April 2019 Anthem Maine Provider Newsletter

New AIM Rehabilitative program effective July 1, 2019

Effective July 1, 2019, we will require medical necessity review for rehabilitative (restoring function) and habilitative (enhancing function) services for fully insured members. AIM Specialty Health® (AIM), a separate company, will manage these therapy service reviews.

AIM will manage these physical therapy (PT), occupational therapy (OT) and speech therapy (ST) medical necessity reviews using the following Anthem Clinical UM Guidelines: CG-REHAB-04 Physical Therapy, CG-REHAB-05 Occupational Therapy, and CG-REHAB-06 Speech-Language Pathology Services. Please note, this does not apply to procedures performed in an inpatient or observation setting, or on an emergent basis. The clinical criteria to be used for these reviews can be found on our Clinical UM Guidelines page. A complete list of CPT codes requiring pre-service clinical review for the AIM Rehabilitative program is available on the AIM Rehabilitation microsite. There you can learn more about the program and access helpful information and tools such as order entry checklists and FAQs.

AIM will begin accepting pre-service clinical review requests on June 17, 2019 for dates of service on and after July 1, 2019. To determine if pre-service review is needed for an Anthem member, please check online or call the pre-service review number located on the back of the member's ID card. The program will be offered to new local self-funded accounts, also known as administrative services only (ASO), to add to their members' benefit package as of July 1, 2019.

Ordering and servicing providers may submit pre-service clinical review 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 pre-service clinical review.
- Access AIM via the Availity Web Portal at http://www.availity.com/.
- Call the AIM Contact Center toll-free number – 866-714-1107, Monday – Friday, 8:00 a.m. – 5:00 p.m.

AIM Rehabilitation training webinars

We invite you to take advantage of a free informational webinar that will introduce you to the program and the robust capabilities of the AIM ***Provider****Portal*$_{SM}$. Go to the AIM Rehabilitation microsite to register for an upcoming webinar. If you have previously registered for other services managed by AIM, there is no need to register again. The training will be recorded and can be viewed at a time convenient for you!

Update to AIM Advanced Imaging of the Head and Neck Clinical Appropriateness Guidelines

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Advanced Imaging of the Head and Neck Clinical Appropriateness Guidelines.

- Sinusitis/rhinosinusitis
    - Expanded the scope of complicated sinusitis
    - Defined a minimal treatment requirement for uncomplicated sinusitis
    - Identified reasons for repeat sinus imaging, aligned with Choosing Wisely
    - Subacute sinusitis to be treated as more like acute or chronic rhinosinusitis based on the AAO-HNS acute sinusitis guideline
    - Defined indications for preoperative planning for image navigation following a clinical policy statement on appropriate use from the AAO-HNS
    - Removed CT screening for immunocompromised patients
- Infectious disease – not otherwise specified
    - Added MRI TMJ to this indication
- Inflammatory conditions – not otherwise specified
    - Allow MRI TMJ for suspected inflammatory arthritis following radiographs
- Trauma
    - Radiograph requirement for suspected mandibular trauma
    - MRI TMJ in trauma for suspected internal derangement in surgical candidates
- Neck mass (including lymphadenopathy)
    - Align adult neck imaging guideline with the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) guideline
    - Expand definition of neck mass beyond palpable (seen on laryngoscopy)
    - Allow imaging for pediatric neck masses when initial ultrasound is not diagnostic
- Parathyroid adenoma
    - Further defined the patient population that needs evaluation
    - Removed the requirement for aberrant anatomy in preoperative planning
    - Position CT as a diagnostic test after both ultrasound and parathyroid scintigraphy
    - Remove MRI as a modality to evaluate based on lack of evidence
- Temporomandibular joint dysfunction
    - Removed standalone “frozen jaw” indication
    - Allow ultrasound in addition to radiographs as preliminary imaging
    - Allow advanced imaging without preliminary radiographs or US in the setting of mechanical signs or symptoms
    - Changed “Panorex” to “Radiographs” to allow for TMJ radiographs
    - Added requirement for conservative treatment and planned intervention for suspected osteoarthritis
- Cerebrospinal fluid (CSF) leak of the skull base

    - Added modalities and criteria to evaluate for CSF leak
- Dizziness or vertigo
    - Add Tullio's phenomenon for lateral semicircular canal dehiscence
    - Expand definition of abnormal vestibular function testing
- Hearing loss
    - Added indication for sudden onset hearing loss in adult patients
    - More clearly delineated appropriate modalities based on types of hearing loss in pediatric patients
    - Allow either CT or MRI for mixed hearing loss

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
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Please note, this program does not apply to the Federal Employee Program® (FEP®), Taft-Hartley and BlueCard® Plans and programs.

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.

Update to AIM Advanced Imaging of the Heart Clinical Appropriateness Guideline

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Clinical Appropriateness Guidelines for Advanced Imaging of the Heart and AIM Clinical Appropriateness Guidelines for Arterial Ultrasound.

Advanced imaging of the heart

- Resting transthoracic echocardiography (TTE)
    - Changes made to address frequency of surveillance of LV function for cardio-oncology.

- TTE
    - Changes made to address frequency of surveillance echocardiography following transcatheter mitral valve repair. These recommendations follow the Centers for Medicare & Medicaid Services guidelines.

Arterial ultrasound

- Upper extremity arterial duplex
    - Indication added for creation of arteriovenous (AV) fistulae for dialysis

- Lower extremity arterial duplex
    - The American College of Cardiology (ACC) guideline for management of peripheral arterial disease (2016) indicates that duplex imaging should be performed only after the decision to revascularize has been made. There is no role for duplex imaging in the initial diagnosis of peripheral arterial disease. The current AIM guideline is not aligned with this position and the proposed changes address that malalignment.

    - Language changed to account for the fact that critical limb ischemia should include patients with non-healing ulcers and gangrene

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Update to AIM Sleep Disorder Management Clinical Appropriateness Guidelines

Effective for dates of service on and after June 29, 2019, the following updates will apply to the AIM Sleep Disorder Management Clinical Appropriateness Guidelines.

- Reconfigured structure of BPAP with and without back-up rate feature criteria for patients with established central sleep apnea (CSA)
- Removed the criteria to try rate support for CSA

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Specialty pharmacy pre-service clinical review list expanded effective July 1, 2019

Effective for dates of service on or after July 1, 2019, the following drug code from the current clinical guideline will be included in our specialty pharmacy pre-service clinical 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.

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

Clinical Guideline	HCPCS Codes	NDC Codes	Drug

CG-THER-RAD-03	A9699, C9408	71258-0015-02, 71258-0015-22	Azedra®

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 other requirements, restrictions or limitations that apply to certain drugs, visit anthem.com/pharmacyinformation.

- To locate the commercial drug list, select 'Click here to access your drug list'.
- To locate the Marketplace Select Formulary and pharmacy information, scroll down to 'Select Drug Lists', then select the applicable state's drug list link.

The commercial and marketplace drug lists are reviewed and updates are posted to the website quarterly (the first of the month for January, April, July and October).

Federal Employee Program (FEP) pharmacy updates and other pharmacy related information may be accessed at www.fepblue.org > Pharmacy Benefits. This drug list is also reviewed and updated regularly as needed.

Commercial risk adjustment (CRA) reporting update

In a continuation of our CRA reporting update in March 2019, we request your assistance with respect to our commercial risk adjustment (CRA) reporting processes. There are two approaches that we take (retrospective and prospective) that work to improve risk adjustment reporting accuracy. We are focusing on performing appropriate interventions and chart reviews for patients with undocumented hierarchical condition categories (HCC), to close the documentation and coding gaps that we are seeing with our members enrolled in our Affordable Care Act (ACA) compliant plans.

With both our prospective and retrospective approaches, accurate documentation and coding are what we are encouraging physicians to achieve. As a physician for our members with ACA compliant plans, you play a vital role in the success of our CRA reporting processes and ACA compliance. When members visit your office, we encourage you to document ALL of the members' health conditions, especially chronic diseases on the claim. As a result, there will be ongoing documentation that indicates these conditions are being properly assessed and managed. Additional benefits of accurate coding include:

- Reduced volume in medical chart requests in the future due to the increased level of specificity in documentation and coding, as part of our retrospective approach; and
- Reduced volume of health assessment requests by ensuring your patients with our ACA compliant plans are seen for their annual exams each and every year, as part of our Prospective approach.

Please note: It's important to ensure that all diagnosis codes captured in your EMR system are included on the claims, and are not being truncated by your claims software management system. For example, some EMR systems may capture up to 12 diagnosis codes, but a claim system may only have the ability of capturing four (4). If your claim system is truncating some of the listed diagnosis codes, please work with your vendor/clearing house to ensure all codes are being captured.

Reminder about ICD-10 CM coding
As you may be aware, the ICD-10 CM coding system serves multiple purposes including identification of diseases, justification of the medical necessity for services provided, tracking morbidity and mortality, and determination of benefits. Additionally, we use ICD-10 CM codes submitted on health care claims to monitor health care trends and costs, disease management and clinical effectiveness of medical conditions.

We encourage you to follow the principles below for diagnostic coding to properly demonstrate medical necessity and complexity:

- Code the primary diagnosis, condition, problem or other reason for the medical service or procedure in the first diagnosis position of the claim whether on a paper claim form or the 837 electronic claim transaction, or point to the primary diagnosis by using the correct indicator/pointer.
- Include any secondary diagnosis codes that are actively managed during a face-to-face, provider-patient encounter, or any condition that impacts the provider's overall management or treatment of that patient in the remaining positions.
- Include all chronic historical codes, as they must be documented each year under the ACA. (E.g. an amputee must be coded each and every year even if the visit is not addressing the amputated limb specifically).

Provider manual to be updated July 1, 2019

The Provider Manual will be updated for an effective date of July 1, 2019, and will be available on our website by May 1, 2019. To view the updated manual after May 1, go to anthem.com/provider > Change State > Maine > scroll down to Find Resources for Maine > Provider Reference Materials/Provider Manuals > Provider Manual (effective 7/1/19).

Why do patients stop taking their prescribed medications and what can you do to help them?

You want what's best for your patients' health. So, it's challenging when a patient doesn't follow your prescribed treatment plan. Why do approximately 50% of patients with chronic illness stop taking their medications within one year of being prescribed1? What can be done differently? The missed opportunity may be that you're only seeing and hearing the tip of the iceberg—the observable portion of the thoughts and emotions your patient is experiencing. The barriers that exist under the waterline -- the Titanic-sized, often invisible, patient self-talk that may not get discussed -- can create a misalignment between patient and provider.

So we've created an online learning experience for the skills and techniques that may help you navigate these uncharted patient waters. After completing the learning experience you'll know how to see the barriers, use each appointment as an opportunity to build trust, and bring to light the concerns that may be occurring beneath the surface of your patient interactions. Understanding and addressing these concerns may help improve medication adherence—and you'll earn CME credit along the way.

Take the next step. Go to MyDiversePatients.com > The Medication Adherence Iceberg: How to navigate what you can't see to enhance your skills. The course is approximately one hour and accessible by smart phone, tablet or desktop at no cost.

1 Centers for Disease Control and Prevention. (2017, Feb 1). Overcoming Barriers to Medication Adherence for Chronic Conditions. Retrieved from https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm

Clinical practice and preventive health guidelines available on anthem.com

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 at anthem.com/provider > scroll down and select 'Find Resources for [state]' > Health and Wellness > Practice Guidelines.

Chronic care management and advanced care planning service benefits

We began providing benefits for chronic care management (CCM) and advanced care planning (ACP) services for our commercial members effective for claims with service dates of February 23, 2019 and forward.

- CCM services is care rendered by a physician or non-physician health care provider and their clinical staff, once per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only one (1) practitioner can bill a CCM per service period (month). Three CCM codes are included in this payment policy change: 99490, 99487 and 99489.
- ACP is a face-to-face service between a physician or other qualified health care professional and a patient discussing advance directives with or without completing relevant legal forms. An advance directive is a document in which a patient appoints an agent and/or records the wishes of a patient pertaining to their medical treatment at a future time if they cannot decide for themselves at that time. No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary.

We require patient consent prior to CCM or ACP service(s) being provided. Please refer to the current Claims Requiring Additional Documentation policy for more information. See the attached FAQ document and flyer to learn more, and review our Bundled Services and Supplies policy by visiting the Reimbursement Policy page at anthem.com/provider.

National Consumer Cost Tool (NCCT) provider cost data available for review

We continue to support cost transparency, which involves making provider cost information available to members. We do this via our consumer transparency tools, BCBS AXIS/NCCT Cost Comparison, Estimate Your Cost (EYC), and Castlight. We display costs for common procedures that are non-emergent, high-cost, or high-volume. For these procedures, we derive a cost range for the total episode of care, which includes all facility, professional, and ancillary services provided during an admission or outpatient visit. These costs are based on historical rates.

Cost and quality information is available nationally through the Blue Cross and Blue Shield Association and is known as the National Consumer Cost Tool (NCCT). In addition, the NCCT

data are used as the basis for the EYC tool and other third party transparency initiatives, which can be found on the home page of our Consumer Portal website at anthem.com.

We have expanded the cost information that will be made available to members through the EYC tool. Members using EYC will be able to view provider-specific costs for additional professional and ancillary services, including provider-specific office visit cost data.

The current version of the cost comparison transparency data will be updated in June, 2019, and will be available in April for provider review prior to its release via the Anthem POIT web tool through Availity. If you have questions regarding Anthem Care Comparison, Estimate Your Cost, or our expanded transparency initiatives, please contact David Spencer, Sr. Provider Network Manager at david.spencer@anthem.com.

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

We have 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 our policy on use of modifier 25.

Beginning with claims processed on or after May 1, 2019, we 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.

New Partial Hospitalization Program and Intensive Outpatient Program Services Facility Reimbursement Policy

Beginning with dates of service on or after July 1, 2019, we will implement the new facility reimbursement policy, Partial Hospitalization Program and Intensive Outpatient Program Services. This policy applies a limit of one (1) unit of service per day for partial hospitalization

program and/or intensive outpatient programs. For more information about this new policy, visit the Administrative, Billing and Reimbursement Policies page at anthem.com/provider.

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Reimbursement for select HEDIS related CPT II codes for Medicare Advantage members coming soon

CPT Category II codes are supplemental tracking codes used to support quality patient care and performance management. CPT II codes are:

- Billed in the procedure code field in the same way as CPT Category I codes.
- Used to describe clinical components usually included in evaluation, management or clinical services.
- Billed with a $0 billable charge amount since they are not usually associated with any relative value.

Under this new incentive program, we will reimburse contracted Medicare Advantage providers for submitting select HEDIS®-related CPT Category II codes for eligible members. Using these CPT Category II codes for Medicare Advantage members will:

- Help providers address clinical care opportunities.
- Facilitate timely and accurate claims payments.

Detailed information about this program, including a list of applicable codes, will be sent to providers when the program is implemented.

ABSCARE-0006-19
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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
- 2019 risk adjustment provider training
- New provider learning opportunity: Put the AIM *ProviderPortal*$_{SM}$ to work for you
- New provider service phone number beginning January 1, 2019

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