Indiana Provider News

July 2022 Anthem Provider News - Indiana

Medicaid:

Medicare:

Introducing Elevance Health — Focusing on whole health and its most powerful drivers

Published: Jun 24, 2022 - **Administrative**

I am pleased to announce that our shareholders voted to approve our parent company's name change from Anthem, Inc. to **Elevance Health, Inc. (NYSE Ticker Symbol — ELV) effective June 28, 2022**.

Here is what you can expect:

- **A bold new vision for the future of health.** We chose the name Elevance Health to better reflect our business as we **elevate** the importance of whole health and **advance** health beyond healthcare for consumers, their families, and our shared communities. This new vision fuels our transformation from a traditional health benefits organization to a health company that looks beyond the traditional scope of physical health.

- No action is needed by you, and we remain committed to helping you deliver whole-person care for your patients, our customers. **Importantly, there is no impact or changes to your contract, reimbursement, or level of support. For your patients, it will not change their plan or coverage or change how they receive their medications. Provider networks will not be changing**.

- **A more holistic approach to health that improves affordability and outcomes.** Bringing together a broad portfolio of health plans, including pharmacy, behavioral, clinical, and complex care provider partners, we can deliver integrated, holistic health solutions to meet the increasing needs of our customers and care provider partners. This includes two notable changes:

- **Our healthcare service partners will operate under a new brand called Carelon.** This includes Beacon Health Options, AIM Specialty Health®, CareMore, and IngenioRx. You can find us at **Carelon.com**.

- **IngenioRx, our pharmacy benefit management partner**, will become **CarelonRx** on January 1, 2023. This name change will not impact your patient's benefits, coverage, or how their medications are filled. We will communicate detailed information about this

change soon.

- **A simpler brand portfolio that makes it easier to do business with us.** We have streamlined and simplified the complexity of our health plan and service businesses and reduced the number of brands we have in the market, so our partners and customers clearly understand where we serve, who we serve, and what our brands do.

What does this mean for care providers?
We will operate as Anthem Blue Cross or Anthem Blue Cross and Blue Shield in our 14 Blue-licensed markets. Our existing Anthem-branded health plans are not changing and will continue to operate in their current states. There will be no impact to plans, coverage, or level of support.

Looking forward together
As your partner, we will continue to keep you updated with new information as soon as it becomes available. In the meantime, you can visit us at **ElevanceHealth.com** or contact your provider representative with any questions.

Thank you for joining us on this exciting path forward as we reimagine what is possible for every moment of health.

Sincerely,

Bryony Winn
President, Health Solutions

INBCBS-CDCRCM-001856-22-CPNB1793

URL: https://providernews.anthem.com/indiana/article/introducing-elevance-health-focusing-on-whole-health-and-its-most-powerful-drivers-16

New digital provider enrollment tool added to Availity

Published: Jul 1, 2022 - **Administrative**

Effective April 27, 2022, Anthem Blue Cross and Blue Shield (Anthem) added new functionality to Indiana's provider enrollment tool hosted on the Availity* Portal to further automate and improve your online enrollment experience.

Who can use this new tool?
Professional providers whose organizations do not have a credentialing delegation agreement with Anthem can use this tool.

Note: Providers who submit via roster or have delegated agreements will continue to use the process in place.

How can this new tool be used?

- Add new providers to an already existing group.
- Apply and request a contract. After review, a contract can be sent back to you digitally for an electronic signature. This eliminates the need for paper applications or paper contracts.
- Enroll a new group of providers.
- Use a dashboard for real time status on the submitted applications.
- Create streamlined complete data submission.

How the online enrollment application works
The system automatically accesses CAQH® to pull all updated information you've already included in your CAQH application. The information automatically populates the details Anthem needs to complete the enrollment process (including credentialing and loading new providers to our database). Please ensure that your provider information on CAQH is updated and is in a complete or reattested status.

Availity's online application will guide you through the enrollment process, providing status updates using a dashboard so you know where each provider is in the process without having to call or email for a status update.

Note: For any changes to your practice profile and demographics, continue to use the online *Provider Maintenance Form* that allows you to electronically submit any changes to your practice profile and demographics to Anthem.

Accessing the provider enrollment application

Log on to the Availity Portal and select **Payer Spaces > Anthem Blue Cross and Blue Shield > Applications > Provider Enrollment** to begin the enrollment process.

If your organization is not currently registered for the Availity Portal, the person in your organization designated as the Availity administrator should go to availity.com and select **Register**.

For organizations already using the Availity Portal, your organization's Availity administrator should go to **My Account Dashboard** from the Availity homepage to register new users and update or unlock accounts for existing users. Staff who need access to the provider enrollment tool need to be granted the role of *provider enrollment*. (Availity administrators and user administrators will automatically be granted access to provider enrollment.)

If you are using Availity today and need access to provider enrollment, work with your organization's administrator to update your Availity role. Go to **My Account Dashboard > My Administrators** to determine who your administrator is.

Need assistance with registering for the Availity Portal?
Contact Availity Client Services at **800-AVAILITY** (**800-282-4548**).

INBCBS-CRCM-002669-22/AIN-NU-0372-22-A

URL: https://providernews.anthem.com/indiana/article/new-digital-provider-enrollment-tool-added-to-availity-1

Update to facility editing: HCPCS code G0463

Published: Jul 1, 2022 - **Administrative**

We are enhancing our outpatient facility editing to help align with correct coding guidelines for usage of HCPCS code G0463.

The code description for G0463 is "hospital outpatient clinic visit for assessment and management of a patient". Based on this code description, HCPCS code G0463, should only be billed with revenue codes which support the billing of clinic visits/assessment and management services. When G0463 is billed with an inappropriate revenue code, it will be denied.

For assistance with coding guidelines, the National Uniform Billing Committee (NUBC) is a valuable resource.

MULTI-BCBS-COMM-002028-22-CPN1882

URL: https://providernews.anthem.com/indiana/article/update-to-facility-editing-hcpcs-code-g0463-3

Coding tips for reporting administration of Spravato®

Published: Jul 1, 2022 - **Administrative**

These guidelines are developed to provide helpful information on how to report services to Anthem Blue Cross and Blue Shield (Anthem) for the administration and observation of the drug Spravato®.

Eskatamine is sold under the brand name Spravato® and is indicated for adults with treatment-resistant depression. Based on the prescribing information, patients who have the drug administered in the professional provider's office should be monitored for two hours to assess for complications.

A main component in understanding how to report the administration of this drug is to identify whether the professional provider has purchased the drug for administration or whether the drug has been supplied and reported by a pharmacy. There are specific codes to report for each scenario.

Professional provider purchased and administered:
For professional providers that supply, administer, and provide the required observation of Spravato®, one of the following packaged service codes should be billed and should not include separate billing of the drug or the billing of the post-administration observation:

HCPCS Code	Description
G2082	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified healthcare professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation.
G2083	Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified healthcare professional and provision of greater than 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation.

Note: When Spravato® is being supplied by the outpatient hospital and administered in an outpatient hospital, the facility should bill G2082 and G2083 in conjunction with revenue center code (RCC) 919 and the drug should not be billed separately. In addition, there should not be a separate professional claim submitted as procedure codes G2082 and G2083 describe both the drug and the professional services.

Pharmacy supplied and professional provider administered:
When a pharmacy supplies Spravato® and is reporting this service in a separate claim, the drug should be billed with the HCPCS code, S0013 – Esketamine, nasal spray, 1 mg.

If the provider administering Spravato® did not purchase the drug, then the provider should not report the supply of the drug on their claim, as this will be reported by the pharmacy.

Post-administration observation:
When the provider does not bill a packaged service code (listed above), the professional provider may report an Evaluation and Management (E/M) service including the appropriate prolonged services code.

CPT Codes	Description
99202 – 99205	Office or other outpatient visit for the evaluation and management of a new patient
99212 – 99215	Office or other outpatient visit for the evaluation and management of an established patient
99417	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes

In accordance with the American Medical Association's (AMA's) CPT® Manual, CPT code 99417 should only be billed when reported with CPT codes 99205 and 99215. Medical records must support coding. Please refer to Anthem's *Prolonged Services – Professional* reimbursement policy for additional information.

2090-0522-PN-CNT

URL: https://providernews.anthem.com/indiana/article/coding-tips-for-reporting-administration-of-spravato-6

Help patients heal from the comfort of home with Hospital in Home care

Published: Jul 1, 2022 - **Administrative**

This communication applies to the Commercial and Medicare Advantage programs from Anthem Blue Cross and Blue Shield (Anthem).

In an effort to help deliver on Anthem's purpose to improve the health of humanity, we now have a program for in-home patient care for acute conditions.

Anthem's Hospital in Home program can advise capable, innovative hospital partners in developing their own hospital in home programs. Once implemented, patients can recover in a more comfortable environment, allowing hospitals to keep beds available for patients with more complex needs.

Inpatient level of care in the home can be a welcome alternative to traditional hospital settings. Patients may find acute care at home to be more convenient and less stressful, and studies have shown acute care at home can be safe and allow for smoother transition to self-care management after the acute illness. Hospital in Home clinical trials demonstrate a **25% decrease in readmissions** and a **50% reduction in time spent in bed**.[1]

Anthem's Hospital in Home program has a set of minimum requirements that are designed to promote patient safety. These requirements include aspects of the member's home environment, the clinical scenario, remote monitoring capabilities, and plans for program evaluation.

Please contact your Anthem contracting representative to learn more about Anthem's Hospital in Home program.

1 Levine, D. M., Ouchi, K., Blanchfield, B., Saenz, A., Burke, K., Paz, M., Diamond, K., Pu, C. T., & Schnipper, J. L. (2020). Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Annals of internal medicine, 172(2), 77–85. https://doi.org/10.7326/M19-0600.

MULTI-BCBS-CRCM-001918-22-CPN1554

URL: https://providernews.anthem.com/indiana/article/help-patients-heal-from-the-comfort-of-home-with-hospital-in-home-care-7

CAA: Keep your provider directory information current

Published: Jul 1, 2022 - **Administrative**

Current provider directory information helps Anthem Blue Cross and Blue Shield members find the most up-to-date information available. As a partner in the care of our members, we ask that you review your online provider directory information regularly and provide updates as needed.

If changes are needed, please take the time to update your information by submitting updates and corrections to us on our online Provider Maintenance Form. Online update options include:

- Adding/changing an address location
- Name change
- Tax ID changes
- Provider leaving a group or a single location

- Phone/fax number changes
- Closing a practice location

Once you submit the Provider Maintenance Form, you will receive an email acknowledging receipt of your request. Visit the Provider Maintenance Form landing page for complete instructions.

The Consolidated Appropriations Act (CAA), effective January 1, 2022, contains a provision that requires online provider directory information be reviewed and updated (if needed) at least every 90 days. Thank you for doing your part in keeping our provider directories current.

MULTI-BCBS-COMM-002040-22

URL: https://providernews.anthem.com/indiana/article/caa-keep-your-provider-directory-information-current-4

More potato chips, sugary drinks and less physical activity are key contributors to childhood obesity

Published: Jul 1, 2022 - **Administrative**

In a recent study published by *Pediatrics,* economic hardship, school closing, and shutdowns led to sedentary lifestyles and increases in childhood obesity. The research analyzed doctor visits pre-pandemic then during the pandemic period, and the increases were dramatic. Overall obesity increased from 13.7% to 15.4% in patients 5 to 9 years. Increases from 1% in children aged 13 to 17 to 2.6% for those aged 5 to 9 years were observed.

The study recommended new approaches to Weight Assessment and Counseling. These include recommending virtual activities that promote increased physical activity. Focusing on ways to remain safe and active with outside activities, such as park visits, walks, and bike riding were also suggested.

The Centers for Disease Control and Prevention has a great resource called *Ways to Promote Health with Preschoolers*. This fun flyer shows how we can all work together to support a healthy lifestyle. You can download a copy here.

The HEDIS® measure *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* requires a nutritional evaluation and pro-active guidance as part of a routine health visit.

- When counseling for nutrition, document current nutritional behavior, such as meal patterns, eating and diet habits, and weight counseling.
- When counseling for physical activity, document current physical activity behavior, such as exercise routine, participation in sports activities, bike riding and play groups.
- Handouts about nutrition and physical activity also count toward meeting this HEDIS measure when documented in the member's health record.

HEDIS® measure WCC looks at the percentage of members, 3 to 17 years of age, who had an outpatient visit with a PCP or OB/GYN and have documented evidence for all the following during the measurement year:

- Body mass index (BMI) percentile (percentage, not value)
- Counseling for nutrition
- Counseling for physical activity

Telehealth, virtual check-in, and telephone visits all meet the criteria for nutrition and physical activity counseling. Counseling does not need to take place only during a well-visit, WCC can also be completed during sick visits. Documenting guidance in your patient's records is key.

Code services correctly to measure success
These diagnosis and procedure codes are used to document BMI percentile, weight assessment, and counseling for nutrition and physical activity:

Description	CPT®	ICD-10-CM	HCPCS
BMI percentile		Z68.51 – Z68.54	
Counseling for nutrition	97802, 97803, 97804	Z71.3	G0270, G0271, G0447, S9449, S9452, S9470
Counseling for physical activity		Z02.5, Z71.82	G0447, S9451
Codes to identify outpatient visits	99201 – 99205, 99211 – 99215, 99241 – 99245, 99341 – 99345, 99347 – 99350, 99381 – 99387, 99391 – 99397, 99401 – 99404, 99411, 99412, 99429, 99455, 99456, 99483		G0402, G0438, G0439, G0463, T1015

Reference: American Academy of Pediatrics. American Academy of Pediatrics raises concern about children's nutrition and physical activity during pandemic. Available at: http://services.aap.org/en/news-room/news-releases/aap/2020/american-academy-of-pediatrics-raises-concern-about-childrens-nutrition-and-physical-activity-during-pandemic/. Accessed December 10, 2020.

MULTI-BCBS-CM-002326-22-CPN1916

URL: https://providernews.anthem.com/indiana/article/more-potato-chips-sugary-drinks-and-less-physical-activity-are-key-contributors-to-childhood-obesity-5

Clearing up coding confusion for diabetic retinal screenings

Published: Jul 1, 2022 - **Administrative**

3072F: new language about two-year compliance

The Comprehensive Diabetes Care HEDIS® measure Diabetic Retinal Eye Exam (DRE) valuates the percent of adult members ages 18 to 75, with diabetes (type 1 and type 2), who had a retinal eye exam during the measurement year.

Changes to 3072F

The definition for the code 3072F (negative for retinopathy) has been redefined to *low risk for retinopathy (no evidence of retinopathy in the prior year).* This can be particularly confusing because it would not be used at the time of the exam. It would be used the following year, along with the exam coding for the current year, to indicate that retinopathy was not present the previous year.

A simpler coding solution

Using these three codes count toward the DRE measurement if they are billed in the current measurement year **or** the prior year. This means you can submit the appropriate code at the time of the exam, and it covers both years:

2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (DM)
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)

For more about diabetic retinopathy, visit CMS.gov or use this link to read more.

Meeting the measurement for all diabetes care

These exams are also important in evaluating the overall health of diabetic patients, as well as meeting the Comprehensive Diabetes Care HEDIS measure:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (> 9.0%)
- HbA1c control (< 8.0%)
- Retinal Eye exam performed
- Blood Pressure control (< 140/90 mm Hg)

Record your efforts in the member's medical records for the HbA1c tests and results, retinal eye exam, blood pressure, urine creatinine test, and the estimated glomerular filtration rate test. Meeting the mark and closing gaps in care is key to good health outcomes.

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

MULTI-BCBS-COMM-002331-22-CPN1921

URL: https://providernews.anthem.com/indiana/article/clearing-up-coding-confusion-for-diabetic-retinal-screenings-4

Coming soon: The Anthem Provider Learning Hub makes Availity learning easier

Published: Jul 1, 2022 - **Administrative** / Digital Tools

Anthem Blue Cross and Blue Shield (Anthem) is setting up a new digital education platform called the **Provider Learning Hub**. Initially, the Provider Learning Hub will include how-to instructions for Availity* registration and onboarding. Our first featured training is focused on the *Attachment* application with special emphasis on new processes that should make submitting attachments more efficient.

You can access the new Provider Learning Hub from the home page on our public website under **Important Announcements** in mid-July.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

MULTI-BCBS-COMM-002393-22

URL: https://providernews.anthem.com/indiana/article/coming-soon-the-anthem-provider-learning-hub-makes-availity-learning-easier-1

Enhancing claims attachment processes through the digital application Claims Status Inquiry

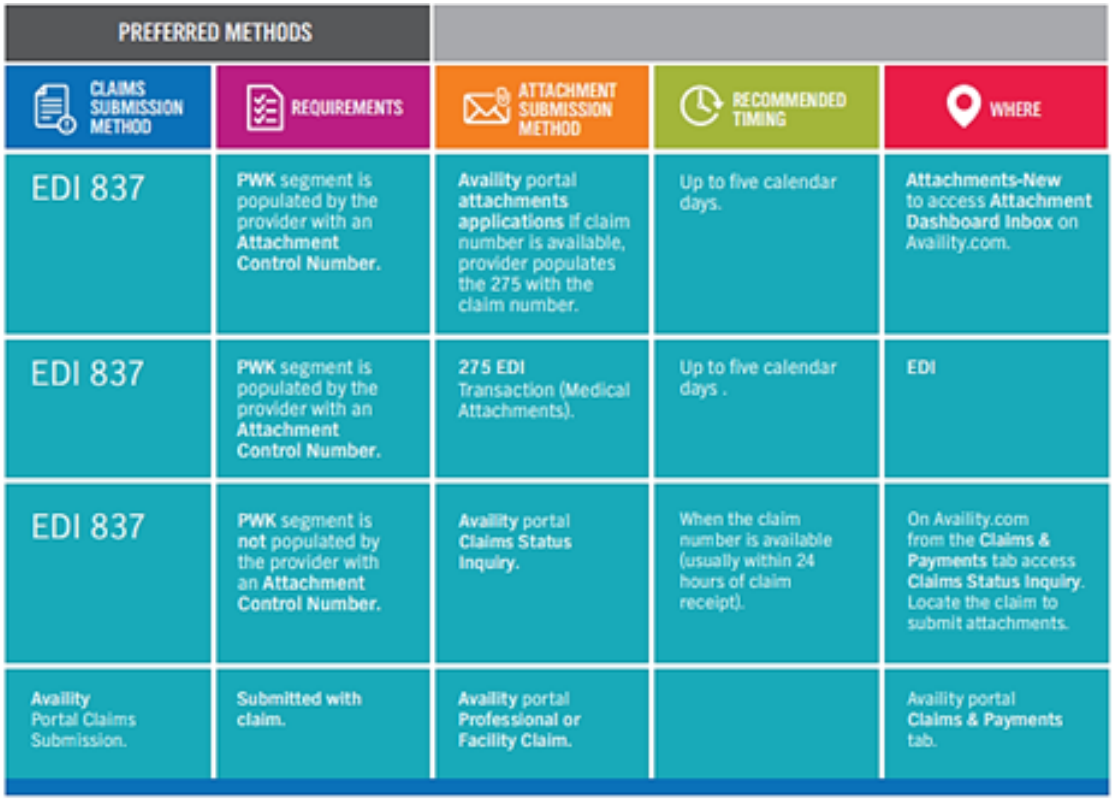
Published: Jul 1, 2022 - **Administrative** / Digital Tools

Submitting attachments electronically is the most efficient way for you to receive your claim payments faster. That’s why we have been hard at work making the digital attachment process easier, more intuitive and streamlined. We’re preparing to launch an enhancement to the Claims Status Inquiry application that will enable you to submit claims attachments directly to the claim from Availity.com.

Submitting attachments electronically:

- Reduces costs associated with manual submission
- Reduces errors associated with matching the claim when attachments are submitted manually
- Reduces delays in payments
- Saves time: No need to copy, fax, or mail
- Reduces the exchange of unnecessary member information and too much personal health information sharing

If your workflow for attachments is through EDI submissions or directly through the Availity application, we have a solution for that.



PREFERRED METHODS				
CLAIMS SUBMISSION METHOD	REQUIREMENTS	ATTACHMENT SUBMISSION METHOD	RECOMMENDED TIMING	WHERE
EDI 837	**PWK** segment is populated by the provider with an **Attachment Control Number.**	**Availity** portal **attachments applications** If claim number is available, provider populates the 275 with the claim number.	Up to five calendar days.	**Attachments-New** to access **Attachment Dashboard Inbox** on Availity.com.
EDI 837	**PWK** segment is populated by the provider with an **Attachment Control Number.**	**275 EDI** Transaction (Medical Attachments).	Up to five calendar days .	**EDI**
EDI 837	**PWK** segment is **not** populated by the provider with an **Attachment Control Number.**	**Availity** portal **Claims Status Inquiry.**	When the claim number is available (usually within 24 hours of claim receipt).	On Availity.com from the **Claims & Payments** tab access **Claims Status Inquiry.** Locate the claim to submit attachments.
Availity Portal Claims Submission.	**Submitted with claim.**	**Availity** portal **Professional or Facility Claim.**		Availity portal **Claims & Payments** tab.

Didn’t submit your attachment with your claim? No problem!
If you submitted your claim through EDI using the 837, and the PWK segment contains the Attachment Control Number, there are three options for submitting attachments:

1. Through the Attachments Dashboard Inbox

- From com, select the Claims & Payments tab to access Attachments – New and your Attachments Dashboard Inbox

1. Through the 275 attachment

- Important: you must populate the PWK segment on the 837 with your document control number to ensure the claim can match to the attachment

1. Through the Availity.com application

Article Attachments

- From com, select the Claims & Payments tab to run a Claims Status Inquiry to locate your claim. When you have found your claim, use the Send

If you submitted your claim through the Availity application:

1. Simply submit your attachment with your claim
2. If you need to add additional attachments, to add a forgotten attachment, or for claims adjustments:

    - From Availity.com, select the Claims & Payments tab and run a Claims Status Inquiry to locate your claim. When you have found your claim, use the Send Attachments button.

For more information and educational webinars
In collaboration with Availity, we will hold a series of educational webinars that includes a deep dive into EDI attachment submissions, as well as the new Claims Status Inquiry workflow. Sign up today.

MULTI-BCBS-COMM-002397-22

URL: https://providernews.anthem.com/indiana/article/enhancing-claims-attachment-processes-through-the-digital-application-claims-status-inquiry

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Enhanced reimbursement for voluntary Cancer Care Quality program to be discontinued effective December 31, 2022

Published: Jul 1, 2022 - **Products & Programs**

Effective December 31, 2022, the enhanced reimbursement billing opportunity (S-codes) for medical oncologists selecting on-pathway drug regimens as part of the AIM Specialty Health®* Medical Oncology Solution/ Cancer Care Quality Program (CCQP) chemotherapy authorization process will be discontinued.

The CCQP S-codes S0353 and S0354 were activated on July 1, 2014, and have supported providers with member care coordination, and adoption of optimal, evidence-based oncology drug regimens.

The CCQP/AIM pathways will continue to enable the delivery of clinically appropriate cancer treatment, and supportive medication that ensures members receive high-quality, patient-centered care. The AIM pathways will remain available to medical oncologists and related subspeciality providers via the AIM provider website.

As the CCQP continues to evolve, the program will become a key component of more comprehensive value-based cancer care improvement initiatives, including the Oncology Medical Home Plus (OMH+) program, launching on July 1, 2022, and January 1, 2023.

Contact your Anthem Blue Cross and Blue Shield network representative or your oncology provider engagement liaison for more information.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield.

MULTI-BCBS-COMM-002022-22

URL: https://providernews.anthem.com/indiana/article/enhanced-reimbursement-for-voluntary-cancer-care-quality-program-to-be-discontinued-effective-december-31-2022-6

Pharmacy information available at anthem.com

Published: Jul 1, 2022 - **Products & Programs** / Pharmacy

Visit the Drug Lists page on anthem.com for more information on:

- Copayment/coinsurance requirements and their applicable drug classes
- Drug lists and changes
- Prior authorization criteria
- Procedures for generic substitution
- Therapeutic interchange
- Step therapy or other management methods subject to prescribing decisions
- Any other requirements, restrictions, or limitations that apply to using certain drugs

The commercial drug list is posted to the website 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.

MULTI-BCBS-COMM-002038-22

URL: https://providernews.anthem.com/indiana/article/pharmacy-information-available-at-anthemcom-44

New reimbursement policy: Transitional Care Management - professional

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

Anthem Blue Cross and Blue Shield (Anthem) has added value to the Transitional Care Management definition to include discharge from the emergency room to help prevent future emergency room encounters or hospital admissions.

As of April 27, 2022, Anthem implemented a new professional reimbursement policy: Transitional Care Management. When a member requires a transition to a community setting, the Transitional Care Management period begins upon the member's discharge and continues for 29 days.

For specific policy details, visit the reimbursement policy page at anthem.com provider website.

MULTI-BCBS-COMM-002024-22

URL: https://providernews.anthem.com/indiana/article/new-reimbursement-policy-transitional-care-management-professional-3

New reimbursement policy: Modifier FB - Professional and Facility*

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

Change to Prior Authorization Requirements

Beginning with dates of service on or after October 1, 2022, Anthem Blue Cross and Blue Shield (Anthem) will implement a new professional and facility reimbursement policy titled, *Modifier FB — Professional and Facility*. Modifier FB should be appended to all devices, supplies, or drugs obtained at no cost to the provider. Services appended with modifier FB are not eligible for reimbursement.

In addition, modifier FB has been removed from the *Modifier Rules — Professional* policy.

For specific policy details, visit the reimbursement policy page at anthem.com provider website.

MULTI-BCBS-COMM-002041-22

URL: https://providernews.anthem.com/indiana/article/new-reimbursement-policy-modifier-fb-professional-and-facility-2

Reimbursement policy update: Modifier Rules - Professional*

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

Change to Prior Authorization Requirements

Beginning with dates of service on or after October 1, 2022, Anthem Blue Cross and Blue Shield (Anthem) will update the Modifiers Impacting Adjudication code list to not allow reimbursement for CPT® code 99211 when appended with a modifier 25.

For specific policy details, visit the reimbursement policy page at anthem.com provider website.

MULTI-BCBS-COMM-002043-22

URL: https://providernews.anthem.com/indiana/article/reimbursement-policy-update-modifier-rules-professional-10

Reimbursement policy update: Laboratory and venipuncture services - professional and facility*

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

Change to Prior Authorization Requirements

Beginning with dates of service on or after October 1, 2022, the Anthem Blue Cross and Blue Shield Laboratory and Venipuncture Services policy is expanded to include facility providers. The related coding section is updated to clarify coding for professional and facility providers.

Facility providers are not eligible for separate reimbursement for the following select specimen-handling CPT®/HCPCS codes: 99000, 99001, H0048, P9603, and P9604. In addition, the Related Coding section I in the Bundled Services and Supplies policy is updated to remove these codes.

For specific policy details, visit the reimbursement policy page at anthem.com provider website.

MULTI-BCBS-COMM-002042-22

URL: https://providernews.anthem.com/indiana/article/reimbursement-policy-update-laboratory-and-venipuncture-services-professional-and-facility-1

Reimbursement policy update: Place of Service - Facility*

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

Change to Prior Authorization Requirements

Beginning with dates of service on or after October 1, 2022, Anthem Blue Cross and Blue Shield will update the policy language to indicate the following:

- The title of the policy will be renamed to *Place of Service – Facility* from *Place of Service Evaluation and Management Services – Facility*.
- Professional services billed under revenue codes 960-983 are non-reimbursable when submitted on a UB-04.

- Preventive Counseling CPTs 99406–99409, 99411, and 99412 are non-reimbursable when billed in an outpatient setting.

As a reminder, Evaluation and Management (E/M) services and professional services (excluding evaluation and management services rendered in the emergency room and billed with ER revenue codes) are required to be billed on a CMS 1500 form.

For specific policy details, visit the reimbursement policy page at anthem.com provider website.

MULTI-BCBS-COMM-001884-22

URL: https://providernews.anthem.com/indiana/article/reimbursement-policy-update-place-of-service-facility-1

Retraction for reimbursement policy: Sexually Transmitted Infections - Professional

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

In September 2021 edition of *Provider News*, we announced that a new commercial reimbursement policy titled *Sexually Transmitted Infections – Professional* would be effective for dates of service on or after December 1, 2021. We have made a decision to retract this reimbursement policy.

MULTI-BCBS-COMM-002035-22

URL: https://providernews.anthem.com/indiana/article/retraction-for-reimbursement-policy-sexually-transmitted-infections-professional-7

Reimbursement policy update: Distinct Procedural Service, Modifiers 59, XE, XP, XS, XU - professional*

Published: Jul 1, 2022 - **Policy Updates** / Reimbursement Policies

Change to Prior Authorization Requirements

Beginning with dates of service on or after October 1, 2022, Anthem Blue Cross and Blue Shield will implement the following:

- 96365, 96369, 96372, 96373, 96374, 96379 will deny when reported with 78265, 78830 or 78835
- 95957 will deny when reported with 95700 on the same day:
    - The reference to subsequent dates of service was removed from this code pair.

For specific policy details, visit the reimbursement policy page at anthem.com provider website.

MULTI-BCBS-COMM-002032-22-CPN1910

URL: https://providernews.anthem.com/indiana/article/reimbursement-policy-update-distinct-procedural-service-modifiers-59-xe-xp-xs-xu-professional-1

Keep up with Medicaid News - July 2022

Published: Jul 1, 2022 - **State & Federal** / Medicaid

Please continue to check Provider Communications & Updates on the provider webpage for the latest information, including:

- Billing for non-reimbursable implantable DME devices

URL: https://providernews.anthem.com/indiana/article/keep-up-with-medicaid-news-july-2022-2

Evaluation and management services for COVID testing - professional

Published: Jul 1, 2022 - **State & Federal** / Medicaid

Effective with dates of service on or after October 1, 2022, Anthem will facilitate review of selected claims for COVID-19 visits reported with evaluation and management (E/M) services submitted by professional providers to align with CMS reporting guidelines. When the purpose of the visit is for COVID-19 testing only, reimbursement for CPT® code 99211 (office or other outpatient visit) is allowed when billed with place of service office (11), mobile unit (15), walk-in retail health clinic (17), or urgent care facility (20). Claims for exposure only may be affected. Professional providers are encouraged to code their claims to the highest level of specificity in accordance with ICD-10 coding guidelines.

Prior to payment, Anthem will review the selected claims to determine, in accordance with correct coding requirements and/or reimbursement policy as applicable, whether the E/M code level submitted is appropriate for the COVID-19 visit reported. If the visit is determined to be solely for the purpose of COVID-19 testing, Anthem will reimburse using CPT code 99211.

Professional providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E/M service will be able to follow the Claims Payment Dispute process (including submission of such documentation with the dispute) as outlined in the provider manual.

If you have questions on this program, contact your Provider Experience representative.

AIN-NU-0376-22

URL: https://providernews.anthem.com/indiana/article/evaluation-and-management-services-for-covid-testing-professional-11

Keep up with Medicare News - July 2022

Published: Jul 1, 2022 - **State & Federal** / Medicare

Please continue to read news and updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- New specialty pharmacy medical step therapy requirements

URL: https://providernews.anthem.com/indiana/article/keep-up-with-medicare-news-july-2022-4

Update use of Modifier 25 for billing for visits that include preventive services and problem-oriented evaluation and management services

Published: Jul 1, 2022 - **State & Federal** / Medicare

Beginning with claims processed on or after August 1, 2022, Anthem Blue Cross and Blue Shield will implement additional steps to review claims for evaluation and management (E/M) services submitted by professional providers when a preventive service (CPT® codes 99381 to 99397) is billed with a problem-oriented E/M service (CPT codes 99202 to 99215) and appended with Modifier 25 (for example, CPT code 99393 billed with CPT code 99213 to 99225).

According to the American Medical Association (AMA) CPT Guidelines, E/M services must be “significant and separately identifiable” in order to appropriately append Modifier 25. Based upon review of the submitted claim information, if the problem-oriented E/M service is determined not to be a significant, separately identifiable service from the preventive service, the problem-oriented E/M service will be bundled with the preventive service.

Providers that believe their medical record documentation supports a significant and separately identifiable E/M service should follow the Claims Payment Dispute process (including submission of such with the dispute) as outlined in the provider manual.

If you have questions on this program, contact your contract manager or Provider Experience.

ABSCRNU-0342-22

URL: https://providernews.anthem.com/indiana/article/update-use-of-modifier-25-for-billing-for-visits-that-include-preventive-services-and-problem-oriented-evaluation-and-management-services-8

Cancer Care Navigator

Published: Jul 1, 2022 - **State & Federal** / Medicare

The Cancer Care Navigator (CCN) program is a comprehensive cancer support solution for oncologists and Anthem Blue Cross and Blue Shield (Anthem) members who are at high risk for complications during treatment. This program is aimed at helping to simplify the complexities of cancer care for members.

Practices are given a single point of contact to connect the practice to the right people at Anthem to help lessen administrative burdens. CCN also gives the practice access to Anthem's advanced predictive analytics to help identify patients at high risk for complications, in turn allowing providers the opportunity to take preventive action and guide targeted interventions.
Patients are provided with a wealth of support through supplemental services (dietitians, pharmacists, etc.), medication adherence assistance, individualized care plans, and goal setting, as well as after-hours telephonic and digital support.

CCN is the ultimate support service to improve the care experience and quality of life to allow patients time to focus on overall health and well-being. Please feel free to reach out to the CCN team at **866-649-0669**.

MULTI-BCBS-CARE-001242-22

URL: https://providernews.anthem.com/indiana/article/cancer-care-navigator-18

Reminder: Authorizations for post-acute care services for Medicare Advantage individual, Group retiree solutions, and Dual-eligible plan members

Published: Jul 1, 2022 - **State & Federal** / Medicare

For services beginning on July 1, 2022, prior authorization requests for admission to or concurrent stay in a skilled nursing facility (SNF), an inpatient acute rehab facility (IRF), or a long-term acute care hospital (LTACH) will be reviewed by myNEXUS.* Through this program, myNEXUS clinicians will collaborate with members, caregivers, and facility care managers/discharge planners to provide transition planning, as well as the pre-service and concurrent review authorizations of post-acute care services. The goal of this program is to support members through their recovery process in the most appropriate, least restrictive environment.

How to submit or check a prior authorization request

For SNF, IRF, or LTACH admissions, myNEXUS will begin receiving requests on Wednesday, June 29, 2022, for members whose anticipated discharge date is July 1, 2022, or after.

Providers are encouraged to request authorization using NexLync. Go to the MyNEXUS portal to get started. You can upload clinical information and check the status of your requests through this online tool seven days a week, 24 hours a day. If you are unable to use the link or website, you can call the myNEXUS Provider Call Center at **844-411-9622** during normal operating hours from 8 a.m. to 8 p.m. ET, Monday through Friday, or send a fax to myNEXUS at **833-311-2986**.

Note: Anthem Blue Cross and Blue Shield (Anthem) will continue to review authorization requests for durable medical equipment (DME), ambulance, and other related services that do not fall under Medicare-covered home healthcare services, such as home infusion, hospice, outpatient therapy, or supplemental benefits that help with everyday health and living such as personal home helper services offered under essential/everyday extras.

To learn more about myNEXUS and upcoming training webinars, visit www.myNEXUScare.com/Anthem or email us at Provider_Network@myNEXUScare.com.

If you have additional questions, please call the myNEXUS Provider Call Center at **844-411-9622**.

*Concurrent stay review requests for members admitted to SNF, IRF or LTACH facilities **prior to** July 1, 2022, should be directed to Anthem.*

* myNEXUS is an independent company providing long term hospital care on behalf of Anthem Blue Cross and Blue Shield.

ABSCRNU-0346-22

URL: https://providernews.anthem.com/indiana/article/reminder-authorizations-for-post-acute-care-services-for-medicare-advantage-individual-group-retiree-solutions-and-dual-eligible-plan-members

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New digital provider enrollment tool added to Availity

Published: Jul 1, 2022 - **State & Federal** / Medicare

Effective April 27, 2022, Anthem Blue Cross and Blue Shield (Anthem) added new

Who can use this new tool?
Professional providers whose organizations do not have a credentialing delegation agreement with Anthem can use this tool.

Note: Providers who submit via roster or have delegated agreements will continue to use the process in place.

How can this new tool be used?

- Add new providers to an already existing group.
- Apply and request a contract. After review, a contract can be sent back to you digitally for an electronic signature. This eliminates the need for paper applications or paper contracts.
- Enroll a new group of providers.
- Use a dashboard for real time status on the submitted applications.
- Create streamlined complete data submission.

How the online enrollment application works
The system automatically accesses CAQH® to pull all updated information you've already included in your CAQH application. The information automatically populates the details Anthem needs to complete the enrollment process (including credentialing and loading new providers to our database). Please ensure that your provider information on CAQH is updated and is in a complete or reattested status.

Availity's online application will guide you through the enrollment process, providing status updates using a dashboard so you know where each provider is in the process without having to call or email for a status update.

Note: For any changes to your practice profile and demographics, continue to use the online *Provider Maintenance Form* that allows you to electronically submit any changes to your practice profile and demographics to Anthem.

Accessing the provider enrollment application
Log on to the Availity Portal and select **Payer Spaces > Anthem Blue Cross and Blue Shield > Applications > Provider Enrollment** to begin the enrollment process.

If your organization is not currently registered for the Availity Portal, the person in your organization designated as the Availity administrator should go to availity.com and select **Register**.

For organizations already using the Availity Portal, your organization's Availity administrator should go to **My Account Dashboard** from the Availity homepage to register new users and update or unlock accounts for existing users. Staff who need access to the provider enrollment tool need to be granted the role of *provider enrollment*. (Availity administrators and user administrators will automatically be granted access to provider enrollment.)

If you are using Availity today and need access to provider enrollment, work with your organization’s administrator to update your Availity role. Go to **My Account Dashboard > My Administrators** to determine who your administrator is.

Need assistance with registering for the Availity Portal?
Contact Availity Client Services at **800-AVAILITY** (**800-282-4548**).

INBCBS-CRCM-002669-22/AIN-NU-0372-22-A

URL: https://providernews.anthem.com/indiana/article/new-digital-provider-enrollment-tool-added-to-availity-2
