April 2019 Anthem Provider Newsletter - Nevada

Pharmacy information available at 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.

Drug fee schedule update

CMS average sales price (ASP) second quarter fee schedule with an effective date of April 1, 2019 will go into effect with Anthem Blue Cross and Blue Shield (Anthem) on May 1, 2019. To view the ASP fee schedule, please visit the CMS website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

Working with Anthem Webinars - April 2019 schedule: new Digital Provider Enrollment Application tool and Provider Maintenance Form

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 - April schedule

Topic:	**New Digital Provider Enrollment application on Availity and Provider Maintenance Form**
Date/Time:	**April 24, 12pm PT**

Description:	**Learn about the new functionality now on Availity allowing providers to submit a Provider Enrollment application online, as well as tips on submitting a Provider Maintenance Form.** Digital provider enrollment offers many benefits**:** • Supports enrollment of professional providers, whose organizations do not have a credentialing delegation agreement with Anthem. • New individual providers or groups can request a contract. • Existing groups can add providers to their existing contract. • Providers can check the status of an application in real-time using the enrollment dashboard. Provider Maintenance Form: • Learn tips for submitting demographic changes to Anthem such as: • Address changes • Tax ID changes • Provider add/terms to a practice • Plus more This webinar will walk you through an overview of the tools for submitting Provider Enrollment applications and Provider Maintenance Forms, and start saving you time!
Registration link:	https://antheminc.webex.com/antheminc/onstage/g.php?PRID=4dd9e774f237f0ecd17223a71abe7559

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.

Anthem’s new Digital Provider Enrollment application - now available

Anthem Blue Cross and Blue Shield (Anthem) continues to make it easier and more convenient to become a participating provider. The Digital Provider Enrollment application has been designed to speed up the enrollment process, allow providers to submit data at one time, and obtain real-time updates on the status of an application.

Access to the new application is available through Availity, Anthem’s secure web-based provider portal. New and current Availity users should ensure their user ID has the correct access. Please ensure that you have been assigned to *Provider Enrollment*.

Digital provider enrollment offers many benefits**:**

- Supports enrollment of professional providers, whose organizations do not have a credentialing delegation agreement with Anthem.
- New individual providers or groups can request a contract.
- Existing groups can add providers to their existing contract.
- Providers can check the status of an application in real-time using the enrollment dashboard.

To use the new Digital Enrollment application, please ensure your provider data on CAQH is current and in a *complete* or *re-attested* status, then log into Availityand use the following navigation: Choose your state > Payer Spaces > Provider Enrollment.

“Working with Anthem” webinars

Don’t forget we are also hosting our “Working with Anthem” webinars and this month’s topic will be the new Digital Provider Enrollment application tool. We will have a guest presenter providing a live demo. Check out our registration link to register today!

New look to our Medical Attachment submission tool

As you start using the updated medical attachment tool on the Availity Portal, you will notice the following changes:

- You now have the ability to submit an itemized bill
- A different link titled “Attachment - New” where you will now submit medical records when Anthem has requested additional information to process a claim
- File size - each attachment can be up to 10 MB with a maximum of 30 MB as the file size limit
- A new link on the attachment page called “Send Attachment” will allow you to start the process
- A record history of each entry provides you increased visibility of your submission

If you have not tried the **Medical Attachment tool** to submit electronic documentation in support of a claim, now is the time to give it a try! This tool makes the process of submitting requested medical records simple and streamlined. You can use your tax identification number (TIN) or your NPI to register and submit *solicited* (requested by Anthem) medical record attachments through the Availity Portal.

The existing Medical Attachment tool will be removed soon from the Availity Portal so we encourage you to start utilizing the ‘Attachment – New’ option now.

How to Access *solicited* Medical Attachments for Your Office

Availity Administrator, complete these steps:
From ***My Account Dashboard,*** select ***Enrollments Center > Medical Attachments Setup,*** follow the prompts and complete the following sections:

1. Select Application>choose **Medical Attachments Registration**
2. Provider Management>Select **Organization** from the drop-down. Add NPIs and/or Tax IDs (Multiples can be added separated by spaces or semi-colons)

3. Assign user access by checking the box in front of the user's name. Users may be removed by unchecking their name

Using Medical Attachments

Availity User, complete these steps:

1. Log in to www.availity.com
2. Select **Claims and Payments** > **Attachments-New** >**Send Attachment** Tab
3. Complete all required fields of the form
4. Attach supporting documentation
5. Submit

Need Training?

To access additional training for this Availity feature:

1. Log in to the Availity Portal at www.availity.com
2. At the top of any Availity portal page, click ***Help and Training > Get Trained*** (Make sure you do not have a pop-up blocker turned on or the next page may not open.)
3. In the new window a list of available topics will open. Locate and click ***Medical Attachments***
4. Under the Recordings section, click ***View Recording***

Anthem Commercial Risk Adjustment (CRA) Reporting Update: Accurate coding helps provide a comprehensive picture of patients' health and services provided

In a continuation of our CRA reporting update in March 2019, Anthem requests 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 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, Anthem uses 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).

New LabCorp Service locations available

New LabCorp service location recently opened in Nevada:

- **Elko**: 1775 Browning Way #103, Elko, NV 89801, (775) 777-8619

To find a LabCorp location near you, go to www.LabCorp.com or call one of the phone numbers below.

For information about specialized assays or about requirements for special collection kits and specimen handling, call LabCorp at 303-792-2600 or toll free at 888-LABCORP (888-522-2677).

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.

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 **Nevada**. 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, or contracted pathologists.

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

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 May 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.

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Coming soon: Reimbursement for select HEDIS-related CPT II codes for Medicare Advantage members

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, Anthem 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.

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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 March 7, 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 Blue Cross and Blue Shield (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:

1. Log in to Availity at https://www.availity.com and select **Help & Training | Get Trained**.
2. Type **Appeals** in the search field.
3. Enroll in a course.

Providers who have questions as they begin to use the new functionality should contact Anthem at the number found on the back of the member ID card.

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 to work for you
- New provider service phone number beginning January 1, 2019

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Electronic claim payment reconsideration

Click here for additional information about the Electronic claim payment reconsideration

Coding Spotlight: Cancer - A provider's guide to properly code cancers

Click here for additional information about the Coding Spotlight: Cancer

Clinical Criteria updates

Click here for additional information about the Clinical Criteria updates

Practitioners' rights during credentialing process

The credentialing process must be completed before a practitioner begins seeing members and enters into a contractual relationship with a health care insurer. As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:
Review information submitted to support their credentialing application.
Correct erroneous information regarding a credentialing application.
Be notified of the status of credentialing or recredentialing applications.

The Council for Affordable Quality Healthcare (CAQH®) universal credentialing process is used for individual providers who contract with Amerigroup Community Care. To apply for credentialing with Amerigroup, go to the CAQH website at **https://www.caqh.org** and select CAQH ProView™. There is no application fee.

Provider surveys

Each year we reach out to you to ask what we are doing well and how we can continue to improve our services. We use this feedback to continually improve our operations and strengthen our relationship with our providers.

Thank you for participating in our network, for providing quality health care to our members and for your timely completion of any surveys you receive.

Correction: Cervical length measurement by transvaginal ultrasound

This is a correction to a newsletter article from October, 2018. The correct codes (also listed below) are 76801, 76805 and 76811.

In our efforts to improve pregnancy outcomes, including the prevention of preterm birth, Anthem Blue Cross and Blue Shield Healthcare Solutions previously communicated our endorsement of the American College of Obstetricians and Gynecologists (ACOG) and Society for Maternal Fetal Medicine (SMFM) guidelines on cervical length (CL) screening and progesterone treatment.

We continue to encourage you to obtain a CL measurement with your patient's routine prenatal anatomic evaluation ultrasound. For claims submitted on or after January 1, 2019, if a vaginal approach is necessary in addition to an abdominal scan to obtain this measurement, the transvaginal ultrasound will be considered for a multiple procedure reduction.

When a routine anatomic evaluation ultrasound (76801, 76805 and 76811) and a transvaginal ultrasound (76817) are billed on the same day by the same provider, the transvaginal ultrasound is considered a part of the multiple procedure payment reduction policy and will be paid at 50% of the applicable fee schedule, and the complete procedure will be paid at the full applicable fee schedule.

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services toll free at **1-844-396-2330**.

Thank you for being a valued provider.