February 2019 Anthem Provider Newsletter - CO

Member Satisfaction with Behavioral Health Outpatient Services

Anthem conducts an annual satisfaction survey of our Member's behavioral health outpatient service experience. The random survey is conducted based on receipt of claims. We have recently reviewed the 2018 survey experience results and wanted to share highlights with our network of behavioral health providers. The survey inquires about the member's satisfaction with timeliness of treatment, practitioner service/attitude and office environment, care coordination (among the member's various providers), prescriptions/medication management process (if applicable), financial and billing process, and their perceived clinical improvement. Our member is also asked to give an overall rating of the experience. The 2018 overall practitioner rating was 82% in CO based on the survey results.

We were pleased to see overall improvement in the survey results. In particular, two areas of focus over the last year, access and coordination of care. Members responding to the survey, indicated that obtaining an appointment was fairly easy and many respondents indicated that care was being coordinated among their providers, including medical. Care coordination and collaboration, particularly medical-behavioral integration, is a key focus at Anthem. We also encourage ongoing understanding of an individual's cultural, spiritual and religious beliefs while in treatment.

While we are pleased with our member's experience with our participating provider network and thank you for your network participation and the services you provide, we'd like to remind you of two key areas to maintain and improve satisfaction:

- **Member's Access to Behavioral Health Care**

  As a participating provider please be reminded of Anthem's expectation, based on NCQA definitions, of access to behavioral healthcare to help ensure our members have prompt access to behavioral health care:

  - **Non-Life Threatening Emergency Needs - must be seen, or have appropriate coverage directing the Member, within 6 hours.** When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.

  - **Urgent Needs - must be seen, or have appropriate coverage directing the Member, within 48 hours**. Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to

escalate into an emergency without clinical intervention.

- **Routine office visit - must be within 10 business days**. Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

We use several methods to monitor adherence to these standards. Monitoring is accomplished by a) assessing the availability of appointments via phone calls and surveys by our staff or designated vendor to the provider's office; b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members. Anthem continues to look at gaps, barriers and alternative options to improve access to behavioral healthcare including tele-health services.

- **Members Held Harmless**

  As a participating provider in Anthem's behavioral health provider network, a participating provider shall look solely to Anthem for compensation for covered services and under no circumstances shall render a bill or charge to any member except for applicable co-payments, deductibles and coinsurance and for services that are not medically necessary or are otherwise not covered, provided that the Provider obtains the consent of the Member before providing such service. We recommend that consent be in writing and dated, in order to protect our members and providers from disputes.

  In addition, Anthem also reminds our participating providers that Anthem members must be advised of missed or cancelled appointment policies at the onset of treatment. We also recommend that the advisement be acknowledged by the member in writing, and that acknowledgement is dated.

Thank you again for the services that you provide to our members.

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

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

Working with Anthem Webinars - February 2019 schedule: WellChoice Network and Plans Overview

We are continuing our series of “Working with Anthem” webinars for 2019. These webinars are focused on one topic each session, and designed to help our providers and their staff learn how to use the tools currently available to improve operational efficiency when working with Anthem Blue Cross and Blue Shield (Anthem).

2019 Subject Specific Webinars - February schedule

Topic:	**WellChoice Network and Plans Overview**
Date/Time:	**February 26, 2019 at 12:00-1:00pm MT**
Description:	**Learn about our WellChoice network including:** • Overview of our WellChoice plans • Anthem’s WellChoice network • WellChoice tiered benefit design • How to identify members accessing the WellChoice Networks • Sample ID cards
Registration Link:	**Registrater Today**

Webinars are offered using Cisco WebEx. There is no cost to attend. Access to the internet, an email address and telephone is all that's needed. **Attendance is limited, so please register today.**

Watch for additional topics and dates in future issues of our monthly provider newsletter throughout the year. We also will continue to offer our Fall Provider Seminars which will continue to cover a variety of topics in face-to-face and webinar options.

Updated Escalation Contact List

The Escalation Contact List has been updated. Access the updated list online. Please go to **anthem.com**. Select **Providers**. Under the *Communcations* heading, select **Contact Us**. Choose **Colorado**, then select **Escalation Contact List**.

Updated Prefix Reference List

The Prefix Reference List has been updated with the following changes:

- **PQC** had been updated to indentify this prefix expired on December 31, 2018.
- **QWP** has been corrected to reflect (Pathway - National Accounts), rather than HMO. Our system has been processing claims correctly against our Pathway network, but our Prefix Reference List needed to be updated.

Access the updated list online. Please go to **anthem.com**. Select **Providers**. Under the *Communcations* heading, select **Contact Us**. Choose **Colorado**, then select **Prefix Reference List**.

Provider and Facility identified Overpayments (aka “voluntary” or “unsolicited”)

If Anthem is due a refund as a result of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

- Submit a refund check with supporting documentation outlined below, or
- Submit the **Provider Refund Adjustment Request Form** with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

When voluntarily refunding Anthem on a Claim overpayment, please include the following information:

- **Provider Refund Adjustment Request Form (see directions below for how to access online)**
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Covered Individual ID number
- Covered Individual’s name
- Claim number
- Date of service

- Reason for the refund (as indicated on the form of common overpayment reasons)

Please be sure the copy of the provider remittance advice is legible and the Covered Individual information that relates to the refund is circled. By providing this critical information, Anthem will be able to expedite the process, resulting in improved service and timeliness to Providers and Facilities.

Important Note: *If a Provider or Facility is refunding Anthem due to coordination of benefits and the Provider or Facility believes Anthem is the secondary payer, please* ***refund the full amount paid****. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.*

How to access the Provider Refund Adjustment Request Form online:

To download the "Provider Refund Adjustment Request Form" directly from anthem.com. Select **Providers**, and **Providers Overview**. Select **Find Resources in Your State**, and pick **Colorado**. From the **Provider Home** page, Under the *Self Service and Support* heading, choose **Download Commonly Requested Forms** and select Provider Refund Adjustment Request Form.

Please utilize the proper address noted in the grid below to return payment:

Line of Business (Blue Branded)	Type of Refund	Make Check Payable To:	Regular Mailing Address:	Overnight Delivery Address:
ALL	Voluntary *or* Solicited Refund with Payment Coupon	Anthem Blue Cross and Blue Shield	Anthem Blue Cross and Blue Shield PO Box 73651 Cleveland, OH 44193-1177	Anthem Attn: Central - 73651 4100 W 150th Street Cleveland, OH 44135-1304

Update regarding evaluation and management with modifier 25 same day as procedure when a prior E/M for the same or similar service has occurred (Professional)

Anthem Blue Cross and Blue Shield (Anthem) has identified that providers often bill a duplicate Evaluation and Management (E/M) service on the same day as a procedure even when the same provider (or a provider with the same specialty within the same group TIN) recently billed a service or procedure which included an E/M for the same or similar diagnosis. The use of modifier 25 to support separate payment of this duplicate service is not consistent with correct coding or Anthem's policy on use of modifier 25.

Beginning with claims processed on or after March 1, 2019 Anthem may deny the E/M service with a modifier 25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record.

If you believe a claim should be reprocessed because there are medical records for related visits that demonstrate an unrelated, significant, and separately identifiable E/M service, please submit those medical records for consideration.

Significant Edits (Professional)

We have updated our *Significant Edits* posting to reflect the 2018 analysis of claims data for significant edits. We define a significant edit as: A code pair edit that, based on experience with submitted claims, will cause, on initial review of submitted claims, the denial of payment for a particular CPT code or HCPCS code submitted more than two-hundred and fifty (250) times per year in the Plan's service area.

Reminder: Review ICD-10-CM Coding Guidelines (Professional)

To help ensure the accurate processing of submitted claims, keep in mind ICD-10-CM Coding Guidelines when selecting the most appropriate diagnosis for patient encounters. Remember, ICD-10-CM has two different types of excludes notes and each type has a different definition. In particular, one of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes 1 Notes. An Excludes 1 Note is used to indicate when two conditions cannot occur together (Congenital form versus an acquired form of the same condition). An Excludes 1 Note indicates that the excluded code identified in the note should not be used at the same time as the code or code range listed above the Excludes 1 Note. These notes are located under the applicable section heading or specific ICD-10-CM code to which the note is applicable. When the note is located following a section heading, then the note applies to all codes in the section.

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.

Clear Claim Connection: our web-based claim edit tool

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**.

HEDIS 2019 Federal Employee Program® medical record request requirements

Centauri Health Solutions is the contracted vendor to gather member medical records on behalf of the Blue Cross and Blue Shield Federal Employee Program. We value the relationship with our providers, and ask that you respond to the requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. Centauri Health will work with you to obtain records via fax, mail, remote electronic medical record (EMR) access, or onsite scanning/EMR download (as necessary).

We ask that you please promptly comply within **five (5) business days** of the record requests. If you have any questions, please contact Catherine Carmichael with Blue Cross Blue Shield Federal Employee Program at (202) 942-1173 or Carol Oravec with Centauri at (440)793-7727.

Reminder - Anthem follows Original Medicare policies

Anthem is required to follow all clinical and reimbursement policies established by Original Medicare in the processing of claims and determining benefits. Anthem follows all Original Medicare local coverage determinations, national coverage determinations, Medicare rulings, code editing logic and the *Social Security Act*.

Anthem *may* offer additional benefits that are not covered under Original Medicare. Certain benefits are only covered when provided by a vendor selected by Anthem. More information can be found at anthem.com/medicareprovider. You may also contact Provider Services at the phone number on the back of the member ID card.

Use grouped CPT codes for AIM Specialty Health authorizations

AIM Specialty Health® groups CPT codes on authorizations so they can be reviewed together to support a procedure or therapy. Grouped codes are used for radiology, cardiology, and sleep and radiation therapy programs. The groupings can be found at **http://aimspecialtyhealth.com/ClinicalGuidelines.html** by selecting the appropriate solution and then the exam or therapy being performed. Additional information is available at anthem.com/medicareprovider under *Important Medicare Advantage Updates*.

Anthem eye refraction and routine eye exam billing information

Refractions and routine eye exams are **not** covered under medical insurance for Anthem members. These benefits may be available through the member's supplemental insurance. These services must be billed to the supplemental vendor. Check your patient's Anthem ID card for the name of the vendor.

Additional information, including billing modifiers and documentation requirements, will be available at anthem.com/medicareprovider under *Important Medicare Advantage Updates*.

New specialty Medicare Part B device preferred product program

Effective for dates of service beginning **January 1, 2019**, the following Medicare Part B devices will be preferred to support cost-effective benefits. During precertification initiation or renewal, providers requesting a nonpreferred device will be encouraged to switch to a preferred product. The preferred and nonpreferred products are listed below.

Preferred devices	**Nonpreferred devices**
Euflexxa® (J7323)	Gel-One® (J7326)
Hyalgan®/Supartz®/Visco-3® (J7321)	Gelsyn-3® (J7328)
Durolane® (J7318)	Genvisc 850® (J7320)
	Hymovis® (J7322)
	MonoviscTM (J7327)
	Orthovisc® (J7324)
	Synvisc® or Synvisc-One® (J7325)
	TriviscTM (J7329)

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Keep up with Medicare news

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

- 2019 risk adjustment provider training
- New provider learning opportunity: Put the AIM ProviderPortal to work for you
- New provider service phone number beginning January 1, 2019
- Medicare Advantage reimbursement policy provider bulletin
- CMS issues regulatory changes for short- and long-acting narcotics; days' supply limits effective Jan. 1, 2019

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