December 2018 Anthem Provider Newsletter - CO

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Case Management Program

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem is available to offer assistance in these difficult moments with our *Case Management Program*. Our case managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

How do you contact us?

CM Email Address	CM Telephone Number	CM Business Hours
Case.management@anthem.com	Phone 888-613-1130	Monday - Friday 8:00 am - 7:00 pm MT
National NationalWest-CM@anthem.com	1-877-783-2756	Mon - Friday 8am-9pm PST, Saturday 9am-4:30pm PST
Federal Employee Program (FEP) No email	1-800-711-2225	8am-7:00pm EST

ConditionCare Program Benefits Patients and Physicians

Anthem members have additional resources available to help them better manage chronic conditions. The ConditionCare program helps members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. A team of registered nurses with added support from other health professionals such as dietitians, pharmacists and health educators work with members to help them understand their condition(s), their doctor's orders and how to become a better self-manager of their condition.

Engagement methods vary by the individual's risk level but can include:

- **Education** about their condition through mailings, email newsletters, telephonic outreach, and/or online tools and resources.
- **Round-the-clock phone access** to registered nurses.
- **Guidance and support** from Nurse Care Managers and other health professionals.

Physician benefits:

- **Save time** by answering patients' general health questions and responding to concerns, freeing up valuable time for the physician and their staff.
- **Support the doctor-patient relationship** by encouraging participants to follow their doctor's treatment plan and recommendations.
- **Inform** the physician with updates and reports on the patient's progress in the program.

Please visit our website to find more information about the program such as program guidelines, educational materials and other resources. Go to **anthem.com**. Select **Providers**, and **Providers Overview**. Select **Find Resources for Your State** and pick **Colorado**. From the **Health & Wellness** tab, select the **Condition Care** link. Also on our website find the **Referral Form**, which you can use to refer other members you feel may benefit from our program.

If you have any questions or comments about the program, call **877-681-6694**. Our nurses are available Monday-Friday, 8:00 a.m. to 9:00 p.m., and Saturday, 9:00 a.m. to 5:30 p.m.

Integrated Care Model for plans purchased on the Health Insurance Marketplace / Connect for Health Colorado benefits patients and physicians

An Integrated Care Model affords members with plans purchased on the Health Insurance Marketplace (also called the exchange) the ability to have continuity of care with each care management case. A single Primary Care Nurse provides case and disease assessment and management. This continuity provides opportunity for the member to get assistance working through an acute phase of an illness and then work with their nurse on the necessary behavioral changes needed to improve their health and enhance their well-being. The program is based on nationally recognized clinical guidelines and serves as an excellent adjunct to physician care.

The Integrated Care Model helps exchange members better understand and control certain medical conditions like diabetes, COPD, heart failure, asthma and coronary artery disease. Our nurse care managers are part of an interdisciplinary team of clinicians and other

resource professionals that are there to support members, families, primary care physicians and caregivers.

Nurse Care Managers encourage participants to follow their physician's plan of care; not to offer separate medical advice. In order to help ensure that our service complements the physician's instructions, we collaborate with the treating physician to understand the member's plan of care and educate the member on options for their treatment plan.

Members or caregivers can refer themselves or family members by calling the number located in the grid below. How do you contact Case Management?

CM Telephone Number	CM Email Address	CM Business Hours
Phone 888-613-1130, Fax 800-947-4074	Case.management@anthem.com	Monday - Friday 8:00 am to 7:00 pm MT

Coordination of Care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. Anthem would like to take this opportunity to stress the importance of communicating with your patient's other health care practitioners. This includes primary care physicians (PCPs) and medical specialists, as well as behavioral health practitioners.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. Anthem urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between Behavioral Health and other health care practitioners at the time treatment begins.

We expect all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is

not limited to:

- Diagnosis
- Treatment plan
- Referrals
- Psychopharmacological medication (as applicable)

In an effort to facilitate coordination of care, Anthem has several tools available on the Provider website including a Coordination of Care template and cover letters for both Behavioral Health and other Healthcare Practitioners.* In addition, there is a Provider Toolkit on the website with information about Alcohol and Other Drugs which contains brochures, guidelines and patient information.**

*Access to the forms and cover letters are available at **anthem.com** > **Providers** > **Providers Overview** > **Find Resources for Your State** > **Colorado** > **Provider Home** > **Answers@Anthem**

Access to the Toolkit is available at **anthem.com > **Providers** > **Providers Overview** > **Find Resources for Your State** > **Colorado** > **Provider Home** > **Health and Wellness**

Important Information about Utilization Management

Our utilization management (UM) decisions are based on written criteria, the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service or care. Nor, do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem's medical policies are available on Anthem's website at anthem.com.

You can also request a free copy of our UM criteria from our medical management department, and providers may discuss a UM denial decision with a physician reviewer by calling us at the toll-free numbers listed below. UM criteria are also available on the web. Just select "Medical Policies, Clinical UM Guidelines, and Pre-Cert Requirements" from the Provider home page at anthem.com.

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll free from 8:30 a.m. - 5 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program

hours are 8:00 a.m. - 7 p.m. Eastern.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.
- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staffs. Members should call the customer service number on their health plan ID card.

To discuss UM Process and Authorizations	**To Discuss Peer-to-Peer UM Denials w/Physicians**	**To Request UM Criteria**	**TTY/TDD**
Phone 800-832-7850 Fax 800-763-3142 Autism 844-269-0538 For members with a pre-existing condition and/or active lifetime benefit exclusion, fax to: 800-947-4074 FEP Phone 800-860-2156 Fax 800 732-8318 (UM) Fax 877 606-3807(ABD)	Local: 303-764-7227 Toll-free: 866-287-1654 No fax number to request Peer-to-Peers. FEP Phone 800-860-2156	800-797-7758 No fax number. Providers leave message with: provider name, provider phone number, member's name, member ID, and reference number. FEP Phone 800-860-2156 FAX 800 732-8318 (UM) FAX 877 606-3807(ABD)	711 or **TTY / Voice** 800-659-2656(T)/ 800-659-3656(V)

For language assistance, **members can simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them.**

Our utilization management associates identify themselves to all callers by first name, title and our company name when making or returning calls. They can inform you about specific utilization management requirements, operational review procedures, and discuss utilization management decisions with you.

Pharmacy information available 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, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The commercial drug list is posted to the web site quarterly (the first of the month for January, April, July and October).

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

AllianceRX Walgreens Prime is the specialty pharmacy program for the Federal Employee Program. You can view the Specialty Drug List or call us at 1-888-346-3731 for more information.

Members' Rights and Responsibilities

The delivery of quality health care requires cooperation between patients, their providers and their health care benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners and members in our system, *Anthem Blue Cross and Blue Shield* has adopted a Members' Rights and Responsibilities statement.

It can be found on our website. Go to **anthem.com**, and select the **Providers**, and **Providers Overview. Select Find Resources for Your State**, and pick **Your State**. From the **Health & Wellness** tab, select the link titled **Quality Improvement and Standards**, and then the link titled "**Member Rights & Responsibilities**". Practitioners may access the FEP member portal at www.fepblue.org/memberrights to view the FEPDO Member Rights Statement.

Vaginal Birth after Cesarean (VBAC) Certified Shared Decision Making Aid Available on the Web

As part of our commitment to provide you with the latest clinical information, we have posted a VBAC shared decision making aid to our provider portal. This is a tool for you to discuss with your patients to aid in making a decision regarding their treatment options. This has been reviewed and certified by the Washington Health Care Authority (HCA) and is available on our website. To access the aid, go to anthem.com and select "**Provider**" from the top menu. From there, click on "Providers Overview," select your state and scroll down

and choose “Find Resources in your state.” From the *Health & Wellness* page, choose “**Practice Guidelines**,” then “**Shared Decision Making Aid**.”

Clinical Practice and Preventive Health Guidelines available on the web

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable, medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research.

All guidelines are reviewed annually, and updated as needed. The current guidelines are available on our website. To access the guidelines, go to **anthem.com**, and select the **Providers**, and **Providers Overview. Select Find Resources for Your State**, and pick **Your State**. From the **Health & Wellness** tab, select the link title “**Practice Guidelines**”. You can then choose from Clinical Practice Guidelines, Preventive Health Guidelines, or Behavioral Health Clinical Practice Guidelines.

Anthem accepts electronic prior authorization requests for prescription medications online

Anthem Blue Cross and Blue Shield (Anthem) accepts electronic medication prior authorization (ePA) requests for commercial health plans through covermymeds.com. This feature reduces processing time and helps determine coverage quicker. Some prescriptions are even approved in real time so that your patients can fill a prescription without delay. For example, medications such as celecoxib (Celebrex®), ezetimibe (Zetia®), fluocinolone acetonide (Synalar®), Victoza®, and long acting opioids are automatically approved when a member meets step therapy and/or clinical criteria (as applicable).

Electronic ePA offers many benefits:

- More efficient review process
- Ability to identify if a prior authorization is required
- Able to see consolidated view of ePA submissions in real time
- Faster turnaround times
- A renewal program that allows for improved continuity of care for members with maintenance medications

Providers can submit ePA requests by logging in at covermymeds.com. Creating an account

is FREE.
For questions, please contact the provider service number on the member ID card.

Introducing the new Clinical Criteria page for injectable, infused or implanted drugs

Beginning January 2019, providers will be able to visit the **Clinical Criteria** tab of the Pharmacy Information page to review clinical criteria for all injectable, infused or implanted prescription drugs.

Injectable oncology medical specialty drug clinical criteria will be located on the new site at a later date in 2019.

Pharmacy information available 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, and any other requirements, restrictions, or limitations that apply to using certain drugs, visit anthem.com/pharmacyinformation. The commercial and marketplace drug lists are posted to the web site quarterly (the first of the month for January, April, July and October).

To locate "Marketplace Select Formulary" and pharmacy information, go to Customer Support, select your state, Download Forms and choose "Select Drug List." This drug list is also reviewed and updated regularly as needed.

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

AllianceRX Walgreens Prime is the specialty pharmacy program for the Federal Employee Program. You can view the Specialty Drug List or call us at 1-888-346-3731 for more information

Request a Clinical Appeal through new functionality in our Interactive Care Reviewer (ICR) tool on Availity

Interactive Care Reviewer (ICR), Anthem's online authorization tool is adding a new feature to further increase the efficiency of your authorization process. In mid-December, you can begin

using ICR to request a clinical appeal for denied authorizations and check the status of a clinical appeal. This feature is available for authorization requests submitted through ICR, phone or fax.

Requesting a clinical appeal is easy:

Logon to ICR from the Availity Portal and locate the case using one of the search options, or from your ICR dashboard.

- Select the **Request Tracking ID** link to open the case. If the case is eligible for an appeal you will see the **Request Appeal** menu option on the **Case Overview** screen.
- Select **Request Appeal** to open the **Appeal Details** screen and complete the required fields on the appeal template. (You also have the option of uploading attachments and images to support your request.)
- Select Submit

Take the steps below to check the status of a clinical appeal:

Logon to ICR from the Availity Portal

- Select **Check Appeal Status** from the ICR top menu bar
- Type the **Appeal Case ID** and **Member ID** in the allocated fields
- Select **Submit**

The appeal status and detail of the decision will open on the bottom of the screen.

Need more information on how to navigate the new ICR Appeals feature?

Download the *ICR Clinical Appeals Reference Guide* located on the Availity Portal. Select: **Payer Spaces | Applications | Education and Reference Center | Communication and Education**. Find the link to the reference guide below the ICR menu.

Additional Training:

If you are new to ICR or want to get a refresher please attend our monthly ICR webinar. The next event is taking place on December 6 at 1 PM ET. **Register Here**

Availity to serve as EDI entry point for electronic submissions

Anthem Blue Cross and Blue Shield (Anthem) has designated Availity to operate and serve as

your electronic data interchange (EDI) entry point or also called the EDI Gateway. The EDI Gateway is a **no-cost option** to our direct trading partners. With this change, Anthem continues our efforts to ensure consistency between your provider portal and the EDI Gateway.

As a mandatory requirement, all trading partners who currently submit directly to the Anthem EDI Gateway must transition to the Availity EDI Gateway. Availity is well known as a Web portal and claims clearinghouse. In addition, Availity functions as an EDI Gateway for multiple payers and is the single EDI connection for our company.

Your organization can submit and receive the following electronic transactions through Availity's EDI Gateway**:**

- 837- Institutional Claims
- 837- Professional Claims
- 837- Dental Claims
- 835 - Electronic Remittance Advice
- 276/277- Claim Status
- 270/271- Eligibility Request

If you wish to become a direct a trading partner with Availity, the setup is easy.
Use the Availity Welcome Application to begin the process of connecting to the Availity EDI Gateway for your Anthem EDI transmissions.

If you prefer to use your clearinghouse or billing company, please work with them to ensure connectivity.

Need Assistance?

The Availity Quick Start Guide will assist you with any EDI connection questions you may have.

835 Electronic Remittance Advice (ERA)

Effective June 1, 2018, please use Availity to register and manage account changes for ERA. If you were previously registered to receive ERA, you must register using Availity to manage account changes.

Electronic Funds Transfer (EFT)

To register or manage account changes for EFT only, use the EnrollHub™, a CAQH Solutions™

enrollment tool, a secure electronic EFT registration platform. This tool eliminates the need for paper registration, reduces administrative time and costs, and allows you to register with multiple payers at one time.

If you were previously registered to receive EFT only, you must register using EnrollHub to manage account changes. No other action is needed.

Contacting Availity

If you have any questions, contact Availity Client Services at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. Eastern Time.

Anthem works to simplify payment recovery process for National Accounts membership

In Anthem's ongoing efforts to streamline and simplify our payment recovery process, we continue to consolidate our internal systems and will begin transitioning our National Accounts membership to a central system in 2019. While this is not a new process, we are transitioning the National Accounts membership to align with the payment recovery process across our other lines of business.

Currently, our recovery process for National Accounts membership is reflected in the EDI PLB segment on the electronic remittance advice (835). This segment will show the negative balance associated with the member account number. Monetary amounts are displayed at the time of the recovery adjustment.

As National Accounts membership transitions to the new system and claims are adjusted for recovery, the negative balances due to recovery are held for 49 days to allow ample time for you to review the requests, dispute the requests and/or send in a check payment. During this time, the negative balances due are reflected on paper remits ***only*** within the "Deferred Negative Balance" sections.

After 49 days, the negative balances due are reflected within the 835 as a corrected and reversed claim in PLB segments.

If you have any questions or concerns, please contact the E- Solutions Service Desk toll free at (800) 470-9630.

Non-participating lab referrals

This is a reminder to ensure that you are referring Anthem members to participating labs. Not only does your Anthem agreement obligate you to refer to participating labs where available, but members will only receive their full benefits from participating providers. As a result, referring your patient and our member to a non-participating lab may expose them to a greater financial responsibility.

Unfortunately, there are certain non-participating labs that are offering to waive or cap co-payments, coinsurance or deductibles to our members in order to increase their overall revenue. These practices undermine member benefits and may encourage over-utilization of services.

These billing practices are also questionable in their legality. Such a practice may present violations under state or federal anti-kickback laws, and may constitute abuse of health insurance under the Colorado criminal code.

For a listing of Anthem participating laboratories, please check our online directory. Go to **anthem.com**. Choose Select **Providers**, and **Providers Overview**. Select **Find Resources in Your State**, and pick **Colorado**. From the **Provider Home** tab, select the **enter** button from the blue box on the left side of page titled **Find a Doctor**.

Note: When searching for laboratory, pathology, or radiology services, under the field *"I am looking for a:"* select **Lab/Pathology/Radiology**; and then under the field *"Who specializes in:"*, select **Laboratories**, **Pathology**, or **Radiology** as appropriate for your inquiry.

LabCorp is our preferred lab provider and offers a Single Source Solution to your testing needs:
LabCorp is capable of providing services that range from routine testing, such as basic blood counts and cholesterol tests, to highly complex diagnosing of genetic conditions, cancers, and other rare diseases. LabCorp has specialized laboratories which cover the following areas of testing:

• Allergy Program • Cancer Testing • Cardiovascular Disease • Companion Diagnostics • Dermatology • Diabetes • DNA Testing • Endocrine Disorders • Esoteric Coagulation • Gastroenterology	• Genetic Testing • Genetic Counseling • Genomics • HLA Lab for National Marrow Donor Program • Hematopathology • Infectious Disease • Immunology • Liver Disease • Kidney Disease	• Medical Drug Monitoring • Molecular Diagnostics • Newborn Screening • Pain Management • Pathology Expertise w/range of Subspecialties • Pharmacogenomics • Preimplantation Genetic Diagnosis • Reproductive Health	• Obstetrics/Gynecology • Oncology • Toxicology • Whole Exome Sequencing • Virology • Women's Health • Urology

Note: This relationship with LabCorp ***does not affect*** network hospital-based lab service providers, contracted pathologists, or contracted independent laboratories.

HEDIS® 2018 Commercial Results Are In

Thank you for participating in the annual Healthcare Effectiveness Data and Information Set (HEDIS) commercial data collection project for 2018. You play a central role in promoting the health of our members. By documenting services in a consistent manner, it is easy for you to track care that was provided and identify any additional care that is needed to meet the recommended guidelines. Consistent documentation and responding to our medical record requests in a timely manner eliminates follow up calls to your office and also helps improve HEDIS scores, both by improving care itself and by improving our ability to report validated data regarding the care you provided. The records that you provide to us directly affect the HEDIS results that are listed below.

Each year our goal is to improve our process for requesting and obtaining medical records for our HEDIS project. In order to demonstrate the exceptional care that you have provided to our members and in an effort to improve our scores, you and your office staff can help facilitate the HEDIS process improvement by:

- Responding to our requests for medical records within five days, if possible
- Providing the appropriate care within the designated timeframes
- Accurately coding all claims
- Documenting all care clearly in the patient’s medical record

Further information regarding documentation guidelines and administrative codes can be found on the HEDIS page of our Provider Portal. In addition more information on HEDIS can be found by visiting the provider portal at: www.anthem.com > Provider > Choose State > Find Resources > Health & Wellness (top blue bar) > Quality Improvement and Standards > HEDIS Information. You will find reference documents entitled “HEDIS 101 for Providers” and “HEDIS Physician Documentation Guidelines and Administrative Codes”.

The following table shows some of our key measure rates across Colorodo.

- Yellow boxes indicate rates that are above the national average.
- **Bold** indicates improvement in rate over the previous year.
- B/R = Biased Rate
- Comprehensive Diabetes Care - Poor HbA1c Control (>9): Lower rate is good

HEDIS 2018 COMMERCIAL COLORODO HMO & PPO results

Now is the time to review your patient's records to ensure that they have received their preventative care and/or immunizations before the end of the year.

Again, we thank you and your staff for demonstrating teamwork as we work together to improve the health of our members and your patients. We look forward to working with you again next HEDIS season.

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

Plans offered in 2019

Our Plans Offered in 2019 has been updated. Access the updated list online. Go to **anthem.com.** Select the **Providers**, then **Providers Overview**. Select **Find Resources in Your State**, and pick **Colorado**. From the *Provider Home page*, under *Communications and Updates* heading, select **Provider Toolkit** link, then **Plans Offered in 2019 - Colorado** .

Networks at a Glance

Our Networks at a Glance document has been updated. Access the updated document online. Go to **anthem.com.** Select the **Providers**, then **Providers Overview**. Select **Find Resources in Your State**, and pick **Colorado**. From the *Provider Home page*, under *Communications and Updates* heading, select **Provider Toolkit** link, then **Networks at a Glance - Colorado** .

Updated Escalation Contact List

The Prefix Reference List has been updated. Access the updated list online. Please go to **anthem.com**. Select **Menu**, and under the *Support* heading, select **Providers**. Select **Find Resources for Your State**, and pick **Colorado**. From the **Provider Home** page, under the *Self Service and Support* heading, choose **Contact Us (Escalation Contact List & Alpha Prefix List)**, and then **Escalation Contact List**.

Updated Prefix Reference List

The Prefix Reference List has been updated. Access the updated list online. Please go to

anthem.com. Select **Provider**, and **Providers Overview**. Select **Find Resources for Your State**, and pick **Colorado**. From the **Provider Home** page, under the *Self Service and Support* heading, choose **Contact Us (Escalation Contact List & Prefix List)**, and then **Prefix Reference List**.

Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance marketplace / affordable care act information may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance marketplace / affordable care act, and all achieved articles, go to **anthem.com**. Select **Providers**, and **Providers Overview**. Select **Find Resources in Your State**, and pick **Colorado**. Select the **Provider Home** tab at the top of the page. Under the *Communications and Updates* heading, choose **Health Care Reform Updates and Notifications** or **Health Insurance Exchange Marketplace / Affordable Care Act information**.

Update to AIM Clinical Appropriateness Guidelines

Effective for dates of service on and after March 9, 2019 , the following updates will apply to all of AIM's Clinical Appropriateness Guidelines, including Advanced Imaging, Cardiac, Sleep, Radiation Oncology and Musculoskeletal guidelines.

- Clinical Appropriateness Framework

Replacing pretest requirements, this section will more accurately describe the guideline's purpose, which is to provide a summary of the fundamental components of a decision to pursue diagnostic testing. In order to support the full spectrum of AIM solutions, the terms "imaging request" or "diagnostic imaging" are replaced with "diagnostic or therapeutic intervention".

- Ordering of Multiple Diagnostic or Therapeutic Interventions

Replacing ordering of multiple studies, this section expands its applicability to AIM solutions outside of diagnostic imaging. Terminology specific to imaging studies is replaced with the term "diagnostic or therapeutic intervention" to reflect a broader application of the principles included here.

- Repeat Diagnostic Testing and Repeat Therapeutic Intervention

Replacing repeated imaging, these sections establish conditions in which duplication of the initial test or intervention may be warranted, and where such requests will require peer-to-peer discussion.

As a reminder, ordering and servicing providers may submit pre-certification requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*SM directly at providerportal.com.
  - Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 877-291-0366, Monday-Friday, 8:00 a.m.-6:00 p.m. MT

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Restructure of AIM Advanced Imaging Clinical Appropriateness Guidelines

AIM advanced imaging clinical appropriateness guidelines have been restructured to improve usability and to further link clinical criteria with supporting evidence. These structural enhancements resulted in no changes to existing clinical criteria or content.

- Access AIM's ***Provider****Portal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 877-291-0366, Monday-Friday, 8:00 a.m.-6:00 p.m. MT

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Updates to AIM Musculoskeletal Surgery Clinical Appropriateness

Guidelines

Beginning with dates of review on and after January 1, 2019, the following updates will apply to AIM Musculoskeletal Spine Surgery Clinical Appropriateness Guidelines as indicated by section below:

- Cervical Decompression with or without Fusion
    - Added criteria for the appropriate use of laminectomy for cordotomy and biopsy, excision, or evacuation
    - Added indications for non-traumatic atlantoaxial instability
- Lumbar Laminectomy
    - Added criteria for the appropriate use of laminectomy for biopsy, excision, or evacuation
    - Added indication of Dorsal Rhizotomy

Beginning with dates of review on and after January 1, 2019, the following updates will apply to AIM Musculoskeletal Interventional Pain Management Clinical Appropriateness Guidelines as indicated by section below:

- Paravertebral Facet Injection/Nerve Block/Neurolysis
    - Exclusions: Radiofrequency neurolysis for sacroiliac (SI) joint pain is considered not medically necessary

These services or procedures were previously reviewed by Anthem, but will now be reviewed by AIM as part of the Musculoskeletal program. To view the CPT codes, you may access and download a copy of the current guidelines here.

Ordering and servicing providers may submit pre-certification requests to AIM in one of the following ways:

- Access AIM ***Provider****Portal*SM directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number: 877-291-0366, Monday-Friday, 8:00 a.m.-6:00 p.m. MT

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current guidelines here.

Reimbursement for Convenience Surgical Supply Kits - Professional

Anthem Blue Cross and Blue Shield (Anthem) periodically reviews claims submitted by providers to help ensure that benefits provided are for services that are included in our members' benefit plans. Some providers are submitting claims for point-of-use convenience kits that are used in the administration of injectable medicines or other office procedures. These prepackaged kits contain not only the injectable medicine, but also non-drug components including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze.

Typically, the cost of a convenience kit exceeds the cost of its components when purchased individually. As a reminder, non-drug components included in the kits are inclusive of the practice expense for the procedure performed for which no additional compensation is available to the provider.

Please refer to Anthem's *Global Surgery* and/or *Bundled Services and Supplies* Reimbursement Policies for additional information.

Reimbursement Policies are available online

Go to **anthem.com**, select **Providers**, then **Providers Overview.** Select **Find Resources for Your State**, and pick **Colorado**. From the **Answers@Anthem** tab, select the Reimbursement Policies - Facility or Reimbursement Policies - Professional link. Then search for the Policy you would like to view.

Scope of License - Reimbursement Policy Update (Professional)

The December 2017 edition of our Provider Newsletter announced Anthem Blue Cross and Blue Shield (Anthem) will not reimburse services to a provider that is outside of their state requirements through Anthem's Scope of License policy. Anthem is updating its editing systems to deny services deemed to be outside of a specific specialty's scope of license.

Please refer to Anthem's *Scope of License* Reimbursement Policy for additional information.

Reimbursement Policies are available online

Go to **anthem.com**, select **Providers**, then **Providers Overview.** Select **Find Resources for Your State**, and pick **Colorado**. From the **Answers@Anthem** tab, select the Reimbursement Policies - Facility or Reimbursement Policies - Professional link. Then search for the Policy you would like to view.

"Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services - Professional

Please note: We have updated the title of our *"Rule of Eight" Reporting Guidelines for Physical Medicine and Rehabilitation Services* reimbursement policy to *Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation Services*.

System updates for reimbursement policies in 2019 - Professional

As a reminder, our claim editing software will be updated monthly throughout 2019 with the most common updates occurring quarterly in February, May, August and November of 2019. These updates will:

- reflect the addition of new, and revised codes (e.g. CPT, HCPCS, ICD-10, modifiers) and their associated edits
- include updates to National Correct Coding Initiative (NCCI) edits
- include updates to incidental, mutually exclusive, and unbundled (rebundle) edits
- include assistant surgeon eligibility in accordance with the policy
- include edits associated with reimbursement policies including, but not limited to, frequency edits, bundled services and global surgery preoperative and post-operative periods assigned by The Centers for Medicare & Medicaid Services (CMS)

Modifier 79 - Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period - Professional

This coding tip is based on recent findings for claims processed with modifier 79 during a postoperative period. *Current Procedural Terminology* (CPT®) specifically states modifier 79 should be reported by the same individual when reporting unrelated procedures or services during the postoperative period. For example, this modifier is used when a patient presents with a problem that is unrelated to a previous surgery (yet within the postoperative period) and requires additional services by the **same provider/individual**. When modifier 79 is appended for a different provider (e.g. Nurse Practitioner or Physician Assistant) during the postoperative period the claim line will deny.

In addition to modifier 79, modifiers 58 and 78 are also based on **Same Physician or Other Qualified Health Care Professional** as documented below:

- 58 - Staged/Related Procedure/Service by the Same Physician/Other Qualified

Health Care Professional during the Postoperative Period.

- 78 - Unplanned Procedure/Service by Same Physician/Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure during the Postoperative Period.

Reimbursement Policies are available online

Go to **anthem.com,** select **Providers**, then **Providers Overview.** Select **Find Resources for Your State**, and pick **Colorado**. From the **Answers@Anthem** tab, select the **Reimbursement Policies - Facility** or **Reimbursement Policies - Professional**.

Clear Claim Connection

On the date the new edit becomes effective, Clear Claim Connection, our web-based editing tool, will be updated to incorporate the new editing rules outlined above and will include an interface that will allow you to view the clinical rationale for the edit when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Clear Claim Connection is located on the Availity Portal. Log into **Availity.com**. Once logged in, select **Payer Spaces**, and choose the **Anthem icon**. Under **Applications**, select **Clear Claim Connection**.

BlueAdvantage HMO on the Pathway HMO Network for Federal Employees

Effective January 1, 2019, Federal Employees have access to the HMO option in Colorado. This HMO offering is only available in these Colorado counties:

- Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso (Colorado Springs Region), Jefferson and Larimer (Fort Collins Region).

The new prefix for this plan will be **QAB**.

The Plan and enrollment codes for the FEHB members are:

- WW1 - Self Only
- WW2 - Self & Family
- WW3 - Self + 1

Detailed information about this product for the FEHB members can be found at www.anthem.com/federal/co. This site contains the members benefit brochure and summary of benefits and coverage.

FEP BlueAdvantage HMO on the Pathway HMO Network Sample ID card

For questions, please call Customer Service at 1-833-611-6919

Coordination of Benefits for an FEP® member

Anthem Blue Cross and Blue Shield (Anthem) values the relationship we have with our providers, and always look for opportunities to help expedite the claim processing. When a Federal Employee visits the provider office, obtaining the most current medical insurance information will help to establish the primary carrier, and will alleviate claim denials and support accurate billing. For questions please contact the Federal Employee Customer Service at: 800-852-5957

Colorado Public Employees' Retirement Association (PERA) Offers Medicare Advantage Option

Effective January 1, 2019, Colorado PERA will offer two Anthem Medicare Preferred (PPO) plans. These two Anthem Medicare Preferred (PPO) plans will replace the current Anthem Medicare Supplement Plans, Rocky Mountain Health Plans Medicare HMO and UnitedHealthcare Medicare HMO plans. The plans include the National Access Plus benefit. With the National Access Plus benefit, retirees are free to receive services from any in-network provider, as well as any out-of-network provider who is eligible to receive payments from Medicare. Colorado PERA retirees will pay the same cost share for both in-network and out-of-network services. The MA plan offers the same hospital and medical benefits that Medicare covers and also covers additional benefits that Medicare does not, such as hearing, vision, chiropractic care, LiveHealth Online and SilverSneakers®.

The prefix on Colorado PERA cards will be CBH. The cards will also show the Colorado PERA logo and National Access Plus icon.

Providers can submit claims electronically using the electronic payer ID for the Blue Cross Blue Shield plan in their state or submit a UB-04 or CMS-1500 form to the Blue Cross Blue Shield plan in their state. Claims should not be filed with Original Medicare. Contracted and non-contracted providers may call Provider Services at 1-833-244-3888 for benefit eligibility, prior authorization requirements and any questions about Colorado PERA member benefits or

coverage.

Detailed prior authorization requirements also are available to contracted providers by accessing the Provider Self-Service Tool at Availity.com.

PROVIDERS: If you have an approved prior authorization with a date of service that is October 1, 2018 or later, please fax the approval to Anthem at 866-959-1537. We will enter the approval in our system and no other action is needed on your part.

For additional information, also reference previous publication New 2019 Health Care Plan information for all Colorado PERA Retirees - CO

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New Medicare Advantage provider service phone number beginning January 1, 2019

Effective January 1, 2019, Medicare providers will have toll free phone numbers specifically designated for their service inquiries. These new provider numbers will be listed separately on the back of the member ID cards and should be used beginning January 1, 2019. The associates answering your provider service calls are trained to answer your questions and resolve your issues as quickly as possible. To ensure you receive the most efficient service, please refrain from using the member services line and use only 844-421-5662 or the provider services phone number listed on the back of the member ID card for individual Medicare Advantage calls beginning January 1, 2019.

2019 Medicare Advantage individual benefits and formularies

Summary of benefits, evidence of coverage and formularies for 2019 individual Medicare Advantage plans will be available at anthem.com/medicareprovider. An overview of notable 2019 benefit changes also is available at Important Medicare Advantage Updates at anthem.com/medicareprovider. Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information.

CMS Medicare Preclusion List effective April 1, 2019

The U.S. Centers for Medicare and Medicaid Services (CMS) and Medicare Advantage and Part D organizations, including Anthem, will implement a new initiative, the Preclusion List, to protect the integrity of the Medicare Trust Funds. Beginning April 1, 2019, Medicare

Advantage and Part D organizations will deny payment for items and services furnished by providers that CMS has placed on the Preclusion List. For more information, visit www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html.

When and how to initiate Medicare Advantage reopenings

When a claim must be corrected beyond the initial claim timely filing limit of one year from the **date of service**, a normal adjustment bill is not allowed. Providers must use the reopening process to correct the error. To learn when and how to initiate reopenings and adjustments, check Important Medicare Advantage Updates at anthem.com/medicareprovider.

Individual Medicare plans move compound drugs off formulary beginning January 1, 2019

Beginning January 1, 2019, Individual Medicare Advantage plans will move compounded drugs to non-formulary with the exception of home infusion drugs. Group-sponsored Medicare Advantage members will continue to have compounded drug coverage; these drugs will require prior authorization. Compounded home infusion drugs will continue to be covered for both Individual Medicare and group-sponsored members without prior authorizations. Members and/or providers can request a non-formulary exception for compounded drugs.

Medicare Part B drugs may include Step Therapy beginning January 1, 2019

CMS updated its guidance to allow Medicare Advantage plans the option of implementing step therapy for Part B drugs as part of a patient-centered care coordination program beginning January 1, 2019. The goal is to lower drug prices while maintaining access to covered services and drugs for beneficiaries. Anthem will implement step therapy edits to promote clinically appropriate and cost effective drug options for our members. A patient-centered care coordination program will be created to ensure member access to necessary drugs, provide medication reviews and reconciliations, educate members regarding their medications, encourage medication adherence, and provide incentives to members who complete care coordination programs.

Keep up with Medicare news

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

- CO 2019 Annual Notice of Change
- NV 2019 Annual Notice of Change
- Prior authorization requirements for Colonoscopy and Upper Gastrointestinal Endoscopy
- Medicare Advantage Reimbursement Policy October Provider Bulletin
- Prior authorization requirements for Part B drugs: Moxetumomab Pasudotox, Cemiplimab and Fulphila
- July Medicare Advantage reimbursement policy
- Submit PA medication requests electronically; new phone number for MA prescription PAs
- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective January 1, 2019
- Inpatient Readmissions
- Submit PA medication requests electronically; new phone number for MA prescription prior authorizations effective September 1

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