July 2019 Anthem Provider News - Virginia

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.

Ethics and Fairness in Carrier Business Practices

Effective **July 1, 2019**, Anthem Blue Cross and Blue Shield is required to, in the case of a previously authorized medically necessary invasive or surgical procedure, pay claims when there is clinical evidence prompting a less or more extensive or complicated procedure than was previously authorized if the procedure is:

- Not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan
- Appropriately coded consistent with the procedure actually performed; and
- Compliant with our post-service claims process, including required timing for submission.

As a reminder, the *Virginia Professional Provider Manual* specifies the following provision to handle post- service additions to a previously authorized request:

> *The Program's medical management unit will conduct a Retrospective Review for requests received within 10 business days of the date the Member received the*

service. If the request for review is received 11 business days or more after the date of service, the provider must submit the claim either electronically or on paper to the post-service claim review unit for adjudication. The claim will be reviewed prior to the claim adjudication. Some claims may be denied for lack of prior authorization pursuant to the provisions of your facility and/or professional contract.

Adhering to this provision will ensure that any services not previously authorized are consistent with the type of procedures covered under the previous authorization, are not investigative in nature, and the additional procedure(s) are compliant with the post-service claims process. Updates to a previously authorized request can be completed by logging into Availity using our Point of Care online tool (http://www.Anthem.com) or by calling Anthem toll free at 1-800-533-1120 to speak to someone in Group Plan Services.

Telemedicine Services: Expansion of Section 38.2-3418.16 of the Code of Virginia

Effective **July 1, 2019**, we are expanding coverage for telemedicine services to include medically necessary remote patient monitoring services. Remote patient monitoring services means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including:

- Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data;
- Medication adherence monitoring; and
- Interactive video conferencing with or without digital image upload.

Remote patient monitoring services allows members to use mobile medical devices and technology to gather health data, for example their blood pressure, and send it to their doctor.

We will not reimburse for technical fees or costs for the provision of these services.

New state legislation prompts changes for reimbursement of services during credentialing process for mental health professionals

Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. are working to

comply with Virginia legislative Senate Bill (SB) 1685 that's effective **July 1, 2019**. If you are a mental health professional* under review to be credentialed for participation in provider networks offered by Anthem and HealthKeepers, Inc., SB 1685 will allow you to see Anthem patients and retroactively receive payments if you are ultimately credentialed.

This means that on or after July 1, 2019, if you are a mental health professional who submits a credentialing application to us, Anthem and HealthKeepers, Inc. will adhere to the requirements specified in SB 1685. Requirements in the bill do not apply to credentialing applications that were submitted BEFORE July 1 but which are still being processed after the July effective date.

Under the new law, we are required to establish protocols and procedures for reimbursing mental health professionals at the contracted in-network rate for approved, covered mental health services that are provided during the period in which a mental health professional's credentialing application is pending. Effective July 1 under SB 1685, the credentialing period begins with the receipt of a fully completed credentialing application. Incomplete credentialing applications and denied applications are excluded.

What lines of our business are impacted?

Members enrolled in the following health benefit plans are impacted by the new state legislation:

- Anthem's PAR/PPO health benefit plans.
- HealthKeepers, Inc.'s Anthem HealthKeepers (commercial, non-Medicaid) health benefit plans. This includes health plans members purchase on or off the Health Insurance Marketplace (commonly referred to as the exchange).
- Commonwealth of Virginia COVA Care and COVA HDHP health benefit plans, the Local Choice (TLC) health benefit plans, and the Line of Duty (LODA) health benefit plans.
- Medicare Supplement health benefit plans.

Those lines of business NOT impacted are:

- Blue Cross and Blue Shield Service Benefit Plan (also called the Federal Employee Program or FEP).

- Administrative services only (ASO) health plans.
- HealthKeepers, Inc.'s Anthem HealthKeepers Plus/FAMIS (Medicaid) health plans.
- Medicare Advantage health plans.

Impact to physicians – Call to action

Hold claims for Anthem members: During the credentialing period, mental health professionals **are required to hold claims** for our members until Anthem sends a final notification of a credentialing decision. If you submit claims to Anthem during the credentialing period before receiving a credentialing decision, claims will be rejected indicating that the claims must be resubmitted upon a final credentialing decision. Members will be protected from inappropriate billing and held harmless during this period.

Patient financial responsibility: Upon receiving notice of Anthem's final credentialing approval mental health professionals may collect any applicable member cost shares based on members' health benefit plans as appropriate. Mental health professionals with approved credentialing applications are required to submit claims under their contract with Anthem and HealthKeepers, Inc. Those with denied applications, while not obligated to so do, are encouraged to file claims to us on behalf of members to help speed claims processing and payments as appropriate. As always, we encourage you to verify eligibility and benefits for members via our secure Web-based provider tool – Availity.

Notify Anthem members as required by SB 1685: In order to submit claims pursuant to SB 1685, mental health professionals are required to take the following actions regarding members enrolled in health benefit plans offered by Anthem and HealthKeepers, Inc.:

- Notify members – either in writing or electronically – stating that the mental health professional's credentialing application has been submitted to Anthem and is under review.
- Provide the notice in advance of providing treatment to members.
- Include in the notice to members certain credentialing information as outlined in SB 1685. Please refer to the legislation for actual requirements and how they impact you.

Questions

If you have questions about the status of your credentialing application, please email our credentialing area at credentialing@anthem.com. All other questions about the credentialing process should be directed to your Anthem network manager.

Please forward this information to those in your practice who may need this information.

*We credential and contract with the following mid-level mental health practitioners in the commonwealth of Virginia:

- **PhD**: Licensed Clinical Psychologists and Licensed Psychologists.
- **Master Levels:** Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Counselors, Clinical Nurse Specialists.
- **Autism Provider/Behavioral Analyst:** Licensed Board Certified Behavior Analysts and Licensed Board Certified Assistant Behavior Analysts.

ICD-10-CM coding guidelines and laterality: Professional

With the adoption of 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.

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.

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 Anthem 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 Anthem EDI transmissions.

Do you use a clearinghouse today?

- We encourage you to contact your clearinghouse to ensure they have made the transition to the Availity EDI Gateway.

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 toll free at 1-800-Availity (1-800-282-4548), Monday through Friday 8 a.m. to 7:30 p.m. Eastern Time.

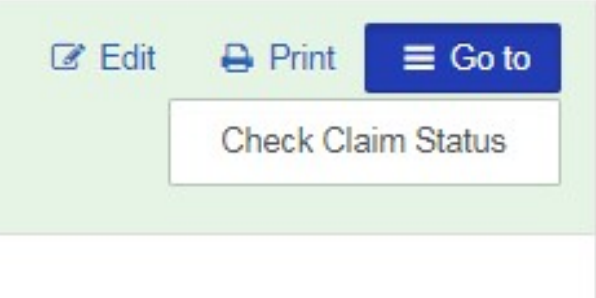
*Electronic Data Interchange (EDI) Gateway

Changes coming to Claim Status Inquiry and Secure Messaging on the Availity Portal

Claim Status Inquiry Changes

Starting mid-July, you will have a new way to check the status of a claim on the Availity Portal for Anthem. The link under the Claims & Payments menu is titled **Claim Status and Remittance Inquiry**.

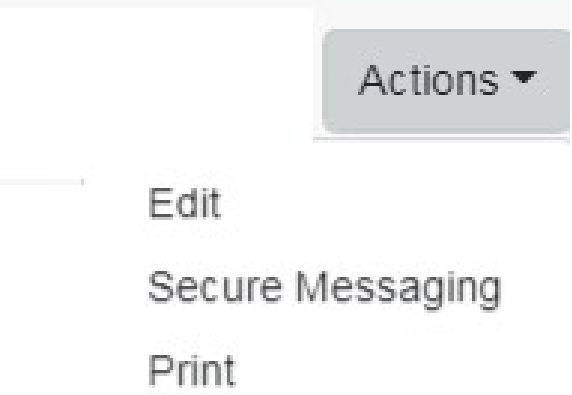
You may also use the **Go To** menu on the patient eligibility and benefit detail page to navigate seamlessly to the new look.



The new claim status look includes color-coded patient ID cards and easy-to-read claim detail.

Secure Messaging Changes

A new **Actions** menu on the updated Claim Status page will be used to access the Secure Provider Messaging tool. The link "*Do you have a question about this claim?"* will no longer be available with the new claim screen. You can also use the **Actions** menu to edit or print the claim screen.



For more information on the changes, a Claim Status – Training webinar is coming mid-month. Access the training **Enroll** link by logging in to the Availity Portal and selecting Help & Training | Get Trained.

REMINDER: Change to toll-free phone lines for Provider Services in Virginia

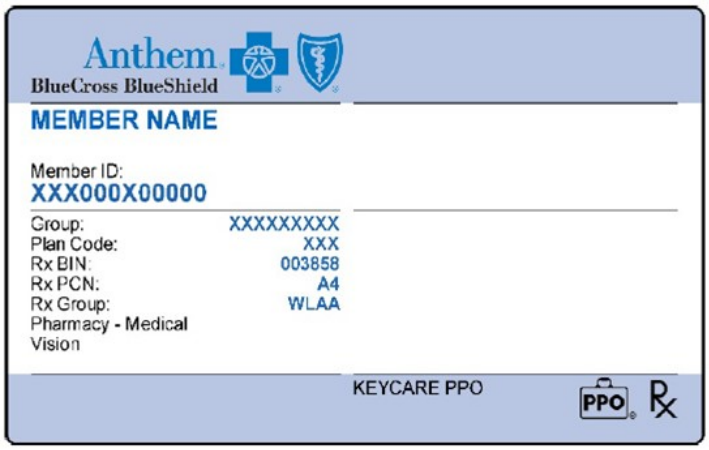
Anthem Blue Cross and Blue Shield respects your time, and we want your service experience to be exceptional. Effective **June 13, 2019**, we made slight changes to the prompts within our interactive voice response (IVR) system that you use when dialing in to Anthem's Provider Service areas. These enhancements were designed to make it easier for you to get the information you need quickly when you call and to streamline your call-in experience – saving you time in the process.

As a reminder, always refer to the back of members' health insurance ID cards for the most accurate Provider Services telephone number. This will help prevent unnecessary misroutes or delays. The back of the member's ID card (text at the bottom) will also identify the Home Plan issuing the member's policy.

If you do not have the member's ID card available, please refer to the following as general guidance:

Toll-free Telephone Numbers	When to Use
800-533-1120	Dial this phone number when calling about a local Virginia Plan member whose ID card has Plan code **923, 924 or 925**. Follow prompts on the IVR for proper routing.
844-545-1430 **NEW!**	Dial this phone number when calling about **claim status** for members whose policies are issued by **other** Blue Cross and Blue Shield Plans. (These are non-Virginia BlueCard members.)
800-676-BLUE (2583)	Dial this phone number when calling about a non-Virginia BlueCard member enrolled in another Blue Cross and Blue Shield Plan. This phone number will connect you with the member's Home Plan where you can **check eligibility, benefits and obtain precertification,** if required.

Sample ID card below showing where the Plan code on the member's ID card can be found.



NOTE:
Please make sure you are checking the member's ID card for the Plan code.

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: 866-789-0397, Monday – Friday, 8 a.m. to 5 p.m. ET.

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.

Anthem Commercial Risk Adjustment reporting update: 2019 Program year progression

2019 Program year progression: What's in it for you and your patients?

Continuing our 2019 Commercial Risk Adjustment (CRA) reporting updates, Anthem Blue Cross and Blue Shield requests your assistance with respect to our CRA reporting processes.

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?

First, monthly you will 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.

Second, 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' overall health.

Finally, when you see Anthem members and submit assessments, **we pay incentives of $100 for an electronic submission and $50 for a paper 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?

Anthem has completed monthly postcard campaigns with messaging to encourage members with Affordable Care Act (ACA) compliant coverage to call their primary care providers (PCPs) to schedule annual checkups when we suspect high risk conditions. 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 2019 to encourage 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:

- Alicia.Estrada@anthem.com

An important reminder from Anthem about home sleep testing with NovaSom

Previously, Anthem Blue Cross and Blue Shield shared information about the authorization process for home sleep testing. Once again, we are including a reminder about the process in this edition of *Provider News*. The authorization process for home sleep testing (HST) with NovaSom is designed to be simple for ordering physicians. NovaSom is a network participating provider of home sleep testing equipment and interpretation.

Anthem delegates the management of sleep testing and treatment services to AIM Specialty

Health® (AIM) on our behalf. To request an authorization for HST with NovaSom, just contact AIM via Availity (see below), or toll free at the numbers noted below:

- Anthem Medicare and Medicaid: 1-800-714-0040 (weekdays, 8 a.m. to 5 p.m. EST), or
- Anthem Commercial Business: 1-866-789-0158 (weekdays, 8 a.m. to 5 p.m. EST).

If your authorization request is approved, an order is automatically sent to NovaSom for you. There is no need to contact or fax an order form to NovaSom on your patient's behalf.

Home sleep testing with NovaSom

Anthem members suspected of having noncomplicated obstructive sleep apnea have the ability to test at home using NovaSom's AccuSom® wireless HST device. AccuSom wireless sleep studies are performed in the patient's home and self-administered, which may be more comfortable and reflective of typical sleep behaviors than those provided in a lab.

NovaSom provides telephonic clinical support. All data is wirelessly transmitted from the AccuSom sleep testing device to the NovaSom secure portal during the test process. Data is reviewed by sleep technicians to help promote quality. Daily clinical telephonic support is provided to coach the patient throughout the testing process. Once the study is complete, a board-certified sleep physician interprets the study and provides a report with treatment recommendations. The goal is to provide reports within 48 hours of study completion to the ordering practitioner.

Please note that this notice impacts claims for members enrolled in our Anthem PPO, Anthem HealthKeepers, Anthem HealthKeepers Plus (Medicaid), Commonwealth Coordinated Care Plus (Anthem CCC Plus), and Anthem Medicare Advantage health benefit plans. If you have any questions about NovaSom or the authorization process, please contact your local Anthem network manager.

Accessing AIM via Availity

You can view AIM information using one of Anthem's Web-based provider tools – Availity. Just navigate to the AIM Specialty Health site via the Availity portal at www.availity.com. Once logged into Availity, you can access the AIM Specialty Health link under Auths and Referrals on the left navigation menu of the Availity portal.

In addition, you may choose to use AIM's provider portal at www.providerportal.com in place of Availty.

Clinical criteria coding updates for specialty pharmacy are available

Coding updates

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

Access the **clinical criteria information** on anthem.com.

Oncology 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 have changed. Access the **clinical criteria information** online. The table below will assist you in identifying the new document number for the clinical criteria that corresponds with the previous Clinical Guideline/Coverage Guideline.

For Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc., pre-service clinical review of these specialty pharmacy drugs will be managed by Anthem. Drugs used for the treatment of oncology will still require pre-service clinical review by AIM Specialty Health® (AIM), a separate company.

This applies to members with Preferred Provider Organization (PPO) plans, Anthem HealthKeepers (HMO) plans, POS AdvantageOne, and Act Wise (CDH plans).

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

Anthem 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 medications:

List of medications by name and code

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

J1572	Injection, immune globulin, **(Flebogamma)**	

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 Anthem site-of-care criteria and who can safely receive their medications in a location other than an outpatient hospital, including the home.

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

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

Sepsis diagnosis coding and billing reminder

To help ensure compliance with the coding and billing of Sepsis by Anthem HealthKeepers Plus providers, HealthKeepers, Inc. reviews 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 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 Sepsis. The claim may be subject to an adjustment in reimbursement when Sepsis is not supported based on the Sepsis-3 definition and criteria.

Unspecified diagnosis code update

HealthKeepers, Inc. previously communicated that as of July 1, 2018, we now require unspecified diagnosis codes to be used only when an established diagnosis code does not exist to describe the diagnosis for Anthem HealthKeepers Plus members. Our goal is to align with ICD-10-CM requirements, using more specific diagnosis codes when available and appropriate. This includes codes that ICD-10-CM provides with laterality specifying whether the condition occurs on the left, right or is bilateral. The target effective date has been delayed for implementing the corresponding code edit. However, providers are encouraged to ensure their billing staff is aware of the required specificity in reporting ICD-10-CM diagnosis codes to prevent future denials.

HealthKeepers, Inc. will be sending out a follow-up article to inform providers of when to expect this requirement to go live and any additional details for the changes made.

Coding Spotlight: Hypertension

A providers' guide for coding hypertension for Anthem HealthKeepers Plus members

ICD-10-CM hypertension coding highlights:

- Hypertensive crisis can involve hypertensive urgency or emergency.
- Hypertension can occur with heart disease, chronic kidney disease (CKD) or both.
- ICD-10-CM classifies hypertension by type as essential or primary (categories I10-I13) and secondary (category I15).[1]
- Categories I10-I13 classify primary hypertension according to a hierarchy of the disease from its vascular origin (I10) to the involvement of the heart (I11), CKD (I12), or heart and CKD combined (I13).[1]

Hypertension categories:

Code	Description
I10	Essential (primary) hypertension
I11.0	Hypertensive heart disease with heart failure
I11.9	Hypertensive heart disease without heart failure
I12.0	Hypertensive CKD with stage 5 CKD or end-stage renal disease (ERSD)
I12.9	Hypertensive CKD with stage 1 through stage 4 CKD or unspecified CKD
I13.0	Hypertensive heart and CKD with heart failure and stage 1 through stage 4 CKD or unspecified CKD
I13.10	Hypertensive heart and CKD without heart failure with stage 1 through stage 4 CKD or unspecified CKD
I13.11	Hypertensive heart and CKD without heart failure with stage 5 CKD or ERSD
I13.2	Hypertensive heart and CKD with heart failure and with stage 5 CKD or ERSD
I15.-	Secondary hypertension
I16.-	Hypertensive crisis

Hypertensive heart disease

ICD-10-CM presumes a causal relationship between hypertension and heart involvement and classifies hypertension and heart conditions to category I11 (hypertensive heart disease) because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them. Code first I11.0 (hypertensive heart disease with heart failure) as instructed by the note at category I50 (heart failure). If the provider specifically documents different causes for the hypertension and the heart condition, the heart condition (I50.-, II51.4 to I51.x9) and hypertension are coded separately.[1]

Category I11 is subdivided to indicate whether heart failure is present. However, an additional code from category I50 is required to specify the type of heart failure, if known.

Documentation may vary, but coding instructions remain the same. For example:

- Congestive heart failure due to hypertension: I11.0 + I50.9
- Hypertensive heart disease with congestive heart failure: I11.0 + I50.9
- Congestive heart failure with hypertension: I11.0 + I50.9

Other heart conditions that have an assumed causal connection to hypertensive heart disease:

Code	Description
I51.4	Myocarditis, unspecified
I51.5	Myocardial degeneration
I51.7	Cardiomegaly
I51.81	Takotsubo syndrome
I51.89	Other ill-defined heart diseases
I51.9	Heart disease, unspecified

Hypertension and CKD

When the diagnostic statement includes both hypertension and CKD, ICD-10-CM assumes there is a cause-and-effect relationship. A code from category I12 (hypertensive CKD) is assigned because the two conditions are linked by the term “with” in the *Alphabetic Index of ICD-10-CM*. These conditions should be coded as related even in the absence of provider documentation linking them, unless the documentation clearly states the conditions are unrelated.[1]

A fourth character is used with category I12 to indicate the stage of the CKD. The appropriate code from category N18 should be used as a secondary code to identify the stage of CKD.

Hypertensive heart and CKD

Combination category I13 codes are assigned for hypertensive heart and CKD when there is hypertension with both heart and kidney involvement. If heart failure is present, an additional code from category I50 is assigned to identify the type of heart failure.[1]

The appropriate code from category N18 (CKD) should be used as secondary code with a code from category I13 to identify the stage of CKD.

Hypertensive cerebrovascular disease

For hypertensive cerebrovascular disease, first the appropriate code from categories I60 to I69 is assigned followed by the hypertension code.

Hypertensive retinopathy

Subcategory H35.0 (background retinopathy and retinal vascular changes) should be used with a code from category I10 to I15 (hypertensive disease to include the systemic hypertension).[2]

Hypertension, secondary

Two codes are required — one to identify the underlying etiology and one from category I15 to identify the hypertension. For example:

- Hypertension due to systemic lupus erythematosus: M32.10 + I15.8
- Acromegaly with secondary hypertension seen for hypertension management: I15.2 + E22.0

Hypertension, transient

Code R03.0 (elevated blood pressure reading without diagnosis of hypertension) is assigned unless the patient has an established diagnosis of hypertension. For transient hypertension of pregnancy, code O13.- (gestational [pregnancy-induced] hypertension without significant proteinuria) or O14.- (pre-eclampsia).

Hypertensive crisis

A code from category I16 (hypertensive crisis) is assigned for any documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Report two codes, at a minimum, for hypertensive crisis. The crisis code is reported in addition to the underlying hypertension code (I10 to I15).[1]

- Hypertensive urgency: I16.0
- Hypertensive emergency: I16.1
- Hypertensive crisis, unspecified: I16.9

Pulmonary hypertension

Pulmonary hypertension is classified to category I27 (other pulmonary heart diseases). For secondary pulmonary hypertension (I27.1, I27.2-), any associated conditions or adverse effect of drugs or toxins should be coded.[2]

More coding tips

Blood pressure and medication management should be assessed at every encounter involving a hypertensive patient. Clarity is important in documenting hypertension. Ensure that the diagnosis is captured by noting it in the medical record documentation:

- Specify a pregnant patient with hypertension as having a pre-existing, gestational, pre-eclampsic or eclampsic hypertension.

- Document and code the smoking status of a patient with hypertension:

Current smoker: F17
Personal history of tobacco dependence: Z87.891
Tobacco use: Z72.0
Exposure to environmental tobacco smoke: Z57.31

- Document any causal relationship between hypertension and background retinopathy or other condition in which the hypertension caused vascular changes and organ damage.

HEDIS® Quality Measures for hypertension

The Controlling High Blood Pressure (CBP) measure looks at a sample of members ages 18 to 85 years of age who have a diagnosis of hypertension and whose blood pressure (BP) is regularly monitored and controlled.[3]

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

Record your efforts

Document blood pressure and diagnosis of hypertension. Patients whose BP is adequately controlled include patients ages 18 to 59 with less than 140/90 mm Hg.

Both systolic and diastolic values must be below the stated value. The most recent BP measurement during the year counts toward compliance.

What does not count?

- A BP measurement taken on the same day or one day before the test or procedure (fasting blood tests not included).
- Patient reported BP measurements.
- A BP measurement taken on the same day as a diagnostic test or procedure that requires a change in diet or medication regimen. For example:

Procedures that require a change in diet or medication regimen: colonoscopy, dialysis, infusions, chemotherapy, nebulizer treatment with albuterol and injection of lidocaine prior to mole removal.

Procedures (low-intensity or preventive) that would not disqualify the BP reading: vaccinations, injections, TB test, intrauterine device insertion and eye exam with dilating agents.

Codes to identify hypertension

ICD-10-CM	CPT Category II codes[4]

I10	3074F: systolic BP <130 3075F: systolic BP 130 to 139 3077F: systolic BP ≥140 3078F: diastolic BP <80 3079F: diastolic BP 80 to 89 3080F: diastolic BP ≥90

Strategies for success

- Improve the accuracy of BP measurements performed by your clinical staff by:

Providing training materials from the American Heart Association.
Conducting BP competency tests to validate the education of each clinical staff member.
Making a variety of cuff sizes available.

- Instruct your office staff to recheck BPs for all patients with initial recorded readings greater than systolic 140 mm Hg and diastolic of 90 mm Hg during outpatient office visits; have your staff record the recheck in the patient's medical records.

- Educate your patients (and their spouses, caregivers or guardians) about the elements of a healthy lifestyle, such as:

Heart-healthy eating and low-salt diet.
Smoking cessation and avoiding secondhand smoke.
Adding regular exercise to daily activities.
Home BP monitoring.
Ideal body mass index.
The importance of taking all prescribed medications as directed.

- Remember to include the applicable Category II reporting codes on the claim form to help reduce the burden of HEDIS medical record review.

Resources

[1] "ICD-10-CM Expert for Physicians. The complete official code set," Optum360, LLC (2019).
[2] Elsevier, "ICD-10-CM/PCS Coding, Theory and Practice — 2019/2020 Edition."
[3] "HEDIS Measures and Technical Resources," NCQA, accessed April 15, 2019, https://www.ncqa.org/hedis/measures.
[4] "CPT 2019 Professional Edition," American Medical Association (2019).

[5] “HCPCS Level II,” American Medical Association (2019).

New service types added to Availity

Enhancements have been made to the Availity Portal that will now allow you to access more service types when using the Eligibility and Benefits Inquiry tool and will also allow us to share even more valuable information with you electronically regarding your Anthem HealthKeepers Plus members.

You may have already noticed new additions to service types, including:

- Medically related transportation.
- Long-term care.
- Acupuncture.
- Respite care.
- Dermatology.
- Sleep study therapy (found under diagnostic medical).
- Allergy testing.

Note, although there is an extensive list of available benefit types available when submitting an eligibility and benefits request, these types do vary by payer.

Here are some important points to remember when selecting service types:

- The benefit/service type field is populated with the last benefit type you selected. If you don’t see a specific benefit in the results, submit a new request and select the specific benefit type/service code.

- You have the ability to inquire about 50 patients at one time using the Add Multiple Patients feature.

Update to rules governing reimbursement for LMHPs for servicing only Anthem HealthKeepers Plus members

Please read this important update regarding licensed mental health professionals (LMHPs) servicing *only* Anthem HealthKeepers Plus members.

Effective May 1, 2019, unlicensed providers who have their supervision registered with the Board of Health Professions (LPC, LCSW, LCP, LMFT, LSATP) may provide services to Anthem HealthKeepers Plus members under the following conditions:

1. The supervising practitioner must be licensed with the appropriate board (as both a practitioner and supervising practitioner) under the Virginia Department of Health Professions for those services offered by the unlicensed provider.

2. The supervising practitioner must be credentialed and contracted with Anthem HealthKeepers Plus for the group under which services are being provided by the unlicensed provider.

3. Claims must be billed under the supervising practitioner's NPI.

If you have any questions about this communication, call Provider Services at **1-800-901-0020** or Anthem CCC Plus Provider Services at **1-855-323-4687**.

Electronic claim payment reconsideration

Currently, providers can submit claim payment reconsideration requests for Anthem HealthKeepers Plus members verbally, in writing or electronically. We are reaching out to notify you about some exciting, new tools for electronic submission of Medicaid claims that

will become available through the Availity Portal. You should soon see changes in your provider manual that will outline this new information. Read about the changes here.

Keep up with Medicaid news

Please continue to check our website https://mediproviders.anthem.com/va/Pages/home.aspx for the latest information for Anthem HealthKeepers Plus and the Commonwealth Coordinated Care Plus (Anthem CCC Plus) providers. Here are some topics we're addressing in this edition of *Provider News*:

Falls prevention

Upcoming provider orientations schedule

Home health billing guidelines for contracted providers

Category: Medicare

This *information is intended for home health agencies that* ***do not*** *submit their claims to MyNexus and are contracted with Anthem Blue Cross and Blue Shield (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.*

These billing guidelines are recommended for home health providers when billing a Request for Anticipated Payment (RAP) and final claim to Anthem Blue Cross and Blue Shield (Anthem). This information will assist home health providers in receiving the correct and timely payment according to Medicare guidelines and their contract. Read these helpful guidelines here.

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Outpatient Rehabilitation Program transitioning to AIM

Category: Medicare

Effective **October 1, 2019**, Anthem Blue Cross and Blue Shield (Anthem) 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. Anthem has an existing relationship with AIM in the administration of other programs. Read about the AIM transition here.

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Electronic claim payment reconsideration: Virginia

Category: Medicare

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 **July 22, 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. Learn about these exciting tools 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

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