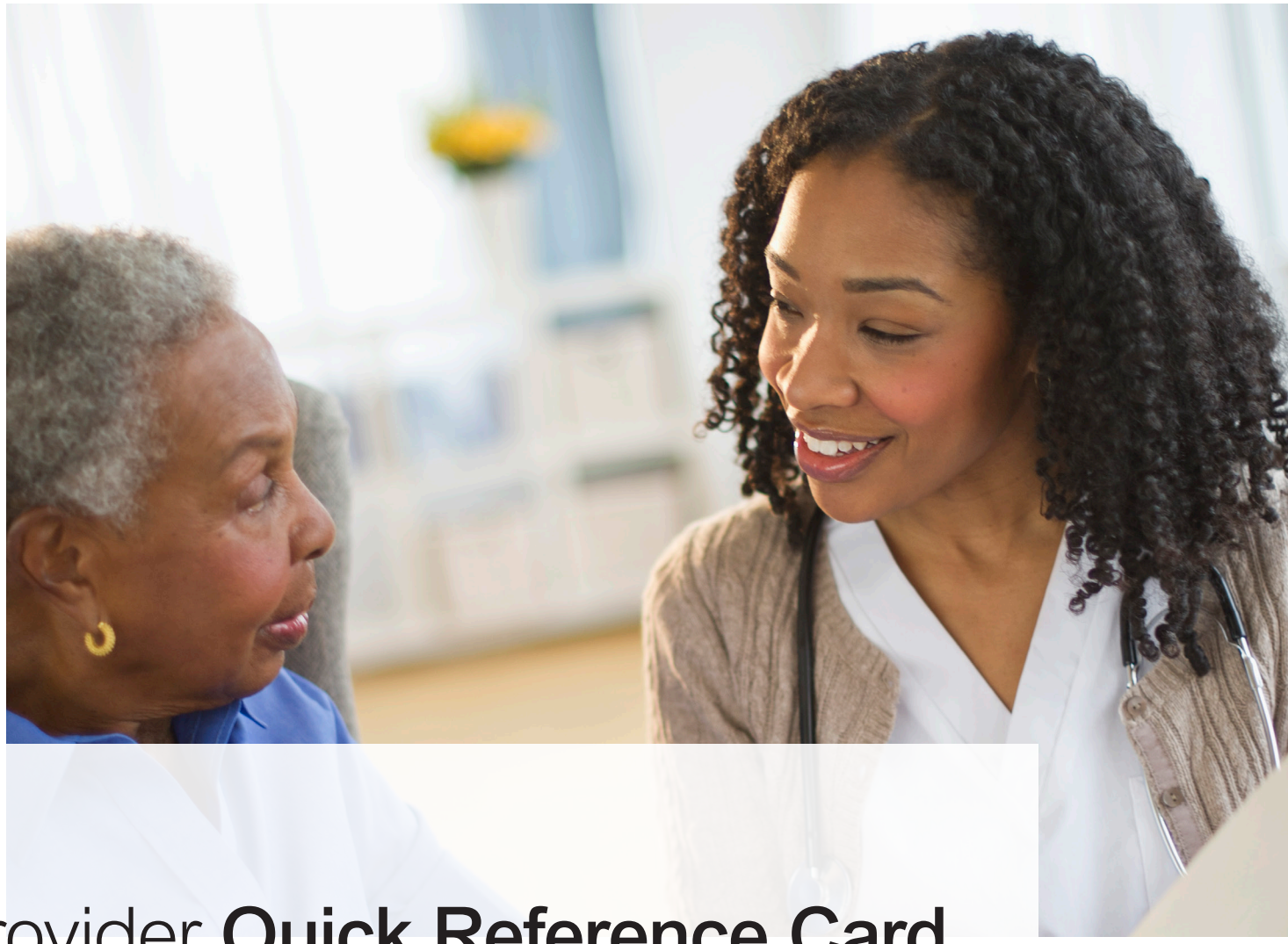
Anthem Blue Cross and Blue Shield Healthcare Solutions |
Medicaid Managed Care



Provider **Quick Reference Card**

Prior Authorization/notification requirements | Important phone numbers | Revenue codes

Nevada Medicaid and Nevada Check Up

providers.anthem.com/nv

Easy access to prior authorization/notification requirements and other important information for Anthem

For more information about requirements, benefits, and services, visit our provider website to get the most recent, full version of our provider manual.

If you have questions about this quick reference card (QRC), call Provider Services at **844-396-2330**.

Prior authorization/notification instructions and definitions

Request prior authorizations and give us notifications:

- Log in to Availity Essentials From Availity's home page, select **Patient Registration**, then **Authorizations & Referrals**.
- By phone: **844-396-2330**
- By fax: **800-964-3627**
- For behavioral health requests, they should be submitted using our preferred digital method at **Availity.com**. If you prefer to paper fax, use correct forms at **providers.anthem.com/nv**.

Prior authorization — the act of authorizing specific services or activities before they are rendered or occur

Notification — telephonic, fax, or electronic communication received from a provider to inform us of his or her intent to render covered medical services to a member:

- Give us notification prior to rendering services outlined in this document.
- For emergency or urgent services, give us notification within 24 hours or the next business day if a member is admitted.
- There is no review against medical necessity criteria; however, we verify member eligibility and provider status (network and non-network).

For code-specific requirements for all services, visit **providers.anthem.com/nv** and select **Prior Authorization & Claims** from the menu.

Requirements listed are for network providers. In many cases, out-of-network providers may be required to request prior authorization for services when network providers do not.

If services are rendered when prior authorization has been denied or not obtained claims may deny.

For any claim denials, the dispute and appeal process must be followed or denials will stand. Learn more about disputes in the **Payment Dispute** section of this QRC, by visiting our website **providers.anthem.com/nevada-provider/claims/claims-submissions-and-disputes**, or by calling Provider Services **844-396-2330**.

Behavioral health/substance abuse services:

- Prior authorization is required for coverage of inpatient mental health and substance use disorder services.
- Residential substance use disorder detox requires prior authorization and is only available for members under age 21.
- Partial hospitalization and intensive outpatient services require prior authorization.
- No prior authorization is required for the coverage of traditional office-based outpatient services such as individual, group and family therapies, and medication management.
- Certain rehabilitation services (such as basic skills training, psychosocial rehabilitation, and day treatment) require prior authorization or notification. Contact **844-396-2330** for information about specific prior authorization requirements.
- Psychological and neuropsychological testing require prior authorization. The *Request for Authorization — Psychological Testing* form is located on our website.
- Electroconvulsive therapy (ECT) requires prior authorization.

Cardiovascular devices

Prior authorization is required for cardioverters, defibrillators, pacemaker insertions, and ventricular access devices.

Chemotherapy:

- Prior authorization is required for coverage of inpatient chemotherapy services.
- No prior authorization is required for coverage of chemotherapy procedures when performed in outpatient settings by a participating facility, provider office, outpatient hospital, or ambulatory surgery center.

For information on prior authorization requirements for (and coverage of) chemotherapy drugs, see the **Pharmacy** section of this QRC.

Circumcision

Prior authorization is not required up to 1 year of age.

Dermatology services:

- No prior authorization is required for network providers for evaluation and management (E&M), testing, and most procedures.
- Prior authorization is required for wound closure and repair.
- Services considered cosmetic in nature are not covered.
- Services related to previous cosmetic procedures are not covered.

See the **Diagnostic testing** section of this QRC.

Diagnostic testing:

- No prior authorization is required for routine diagnostic testing.
- Prior authorization is required for coverage of magnetic resonance angiograms, MRIs, computerized axial tomographies, positron emission tomographies, and nuclear cardiac scans, video electroencephalograms, and sleep studies.

Durable medical equipment (DME):

- No prior authorization is required for coverage of glucometers dialysis and end-stage renal disease equipment, standard walkers, blood pressure aids, or equipment supplied by network providers.
- Prior authorization is required for all rental DME equipment.
- Prior authorization is required for coverage of certain prosthetics, orthotics and DME. For code-specific prior authorization requirements for DME, prosthetics and orthotics ordered by network providers or network facilities, please refer to our provider website. See **Medical Supplies** for guidelines relating to disposable medical supplies.
- All custom wheelchair requests require an Anthem medical director's review.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) visit:

- Members may self-refer for these services.
- Use the EPSDT schedule and document visits.
- Vaccine serum is received under the Vaccines for Children program.

Emergency services

No prior authorization or notification is required for emergency care given in the ER. If emergency care results in admission, notification to Anthem is required within five business days.

For observation prior authorization requirements, see the **Observation** section of this QRC.

Ear, nose, and throat services (ENT) or otolaryngology:

- No prior authorization is required for network providers for E&M, testing, or certain procedures.
- Prior authorization is required for many services. Refer to our Prior Authorization Lookup Tool at **providers.anthem.com/nv**.

See the **Diagnostic testing** section of this QRC.

Family planning/STD care

Members may self-refer to an in-network or out-of-network provider.

Gastroenterology services:

- No prior authorization is required for network providers for E&M, testing, or certain procedures.
- Prior authorization is required for bariatric surgery (including insertion, removal, and replacement of adjustable gastric restrictive devices), endoscopy, and subcutaneous port components.

See the **Diagnostic testing** section of this QRC.

Gynecology:

- Members may self-refer to network providers.
- No prior authorization is required for E&M, testing, and most procedures.
- Prior authorization is required for repair and services considered cosmetic in nature.

See the **Diagnostic testing** section of this QRC.

Habilitative services:

- Habilitative services include services and devices provided to help a member prevent deterioration of a skill or function, maintain a skill or function, or attain a skill or function never learned or acquired due to a disabling condition.
- Maintenance therapy, covered under habilitative services, includes the skilled therapy necessary for maintenance and development of a safety therapy plan.
- Requirements include a plan of care addressing a condition for which therapy is an accepted method of treatment as defined by standards of medical practice.
- Requirements include a plan of care for a condition that establishes a safe and effective skilled maintenance program.

Prior authorization requirements:

- Habilitative Services are a Nevada Medicaid carve out with State oversight.

Hearing aids

Prior authorization is required for digital hearing aids.

Hearing screening

No notification or prior authorization is required by network providers for coverage of diagnostic and screening tests, hearing aid evaluations, or counseling.

Home healthcare:

- Prior authorization is required.
- Covered services include skilled nursing; home health aide; physical, occupational, and speech therapy services; and physician-ordered supplies.
- Skilled nursing and home health aides require prior authorization. See the **Rehabilitation therapy** section of this QRC.
- Drugs and DME require separate prior authorization. See the **DME** and **Pharmacy** sections of this QRC for more information.

Hospital admission:

- Elective and nonemergent admissions require prior authorization for coverage.
- Emergency admissions require notification within five business days.
- To be covered, preadmission testing must be performed by an Anthempreferred lab vendor or network facility outpatient department. See your *Provider Referral Directory* for a complete listing of participating vendors.
- Rest cures, personal comfort, and convenience items, and services and supplies not directly related to the care of the patient (such as telephone charges, take-home supplies, and similar costs) are not covered.

Hysterectomies:

- Hysterectomies are not covered for the sole purpose of sterilization.
- Hysterectomy consent forms are required for all provider types. Sterilization forms are not required for anesthesiology providers only. Forms can be found at **medicaid.nv.gov/Downloads/provider/FA-50.pdf**.

Laboratory services (outpatient):

- All laboratory services furnished by non-network providers require prior authorization except for hospital laboratory services in the event of an emergency medical condition.
- For offices with limited or no office laboratory facilities, lab tests may be referred to one of the Anthem-preferred lab providers. See your *Provider Referral Directory* for a complete listing of participating providers.

Long-term care

Prior authorization and plan of care are required. Anthem is responsible for the first 180 days of a nursing facility stay. On and after day 181, Medicaid Fee-For-Service covers the stay.

Medical supplies

No prior authorization is required for coverage of disposable medical supplies. Disposable medical supplies are disposed of after use by a single individual.

Musculoskeletal services

Prior authorization is required for arthroscopy, arthrodesis, arthroplasty (including total disc), and vertebroplasty.

Neurology:

- No prior authorization is required for network providers for E&M and testing.
- Prior authorization is required for neurosurgery, spinal fusion, or artificial intervertebral disc surgery.

See the **Diagnostic testing** section of this QRC.

Observation:

- Observation admissions up to 48 hours do not require prior authorization and are allowed per the *Nevada Medicaid Services Manual*. Observation beyond 48 hours is not covered. If observation results in admission, notification to Anthem is required within five business days.

Obstetrical (OB) care:

- No prior authorization is required for coverage of OB services, including OB visits, certain diagnostic tests and laboratory services when performed by a participating provider.
- Notification to Anthem is required at the **first** prenatal visit. No prior authorization is required for coverage of labor/delivery or for circumcision for male newborns up to and including 1 year of age.
- Notification of delivery is required within 24 hours with newborn information (such as baby's sex, weight, gestational age, and disposition at birth).
- OB and Neonatal Intensive Care Unit (NICU) case management programs are available to members.

See the **Diagnostic testing** section of this QRC.

Ophthalmology:

- No prior authorization is required for E&M, testing, or certain procedures.
- Prior authorization is required for repair of eyelid defects.
- Services considered cosmetic in nature are not covered.

See the **Diagnostic testing** section of this QRC.

Oral maxillofacial

Prior authorization is required. Temporomandibular joint (TMJ) syndrome-related services are not covered.

See the **Plastic/cosmetic/reconstructive surgery** section of this QRC.

Otolaryngology (ENT) services

See the **ENT services or otolaryngology** section of this QRC.

Out-of-area/out-of-network care

All out of network services require a prior authorization, except for Emergency Services, Family Planning, and certain OB services.

Outpatient/ambulatory surgery

Prior authorization requirement is based on the service performed. Visit our provider website for procedure-specific prior authorization requirements.

Pain management/physiatry/physical medicine and rehabilitation

Prior authorization is required for coverage of all services and procedures related to pain management.

Pharmacy:

- The pharmacy benefit covers medically necessary prescriptions and over-the-counter medications prescribed by a licensed provider. Exceptions and restrictions exist as the benefit is provided under a closed formulary/*Preferred Drug List* (*PDL*). Please refer to the *PDL* for the preferred products within therapeutic categories as well as requirements around generics, prior authorization, step therapy, quantity edits, and the prior authorization process.
- Most self-injectable medications and self-administered oral specialty medications and many office-administered specialty medications are available through CarelonRx Specialty Pharmacy and require prior authorization. To initiate a prior authorization request; call us at **844-396-2330.** Effective July 1, 2024, most specialty prescriptions will be transferred to BioPlus, CarelonRx, Inc.'s specialty pharmacy.
- Call CarelonRx at **833-262-1726** to schedule delivery once you receive a prior authorization approval notice. For a complete list of drugs available through CarelonRx Specialty, visit the **Pharmacy** section of our provider website.
- To find out if a specific medication requires prior authorization, please refer to our **Prior Authorization Lookup Tool** found in the *Prior Authorization & Claims* section of our provider website.
- Per NV SB167 (2023), antipsychotic step therapy may be bypassed by applicable practitioners. Refer to attestation on the relevant prior authorization forms found at **providers.anthem.com/nv**.

Personal care services:

- To provide assistance for non-skilled needs
- Required FASP/functional assessment by certified physical therapist
- Prior authorization is required

Plastic/cosmetic/reconstructive surgery (including oral maxillofacial services):

- No prior authorization is required for coverage of E&M codes.
- All other services require prior authorization for coverage. Services considered cosmetic in nature are not covered. Services related to previous cosmetic procedures are not covered. Reduction mammoplasty requires an Anthem medical director's review.
- No prior authorization is required for coverage of oral maxillofacial E&M services.
- Prior authorization is required for coverage of trauma to the teeth and oral maxillofacial, medical, and surgical conditions. TMJ-related services are not covered.

See the **Diagnostic testing** section of this QRC.

Podiatry:

- Podiatry services are only available to Medicaid members under 21 through EPSDT. Some prior authorization may be required for this coverage of E&M.
- As a value-added benefit exclusive to Anthem members, Anthem allows reimbursement for some podiatry services for our diabetic members over 21 years of age. See the provider manual for specific coverage.

See the **Diagnostic testing** section of this QRC.

Radiation therapy

Prior authorization is required for radiation therapy and brachytherapy.

Radiology

Anthem has implemented its Physician Radiology Redirection program. The program stipulates that diagnostic procedures for Anthem members will not be reimbursed at the office level (Place of Service 11) and will require that members be directed to one of our in-network free-standing diagnostic locations. Refer to the ***Physician Radiology Redirection*** policy for more information at **https://providers.anthem.com/docs/gpp/NV_CAID_PhysicianRadiologyRedirect.pdf.**

Rehabilitation therapy, occupational therapy, physical therapy, and speech therapy (short term):

- No prior authorization is required for evaluation.
- Prior authorization is required for coverage of treatment.
- Therapy services required to improve a child's ability to learn or participate in a school setting should be evaluated for school-based therapy.
- Other therapy services for rehabilitative care will be covered as medically necessary and as outlined in the *Nevada Medicare Summary Notices*.

Skilled nursing facility

Prior authorization is required.

Sleep studies

Prior authorization is required for in-lab sleep studies.

Sterilization:

- No prior authorization or notification is required for coverage of sterilization procedures, including tubal ligation and vasectomy for members 21 years of age or older.
- **A *Sterilization Consent Form* is required for claims submission.** Sterilization forms are not required for anesthesiology providers only. Hysterectomy consent forms are required for all provider types. Forms can be found at **medicaid.nv.gov/Downloads/provider/FA-56.pdf**.
- Reversal of sterilization is not a covered benefit.

Transportation

No prior authorization or notification is required for emergency transportation.

Urgent care center:

- Members may self-refer to these facilities.
- No notification or prior authorization is required for participating facilities.

Well-woman exam:

- Members may self-refer for these services.
- Well-woman exams are covered one per calendar year when performed by a PCP or in-network gynecologist and include examination, routine lab work, STD screening, mammograms for members age 40 or older, and Pap tests.
- For family planning services, a member can receive services without authorization from any qualified provider and without regard to network affiliation.

Revenue (RV) codes

To the extent the following services are covered benefits, prior authorization or notification is required for all services billed with the following RV codes:

- All inpatient and behavioral health accommodations
- 0023 — home health prospective payment system
- 0240-0249 — all-inclusive ancillary psychiatric
- 0570-0572, 0579 — home health aide
- 0632 — pharmacy multiple sources
- 0901, 0905-0907, 0913, 0917 — behavioral health treatment services
- 0944-0945 — other therapeutic services
- 0961 — psychiatric professional fees
- 3101-3109 — adult day care and foster care

Important contact information

Our service partners

EyeQuest (vision services)	**888-696-9551**
Carelon Medical Benefits Management, Inc. (radiology prior authorization)	**800-714-0040**
MTM (nonemergent transportation) (for Medicaid members oly)	**844-879-7341**

Provider Services team

844-396-2330

Our Provider Services team offers prior authorization, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. Call Monday through Friday from 6 a.m. to 6 p.m. Pacific time.

Anthem provider website — Get help 24/7
providers.anthem.com/nevada-provider/home

Did you know you can verify member eligibility, look up prior authorization/notification requirements, and so much more on our provider website.

Can't access the internet? Call Provider Services at **844-396-2330** and simply say your NPI when prompted by the recorded voice. The recording guides you through our menu of options; just select the information or materials you need when you hear it.

Claims

Submitting your claims:

- Submit using Availity:
  - From the Availity home page, select **Claims & Payments** from the top navigation.
  - Select **Type of Claim** from the drop-down menu.
- Submit electronically through a clearinghouse or use your practice management software:
  - Payer ID: **00265**
  - For a full list, visit **Availity.com**: **https://apps.availity.com/public-web/payerlistui/payerlist-ui/#/**
  - Note: If you use a clearinghouse, billing service or vendor, work with them directly to determine payer ID.
- Submit paper claims:

  Anthem Blue Cross and Blue Shield Healthcare Solutions
  Nevada Claims
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

Timely filing limits:

- 180 days from the date of service to submit a clean claim (unless otherwise stated in the provider agreement)
- Out-of-state and emergency transportation: 365 days from the last date of service
- If other health insurance exists: 180 days from the date of the *Explanation of Payments* (*EOP*) for in-network/participating providers (365 days from the EOP for out of state providers)
- Level One Claim Dispute: 90 days from the date of the *EOP*
- Level Two Claim Dispute: 30 days from the date of the Level One reconsideration decision letter/ correspondence

Claims submitted outside of timely filing limits may deny. For any claim denials, the dispute and appeal process must be followed or denials will stand.

Checking claim status and review claim processing rationale:

- Claims Status inquiry:
  - Check status directly in Availity:
    - From the Availity home page, select **Claims & Payments** from the top navigation.
    - Select **Claims Status** from the drop-down menu.
  - Call Provider Services: **844-396-2330**
- Clear Claims Connection:
  - Our Clear Claims Connection tool is available to help you review procedure code edits and receive edit rationale. **Before disputing a claim,** be sure to use this tool to help reduce the number of disputes you must file.
  - From the Availity home page, select **Payer Spaces** from the top navigation.
  - Select the health plan.
  - From the **Payer Spaces** home page, select the **Applications** tab.
  - Select the **Clear Claims Connection** tile.

Payment dispute and appeal:

- Claims Reconsideration Dispute (Level One):
  - To dispute a claim:
    - From the Availity home page, select **Claims & Payments** from the top navigation.
    - Select **Claims Status** from the drop-down menu.
    - Submit an inquiry and review the **Claims Status Detail** page:
      - If the claim is denied or final, there will be an option to dispute the claim.
    - Select **Dispute the Claim** to initiate the process.
    - Navigate to **Claims & Payments**, then select **Appeals**. Locate your initiated dispute, upload your documentation, and submit.
- Claim Appeal (Level Two):
  - A Second Level Claim Payment Appeal must be received within 30 calendar days from the date of the first level decision/resolution letter.
  - Option 1: Using Availity:
    - From the Availity home page, select **Claims & Payments** from the top menu.
    - Select **Claims Status Inquiry** from the drop-down menu.
    - Submit an inquiry and review the **Claims Status Detail** page:
      - If the claim is denied or final, there will be an option to dispute the claim.
    - Select **Dispute the Claim** to begin the process.
  - Option 2: Mailing a written appeal:
    - A written *Claim Payment Appeal* request can be mailed to the following address:

      Anthem Payment Disputes
      Payment Dispute Unit
      P.O. Box 61599
      Virginia Beach, VA 23466-1599
    - The request must include supporting documentation such as an *EOP* or other written explanation along with the copy of the claim. If not accompanied by a full explanation the claim may be returned and not accepted.

If you have questions on a claim, you may also call Provider Services at **844-396-2330** or use the **Chat with Payer** or **Secure Messaging** features in Availity.

Electronic data interchange (EDI)

Contact Availity Client Services with any questions at **800-Availity (282-4548)**.

Availity's EDI submission options:

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)

or

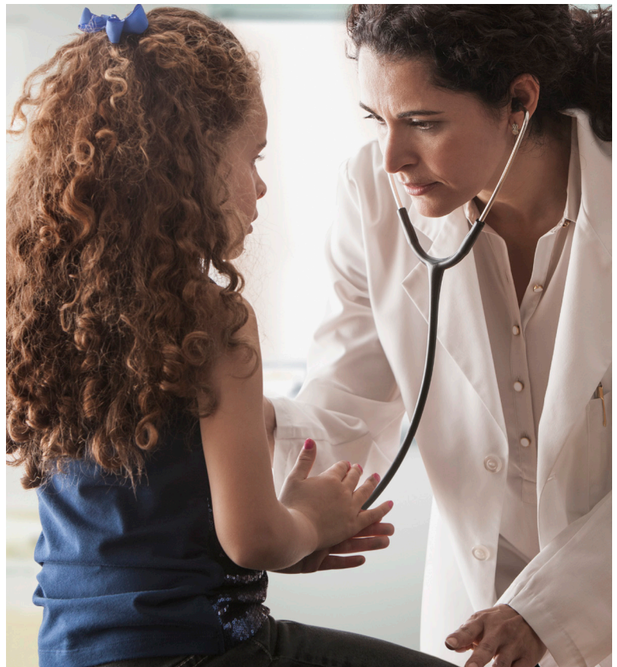
- Use your existing clearinghouse or billing vendor (work with your vendor to ensure connection to the Availity EDI Gateway)

For more information on EDI (or to register), visit **providers.anthem.com/nv**.

Medical appeals

When a prior authorization is denied, medical appeals may be initiated by a member, a person acting on behalf of a member, a member's PCP, or a member's healthcare provider within 60 calendar days from the date of the notice of adverse benefit determination. Medical appeals can be submitted in writing to the following address:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Medical Appeals
P.O. Box 62429
Virginia Beach, VA 23466-2429



Health services

Care management services • 844-396-2330

We offer care management services to members who are likely to have extensive healthcare needs. Our clinical care managers work with you to develop tailored care plans based on comprehensive screeners and assessments including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc. We offer different stratification of Care Management ranging from short-term Care Coordination to higher acuity Case Management.

Condition Care (CNDC) services • 888-830-4300

CNDC/PH services is a form of Care Management focusing on specific disease processes and include educational information such as local community support agencies and events in the health plan's service area. Services are available for members with the following medical conditions: asthma, bipolar disorder, chronic obstructive pulmonary disease, chronic heart failure, coronary artery disease, diabetes, HIV/AIDS, hypertension, major depressive disorder for adult and child/adolescent, schizophrenia, and substance use disorder.

24/7 NurseLine • 844-396-2329 (TTY 711)

Members may call our 24/7 NurseLine for nursing advice 7 days a week, 365 days a year. When a member accesses this service, a report will be faxed to your office within 24 hours of receipt of the call.

Member Services • 844-396-2329 (TTY 711)

Member-facing service to call for general questions, concerns, help finding providers and scheduling appointments, obtaining Value Added Benefits (VABS), and requesting Care Management services.

Learn more about Anthem programs

providers.anthem.com/nv

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