Medicaid Managed Care

Anthem

Provider Quick Reference Card

- Prior authorization/notification requirements
- Important phone numbers
- Revenue codes

Nevada Medicaid and Nevada Check Up
https://providers.anthem.com/nv

Easy access to prior authorization/notification requirements and other important information for Anthem Blue Cross and Blue Shield Healthcare Solutions (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) or recommendations to improve it, call your local Provider Relations representative. We want to hear from you and improve our service so you can focus on serving your patients.

Prior authorization/notification instructions and definitions

Request prior authorizations and give us notifications:

- Online: **https://providers.anthem.com/nv,** then log in to the Availity Portal
- By phone: **844-396-2330**
- By fax: **800-964-3627**
- For behavioral health requests, they should be submitted using our preferred electronic method at **availity.com**. If you prefer to paper fax, submit behavioral health outpatient information to **844-442-8007**; fax behavioral health inpatient information to **844-451-2794**.

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 **https://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.

Behavioral health/substance abuse services

- Prior authorization is required for coverage of inpatient mental health and substance abuse services.
- Residential substance abuse 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. Please 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 requires prior authorization.

Cardiac rehabilitation

Prior authorization is required for coverage of all services.

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, please 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 and nebulizers, 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 24 hours or the next business day.

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. Please refer to our Prior authorization Lookup Tool Online (PLUTO) on **https://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 upper endoscopy, esophagogastroduodenoscopy, 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:

- All maintenance therapy services require prior authorization.

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 24 hours or the next business day.
- To be covered, preadmission testing must be performed by an Anthem-preferred 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 **https://www.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 45 days of a nursing facility stay. On and after day 46, 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 24 hours or the next business day.

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 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

Prior authorization is required except for coverage of emergency care including self-referral, family planning and OB care.

Outpatient/ambulatory surgery

Prior authorization requirement is based on the service performed. Please 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; please call us at **844-396-2330**.
- Please call CarelonRx, Inc. at **833-248-1447** to schedule delivery once you receive a prior authorization approval notice. For a complete list of drugs available through CarelonRx Specialty Pharmacy, please 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.

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. No prior authorization is 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.

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.

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 **https://www.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 35 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 only)	**844-879-7341**

Provider Services Team
Our Provider Services team offers prior authorization, case and disease management, automated member eligibility, claims status, health education materials, outreach services, and more. Call **844-396-2330**, Monday through Friday from 6 a.m. to 6 p.m. PT.

Provider website and interactive voice recording available 24/7: To verify eligibility, check claims and referral authorization status, and look up prior authorization/notification requirements, visit **https://providers.anthem.com/nv.**

Can't access the internet? Call Provider Services 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 services

Timely filing is within 180 days of the date of service or per the terms of the provider agreement. Out-of-state and emergency transportation providers have 365 days from the last date of service.

If other health insurance exists, the claim for services may be submitted up to 180 days from the date on the *Explanation of Payment (EOP)* for network providers. For out-of-state providers, the claim may be filed up to 365 days from the date on the *EOP*.

Electronic data interchange (EDI)

Please 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 **https://providers.anthem.com/nv**.

Paper claims

Submit claims on original claim forms (*CMS-1500*) printed with dropout red ink or typed (not handwritten) in large, dark font. American Medical Association- and CMS-approved modifiers must be used appropriately based on the type of service and procedure code. Mail to:

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

Payment disputes

Payment disputes must be filed within 60 calendar days of the date on the explanation of payment. Anthem will respond to the payment dispute within 30 calendar days of receipt. If the provider is dissatisfied with the resolution, the provider may submit a second-level dispute (appeal) within 30 calendar days of receipt of the notification. Anthem will respond to a second-level dispute within 30 calendar days of receipt. Providers can submit claim payment disputes through the Availity Portal at **https://www.availity.com**, which offers health care providers and professionals free access to real-time information and instant responses in a consistent format. The Availity Portal has a quicker response time and more reliable tracking of disputes and appeals.

If providers choose to submit via mail instead, the forms for provider appeals are located on our website and should be sent to the following address:

Anthem Blue Cross and Blue Shield Healthcare Solutions
Payment Disputes
P.O. Box 61599
Virginia Beach, VA 23466-1599

Medical appeals

Medical appeals may be initiated by a member, a person acting on behalf of a member, a member's PCP or a member's health care provider within 60 calendar days from the date of the notice of actionadverse benefit determination. Medical appeals can be submitted by phone by calling Member Services, or 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 health care needs. Our clinical care managers work with you to develop personal care plans including identifying community resources, providing health education, monitoring compliance, assisting with transportation, etc.

Disease Management/Population Health (DM/PH) services ∘ 888-830-4300
DM/PH services 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)

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan. Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

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