July 2019 Anthem Connecticut Provider News

Updates to AIM Advanced Imaging Clinical Appropriateness Guidelines

Effective for dates of service on and after September 28, 2019, the following updates will apply to the AIM Advanced Imaging Clinical Appropriateness Guidelines.

Brain Imaging Guideline contains updates to the following:
Infection, multiple sclerosis and other white matter diseases, movement disorders (adult only), neurocognitive disorders (adult only), trauma, pituitary adenoma, tumor, hematoma or hemorrhage – intracranial or extracranial, Hydrocephalus/ventricular assessment, pseudotumor cerebri, spontaneous intracranial hypotension, abnormality on neurologic exam, ataxia, dizziness or vertigo, headache, hearing loss and tinnitus.

Extremity Imaging Guideline contains updates to the following:
Congenital or developmental anomalies of the extremity (pediatric only), discoid meniscus (pediatric only), soft tissue infection, osteomyelitis, septic arthritis, bursitis, capitellar osteochondritis, fracture, patellar dislocation, patellar sleeve avulsion, trauma complications, bone lesions, soft tissue mass – not otherwise specified, lisfranc injury, labral tear – hip, labral tear – shoulder, meniscal tear and ligament tear of the knee, rotator cuff tear (adult only), avascular necrosis, lipohemarthrosis (pediatric only), Paget's disease – new multimodality indication and general perioperative imaging (including delayed hardware failure), not otherwise specified.

Spine Imaging Guideline contains updates to the following:
Multiple sclerosis or other white matter disease, spinal infection, cervical injury, thoracic or lumbar injury, Paget's disease, spontaneous (idiopathic) intracranial hypotension (SIH), perioperative imaging, including delayed hardware failure, not otherwise specified, neck pain (cervical), mid-back pain (thoracic)

As a reminder, ordering and servicing providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*$_{SM}$ directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Web Portal at availity.com. Call the AIM Contact Center toll-free number at 866-714-1107, Monday–Friday, 8:00 a.m.–5:00 p.m.

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.

Clinical criteria updates for specialty pharmacy

On December 1, 2018, Anthem introduced the new clinical criteria page for injectable, infused or implanted drugs.

Effective for dates of service on and after August 1, 2019, the following new oncology clinical criteria will be included in our clinical criteria review process. The oncology drugs that require prior authorization will continue to require prior authorization notification with AIM.

Existing precertification requirements have not changed for the specific clinical criteria below. While there are no material changes, the document number and online location has changed. To access the clinical criteria information please click here. The table below will assist you in identifying the new document number for the clinical criteria that corresponds with the previous Clinical Guideline/Medical Policy.

Pre-service clinical review of these specialty pharmacy drugs will be managed by AIM Specialty Health® (AIM), a separate company.

Clinical Guideline	Clinical Criteria Document Number	Clinical Criteria Name	Drug	HCPCS Code
CG-DRUG-76	ING-CC-0089	Mozobil (plerixafor)	Mozobil	J2562

Clinical criteria coding updates for specialty pharmacy

As a result of coding updates in the claims system, the claim system edits for the clinical criteria listed below will be revised. This will result in the review of claims for certain diagnoses before processing occurs to determine whether the service meets medical necessity criteria. As a result, these coding updates may result in a not medically necessary determination.

Effective May 1, 2019, we implemented coding updates in the claims system for the following clinical criteria listed below which may result in not medically necessary determinations for certain services.

- ING-CC-0073 – Alpha-1 Proteinase Inhibitor Therapy

To access the clinical criteria information please click here.

Update to provider/facility UM reimbursement penalties and corresponding update to Provider/Facility Manual

Effective for dates of service beginning October 1, 2019, and after, we will increase the reimbursement penalty for failure to comply with our Utilization Management Program's pre-certification requirements for services rendered to commercial plan members. Late pre-certifications, and late notices in the case of emergency admissions, are currently subject to a penalty and will be subject to the increase in the penalty. Failure to comply with Anthem's pre-certification requirements will result in reimbursement penalties of 50% to the provider and facility (for services managed by Anthem) or a 100% penalty/claim denial to the provider and facility (for high-cost radiology, sleep therapy and cardiology cases managed by AIM).

As a reminder, we require pre-certification prior to certain elective services in both the inpatient and outpatient settings. For an emergency admission, pre-certification is not required; however, you must notify us of the admission within the timeframe specified in the Provider/Facility Manual or as otherwise required by law, as failure to give timely notification for emergency admissions will also result in reimbursement penalties of 50% to providers and facilities.

Enforcement of the program requirement will lead to greater consistency in our processes. This notice updates Anthem's UM Program reimbursement penalties and the corresponding sections of the Provider/Facility Manual effective October 1, 2019, to reflect this change to the reimbursement penalty for non-compliance. As a reminder, providers and facilities may not balance bill the member for any such reduction in payment.

Clinical validation - professional

Effective with dates of service on or after October 1, 2019, we will update our audit process for claims with modifiers used to bypass claim edits by conducting modifier reviews through a pre-payment clinical validation review process. Claims with modifiers such as -25, -59, -57, LT/RT, and other anatomical modifiers will be part of this review process.

In accordance with published reimbursement policies which document proper usage and submission of modifiers, the clinical validation review process will evaluate the proper use of these modifiers in conjunction with the edits they are bypassing (such as National Correct Coding Initiative). Clinical analysts who are registered nurses and coders will review claims pended for validation, along with any related services, to determine whether it is appropriate for the modifier to bypass the edit.

If you believe a claim reimbursement decision should be reviewed, please follow the normal

claims dispute process and include medical records that support the usage of the modifier applied when submitting claims for consideration.

Payment recovery process simplified for National Accounts membership

In our 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.

Commercial Risk Adjustment (CRA) Reporting Update: 2019 Program Year Progression

As we reported in the May and June newsletters, we are completing our prospective and retrospective reviews for 2019. Prospectively, we intervene to encourage the participation of the members we have identified as appropriate for clinical assessments. Retrospectively, certified coders review medical charts to determine if there are diagnosis codes that have not been reported.

What’s in it for you

- Monthly you'll receive lists of our members who are your patients to help you reach out to those who may have gaps in care, so they can come in for office visits earlier.

- We've heard resoundingly from providers that participation in these programs helps them better evaluate their patients (who are our members) and, as a result, perform more strongly in population health management and gain sharing programs. Many cite that they ask different questions today that allow them to better manage their patients end to end.

- When you see Anthem members and submit assessments, **we pay incentives of $50 for a paper submission and $100 for an electronic submission**. For additional details on how to earn these incentives and the options available, please contact our CRA Network Education Representative listed below.

What's in it for your patients

- We have completed monthly postcard campaigns to members with Affordable Care Act (ACA) compliant coverage when we suspect a high risk condition with messaging to encourage the member to call his or her primary care provider (PCP) and schedule an annual checkup. The goal is to get the members in to see their PCPs, so the PCPs have an overall picture of their patients' health and schedule any screenings that may be needed.

- We will continue these monthly postcard mailings throughout all of 2019 to continue to encourage the members to be seen in your office, which supplements any patient outreach you may be doing as well.

If you have any questions regarding our reporting processes, please contact our CRA Network Education Representative at Alicia.Estrada@anthem.com.

Make the move to the Availity EDI Gateway today

If you currently submit claims directly to the Anthem EDI Gateway, now is the time to make the move.
It is mandatory that all trading partners must transition to the Availity EDI Gateway to avoid future disablement.

Do you already have an Availity User ID and Login? You can use the same login for your Brand EDI transactions.

Log in to the Availity Portal and select Help & Training | Get Trained. In the Availity Learning Center, search the catalog by key word “SONG” for live and on-demand resources created especially for you.

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 Brand EDI transmissions.

Do you use a clearinghouse today?
We encourage you to contact your clearinghouse to ensure they have made the move.

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

If you need additional assistance, contact Availity Client Services at 800-Availity (800-282-4548), Monday through Friday, 8:00 a.m. to 7:30 p.m.

State-supplied vaccines reminder - professional

A recent review of claim denial trends has identified that providers are not billing appropriately for state-supplied vaccines. As a reminder, when billing for the administration of state-supplied vaccines, it is important that the state-supplied vaccine be reported with the SL modifier and a $0.00 billed charge along with the corresponding vaccine administration code. Additionally, and just as important, vaccines and their respective vaccine administration procedure codes for a single date of service should be reported on the same claim form.

Modifier 79 reminder - professional

A recent review of our claim trends has identified that many providers are not billing appropriately for modifier 79. According to Appendix A in the CPT Professional Edition, modifier 79 is used to indicate that a procedure or service is an “…unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period”. If the current procedure or service does not fall within the postoperative period of a previously performed 0, (same day), 10 or 90 day postoperative period, by the same provider or a provider in the same group practice, please carefully consider the definition of modifier 79 when adding the modifier to a procedure or service.

Modifier 63 reminder - professional

According to Appendix A of the CPT Professional Edition codebook, modifier 63 is only used when an invasive procedure is performed on neonates or infants up to a present body weight of 4 kg to indicate significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. Unless otherwise designated, this modifier should only be appended to the procedures/services identified in the modifier description. Additionally, based on the modifier description, modifier 63 is not valid for use with evaluation and management, anesthesia, radiology, pathology/laboratory, or medicine codes. Furthermore, many procedures performed on infants for correction of congenital abnormalities include additional difficulty or complexity that are inherent to the procedure and are identified by the code nomenclature and the CPT parenthetical “do not use modifier 63 in conjunction with…”. These codes are also identified in Appendix F of the CPT Professional Edition codebook. Please note, incorrect reporting of modifier 63 may result in claim denials.

ICD-10-CM coding guidelines and laterality - professional

With the adoption of the ICD-10-CM code set, we were introduced to diagnosis codes that now indicate the laterality of a condition. At present, diagnosis code descriptions indicate whether the condition is present on the left, right or exists bilaterally. A recent review of our claim denial trends has identified that many providers are not billing appropriately in regards to laterality. For specific guidance for reporting a diagnosis that designates a condition on the left and right versus a bilateral diagnosis, refer to the ICD-10-CM Official Guidelines for Coding and Reporting FY 2019, specifically, the General Coding Guidelines Section and the Chapter Specific Sections.

Please carefully consider the information contained in the ICD-10-CM Coding Guidelines when trying to decide between reporting a condition using left diagnosis and right diagnosis codes versus a bilateral diagnosis code.

Un-adopted clinical guidelines effective June 1, 2019

(The following guidelines are no longer adopted.)

- CG-DME-07-Augmentative and Alternative Communication (AAC) Devices/Speech Generating Devices (SGD)
- CG-MED-70-Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule
- CG-MED-72-Hyperthermia for Cancer Therapy
- CG-SURG-24-Functional Endoscopic Sinus Surgery (FESS)

- CG-SURG-70-Gastric Electrical Stimulation
- CG-SURG-73-Balloon Sinus Ostial Dilation
- CG-SURG-76-Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
- CG-THER-RAD-04-Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors

Federal Employee Health Benefit Program® (FEP) PPO members will now require prior approval for specific specialty drugs and site of care

Effective July 1, 2019, Anthem Federal Employee PPO members, *(ID numbers beginning with an, **'R'**)*, aged 18 and older, and not Medicare primary, will now need to have prior approval for the following drugs:

Drugs requiring prior approval

Code	Procedure Description
J0129	Abatacept injection **(Orencia)**
J0490	Belimumab injection **(Benlysta)**
J1459	Injection, immune globulin **(Privigen)**
J1555	Injection, immune globulin **(Cuvitru)**
J1556	Injection, immune globulin **(Bivigam)**
J1557	Injection, immune globulin **(Gammaplex)**
J1559	Injection, immune globulin **(Hizentra)**
J1561	Injection, immune globulin **(Gamunex-c/Gammaked)**
J1566	Injection, immune globulin **(Carimune)**
J1568	Injection, immune globulin **(Octagam)**
J1572	Injection, immune globulin , **(Flebogamma)**
J1575	Injection, immune globulin/hyaluronidase **(HyQvia)**
J1599	Injection, immune globulin **(Panzyga)**
J1602	Golimumab IV **(Simponi Aria)**
J1745	Infliximab not biosimilar **(Remicade)**
J2323	Natalizumab injection **(Tysabri)**
J3380	Vedolizumab Injection **(Entyvio)**
Q5103	Infliximab dyyb biosimilar **(Inflectra)**
Q5104	Infliximab abda biosimilar **(Renflexis)**
Q5109	infliximab-qbtx, biosimilar **(Ixifi)**
J1569	Injection, immune globulin, (**Gammagard liquid**)

In addition to acquiring prior approval for the medication, *the outpatient hospital site of care must also be approved.* The prior approval process will identify members who meet the appropriate site of care criteria and who can safely receive their medication in

a location other than an outpatient hospital, including the home.

Effective January 1, 2020, failure to receive prior approval for these drugs may result in non-coverage of the drug and facility services.

To obtain prior approval, please contact the Anthem Federal Employee Program Utilization Management Department at 800-860-2156.

Electronic claim payment reconsideration

As currently outlined in your provider manual, providers can submit claim payment reconsiderations verbally, in writing or electronically. We are reaching out to notify you about some exciting new tools for electronic submission that will become available through the Availity Portal. In addition, the Medicare Advantage provider manual has been updated with new information regarding claim remediation tools through the Availity Portal.

Beginning June 17, 2019, providers will have the ability to submit claim reconsideration requests through the Availity Portal with more robust functionality. For you, this means an enhanced experience when:

- Filing a claim payment reconsideration
- Sending supporting documentation
- Checking the status of your claim payment reconsideration
- Viewing your claim payment reconsideration history

New Availity Portal functionality will include:

- Acknowledgement of submission at the time of submission
- Notification when a reconsideration has been finalized by Anthem
- A worklist of open submissions to check a reconsideration status

With the new electronic functionality, when a claim payment reconsideration is submitted through the Availity Portal, we will investigate the request and communicate an outcome through the Availity Portal. Once an outcome has been determined, the Availity Portal user who submitted the claim payment reconsideration will receive notification through Availity informing the user the reconsideration review has been completed. If you are not satisfied with the reconsideration outcome, continue to follow the process to file a claim payment appeal, as outlined in your provider manual.

You can get a jump start on your training and be ready to go as soon as the tool is fully launched. To learn more about the claim payment dispute tool, register for a live webinar or view a previous recording:

- Log in to Availity at http://www.availity.com
- Select Help & Training | Get Trained
- Enter Appeals in the search field
- Enroll in a course

Providers who have questions as they begin to use the new functionality should contact Availity at 800-282-4548.

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Sepsis diagnosis coding and billing reminder

To help ensure compliance with the coding and billing of services submitted with a diagnosis of sepsis, we review clinical information in the medical records submitted with the claim, including lab results, treatment and medical management. In order to conduct the review accurately and consistently, our review process for sepsis diagnoses applies ICD-10-CM coding and documentation guidelines, in addition to the updated and most recent sepsis-3 clinical criteria published in the Journal of the American Medical Association, February 2016. At discharge, clinicians and facilities should apply the sepsis-3 criteria when determining if their patient's clinical course supports the coding and billing of a sepsis diagnosis. The claim may be subject to an adjustment in reimbursement when sepsis is not supported based on the sepsis-3 definition and criteria.

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Home health billing guidelines for contracted providers

*This information is intended for home health agencies that **do not** submit their claims to MyNexus and are contracted with Anthem to be compensated based on the original Medicare Home Health Prospective Payment System. This information is not intended for home health agencies that are contracted to be compensated based on per visit rates.*
Visit our website to view billing guidelines recommended for home health providers to use when billing a request for anticipated payment (RAP) and final claim to Anthem. This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract.

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Outpatient Rehabilitation Program transitioning to AIM

Effective October 1, 2019, we will transition utilization management of our Outpatient Rehabilitation Program for Medicare Advantage from OrthoNet LLC to AIM Specialty Health® (AIM). AIM is a specialty health benefits company. The Outpatient Rehabilitation Program includes physical, occupational and speech therapy services. We have an existing relationship with AIM in the administration of other programs. Learn more about the transition to AIM here.

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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:

- Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ
- Group Retiree members and National Access Plus
- CT only International Union of Bricklayers and Allied Craftworkers Local 1 Connecticut Health Fund offers Medicare Advantage option

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