July 2019 Anthem Provider News - Wisconsin

Notice of Material Changes/Amendments to Contract and Prior Authorization Changes -- July 2019

Material Changes/Amendments to Contract and Changes to Prior Authorization Requirements may apply for new or updated reimbursement policies, medical policies, or prior authorization requirements starred (*) below.

Clinical Guidelines

- Updates to AIM Advanced Imaging Clinical Appropriateness Guidelines*

Reimbursement

- Clinical Validation: Professional*
- Update to Provider UM reimbursement penalties and corresponding update to Provider Manual*

Other Important Updates

- **Pharmacy**: Clinical criteria updates for specialty pharmacy
- **FEP:** Anthem Federal Employee Health Benefit Program® (FEP) PPO Members will now require prior approval for specific Specialty Drugs and Site of Care

Medicare and Medicaid News

Reminder to providers: Fee schedule information

Fee Schedule information is confidential and proprietary to Anthem Blue Cross and Blue Shield (Anthem) in your Provider Agreement (the “Agreement”). The Agreement has general restrictions regarding disclosure of such confidential information.

For example, neither Anthem nor Provider may disclose confidential and proprietary information except:
1) as required by Regulatory Requirements;
2) upon the express written consent of the parties;
3) as required to perform the obligations of the Agreement; or
4) as required to deliver Health Services or administer a Health Benefit Plan.

Please refer to your specific Agreement for a complete list of disclosure restrictions.

Anthem provider agreements restrict the disclosure of confidential information, including Fee

Schedule information, to third-parties (e.g., consultants, lenders, legal advisors, and business advisors). Absent Anthem's written consent, those restrictions surrounding disclosure extends to those third parties that conduct business on behalf of providers.

Upon disclosure, all third parties are subject to the confidentiality requirements as set forth in the Agreement.

Disclosure of confidential and proprietary information, in violation of the terms of the Agreement, could subject Provider to penalties.

Update to Provider UM reimbursement penalties and corresponding update to Provider Manual*

Effective for dates of service beginning October 1, 2019, and after, Anthem Blue Cross and Blue Shield (Anthem) will increase the reimbursement penalty for failure to comply with the Utilization Management (UM) program's prior authorization requirements for services rendered to commercial plan members. Late prior authorizations, 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 prior authorization requirements, and late notice requirements in the case of emergency admissions, will result in a 50% reduction in reimbursement to the Provider and Facility.

As a reminder, Anthem requires prior authorization prior to the delivery of certain elective services in both the inpatient and outpatient settings. For an emergency admission, prior authorization is not required; however, you must notify Anthem of the admission within the timeframe specified in the Provider 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 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.

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Anthem Works to Simplify Payment Recovery Process for National Accounts Membership

In our company's 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.

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

Anthem Commercial Risk Adjustment (CRA) Reporting Update: 2019 Program Year Progression -- What's in it for you and your patients?

Continuing our 2019 CRA reporting updates, Anthem Blue Cross and Blue Shield (Anthem) 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 end to end.

Finally, 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?

Anthem has 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 by emailing Natalie.Wilder@anthem.com.

Clinical criteria updates for specialty pharmacy

In the December 2018 newsletter, Anthem Blue Cross and Blue Shield (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. You can go online to access the Clinical Criteria information.

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.

Anthem's prior authorization 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 are available

Due to 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. 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.

Clinical Criteria Document Number	Clinical Criteria Name
ING-CC-0073	Alpha-1 Proteinase Inhibitor Therapy

You can go online to access the Clinical Criteria information.

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
- 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
- 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 providers may submit genetic testing prior authorization requests to AIM in one of several ways:

- Access AIM's ***Provider****Portal*℠ 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 800-554-0580, 8:30 a.m.–7:00 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 on the Availity website.

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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.

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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 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.

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 code

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)**
J1569	Injection, immune globulin **(Gammagard liquid)**
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)**

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 medication 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 at (800-860-2156).

Outpatient Rehabilitation Program transitioning to AIM

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.

This transition enables Anthem to expand and optimize this program, further ensuring that care aligns with established evidence-based medicine. AIM will follow the clinical hierarchy established by Anthem for medical necessity determination. For Medicare Advantage, Anthem makes coverage determinations based on guidance from CMS including national coverage determinations (NCDs), local coverage determinations (LCDs), other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, AIM will determine medical necessity using an objective, evidence-based process.

AIM will continue to use criteria documented in Anthem clinical guidelines *GC.REHAB.04*, *CG.REHAB.05* and *CG.REHAB.06* for review of these services. These clinical guidelines can be reviewed online at https://www.availity.com by selecting **Clinical Resources** in the *Education and Reference Center* under *Payer Spaces*.

Detailed prior authorization requirements are available online by accessing the

Precertification Lookup Tool under *Payer Spaces* at https://www.availity.com. Contracted and non-contracted providers should call Provider Services at the phone number on the back of the member's ID card for prior authorization requirements.

Prior authorization review requirements
For services scheduled to be rendered through September 30, 2019, providers must contact OrthoNet LLC to obtain prior authorizations for outpatient rehabilitation services. Any authorizations OrthoNet LLC makes prior to the transition date of October 1, 2019, will be honored and claims will process accordingly.

For services that are scheduled on or after October 1, 2019, providers must contact AIM to obtain prior authorization. Beginning September 15, 2019, providers will be able to contact AIM for prior authorization on services to take place on or after October 1, 2019. Providers are strongly encouraged to verify that they have obtained prior authorization before scheduling and performing services.

How to place a review request
You may place a request online via the AIM ***Provider****Portal*[SM]. This service is available 24/7 to process requests in real time using clinical criteria. Go to www.providerportal.com to register. You can also call AIM at **1-800-714-0040**, Monday to Friday 7 a.m. to 7 p.m. Central time.

For more information
For resources to help your practice get started with the Outpatient Rehabilitation Program, go to www.aimproviders.com/rehabilitation. Our provider website helps you learn more and provides access to useful information and tools such as order entry checklists, clinical guidelines and FAQ.

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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 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.*

Below are some billing guidelines we recommend home health providers 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.

- Anthem should receive the final bill within 120 days after the start date of the episode or 60 days after the paid date of the RAP claim — whichever is greater. If the final bill is not received within this time frame, the RAP payment will be canceled/recouped — This is a **Medicare billing requirement**.

- Bill the full Medicare allowed amount for the episode as the billed charges. Do not bill only the expected additional payment on the final claim as the billed charges. When this happens, the Lesser of Logic term in your contract affects the final payment made for the services. If the billed charges are less than the final allowed, the payment will be reduced to only pay up to the billed charges. The billed charges on the final claim should be for at least the full Medicare allowed amount for the services rendered. This will allow the claim to process correctly according to Medicare guidelines.

    - Example: RAP claim paid $500. The final claim is submitted with billed charges in the amount of $1,000. The Medicare allowed amount is $1,500. Since the billed charges on the final claim are only $1,000, Anthem would only pay an additional $500 for the final allowed according to the Lesser of Logic term in the contract. If the provider would have billed charges in the amount of at least $1,500, then an additional payment of $1,000 would have been paid.

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Sepsis diagnosis coding and billing reminder

To help ensure compliance with the coding and billing of Sepsis, Anthem Blue Cross and Blue Shield 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.

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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 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 Blue and Blue Shield.
- 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 **1-800-282-4548**.

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Keep up with Medicare News -- July 2019

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

ABSCRNU-0040-19 75743MUPENMUB

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.

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.

Electronic claim payment reconsideration

Currently, providers can submit claim payment reconsideration requests 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.

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

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

New Availity Portal functionality will include:

- Immediate acknowledgement of submission.
- Notification when a reconsideration has been finalized by Anthem Blue Cross and Blue Shield.
- A worklist of open submissions to check a reconsideration status.

With the new electronic functionality, when a claim payment reconsideration request is submitted via 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 claims payment reconsideration request will receive notification informing them that the reconsideration review has been completed. If the user is not satisfied with the reconsideration outcome, they should continue to follow the existing process to file a claim payment appeal as outlined in the provider manual.

To register for a webinar or access a recorded webinar:

1. Log in to the Availity Portal at **https://www.availity.com** > Select Help & Training > Select Get Trained.
2. From the Availity Learning Center, enroll using one of the following methods:
    1. Select the Dashboard drop-down arrow > Select Catalog > Select Sessions > Select the date of the webinar > Select the webinar title > Select Enroll.
    2. While in the Catalog, select the Search button > Enter the webinar title > Select

Enroll.

Providers who have questions as they begin to use the new functionality should contact Availity at **1-800-282-4548**.

Sepsis diagnosis coding and billing reminder

To help ensure compliance with the coding and billing of Sepsis, Anthem Blue Cross and Blue Shield 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.

Coding Spotlight: Hypertension

***Coding Spotlight: Hypertension* - A providers' guide for coding**

ICD-10-CM coding for hypertension

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 I51.9) 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:
    - o Current smoker: F17.
    - o Personal history of tobacco dependence: Z87.891
    - o Tobacco use: Z72.0
    - o 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 codes4	
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).

The codes and measure tips listed are informational only, not clinical guidelines or standards of medical care, and do not guarantee reimbursement. All member care and related decisions of treatment are the sole responsibility of the provider. This information does not dictate or control your clinical decisions regarding the appropriate care of members. Your state/provider contract(s), Medicaid, member benefits and several other guidelines determine reimbursement for the applicable codes. Proper coding and providing appropriate care decrease the need for high volume of medical record review requests and provider audits. It also helps us review your performance on the quality of care that is provided to our members and meet the HEDIS measure for quality reporting based on the care you provide our members. Please note: The information provided is based on HEDIS 2019 technical specifications and is subject to change based on guidance given by the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS) and state recommendations. Please refer to the appropriate agency for additional guidance.