Virginia Provider News

October 2021 Anthem Provider News - Virginia

Medicare:

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

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In late 2020, the Price Transparency final rule and the Consolidated Appropriations Act (CAA) were enacted. By law, many of these provisions require that Anthem Blue Cross and Blue Shield (Anthem) and our affiliate HealthKeepers, Inc. 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-VA

URL: https://providernews.anthem.com/virginia/article/federal-price-transparency-and-consolidated-appropriations-act-phase-in-new-mandates-beginning-january-1-2022-3

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, 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 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 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-VA

URL: https://providernews.anthem.com/virginia/article/your-recommendation-is-key-to-encouraging-cancer-screenings-for-your-female-patients-5

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

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

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

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

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

Help your African American and Hispanic patients understand the importance of early screening by sharing information with them about their unique risks. We’ve included links to videos that address breast cancer screening in both African American and Hispanic women. We hope you will share it 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 Centers for Disease Control and Prevention (CDC) 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 continuing medical education (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-VA

URL: https://providernews.anthem.com/virginia/article/are-you-talking-to-all-of-your-patients-about-breast-cancer-screenings-5

Looking to earn continuing medical education credits? Register for these on-demand webinars

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Overview

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

Article Attachments

- 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-VA

URL: https://providernews.anthem.com/virginia/article/looking-to-earn-continuing-medical-education-credits-register-for-these-on-demand-webinars-3

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 Blue Cross and Blue Shield (Anthem) or our affiliate HealthKeepers, Inc. 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 www.anthem.com.

1368-1021-PN-VA

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 remittance advices with payments, you may continue to search with the check/electronic funds transfer (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 10-digit number beginning with 9 (9XXXXXXXXX). Each non-payment remittance issued will be assigned a unique number.

1. 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.

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URL: https://providernews.anthem.com/virginia/article/good-news-non-payment-remittance-advice-enhancements-coming-soon-5

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's online directory, allows Anthem members to search and compare cost and quality measures for in-network providers. This tool allows you to sort providers based on distance, name, or personalized match. Additionally, as we informed you 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 are 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.

Providers 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 > Education & Reference 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 network manager.

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-VA

URL: https://providernews.anthem.com/virginia/article/procedure-searches-in-find-care-3

REMINDER: EnrollSafe, the new electronic funds transfer enrollment portal for Anthem providers - 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 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

Electronic Remittance Advice (ERA), Electronic Funds Transfer (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 at **800-282-4548**	Availity at **800-282-4548** *NOTE – Providers should allow up to 10 business days for ERA enrollment processing.*

1343-1021-PN-VA

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

Coverage guidelines effective January 1, 2022

Published: Oct 1, 2021 - **Guideline Updates** / Coverage and Clinical Guidelines

Anthem Blue Cross and Blue Shield in Virginia and our affiliate, HealthKeepers, Inc., will implement the following new and revised coverage guidelines effective ***January 1, 2022***. These guidelines impact all our products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage, the Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan, and the Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program® or FEP®). Furthermore, the guidelines were among those recently approved at the Medical Policy and Technology Assessment Committee meeting held on August 12, 2021.

The services addressed in these coverage guidelines here and in the attachment under "Article Attachments" on the right will require authorization for all of our HealthKeepers, Inc. products – with the exception of Anthem HealthKeepers Plus (Medicaid), Medicare Advantage and the Commonwealth Coordinated Care Plus (Anthem CCC Plus) plan. A pre-determination can be requested for our PPO products. Please note that FEP is excluded from this requirement as well.

The guidelines addressed in this edition of *Provider News* are:

- Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring (DME.00043)

- TruGraf Blood Gene Expression Test for Transplant Monitoring (GENE.00058)

- Serum Biomarker Tests for Risk of Preeclampsia (LAB.00040)

- Molecular Signature Test for Predicting Response to Tumor Necrosis Factor Inhibitor Therapy (LAB.00042)

- Microprocessor Controlled Knee-Ankle-Foot Orthosis (OR-PR.00007)

- Ultraviolet Light Therapy Delivery Devices for Home Use (CG-DME-41)

- Electric Tumor Treatment Field (TTF) (CG-DME-44)

- Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure (CG-SURG-63)

Article Attachments

Coverage guidelines effective January 1, 2022.pdf
application/pdf - 160.43 KB

1345-1021-PN-VA

URL: https://providernews.anthem.com/virginia/article/coverage-guidelines-effective-january-1-2022

Clinical utilization management guideline update

Published: Oct 1, 2021 - **Guideline Updates** / Coverage and Clinical Guidelines

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. are committed to reducing costs while improving health outcomes. To that end, **CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities** was implemented as of May 1, 2016, with the review of specific diagnosis per the medical necessity criteria.

Effective January 1, 2022, additional diagnosis will be added to the review process. The CPT codes associated with this clinical UM guideline are 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37233, 37234, 37235, 0505T, and 0620T.

1346-1021-PN-VA

URL: https://providernews.anthem.com/virginia/article/clinical-utilization-management-guideline-update

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Specialty pharmacy updates are available

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

Specialty pharmacy updates for Anthem Blue Cross and Blue Shield (Anthem) are listed

For Anthem along with our affiliate HealthKeepers, Inc., prior authorization clinical review of these specialty pharmacy drugs will be managed by Anthem. Drugs used for the treatment of Oncology will still require pre-service clinical review by AIM Specialty Health® (AIM), a separate company.

This applies to members with Preferred Provider Organization (PPO), HealthKeepers (HMO), POS AdvantageOne, and Act Wise (CDH plans).

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.

The Health Plan requires that claims for injection services performed in the office setting must include the applicable HCPCS J-code, Q-code, or S-code, with the corresponding National Drug Code, for the injected substance. This requirement is consistent with the Centers for Medicare & Medicaid Services (CMS) guidelines. A covered drug will not be eligible for reimbursement when the NDC is not reported on the same claim.

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-VA

URL: https://providernews.anthem.com/virginia/article/specialty-pharmacy-updates-are-available

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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 Virginia 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 for Virginia, scroll down to “Select Drug Lists.”This drug list is also reviewed and updated regularly as needed.

The Federal Employee Program® (FEP) Pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits.

1333-1021-PN-VA

URL: https://providernews.anthem.com/virginia/article/pharmacy-information-available-on-anthemcom-108

Diabetes testing and screening HEDIS measures

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

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Comprehensive Diabetes Care HEDIS® measure

The Comprehensive Diabetes Care HEDIS measure evaluates the percent of adult members 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following during the measurement year:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Retinal eye exam performed
- Blood pressure control (<140/90 mm Hg)

Kidney Health Evaluation for Patients with Diabetes

Additionally, the Kidney Health Evaluation for Patients with Diabetes measure was added as a first year HEDIS measure in 2020. This measure evaluates the percent of members 18 to 85 years of age with diabetes who received a kidney health evaluation, including an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR).

Record your efforts

Document results in the in the member's medical record: HbA1c tests and results, retinal eye exam, blood pressure, urine creatinine test, GFR test.

Helpful tips

- Have reminders set in your electronic medical record (EMR) to alert staff when a patient's screenings are due.
- Provide reminders to patients for upcoming appointments and screenings.
- Refer patients to a local lab for screenings.
- Refer patients to participating eye professionals for annual retinal eye exams.
- Follow up on lab test, eye exams and specialist referrals and document in your chart.
- Telephone visits, e-visits and virtual check-ins are acceptable settings for blood pressure readings and should be recorded in the chart.
- Include Category II reporting codes on claims to reduce the burden of HEDIS medical record review.

- Educate patients on topics (for example, home monitoring of blood sugar and blood pressure, taking medications as prescribed, and other healthy lifestyle education like diet, exercise, and smoking cessation).

Other available resources

- Clinical Practice Guidelines are available on our provider self-service website.
- Contact the Health Plan for a copy of *Quality Measures Desktop Reference for Medicaid Providers* and the *HEDIS Benchmarks and Coding Guidelines for Quality*.
- Diabetes programs may be available to our members, contact your Provider Solutions representative for more information.

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.

AVA-NU-0393-21

URL: https://providernews.anthem.com/virginia/article/diabetes-testing-and-screening-hedis-measures-3

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

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

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Effective **November 1, 2021**, EnrollSafe will replace CAQH Enrollhub® as the electronic funds transfer (EFT) enrollment website for our 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 safe, 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. 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?

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.

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.

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

AVA-NU-0421-21

Prior authorization updates for specialty pharmacy

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

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Effective for dates of service on and after November 1, 2021, the following specialty drug codes from current or new clinical criteria documents will require prior authorization.

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

Visit the ***Clinical Criteria*** website to search for the specific clinical criteria listed below.

Clinical Criteria	HCPCS or CPT® code(s)	Drug	Drug classification
ING-CC-0170	J1823	Uplizna	Immunosuppressive agents
ING-CC-0172	J3490, J3590, C9071	Viltepso	Muscular dystrophies
ING-CC-0173	J3490, J3590	Enspryng	MISC conditions
ING-CC-0174	J3490, J3590, C9399	Kesimpta	Multiple sclerosis
ING-CC-0168	J9999, C9073	Tecartus	CAR-T
ING-CC-0171	J9223	Zepzelca	Cancer
ING-CC-0169	J9316	Phesgo	Cancer
ING-CC-0175	J9015	Proleukin	Cancer
ING-CC-0176	J9032	Beleodaq	Cancer
ING-CC-0178	J9262	Synribo	Cancer
ING-CC-0177	J3304	Zilretta	Osteoarthritis
ING-CC-0002	Q5122	Nyvepria	Blood cell deficiency
ING-CC-0038	J3110	Forteo	Osteoporosis

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.

AVAPEC-3051-21

URL: https://providernews.anthem.com/virginia/article/prior-authorization-updates-for-specialty-pharmacy-5

Prior authorization updates for specialty pharmacy

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

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Effective for dates of service on and after November 1, 2021, the following specialty pharmacy codes from current or new *Clinical Criteria* documents will require prior authorization.

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

Visit the ***Clinical Criteria* website** to search for the specific *Clinical Criteria* listed below.

Clinical Criteria	HCPCS or CPT® code(s)	Drug	Generic name	Drug c
ING-CC-0179	J9037	Blenrep	Belantamab	Oncol
ING-CC-0180	J9349	Monjuvi	Tafasitamab-cxix	Oncol
ING-CC-0181	J3490	Veklury	Remdesivir	COVID

What if I need assistance?

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.

AVAPEC-3075-21

URL: https://providernews.anthem.com/virginia/article/prior-authorization-updates-for-specialty-pharmacy-6

Keep up with Medicaid news: October 2021

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

Please continue to check our website https://mediproviders.anthem.com for the latest Medicaid information for members enrolled in HealthKeepers, Inc.'s Anthem HealthKeepers Plus and the Commonwealth Coordinated Care Plus (Anthem CCC Plus) benefit plans. Here are the topics we're addressing in this edition:

- 2021 affirmative statement concerning utilization management decisions
- Medical Policies and Utilization Management Guidelines update
- Generic buprenorphine/naloxone tablets added to Virginia Medicaid Preferred Drug List

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

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

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 519447MUPENMUB

URL: https://providernews.anthem.com/virginia/article/new-medical-step-therapy-requirements-8

Sexually Transmitted Infections Testing: Professional

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

New reimbursement policy
Sexually Transmitted Infections Testing – Professional
(Effective 01/01/2022)

Anthem Blue Cross and Blue Shield (Anthem) allows reimbursement of sexually transmitted infection (STI) tests unless provider, state, federal, or Centers for Medicare & Medicaid Services (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**.

ABSCRNU-0254-21 519310MUPENMUB

URL: https://providernews.anthem.com/virginia/article/new-reimbursement-policy-sexually-transmitted-infections-testing-professional-5

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 Blue Cross and Blue Shield 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 safe, 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. 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?

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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 Anthem Blue Cross and Blue Shield.

ABSCRNU-0258-21 519338MUPENMUB

URL: https://providernews.anthem.com/virginia/article/get-your-payments-faster-when-you-sign-up-for-electronic-funds-transfer-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's (Anthem) Remote Electronic Medical Record (EMR) Access Service. We offer this service so you can allow 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 Health Insurance Portability and Accountability Act (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 responses to the frequently asked questions below.

How do you retrieve our medical records?
Anthem accesses 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 (for example: address, National Provider ID, taxpayer identification numbers, etc.)
- EMR system information (for example: 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.

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

ABSCRNU-0259-21

URL: https://providernews.anthem.com/virginia/article/hedis-medical-record-submission-made-easier-with-our-remote-emr-access-service-15

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 Medicare Advantage information, including:

- 2021 affirmative statement concerning utilization management decisions

- Medical Policies and Utilization Management Guidelines update

URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicare-news-october-2021-5

Information about 2021 Special Needs Plans

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

Introduction

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 **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**.
    - 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 and 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 Blue Cross and Blue Shield (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 postdischarge 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.

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ABSCRNU-0255-21 519271MUPENMUB

URL: https://providernews.anthem.com/virginia/article/information-about-2021-special-needs-plans-8
