Reminder: Anthem Behavioral Health participating providers for Teamsters Local 631 members

Anthem is pleased that Teamsters Local 631 became a new client since February 1, 2017. While we previously communicated information about this group in our January issue of Network Update, we wanted to add further clarification regarding the behavioral health network.

Teamsters Local 631 offers their approximately 10,000 employees/dependents benefit options accessing Anthem’s Indemnity network.

- **Exceptions:** In Nevada, Teamsters Local 631 will be utilizing the Coalition’s hospital network rather than Anthem’s Indemnity Network.

**Note of clarification:** The implementation of this group with Anthem effective February 1, 2017, also includes utilizing Anthem’s behavioral health network. If you are a participation behavioral health provider in Anthem’s indemnity network, then you are considered a participating provider for the Teamsters Local 631 members. These members have a unique alpha prefix of JTL.

Anthem is dedicated to providing excellent customer service for Teamsters Local 631 and their providers and we look forward to building a successful relationship. We appreciate this opportunity to assist you.

New Program for the Nevada Market

Effective April 28, 2017, Equian is expanding their current scope of audits (DRG Validation and Hospital Bill Audits) to include a review of “Complex Duplicates”. This program is a post payment audit of outpatient facility claims for the same member/same provider/same service which appear to have duplicate payments, but further research is needed to make that determination. Equian will work with the facility’s billing department in determining whether the services were paid appropriately. Anthem Blue Cross and Blue Shield (Anthem) and Equian are committed to the coordinated efforts between all our programs and maintaining a professional working relationship with all providers. Should you need additional information, please contact your network representative.

Introducing Patient360 – Get quick and easy access to your Anthem member records

In mid-April 2017, Patient360 was launched on the Availity Web Portal at [availity.com](http://availity.com). This online application lets you quickly retrieve detailed records about your Anthem patients.

Patient360 will be replacing Patient Care Summary that you have been accessing through Eligibility and Benefits tool on the Availity Web Portal. It will also replace Member Medical History Plus (MMH Plus).
What is Patient360?

Patient360 is a real-time dashboard that gives you a robust picture of a patient’s health and treatment history and will help you facilitate care coordination. You can drill down to specific items in a patient’s medical record to retrieve demographic information, care summaries, claims details, authorization details, pharmacy information, and care management related activities.

This level of detail provides you the ability to:

- Spot utilization and pharmacy patterns
- Avoid service duplication
- Identify care gaps and trends
- Coordinate care more effectively
- Reduce the number of communications needed between PCPs and case managers

Access to Patient360 on the Availity Web Portal

To access Patient360 on the Availity Web Portal, users need to be assigned to the Patient360 role. Availity Administrators can locate this within the Clinical Roles options. If a user already has the Patient Care Summary role, they will automatically be re-assigned to the Patient360 role.

You may choose one of the 2 options listed below to navigate to Patient360:

**Option 1:** Select Patient Registration from Availity's top menu bar.
- Choose Eligibility and Benefits
- Complete the required fields on the Eligibility and Benefits screen
- Select the Patient360 link on the member’s benefit screen
- Enter the member information in the required fields

**Option 2:** Select Payer Spaces from Availity's top menu bar
- Choose the Anthem Blue Cross and Blue Shield tile
- From the Applications page, select Patient360
- Enter the member information in the required fields

What if your organization is not registered on the Availity Web Portal?

- Go to [availity.com](http://availity.com)
- Select Register
- Select Get Started
- Complete the online registration form

What if you need assistance?

If you have questions about Patient360 please contact your local Provider Solutions Provider Relations representative.

If you have questions regarding Availity Web Portal registration, please contact Availity Client Services at 1-800-282-4548.
Updated Inovalon ePASS® webinar schedule

Overview

Anthem continues to work with Inovalon – an independent company that provides secure, clinical documentation services – to conduct outreach efforts on our behalf for our health care exchange business. Our goal is to help ensure that our members, who have purchased health care plans that comply with the Affordable Care Act (ACA), get their diagnoses confirmed, corrected, and updated every year, as well as have potential preventive care gaps addressed. To accomplish this goal, Anthem network providers – usually primary care physicians – may receive letters from Inovalon, requesting that physicians perform patient assessments, followed by submission of a Subjective, Objective, Assessment and Plan (also called SOAP Note or Encounter Facilitation Form).

Incentive opportunities available for submitting SOAP Notes

If you receive a request from Inovalon, we understand that completing these SOAP Note requests may take time. We are offering contracted providers the opportunity to increase reimbursement.

<table>
<thead>
<tr>
<th>Contracted providers are eligible to receive for each properly completed and submitted:</th>
<th>Incentive Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic SOAP Note via Inovalon’s ePASS tool</td>
<td>$100 in addition to the office visit fee</td>
</tr>
<tr>
<td>Paper SOAP Note via Inovalon’s secure fax line at 1-866-682-6680</td>
<td>$50 in addition to the office visit fee</td>
</tr>
</tbody>
</table>

To maximize incentive opportunities, Inovalon is offering webinars that provide a practical overview of how the Electronic Patient Assessment Solution Suite (ePASS®) can be used by eligible providers to access a supplemental clinical profile and complete a compliant medical SOAP note for patients identified by Anthem. This overview typically takes 30 minutes followed by time for questions.

Registration

We encourage you to register in advance by sending an email to ePASSProviderRelations@inovalon.com with your name, organization, contact information and the date of the webinar you wish to attend.

Webinar Dates

| Wednesday, May 3, 2017: 12:00 – 1:00pm PT | Wednesday, May 10, 2017: 12:00 – 1:00pm PT |
| Wednesday, May 17, 2017: 12:00 – 1:00pm PT | Wednesday, May 24, 2017: 12:00 – 1:00pm PT |
| Wednesday, May 31, 2017: 12:00 – 1:00pm PT | Wednesday, June 7, 2017: 12:00 – 1:00pm PT |
| Wednesday, June 14, 2017: 12:00 – 1:00pm PT | Wednesday, June 21, 2017: 12:00 – 1:00pm PT |
| Wednesday, June 28, 2017: 12:00 – 1:00pm PT |

How to Join

The following information can be used to join all webinars scheduled in May and June 2017

- **Teleconference:** Dial 1-415-655-0002 (US Toll) and enter access code: 736 436 872
- **WebEx:** Visit [https://inovalonmeet.webex.com](https://inovalonmeet.webex.com) and enter meeting number: 736 436 872

Once you join the call, live support is available at any time by dialing "0"
Reminder: Members managed by OrthoNet available online through Availity Web Portal

In November of 2015, Anthem selected OrthoNet, LLC, a leading musculoskeletal management company, to administer a physical and occupational therapy utilization management program.

The program requires that all outpatient and office based physical and occupational therapy services following the initial evaluation be authorized by OrthoNet. As indicated in previous communications, OrthoNet handles pre-certification requests for all Anthem members except: Medicare Advantage, Medicaid, Medicare supplement, Medicare Part D, Federal Employee Program® (FEP®), BlueCard, National Accounts, and certain self-funded and alternatively-funded groups. Members ages 6 and under are also excluded from participation in this program.

Providers are able to view members online through the Availity Web Portal to determine which members are administered through OrthoNet.

- Log into Availity.com.
- From the Patient Registration tab, select Eligibility and Benefits (E&B) Inquiry
- Enter all required fields
  - Under Benefit / Service Type, select Physical Therapy or Occupational Therapy

Note: Members managed by OrthoNet are available on Availity for all Anthem affiliated plans which include: Anthem plans in CA, CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI, and Blue Cross and Blue Shield of Georgia, and Empire Blue Cross and Blue Shield.

Sample screen shot below is utilizing Physical Therapy as the Benefit/Service Type. Note the OrthoNet message below including the phone number. If you see this message during your E&B inquiry, then please contact OrthoNet for authorization requests for this member. This message will not be displayed for members that are not administered by OrthoNet, saving you time to verify this information prior to submitting an authorization request through OrthoNet.
OrthoNet Quick Reference Guide

To go along with the previous article, and based on provider feedback, we wanted to also remind you of the document we’ve created called the OrthoNet Quick Reference Guide that outlines the OrthoNet program overview and summarizes important details such as:

- Program overview
- Services included and not included in program
- Online verification of Eligibility and Benefits, and members managed by OrthoNet
- Pre-authorizations request options
- Checking status of Pre-authorization Requests
- Timeline for OrthoNet decisions
- Other sources, which includes newly defined escalation process

Access this document online. Go to anthem.com. Select Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. From the Provider Home page, under the Communications and Updates heading select Provider Toolkit, then OrthoNet Quick Reference Guide – Nevada.

Clinical Practice and Preventive Health Guidelines Available online

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to providers on our website. The guidelines, which are used for our Quality programs, are based on reasonable medical evidence, and are reviewed for content accuracy, current primary sources, the newest technological advances and recent medical research. All guidelines are reviewed annually, and updated as needed. The current guidelines are available online at anthem.com. Select Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. Select the Health & Wellness tab, then Practice Guidelines.

HEDIS® 2017: What’s new?

Here are some highlights of the HEDIS measure revisions that went in to place 2017:

Human Papilloma Virus (HPV)

This measure was retired in 2017 but the vaccine requirement was added to the IMA (Immunization for Adolescents) measure.

Immunization for Adolescents (IMA)

The HPV vaccine was added to this measure. It is now required for both male and female members. There are two combination requirements.

- Combination 1 (Meningococcal, Tdap) – Adolescents who are compliant for both the meningococcal conjugate and Tdap vaccines
- Combination 2 (Meningococcal, Tdap, HPV) – Adolescents who are compliant for all three vaccines (meningococcal, Tdap, HPV)

In addition, the tetanus, diphtheria toxoids (Td) and meningococcal polysaccharide vaccines were removed from this measure.
Colorectal Cancer Screening (COL)

These two tests were added as acceptable proof of colorectal screening

- CT Colonography within the last 5 years
- FIT-DNA test within the last 3 years

More information on HEDIS is available online at anthem.com. Select Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. Select the Health & Wellness tab, then choose Quality Improvement and Standards from the drop down list, and scroll down to HEDIS Information.

Thank you for your continued cooperation and support of HEDIS.

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

Update to Claims Processing Edits and Reimbursement Policies

We will be updating our secure provider portal, ProviderAccess, with the following new and/or revised reimbursement policies.

The updates below identify if the article pertains to professional or facility provider billing.

Assistant Surgeon Policy and Coding – Professional

We updated our policy and code list for January 1, 2017 and have posted the changes to ProviderAccess. The changes are based on Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS Level II) coding changes for 2017 as well as updates based on American College of Surgeons (ACS) and the Centers Medicare & Medicaid Services (CMS) information.

- **Added codes:**
  22867, 22869, 27197, 27198, 28291, 31551, 31552, 31553, 31554, 31572, 31573, 31574, 31591, 31592, 33340, 33477, 33957, 33958, 33959, 33962, 36456, 36473, 36474, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37237, 37239, 37247, 37248, 37249, 47383, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62380, 93591, 0446T, 0447T, 0448T, 0449T, 0450T, 0451T, 0452T, 0453T, 0454T, 0455T, 0456T, 0457T, 0458T, 0465T, 0466T, 0467T, and 0468T

- **Deleted codes:**
  11752, 11977, 15170, 15171, 15175, 15176, 20101, 21338, 22858, 27193, 27194, 27927, 28290, 31582, 35471, 35472, 35475, 35476, 39401, 39402, 62310, 62311, 62318, 62319, 69405, 0019T, 0281T, 0282T, 0283T, 0284T, 0288T, and 0289T

Bundled Services and Supplies and Modifiers 59 and XE, XP, XS, and XU – Professional

Effective January 1, 2017, CPT added codes 80305, 80306, and 80307 (*presumptive drug testing of any number of drug classes per date of service*) and the Centers for Medicare & Medicaid Services (CMS) added Healthcare Common Procedure Coding System (HCPCS Level II) code G0659 (*definitive testing of any number of drug classes per day*). As part of our routine maintenance of existing edits, we are documenting our current edit that denies 82570 (*urine creatinine*) or 83986 (*urine pH*) when reported with 80305-80307 and G0659. In addition, for claims processed on or after May 20, 2017 modifiers will not override the edits.

Our current edit denies 82542 (*column chromatography*) when reported with presumptive or definitive drug testing services. We are updating our policies for claims processed on or after May 20, 2017 to include the new CPT codes 80305-80307 and HCPCS code G0659 plus existing HCPCS codes G0480-G0483 (*drug test(s), definitive... qualitative or quantitative, all sources, includes specimen validity testing, per day*) to this edit. Modifiers will not override the edits.
When similar or identical procedures are performed, but are qualified by an increased level of complexity, only the most comprehensive service performed should be reported. Based on this logic, we are documenting in our policies dated May 20, 2017 that our current edit denies G0480-G0483 when reported with G0659. Modifiers will not override this edit.

Durable Medical Equipment and Place of Service – Professional

For claims processed on or after May 20 2017, a select list of specialized hospital beds (E0194, E0301, E0302, E0303, and E0304) and negative pressure wound care items (E2402; please note, A6550 and A7000 are currently allowed) will be eligible for reimbursement when reported with a skilled nursing facility (SNF) place of service (31). These select items are not considered part of the SNF per diem reimbursement rate.

Frequency Editing – Professional

CPT codes 95925, 95926, 95938, and 95927 (short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system...) and 95928, 95929, and 95939 (central motor evoked potential study (transcranial motor stimulation)... ) are currently limited to once per date of service. Based on the indication of plurality within each code’s description, beginning with claims processed on or after May 20, 2017, modifiers will not override the frequency limit of one per date of service on each of these codes.

We currently have frequency limits that are applied per 90 days for diabetic supplies identified by HCPCS codes A4230, A4231, A4232, A4244, A4245, A4250, A4253, and A4259. Beginning with claims processed on or after May 20, 2017 we are decreasing the day span to per 86 days. Please note that the listed frequency limits will still apply to these codes.

Laboratory and Venipuncture Services and Modifier Rules – Professional

We are updating our policies to reflect that modifier 91 (repeat clinical diagnostic laboratory test) will not override our bundling edit for component codes for “Organ and Disease-Oriented Panels.” This edit will be effective for claims processed on or after May 20, 2017.

Reimbursement Policies and Clear Claim Connection are available on our secure provider portal, ProviderAccess

Please review the full policy for any changes referenced above for further information. All professional Reimbursement Policies are located on our secure provider portal, ProviderAccess. Please go to anthem.com. Select Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. From the Provider Home page, go to the ProviderAccess Login tout (blue box on the left side of the page), and select Medical from the drop down list and select the login button.

Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Professional Reimb & Admin Policies”. From the Anthem’s Professional Reimbursement and Administrative Policies overview page, select Continue. Select link titled “Anthem’s Professional Reimbursement & Administrative Policies – By Type”, then select the Reimbursement link, and next the Policy you would like to view.

Clear Claim Connection™ is our web-based editing tool from McKesson and includes an interface that will allow you to view the clinical rationale for ClaimsXten edits when you enter claim scenarios. If you have not used Clear Claim Connection previously, we would like to take this opportunity to encourage you to access this user-friendly tool to explore the ClaimsXten edits. Follow the directions listed above to log into ProviderAccess. Once logged in, from the Claims tab, select the Clear Claim Connection link. Please note: Cotiviti Healthcare edits will not be included in the Clear Claim Connection tool. These edits will be available by calling provider customer service at the number on the back of the member’s ID card.

CPT® is a registered trademark of the American Medical Association

ClaimsXten® is a registered trademark of McKesson Information Solutions LLC
Medicare Advantage Updates

Tetanus vaccine billing guidelines

Effective January 1, 2016, tetanus vaccine (90703) was deleted by Medicare. Effective for dates of service January 1, 2016 and after, providers who have administered a tetanus vaccine for an open wound or laceration should bill 90696, 90697, 90698, 90700, 90702, 90714, 90715 or 90723 in addition to the administration 90471 and/or 90472; with the appropriate diagnosis to indicate open wound or laceration. Tetanus administered in the Emergency Room should be billed with the appropriate revenue codes (0250 or 0636 for vaccine and 0771 for the administration). Please submit the claim to the member’s Medicare Advantage or Medicare Medicaid Plan.

If a tetanus vaccine is administered for a reason other than puncture wound or laceration and the member has pharmacy benefits, please bill their Medicare Part D plan. This applies to the vaccine and the administration charges.

To bill the Medicare Part D plan, you may use TransactRX, a clearinghouse for claims submission. To use TransactRX, please contact the clearinghouse at the web site (http://www.transactrx.com) or call Customer Service at 866-522-3386. Physicians, facilities, health clinics and pharmacies may use this clearinghouse to process Part D claims. There is no charge to providers who use electronic funds deposit to receive payment. There is a service fee of $2.50 for check payments on claims.

The Centers for Medicare & Medicaid Services provides more information on Part D vaccines here.

Keep up with Medicare news

Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Prior authorization requirements for continuous interstitial glucose monitoring
- Retrospective medical record review program launches

Health Care Reform Updates (including Health Insurance Marketplace / Affordable Care Act)

We invite you to go to anthem.com to learn about the many ways health care reform and health insurance marketplace / affordable care act information may impact you. New information is added regularly. To view the latest articles on health care reform and/or health insurance marketplace / affordable care act, and all achieved articles, you can access them all online. Go to anthem.com. Select Menu, and under the Support heading, select Providers. Choose Nevada from the drop down list, and Enter. Select the Provider Home tab at the top of the page. Under the Communications and Updates heading, choose Health Care Reform Updates and Notifications or Health Insurance Marketplace / Affordable Care Act information.