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/member-needs/, 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 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 1st two years prior to the measurement year and December 31st 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-CNT

URL: https://providernews.anthem.com/kentucky/article/your-recommendation-is-key-to-encouraging-cancer-screenings-for-your-female-patients-2

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. We've included links to videos that address breast cancer screening in both African American and Hispanic women. We hope you will share them with your patients either in your waiting rooms, or by offering to play them during their visits.

VIDEO: Why mammograms matter for Black women

VIDEO: 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-CNT

URL: https://providernews.anthem.com/kentucky/article/are-you-talking-to-all-of-your-patients-about-breast-cancer-screenings-2

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

1347-1021-PN-CNT

URL: https://providernews.anthem.com/kentucky/article/clarification-anthems-enhanced-claim-edits-for-outpatient-facility-claims-3

Good news! Non-payment remittance advice enhancements coming soon

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

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 remittance advices with payments, you may continue to search with the check/EFT number.

What's changing?

1. 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.

2. 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-CNT

URL: https://providernews.anthem.com/kentucky/article/good-news-non-payment-remittance-advice-enhancements-coming-soon-2

Clinical appeals

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

The clinical appeal process is designed to provide appropriate and timely review when providers disagree with a decision made by Anthem Blue Cross and Blue Shield (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 (ICR) 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.

1368-1021-PN-CNT

URL: https://providernews.anthem.com/kentucky/article/clinical-appeals-2

Reminder: EnrollSafe, the new EFT enrollment portal for Anthem providers replacing CAQH Enrollhub effective November 1, 2021

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

As a reminder, effective **November 1, 2021**, EnrollSafe will replace CAQH Enrollhub as the electronic funds transfer (EFT) enrollment portal for Anthem Blue Cross and Blue Shield (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. All other CAQH tools will not 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**.

Contact information

Type of transaction	How to register, update, or cancel	For registration related questions, contact	To resolve issues after registration, contact
EFT only	Use EnrollSafe	EnrollSafe help desk at **1-877-882-0384**	EnrollSafe help desk at **1-877-882-0384**
ERA (835) only	Use Availity	Availity Support **1-800-282-4548**	Availity at **1-800-282-4548** *NOTE: Providers should allow up to 10 business days for ERA enrollment processing.*

1343-1021-PN-CNT

URL: https://providernews.anthem.com/kentucky/article/reminder-enrollsafe-the-new-eft-enrollment-portal-for-anthem-providers-replacing-caqh-enrollhub-effective-november-1-2021

Procedure searches in Find Care

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

Find Care, the doctor finder and transparency tool in Anthem Blue Cross and Blue Shield (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.

Personalized match procedure searches is expanding to include additional procedures on or after November 19, 2021. Anthem 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 [provider customer service/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-CNT

Reminder: Updated AIM Musculoskeletal Program site of care reviews effective November 1, 2021

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

As previously communicated in the August edition of Anthem Blue Cross and Blue Shield (Anthem)'s *Provider News*, effective November 1, 2021, AIM Specialty Health® (AIM), will expand the AIM Musculoskeletal program to perform medical necessity review of the requested site of service for certain joint and interventional pain procedures for Anthem fully-insured members, as outlined below.

AIM will continue to manage the AIM Musculoskeletal program and level of care review. The AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures is used for the level of care review. Prior authorization will now also be required for the clinical appropriateness of the site in which the procedure is performed (site of care). A subset of the AIM musculoskeletal program codes will be reviewed for site of care. A complete list of CPT codes requiring prior authorization for the AIM Musculoskeletal site of care program is available on the AIM Musculoskeletal microsite. AIM will use the following Anthem Clinical UM Guideline: CG-SURG-52: Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services. The clinical criteria to be used for these reviews can be found on the Anthem Provider portal Clinical UM Guidelines page. *Please note, this does not apply to procedures performed on an emergent basis.*

Members included in the new program

All Commercial fully-insured members currently participating in the AIM Musculoskeletal program are included.

Prior authorization requirements

For services that are scheduled to begin on or after November 1, 2021, providers may contact AIM to obtain prior authorization review beginning October 18, 2021. The following groups are excluded: Medicare Advantage, Medicaid, Medicare, Medicare supplement, MA EGR, and the Federal Employee Program® (FEP®).

Providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com.
- Call the AIM Contact Center toll-free number at 800-554-0580, Monday–Friday, 8:30 a.m.–7:00 p.m. ET.

AIM Musculoskeletal training webinars

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

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

1363-1021-PN-IN.KY.OH

URL: https://providernews.anthem.com/kentucky/article/reminder-updated-aim-musculoskeletal-program-site-of-care-reviews-effective-november-1-2021-1

Specialty pharmacy updates are available - October 2021

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

Specialty pharmacy updates for Anthem Blue Cross and Blue Shield (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 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(s)	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-CNT

URL: https://providernews.anthem.com/kentucky/article/specialty-pharmacy-updates-are-available-october-2021-3

Pharmacy information available at 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 website 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-CNT

URL: https://providernews.anthem.com/kentucky/article/pharmacy-information-available-at-anthemcom-38

Medical policy and clinical guideline updates - October 2021

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

The following Anthem Blue Cross and Blue Shield medical policies and clinical guidelines were reviewed on August 12, 2021 for Indiana, Kentucky, Missouri, Ohio and Wisconsin.

Determine if prior authorization is needed for an Anthem member by going to anthem.com > select “Providers” > under “Claims” > select “Prior Authorization”, then select your state. Or, you may call the prior authorization phone number on the back of the member’s ID card.

These medical policies to not apply to members enrolled in the Blue Cross and Blue Shield Service Benefit Plan, commonly referred to as the Federal Employee Program® (FEP®). To view medical policies and utilization management guidelines applicable to FEP members, please visit fepblue.org > Policies & Guidelines.

Below are the new medical policies that have been approved.

Title	Information	Effective date
DME.00043 Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring	The use of a neuromuscular electrical training device is considered investigational/not medically necessary (INV&NMN) for the treatment of obstructive sleep apnea or snoring -No specific code for this OSA device considered INV&NMN; listed E1399 NOC	1/1/2022
GENE.00058 TruGraf Blood Gene Expression Test for Transplant Monitoring	TruGraf blood gene expression test is considered INV&NMN for monitoring immunosuppression in transplant recipients and for all other indications -No specific code for TruGraf test considered INV&NMN; listed 81479 NOC	1/1/2022
LAB.00040 Serum Biomarker Tests for Risk of Preeclampsia	Serum biomarker tests to diagnosis, screen for, or assess risk of preeclampsia are considered INV&NMN -Existing CPT PLA code 0243U (effective 04/01/21) for PIGF Preeclampsia Screen will be considered INV&NMN; also listed 81599 NOC code	1/1/2022

LAB.00042 Molecular Signature Test for Predicting Response to Tumor Necrosis Factor Inhibitor Therapy	Molecular signature testing to predict response to Tumor Necrosis Factor inhibitor (TNFi) therapy is considered INV&NMN for all uses, including but not limited to guiding treatment for rheumatoid arthritis -No specific code for this TNF test (PrismRA test) considered INV&NMN; listed 81479, 81599 NOC codes	1/1/2022
OR-PR.00007 Microprocessor Controlled Knee-Ankle-Foot Orthosis	Outlines the MN and NMN criteria for the use of a microprocessor controlled knee-ankle-foot orthosis -Existing HCPCS KAFO code L2006 will be reviewed for MN criteria	1/1/2022

The current clinical guidelines listed below were reviewed and updates were approved.

Title	Change	Effective date
CG-DME-44 Electric Tumor Treatment Field (TTF)	Added medical necessity (MN) indications for continuation therapy	1/1/2022

Policy update

In July 2021, we notified you of the new medical policy effective November 1, 2021 listed below. This policy will be added as a prior authorization requirement on January 1, 2022.

NOTE *Prior authorization required

Title	Change	Effective date
*CG-MED-89 Home Parenteral Nutrition	Outlines the MN and NMN criteria for initial and continuing use of home parenteral nutrition -Existing codes B4164, B4168, B4172, B4176, B4178, B4180, B4185, B4187, B4189, B4193, B4197, B4199, B4216, B4220, B4222, B4224, B5000, B5100, B5200, B9004, B9006, B9999, S9364, S9365, S9366, S9367, S9368 for parenteral nutrition will be reviewed for MN criteria	1/1/2022

1332-1021-PN-CNT

URL: https://providernews.anthem.com/kentucky/article/medical-policy-and-clinical-guideline-updates-october-2021-3

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 issue of *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-CNT

URL: https://providernews.anthem.com/kentucky/article/reimbursement-policy-clarification-claims-requiring-additional-documentation-facility-3

Clarification to reimbursement policy update: Virtual Visits - Professional and Facility

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

Beginning with dates of service on or after November 1, 2021, Anthem Blue Cross and Blue Shield (Anthem)'s current Telehealth policy will be renamed Virtual Visits.

Anthem allows reimbursement for professional and facility Virtual Visits when interactive services occur between the member and the provider, when they are not in the same location, unless provider, state, or federal contracts and/or mandates indicate otherwise. Reimbursement is allowed for professional and facility Virtual Visits rendered at the distant site via live audio visual services and for Remote Patient Monitoring. Services reported by a professional provider with a place of service Telehealth (02) will be eligible for non-office place of service reimbursement. In addition, facility Virtual Visits will be allowed for the originating site fee only when the member is physically **located** in the originating facility. The Related Coding section details the modifiers allowed for reimbursement.

1354-1021-PN-KY

URL: https://providernews.anthem.com/kentucky/article/clarification-to-reimbursement-policy-update-virtual-visits-professional-and-facility

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May 2021 medical policies and utilization management guidelines update

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

The *Medical Policies*, *Clinical Utilization Management (UM) Guidelines* and *Third Party Criteria* below were developed and/or revised to support clinical coding edits. Note, several

Please share this notice with other members of your practice and office staff.
To view a guideline, visit anthem.com/provider/policies/clinical-guidelines/search.

Updates

Effective October 6, 2021, Anthem Blue Cross and Blue Shield Medicaid (Anthem) will begin using the ***AIM Specialty Health®* Clinical Appropriateness Guidelines*** for medical necessity review of the below services. Please note, the Anthem Utilization Management team will complete these reviews using the *AIM Clinical Appropriateness Guidelines*.

- Computed Tomography to Detect Coronary Artery Calcification will be reviewed using the *AIM Imaging of the Heart Guideline*

AKY-NU-0332-21

URL: https://providernews.anthem.com/kentucky/article/may-2021-medical-policies-and-utilization-management-guidelines-update

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2021 affirmative statement concerning utilization management decisions

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

This communication applies to the Medicaid and Medicare Advantage programs in Kentucky.

All associates who make utilization management (UM) decisions are required to adhere to the following principles:

- UM decision making is based only on appropriateness of care and service and existence of coverage.
- We do not reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support, or tend to support, denials of benefits.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization or create barriers to care and service.

If you have any questions about this communication:

- For Medicaid, call Provider Services at 855-661-2028.
- For Medicare Advantage, call the number on the back of the member’s ID card.

AKY-NU-0328-21

URL: https://providernews.anthem.com/kentucky/article/2021-affirmative-statement-concerning-utilization-management-decisions

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Appointment availability and after-hours access requirements

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

To ensure members receive care in a timely manner, primary care providers (PCP), specialists, and behavioral health (BH) providers must maintain the following appointment availability and after-hours access standards as required by the Department for Medicaid Services and Anthem Blue Cross and Blue Shield Medicaid.

General appointment scheduling (PCPs and all specialists, including vision, lab and radiology)	
Emergency examination	Immediate access 24/7
Urgent examination	Within 48 hours of request
Routine examination	Within 30 calendar days of request
Voluntary family planning Members under 18 years of age	Within 30 calendar days of request If complete medical services cannot be provided on short notice, counseling and a medical appointment shall be provided right away, if possible, or within 10 calendar days of request.
Prenatal	Within 14 calendar days of request
Third trimester	Within five calendar days of request
High risk pregnancy	Within 14 calendar days of request
Postpartum exam	Four to eight weeks after delivery
Behavioral health appointment standards	
Life-threatening emergency	Immediately
Crisis stabilization	Within 24 hours of request
Urgent behavioral health services	Within 48 hours of request
Outpatient treatment post-psychiatric inpatient care	Within seven calendar days from the date of discharge
Routine behavioral health visits, including the initial visit and follow-up visits	Within 10 calendar days of request
General and pediatric dental care appointment standards	
Urgent examination	Within 48 hours of request
New patient exam (dental)	Within 30 calendar days of request
Routine exam after initial diagnosis (dental)	Within 30 calendar days of request

After-hours access requirements

PCPs are required to abide by a set of standards to ensure access to care for Anthem Blue Cross and Blue Shield Medicaid members. PCPs must:

- Offer members access to quality, comprehensive healthcare services 24/7.

- Have either a recording or an answering service for members during after-hours for assistance that follow the acceptable after-hours arrangements:
    - Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of 30 minutes;
    - Office phone is answered after hours by a recording directing the enrollee to call another number to reach the PCP or another medical practitioner whom the provider has designated to return the call within a maximum of 30 minutes; and
    - Office phone is transferred, after office hours to another location where someone shall answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of 30 minutes
- Be available to provide medically necessary services or from another
- Follow the referral/precertification guidelines. This is a requirement for covering
- For emergent issues, both the answering service and answering machine will direct the member to call **911** or go to the nearest emergency

Additionally, we strongly encourage offering after-hours appointments in the evenings and on Saturdays. For additional information regarding access and availability, please reference the provider manual on the provider page at https://providers.anthem.com/kentucky-provider/home.

What if I need assistance?
If you have questions, contact your local Provider Experience consultant or call Provider Services at **855-661-2028.**

AKYPEC-2888-21

URL: https://providernews.anthem.com/kentucky/article/appointment-availability-and-after-hours-access-requirements-1

Keep up with Medicare news - October 2021

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

Please continue to read news and updates at anthem.com/medicareprovider for the latest

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

URL: https://providernews.anthem.com/kentucky/article/keep-up-with-medicare-news-october-2021-3

New reimbursement policy: Sexually transmitted infections testing (Professional)

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

Effective January 1, 2022, Anthem Blue Cross and Blue Shield (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 anthem.com/medicareprovider.

ABSCRNU-0254-21

URL: https://providernews.anthem.com/kentucky/article/new-reimbursement-policy-sexually-transmitted-infections-testing-professional-1

Information about 2021 Special Needs Plans

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

Anthem Blue Cross and Blue Shield (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 availity.com.

To access the Custom Learning Center on the Availity Portal:*

1. Log in to the Availity Portal at com.
2. At the top of the Availity Portal, select **Payer Spaces** and select the appropriate payer.
3. On the Payer Spaces landing page, select **Access Your Custom Learning Center** from Applications.
4. In the Custom Learning Center, select **Required Training**.
5. Select **Special Needs Plan and Model of Care Overview**.
6. Select **Enroll**.
7. Select **Start**.
8. 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 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.

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

ABSCRNU-0255-21

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 Blue Cross and Blue Shield (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.

ABSCRNU-0259-21

URL: https://providernews.anthem.com/kentucky/article/hedis-medical-record-submission-made-easier-with-our-remote-emr-access-service-9

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)

ABSCRNU-0266-21/ABSCARE-1058-21

URL: https://providernews.anthem.com/kentucky/article/new-medical-step-therapy-requirements-2