Connecticut Provider News

September 2020 Anthem Connecticut Provider News

Medicare:

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Site of care medical necessity reviews expands to additional surgical procedures beginning December 1, 2020

Published: Sep 1, 2020 - **Products & Programs**

We are committed to being a valued health care partner in identifying ways to achieve better health outcomes, lower costs and deliver access to a better healthcare experience for consumers.

For members enrolled in Anthem commercial plans with dates of service on or after December 1, 2020, the site of care* medical necessity review will expand to additional surgical procedures performed in an outpatient hospital setting. Clinical guideline CG-SURG-52, Site of Care**: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services will apply to the review process. AIM Specialty Health® (AIM) will administer the review.

The site of care review will apply to a wide range of surgical procedures, including but not limited to, the following specialty categories:

- Auditory system
- Digestive/Gastrointestinal system
- Eye/ocular adnexa system
- Female genital system
- Hemic and lymphatic system
- Integumentary system
- Male genital system
- Musculoskeletal system
- Nervous system
- Respiratory system
- Urinary system

For a complete list of procedures, Frequently Asked Questions and additional information, visit aimproviders.com/surgicalprocedures/resources.

AIM will use CG-SURG-52 to evaluate the clinical information in the request and determine if the procedure requested requires a hospital-based outpatient setting. Providers may contact AIM to request a peer-to-peer discussion before or after the review is complete.

*The site of care review only applies to procedures performed in an outpatient hospital setting. T*he site of care review does not apply to procedures performed in a non-hospital setting or as part of an inpatient stay, nor when Anthem is the secondary payer.

Submit a request for review to AIM
Starting November 16, 2020, ordering providers may submit prior authorization requests for the hospital outpatient site of care for the applicable procedures for dates of service on or after December 1, 2020 to AIM in one of the following ways:

- Access AIM's ***Provider****Portal*$_{SM}$ 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 providerportal.com.
- Call the AIM Contact Center toll-free at 866-714-1107, Monday - Friday, 8:00 a.m. - 5:00 p.m.

Beginning in November, AIM will offer webinars to provide information on navigating the AIM ***Provider***Portal. To register for a webinar visit aimproviders.com/surgicalprocedures.

This review applies to local fully insured Anthem members and members covered under self-insured (ASO) benefit plans with services medically managed by AIM. This review does not apply to BlueCard®, Medicare Advantage, Medicaid, Medicare Supplement, or Federal Employee Program® (FEP®).

Providers can view specific guidelines and prior authorization requirements for Anthem members on the Prior Authorization page of anthem.com.

Providers should continue to verify eligibility and benefits for all members prior to rendering services.

If you have questions, please call the Provider Service phone number on the back of the member's ID card.

* In some plans, ‘level of care,’ ‘site of service’ or another term such as ‘setting’ or ‘place of service’ may be the term used in benefit plans, provider contracts, or other materials instead of or in addition to “site of care” and, in some plans, these terms may be used interchangeably. For simplicity, we will hereafter use ‘site of care’.

** At the time of this notice, Anthem is in the process of retitling this guideline to use site of care in place of level of care.

622-0920-PN-CT

URL: https://providernews.anthem.com/connecticut/article/site-of-care-medical-necessity-reviews-expands-to-additional-surgical-procedures-beginning-december-1-2020

Formulary lists updated for commercial health plan pharmacy benefit

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

Effective with dates of service on and after October 1, 2020, and in accordance with the IngenioRx Pharmacy and Therapeutics (P&T) process, we will update our drug lists that support commercial health plans. Updates include changes to drug tiers and the removal of medications from the formulary.

As certain brand and generic drugs will no longer be covered, providers are encouraged to determine if a covered alternative drug is appropriate for their patients whose current medication will no longer be covered. Communications to providers and their patients affected by the changes went out in early August.

Please note, this update does not apply to the Select Drug List and does not impact Medicaid and Medicare plans.

To help ensure a smooth member transition and minimize costs, providers should review these changes and consider prescribing a drug on formulary or on a lower tier, if appropriate.

View a summary of changes here.

IngenioRx, Inc. is an independent company providing pharmacy benefit management services on behalf of Anthem.

Specialty pharmacy updates effective December 2020

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

Prior authorization updates

Effective for dates of service on and after December 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

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

To access the clinical criteria information, please click here.

Prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. *Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company, and are shown in italics.*

Clinical Criteria	HCPCS or CPT Code	Drug
ING-CC-0164	*J3490* *J9999* *C9399*	*Jelmyto*
ING-CC-0165	*J3490* *J3590* *J9999* *C9399*	*Trodelvy*
ING-CC-0061	J1950 J3490	Fensolvi

Site of care updates

Effective for dates of service on and after December 1, 2020, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing prior authorization site of care review process.

To access the site of care drug list, please click here.

Prior authorization clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. *Review of specialty pharmacy drugs for oncology indications will be managed by AIM Specialty Health® (AIM), a separate company, and are in italics.*

Clinical Criteria	HCPCS or CPT Code	Drug
ING-CC-0153	J0791	Adakveo (crizanlizumab)
ING-CC-0139	J3111	Evenity (romosozumab)
ING-CC-0154	J0223	Givlaari (givosiran)
ING-CC-0156	J0896	Reblozyl (luspatercept)
ING-CC-0003	J1558	Xembify (immune globulin)
**ING-CC-0002*	*Q5120*	*Ziextenzo (pegfilgrastim-bmez)*

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

Reminder: process for medical non-oncology specialty drug reviews
Please follow these steps to submit medical non-oncology specialty drug reviews:

Action	Contact
Submit a new prior authorization request for a medical specialty drug review Submit a reauthorization request for a medical specialty drug review previously performed by AIM	Call IngenioRx at 833-293-0659 or Fax IngenioRx at 888-223-0550
Inquire about an existing request (initially submitted to AIM or IngenioRx), peer-to-peer review, or reconsideration	Call IngenioRx at 833-293-0659

Please note:

- AIM continues to be responsible for performing **medical oncology drug** reviews for existing commercial medical benefit for our employer group business.
- Clinical criteria for **medical non-oncology specialty drugs** continue to reside on the Clinical Criteria webpage.
- Post service clinical coverage reviews and grievance and appeals process and teams have not changed.

637-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/specialty-pharmacy-updates-effective-december-2020

New provider directory indicators for medication assisted treatment (MAT) providers

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

We will begin publishing new indicators in our online provider directories to help members easily identify facilities and physicians designated as medication assisted treatment (MAT) providers for opioid use disorder.

These directory indicators fall into four categories related to MAT:

- Facility that provides MAT
- Physician who provides MAT
- Facility with a certified opioid treatment program
- Facility that provides counseling for opioid use disorders

We encourage facilities and individual providers who provide these services to update their demographic information so these MAT indicators can be added to our directories. To submit updated demographic information, please visit anthem.com and locate the Provider Maintenance Form. Please contact Provider Services if you have any questions.

630-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/new-provider-directory-indicators-for-medication-assisted-treatment-mat-providers-1

Interactive Care Reviewer self-service, online prior authorization tool now available for Anthem and FEP membership

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

On August 15, 2020, we introduced Interactive Care Reviewer (ICR), Anthem's online authorization tool for members enrolled in an Anthem Plan. ICR is also available for members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (Federal Employee Program® or FEP). ICR is accessed through the Availity Portal and can be used for many of your medical and behavioral health prior authorization requests. You will be able to submit authorization requests, check case status, update cases and request clinical appeals using one tool and one secure portal.

Ask your Availity administrator to grant you the required ICR role assignment now so you can begin using the tool immediately.

- *Do you create and submit prior authorization requests?*

You'll need the Authorization and Referral Request role assignment.

- *Do you check the status of the case or results of the authorization request?*

You'll need the Authorization and Referral Inquiry role assignment

Once you have the role assignment, follow these steps to navigate to ICR through Availity.

- Select Patient Registration from Availity's home page
- Select Authorizations & Referrals
- Select Authorizations (for requests) | Select Auth/Referral Inquiry (for inquiries)

Register for our September ICR webinars.
We offer training every month to familiarize new users with ICR features and navigation of the tool. Our next webinars are taking place on September 2 and September 16. Register Here

Can't make it to the webinar?
Follow the steps outlined below to access self-paced videos located on the Custom Learning Center.
From Availity's home page, select **Payer Spaces | Anthem tile | Applications | Your Custom Learning Center.**

1. Select Catalog from the menu located on the upper left corner of the Custom Learning Center screen
2. Use the catalog filter and select **Interactive Care Reviewer-Online Authorizations** or **Authorizations** from the **Category** menu
3. **C**lick **Apply** then enroll for the courses (videos) you want to view.

Illustrated reference guides that you can print are located on **Custom Learning Center Resources**. Select **Resources** from the menu located on the upper left corner of the screen. Use the catalog filter and select **Authorizations or Interactive Care Reviewer-Online Authorizations** from the **Category** menu. Select **Download** to view and/or print the reference guide.

641-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/interactive-care-reviewer-self-service-online-prior-authorization-tool-now-available-for-anthem-and-fep-membership

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EDI Gateway migration deadline is September 15, 2020

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

Migrate your EDI transactions to Availity today! We want to remind you, as the Availity migration continues full speed ahead, we will guide you to make it an effortless transition without having to rush.

If you, your clearinghouse or vendor have already migrated over to Availity, thank you and you are a step ahead! If not, start the process today to make the transition before **September 15, 2020**.

Take action now! Availity setup is simple and at no cost for you!
Use this link to learn about Availity to get started today.
All EDI transmissions currently sent or received today via the Anthem gateway are now available on the Availity EDI Gateway.

- 837 Institutional and Professional
- 837 Dental
- 835 Electronic Remittance Advice
- 276/277 Claim Status
- 270/271 Eligibility Request
- 275 Medical Attachments
- 278 Prior Authorization/Referrals
- 278N Inpatient Admission and Discharge Notification

Below are the options you can choose from to exchange EDI transmissions with the Availity EDI Gateway:

- Transition your existing connection with Anthem and become a direct submitter with Availity.
- Use your existing Clearinghouse or Billing Company for your EDI transmissions. (Work with them to ensure connectivity to the Availity EDI Gateway).
- Use Direct Single Claim entry through the Availity Portal with the new attachment function

Share with your team what you learn
Enroll in one of Availity's free courses and training demos at your convenience. Making the switch to Availity's EDI Gateway is easy if you have all the resources that you need.
Follow these steps to register with Availity:

1. Log in and select **Help & Training | Get Trained** to open the Availity Learning Center in a new tab Search Catalog field and choose. It is your dedicated ALC account.
2. Search by keyword (Medical Attachments/Attachments) to find on-demand and live training options.
3. Click **Enroll** to enroll for a course and then go to your **Dashboard** to access it any time.

For questions, contact Availity Client Services at 1-800-Availity (800-282-4548) for assistance Monday – Friday, 8:00 a.m. – 7:00 p.m.

635-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/edi-gateway-migration-deadline-is-september-15-2020-1

Patient360 adds care gap alert feedback for medical providers

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

Patient360 is a real time dashboard you can access through the Availity Portal that gives you a full 360° view of your Anthem patient's health and treatment history and will help you facilitate care coordination. You can drill down to specific items in a patient's medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information and care management-related activities.

What's new:
Medical providers now have the option available to include feedback for Anthem members who have gaps in care. Your practice can locate these care gaps in the Active Alerts section on the Member Care Summary page of the Patient360 application.

Once you have completed the required fields on the Availity Portal to access Patient360, you will land on the **Member Summary** page of the application. To provide feedback, select the **Clinical Rules Engine (CRE)** within the **Active Alerts** section. This will open the **Care Gap Alert Feedback Entry** window. You can choose the feedback menu option that applies to your patient's care gap.

Are you using Patient360 for the first time? You can easily access Patient360 on the Availity Portal.

First, you need to be assigned to the Patient360 Role which your Availity Administrators can locate within the Clinical Roles options.

Once you have the Availity role assignment, navigate to Patient360 through the Availity Portal by selecting the application on Anthem Payer Spaces or by choosing the Patient360 link located on the patient's benefits screen.

Do you need a job aid to help you get started?
The **Patient360 Navigation Overview** illustrates the steps to access Patient360 through the Availity Portal, and instructions on how to provide feedback for your patients who are displaying a Care Gap Alert. This reference is available for you to access online through the **Custom Learning Center.**

- From Availity's home page select Payer Spaces | Anthem payer tile| Applications | Custom Learning Center
- Select Resources from the menu located on the upper left corner of the page
    - *(To use the catalog filter to narrow the results select Payer Spaces from the Category menu.)*
- Select Download to view and/or print the reference guide

641-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/patient360-adds-care-gap-alert-feedback-for-medical-providers-5

Enhanced medical records submission process to support claims processing

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

Anthem now offers a full suite of options to assist with medical record submissions. To ease your administrative burden and recognizing your staff may be working remotely, we have increased the intake channels for required medical records supporting claim submissions.

Leverage any of the following Availity-hosted channels for electronic claim attachment transmission:

- EDI Transaction: X12 275 Patient Information (version 5010)
  - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting claims documentation including medical records (pdf, jpeg, tif file types). Access your X12 275 Companion Guide for more details.
  - Electronic Integrated Submission – Submit the claim via EDI 837 batch file and supporting documentation via x12 275.
- Availity Secure Provider Portal Options
  - Direct Data Entry (DDE) – The direct data entry claim application allows you to upload supporting documentation for a defined claim (unsolicited process).
  - Attachments - New tool - Submit solicited or unsolicited supporting documentation for your claims

Attend an Availity hosted webinar to learn more about all capabilities.

Start your transition today!
Start now to adopt these new processes and experience the many advantages to using an electronic option for claim attachment submission. You may find you are able to use these new processes to replace your more manual processes of submitting supporting documentation via fax or US Mail.
Advantages:

- **Easy submission** of medical documentation to include but not limited to:
  - itemized bills
  - medical records
  - discharge summaries
- **Less administrative burden** – medical records submitted electronically save an average of 4 minutes per record for staff vs. faxing or mailing your records in

- **Electronic acknowledgment with a transaction audit trail** – confirm delivery/receipt
- **Comprehensive history** – view past medical record submissions by your organization
- **Administrative savings** – reduce your mailing expense and/or fax related expenses

Want to learn more?
Register for an upcoming webinar session.

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

- In the Catalog, search by webinar title or keyword (medattach).
- Select the **Sessions** tab to scroll the live session calendar.

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

September and October webinars

Date	Day	Time
09/10/2020	Thursday	11:00 a.m. – 12:00 p.m.
9/21/2020	Monday	12:00 p.m. – 1:00 p.m.
10/7/2020	Wednesday	4:00 p.m. – 5:00 p.m.
10/20/2020	Tuesday	11:00 a.m. – 12:00 p.m.

636-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/enhanced-medical-records-submission-process-to-support-claims-processing-1

BlueCare Prime HMO Plans' PCP referral requirements

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

Effective October 1, 2020, new BlueCare Prime HMO plans will become available to the State of Connecticut Employer Group, and on January 1, 2021 for individuals and small groups in Connecticut. *These plans will require PCP referrals for specialized care.* Following

If a primary care physician (PCP) determines that a member needs specialized care, he or she will authorize the member to receive health care services from another health care provider. A referral for specialized care is not a guarantee of coverage for those services; the service must also be covered within the terms of this Subscriber Agreement. Thus, regardless of medical necessity, no benefits will be provided for care that is not a covered service, even if performed by a PCP or by another provider under a referral authorized by a PCP. Providers may call the Provider Call Center to determine if a service is a covered service.

- If a PCP authorizes a referral to another provider, the PCP must ensure the member understands:

- The name of the provider to whom they are being referred
- The period of time, the number of visits and services for which care is authorized
- Who will schedule appointment(s) with that provider – member or PCP's office staff

- The referred provider should consult with the member's PCP if the care exceeds the initial referral for services.
- If the referred provider recommends a member to another provider, the referred provider must contact the PCP prior to any treatment so he or she can determine if that care will be authorized. Only a PCP can authorize care with another provider.
- If the PCP authorizes these services, benefits will be provided according to the terms of the member's Subscriber Agreement. Care that is not authorized by a PCP is not covered, unless the member's Plan allows for coverage at a self-referred or out-of-network level. Providers may call the Provider Call Center to determine member benefits and if a service is a covered service.
- PCPs must use the Optum referral tool to generate referral authorizations to in-network specialists, unless another referral tool is agreed upon by Optum under the managed program.
- PCPs may issue members a copy of their referral. Members should retain this information as a confirmation of the PCP referral to see a specialist or provider who specializes in treating their specific illness or injury.

- While most services will require a referral some services do not, such services include but are not limited to:

  - Services from the member's PCP
  - Online visits
  - Routine obstetrical and gynecological (ObGyn) including maternity services
  - Mental health and substance abuse services
  - Diagnostic x-rays
  - Diagnostic labs at an independent lab
  - Routine eye exams
  - Medical emergency conditions
  - Walk-in centers
  - Retail health clinics

- Providers may call the Provider Call Center to determine member benefits and to confirm when a referral is required. Referrals do not take the place of prior authorizations. Prior authorizations will need to be obtained when mandated by the benefit plan.
- Note: If a PCP determines a member does not need a referral and the member disagrees, the member has the right to appeal the decision. The member's Subscriber Agreement outlines the necessary steps in submitting an appeal.

Referrals to in-network specialists

PCPs may refer members to in-network specialists. Referrals to in-network specialists are required for HMO gatekeeper plans. Specialists may use an approved referral for derivative services (e.g. laboratory, radiology, inpatient admission) related to that episode of care. Please refer to the Optum training manual for further information with respect to approved referrals for Blue Care Prime members.

Referral to non-network providers

At times, a member may require services that are not available from providers within the network. A PCP may make a referral to an out-of-network provider. Referrals to an out-of-network provider must be pre-approved by Anthem for services to be reimbursed.

Standing referrals

A member with a special condition requiring ongoing care from a specialist may receive a standing referral to a specialist for treatment of the special condition from the member's PCP. A special condition is a condition or disease that is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time. A standing referral must be made according to a treatment plan, approved by our Medical Director in consultation with the member's PCP.

Claims submission

- Professional providers must place the BlueCare Prime referral number in Box 23 of the CMS 1500 form - Loop 2300 REF01/02 with 9F Qualifier - Referral Number or G1 Qualifier - Prior Auth
    - Note: All other Anthem HMO plans' professional providers must continue to place the PCP NPI number in Box 17 B of the CMS 1500 form.
- Facilities must place the BlueCare Prime referral number in Box 63 B of the UB04 form - Loop 2300 REF01/02 - 9F Qualifier - Referral Number or G1 Qualifier - Prior Auth

If the referral number is not present on the claim, and depending on the type of plan, benefits may be non-covered, or processed with deductible and coinsurance. Please check member's benefits by using Availity or by contacting the Provider Call Center.

BlueCare Prime member ID number prefixes:

State of Connecticut Employer Group (effective October 1, 2020)

X6G	State BlueCare Prime HMO (PCP referral required)	HMO-POS

Please see article titled 'Important State of Connecticut Employer Group, State Partnership Plan changes', for more information about benefit changes and ID number prefixes for those members.

Individual Market (plans available beginning January 1, 2021)

Z9T	BlueCare Prime HMO (PCP referral required)	HMO-POE
X6T	BlueCare Prime HMO (PCP referral required)	HMO-POE

Small Group Market (plans available beginning January 1, 2021)

C9T	BlueCare Prime HMO (PCP referral required)	HMO-POE

616-0920-PN-CT

URL: https://providernews.anthem.com/connecticut/article/bluecare-prime-hmo-plans-pcp-referral-requirements

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Important State of Connecticut Employer Group, Connecticut Partnership Plan changes

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

We previously advised that Anthem was selected as the **sole** medical carrier for the State of Connecticut Employer Group and the Connecticut Partnership Plan effective October 1, 2020. In addition, we advised that both would be implementing several changes to their health plan coverage through Anthem in 2020.

A summary of those changes is as follows:

- State of Connecticut employees have a new plan choice – the State BlueCare Prime Plus Point of Service (POS) plan which lets them save on premiums when receiving care *only* from high-quality doctors, specialists and locations in the new State BlueCare Prime network. Note that referrals for specialist care are required as referenced in article titled 'BlueCare Prime gate keeper plans referral process', also published in the September 2020 issue of *Provider News*.
    - The State BlueCare POE, State BlueCare POE Plus*, State BlueCare POS, State Preferred PPO and State Out-of-Area health plans continue to be available.
    - Referrals for specialist care are also required for the POE Plus plan for professional providers *only*. Providers will continue to use the PCP's NPI in Box 17A on the CMS 1500 claim form.

- The State has identified high-quality doctors, hospitals and medical groups for common, full episodes-of-care medical procedures as part of its new ***Networks of Distinction program*** in which providers meeting certain care delivery performance standards are designated as "Networks of Distinction providers." This is available to both State of Connecticut and Connecticut Partnership health plan members who may also be

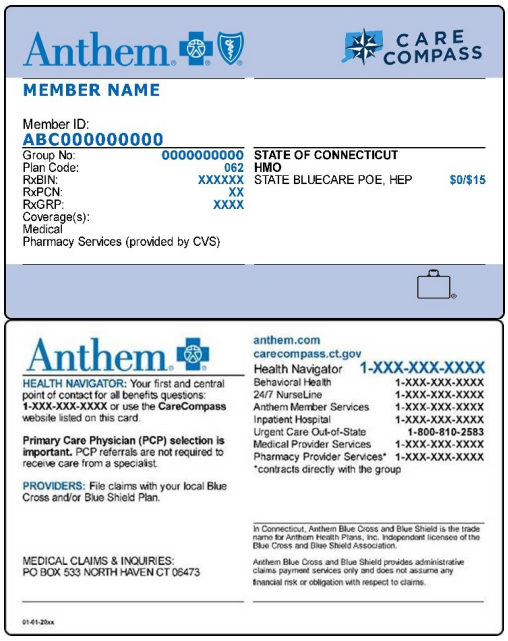
eligible for travel reimbursement and cash incentives for choosing these providers and care locations. Some of the services under this program include bariatric surgery, cardiac procedures, colonoscopies and hip, shoulder and knee surgery.

- The State is introducing the ***Health Navigator program*** to make it easier for employees to find quality care and navigate the health care system. 'Health Navigators' will be central points of contact to help simplify members' health care experience and connect them to the right care particularly around the Networks of Distinction program. Health Navigators will help schedule appointments on behalf of members and will facilitate travel reimbursement and incentive payments for episodes of care events. Their support will complement and be highly coordinated with support offered through Anthem's State of Connecticut Enhanced Dedicated Member Services team.

- Employees enrolled in these health plans will receive ***new medical ID cards*** in the mail ***that apply for BOTH medical and pharmacy benefits*** (example shown below). All State of Connecticut and Connecticut Partnership Plan members will be assigned a new member ID and group ID numbers. You should ensure your patients covered under these plans provide their new ID card information – which they can email to your office using Anthem's new Sydney Health mobile app – for any services provided on or after October 1, 2020 to help avoid claims processing delays.

- Employees covered under the State of Connecticut and Connecticut Partnership health plans will continue to have 100% coverage ($0 copay) for lab tests, X-rays and high-cost imaging services, like MRIs, when they select network providers designated as Site of Service under their plan. These are high-quality, low-cost participating providers for these types of services.

Sample State of Connecticut Member ID Card



For your convenience, we've included a list of State of Connecticut Employer group and State Partnership Plan member ID number alpha prefixes below.

State of Connecticut Employer Group and State Partnership Plan Member ID Number Prefix List

Network Name	Product Type	State of Connecticut	State Partnership Plan
State Preferred	PPO	XGS	N/A
State BlueCare	HMO - Point of Service (PCP referral not required)	XGR	SHP
State BlueCare	HMO - Point of Enrollment (PCP referral not required)	XGT	N/A
State BlueCare	HMO - Point of Enrollment (PCP referral required)	XGL	N/A
State BlueCare Prime (Narrow Network)	HMO (PCP referral required) NOT A TIERED PLAN	X6G	N/A

Article Attachments

645-0920-PN-CT

URL: https://providernews.anthem.com/connecticut/article/important-state-of-connecticut-employer-group-connecticut-partnership-plan-changes

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Receive and respond to medical record requests for postpay audit via Change Healthcare's Assurance Attach Assist Module

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

We are offering providers using Change Healthcare for revenue cycle management an opportunity to have a streamlined in-workflow solution native to Relay Assurance application.

Starting September 1, 2020, we will launch the use of Change Healthcare's Medical Attachment functionality for electronic communications as an additional digital option. This new functionality allows providers to upload medical records and itemized bill documents electronically instead of through traditional paper communications. This functionality can improve communications and increase transparency for medical record requests and will not otherwise impact the audit program.

Important facts regarding this change:

- This change only affects providers who use Assurance Reimbursement Management™ from Change Healthcare and have opted in to using the Attach Assist functionality.
- The new functionality is **only** for medical record requests for postpay claims for the Payment Integrity Quality Claims Review (Provider Audit) department only.
- There will be no duplicate requests (either paper or electronic). If you opt to use this method, paper requests for medical records will not be sent.
- In Assurance Reimbursement Management™, requests for additional documentation will be displayed to the user on the History tab of the claim. Assurance will be configured such that these requests drive workflow to help ensure they are brought to the user's attention.
    - The original letter, historically sent via paper, is accessible as a PDF electronic copy in the provider's downloads folder in Assurance for review. The letter content is exactly the same as it was in paper format.
    - Each request letter (first, second and final attempt) will have a timeframe for responding to the request. After the timeframe has passed for that letter, you will not be able to respond to that letter. If you wish to upload medical records after the response time has expired, please refer to the Change Healthcare training referenced below.
    - Providers can respond to the request by uploading records in Assurance Attach Assist. The attachments are received in almost real time and are delivered electronically to the payer's systems through secure means. Records can be accessed through a hyperlink in Assurance Attach Assist for the particular claim the record is associated.
- The following is out of scope or not impacted:
    - Vendor requests for medical records on behalf of the payer
    - Providers who do not use Assurance Reimbursement Management™ Attach Assist from Change Healthcare or have not configured Attach Assist within Assurance Reimbursement Management™

- The request timing of request letter and the verbiage in the request letter
- The Program Integrity Special Investigations Unit postpay review is not included at this time.

Article Attachments

Change Healthcare Medical Attachment Functionality FAQ.pdf
application/pdf - 136.85 KB

Resources
Training is available on the Change Healthcare Connect Center.

Can I start using the functionality earlier?
Yes, you can. If you chose to opt in earlier, please ensure you are configured within Assurance Reimbursement Management™. Reach out to your Provider Solutions contact or request early access via email at dl-Prod-ChangeHealthcare-Provider-Support@anthem.com.

For additional information, see the attached PDF C*hange Healthcare Medical Attachment Functionality FAQ*.

617-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/receive-and-respond-to-medical-record-requests-for-postpay-audit-via-change-healthcares-assurance-attach-assist-module

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Commercial Risk Adjustment (CRA) reporting update: 2020 prospective program continues

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

We understand you are committed to providing the best care for our members, which may now include telehealth visits. Telehealth visits are an acceptable form for seeing your patients, and assessing if they have risk adjustable conditions in support of the Anthem Commercial Risk Adjustment (CRA) prospective program. The prospective program is well under way for 2020, and focuses on member health assessments for patients with undocumented Hierarchical Condition Categories (HCC's), in order to help close patients' gaps in care. We continue to provide updates regarding the prospective program to solicit

Inovalon requests
Inovalon – an independent company that provides secure, clinical documentation services – helps us comply with the provisions of the Affordable Care Act (ACA) that require us to assess members' relative health risk levels. Please submit health assessments to Inovalon when completed and if you have questions, you can reach Inovalon directly at 877-448-8125.

Prospective program ask of providers:
Anthem network providers – usually PCPs – receive letters from Inovalon, requesting that they:

1. **Schedule a comprehensive in person or telehealth visit with patients** identified by Inovalon to confirm or deny if previously coded or suspected diagnoses exists, and;
2. **Submit a Health Assessment** documenting the previously coded or suspected diagnoses (also called SOAP Notes - *Subjective, Objective, Assessment* and *Plan*).

Incentives offered for properly submitted Health Assessments:

- $100 for each Health Assessment properly submitted electronically via Inovalon's ePASS® tool
- $50 for each Health Assessment properly submitted via fax

ePASS® training is available to ensure health assessment completion accuracy:

- Training webinars every Wednesday - 3:00 p.m. - 4:00 p.m.
- Register by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend. Information will be provided on how to join the webinar.

Alternative engagement
Inovalon's ePASS® tool is our preferred method for submission. However, we offer alternate options to be flexible and meet your needs. If in 2019 your practice utilized these alternative options for prospective member outreach, we thank you for continuing to utilize these alternative forms of program participation in 2020.

For those providers not familiar with alternative options, they are listed here. Telehealth visits are also an acceptable form of a patient visit for these alternative engagement options.

- **EPHC providers using PCMS** - Providers participating in our Enhanced Personal Health Care (EPHC) program can use member reports from our PCMS tool to schedule members for comprehensive visits. PCMS does have a link to take you directly to the Inovalon ePASS® tool where completed health assessments will result in a $100 incentive payment per submitted health assessment.
- **List of members to be scheduled** - Anthem CRA provides member/patient reports for providers to schedule members for comprehensive visits. No health assessment needed. Not eligible for additional incentive because CRA will get the diagnosis for gap closure through claims submission.
- **EPIC Patient Assessment Form (PAF)** - Providers with EPIC as their electronic medical record (EMR) system can fax the EPIC PAF to Anthem CRA at 855-244-0926 with a coversheet indicating "see attached Anthem Progress Note," which is eligible for a $50 incentive payment.
- **Providers Existing Patient Assessment Form (PAF)** - Utilizes providers' existing EMR system and applicable PAF. Must be submitted to Anthem CRA at 855-244-0926 with coversheet indicating, "see attached Anthem Progress Note" which is eligible for a $50 incentive payment.

If you have any questions please contact Alicia Estrada, the Commercial Risk Adjustment Network Education Representative, at Alicia.Estrada@anthem.com.

Thank you for your commitment to assessing your patient's health and closing possible gaps in care.

623-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/commercial-risk-adjustment-cra-reporting-update-2020-prospective-program-continues

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Reimbursement policy update: Distinct Procedural Services - Modifiers 59, XE, XP, XS, XU - professional

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

Beginning with dates of service on or after December 1, 2020, the non-reimbursable section will be updated to include “When multiple related procedures are performed on the same anatomical digit, by the same provider, during the same operative session. Modifiers FA, F1-F9 and TA, T1-T9 should be appended to applicable site specific services”.

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

632-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/reimbursement-policy-update-distinct-procedural-services-modifiers-59-xe-xp-xs-xu-professional-3

Reimbursement policy update: Frequency Editing - professional

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

Beginning with dates of service on or after December 1, 2020, we will apply a frequency limit to CPT® codes 90791 (Psychiatric diagnostic evaluation) and 90792 (Psychiatric diagnostic evaluation with medical services) with the following limitations:

- One (1) per 365 days, per member, per provider NPI for members over 21
- Two (2) per 365 days, per member, per provider NPI for members under age 21

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

CPT® is a registered trademark of the American Medical Association.

633-0920-PN-NE

URL: https://providernews.anthem.com/connecticut/article/reimbursement-policy-update-frequency-editing-professional-6

Medical drug benefit clinical criteria updates

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

On May 15, 2020, the Pharmacy and Therapeutics (P&T) Committee approved *Clinical Criteria* applicable to the medical drug benefit for Anthem Blue Cross and Blue Shield and AMH Health, LLC. These policies were developed, revised or reviewed to support clinical coding edits.

The *Clinical Criteria* is publicly available on the provider websites, and the effective dates will be reflected in the *Clinical Criteria Web Posting May 2020 (Anthem) Clinical Criteria Web Posting May 2020 (AMH Health)*. Visit *Clinical Criteria* to search for specific policies.
If you have questions or would like additional information, use this email.

ABSCRNU-0162-20
AMHCRNU-0030-20

URL: https://providernews.anthem.com/connecticut/article/medical-drug-benefit-clinical-criteria-updates-53

Update: Notice of changes to the AIM musculoskeletal program

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

As you know, AIM Specialty Health® (AIM) administers the musculoskeletal program for Medicare Advantage members, which includes the medical necessity review of certain surgeries of the spine, joints and interventional pain treatment. For certain surgeries, the review also includes a consideration of the level of care.
Effective December 1, 2020, two joint codes (29871 and 29892) will be incorporated into the AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures.
According to the clinical criteria for level of care, which is based on clinical evidence as outlined in the AIM guideline, it is generally appropriate to perform these two procedures in a hospital outpatient setting. To avoid additional clinical review for these surgeries, providers requesting prior authorization should either choose hospital observation admission as the site of service or hospital outpatient department (HOPD).

We will review requests for inpatient admission and will require the provider to substantiate the medical necessity of the inpatient setting with proper medical documentation that demonstrates one of the following:

- Current postoperative care requirements are of such an intensity and/or duration that they cannot be met in an observation or outpatient surgical setting.

- Anticipated postoperative care requirements cannot be met, even initially, in an observational surgical setting due to the complexity, duration, or extent of the planned procedure and/or substantial preoperative patient risk.

On January 1, 2020, CMS removed total hip arthroplasty as well as six spine codes from the inpatient only (IPO) list making these procedures eligible for payment by Medicare in the hospital outpatient setting in addition to the hospital inpatient setting. The two-midnight rule should guide providers on the expected reimbursement. The codes that were removed from the inpatient only list and are also in the AIM Musculoskeletal program are 27130, 22633, 22634, 63265 and 63267. CMS has established a two year grace period (ending December 31, 2021) for site of service reviews of these codes in order to facilitate provider transition to compliance with the two-midnight rule. To this end, it is recommended that providers choose hospital observation or HOPD during the prior authorization process when clinically appropriate to the respective patient. Choosing hospital observation still allows for the surgery to be performed and recovered in the main hospital, so long as discharge is planned for less than two midnights. Alternatively, the provider may choose to perform the procedure in the HOPD. However, the inpatient setting will still be approved should the provider decide it is the optimal setting for the member.

Providers should continue to submit prior authorization requests to AIM using one of the following ways:

- Access AIM ***Provider****Portal*$_{SM}$ directly at http://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 Portal at http://www.availity.com.
- Call the AIM toll-free number at 800-714-0400, Monday – Friday, 8:00 a.m. to 8:00 p.m.

If you have questions, please contact the provider number on the back of the member's ID card.

AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield. Availity, LLC is and independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

ABSCRNU-0163-20

URL: https://providernews.anthem.com/connecticut/article/update-notice-of-changes-to-the-aim-musculoskeletal-program-2

Keep up with Medicare news

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

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

- AIM Musculoskeletal program expansion

URL: https://providernews.anthem.com/connecticut/article/keep-up-with-medicare-news-156
