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Access requirements for behavioral healthcare services

Published: Sep 1, 2019 - **Products & Programs** / Behavioral Health

We have been advising, via this publication and the Provider Manual, of the requirement that your practice provide the capability for a new patient appointment within a given timeframe. We annually conduct appointment access studies to assess how well practices are meeting this provision and a high percentage of behavioral health (BH) offices do not have timely access for new patients.

To be compliant, providers are expected to make best efforts to meet the following access standards:

- Initial routine office visit – A new patient must be seen in the office by a designated BH practitioner or another equivalent practitioner in the practice within ten business days.
 - *Explanation* – This is a routine call for a new patient defined as a patient with non-urgent symptoms, which present no immediate distress and can wait to schedule an appointment without any adverse outcome. It can be after the practitioner's intake assessment or a direct referral from a treating practitioner.

Is your practice compliant?

URL: <https://providernews.anthem.com/connecticut/article/access-requirements-for-behavioral-healthcare-services-1>

Clinical criteria updates for specialty pharmacy

Published: Sep 1, 2019 - **Products & Programs** / Pharmacy

ING-CC-0061

Clinical criteria ING-CC-0061 addresses the use of gonadotropin releasing hormone analogs for the treatment of non-oncologic indications. Effective for dates of service on and after December 1, 2019, the use of Zoladex for the treatment of endometriosis will be limited to 6 months.

The following clinical criteria documents were endorsed at the June 20, 2019 Clinical Criteria meeting.

Revised clinical criteria effective July 15, 2019

(The following clinical criteria was revised to expand medical necessity indications or criteria.)

ING-CC-0124: Keytruda (pembrolizumab)

Revised clinical criteria effective July 15, 2019

(The following clinical criteria were reviewed and may have word changes or clarifications, but had no significant changes to the medical necessity indications or criteria.)

ING-CC-0008: Subcutaneous Hormonal Implants

ING-CC-0048: Spinraza (nusinersen)

ING-CC-0051: Enzyme Replacement Therapy for Gaucher Disease

ING-CC-0076: Nulojix (belatacept)

ING-CC-0077: Palynziq (pegvaliase-pqpz)

New and revised clinical criteria effective September 1, 2019

(The following new clinical criteria were revised to expand medical necessity indications or criteria.)

ING-CC-0103: Faslodex (fulvestrant) [previously CG-DRUG-62]

ING-CC-0121: Gazyva (obinutuzumab) [previously DRUG.00062]

Revised clinical criteria effective December 1, 2019

(The following clinical criteria listed below might result in services that were previously covered now being considered not medically necessary.)

ING-CC-0003: Immunoglobulins

ING-CC-0031: Intravitreal Corticosteroid Implants

ING-CC-0061: GnRH Analogs for the treatment of non-oncologic indications

To access the clinical criteria information for any of the updates above, please click [here](#). If you do not have access to the internet, you may request a hard copy of any updated policy by contacting the [Provider Call Center](#).

Specialty pharmacy prior authorization list to be expanded effective December 1, 2019

Published: Sep 1, 2019 - **Products & Programs** / Pharmacy

Effective for dates of service on or after December 1, 2019, the following drug codes from new or current medical policies or clinical UM guidelines will be included in our specialty pharmacy pre-service clinical review process.

Please note: inclusion of NDC code on claims will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Pre-service clinical review of non-oncology specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. Oncology drugs will be managed by AIM Specialty Health® (AIM®), a separate company.

Clinical Criteria	HCPCS or CPT Code(s)	NDC Code(s)	Drug
ING-CC-0003	J3490 J3590 C9399	68982-0810-01 68982-0810-02 68982-0810-03 68982-0810-04 68982-0810-05 68982-0810-06	Cutaquig®
ING-CC-0003	J1599	69800-0250-01	Asceniv™
ING-CC-0031	J3490	71879-0136-01	Yutiq™

Anthem launches Sydney on September 1; new app offers better digital health care support to members

Published: Sep 1, 2019 - **Administrative**

We are working to deliver a new digital ecosystem that better supports our members. To that end, our new platform is designed to give our members a more personal, simplified experience. We are driving meaningful change through technology and artificial intelligence (AI) powered innovation to deliver an easier to use, more complete Web and mobile health care experience.

We're excited to announce the launch of **Sydney** – our new mobile app that runs on intelligence – as part of our digital strategy. Launching **September 1, 2019**, the new app replaces Anthem Anywhere and provides the same services that members receive from Anthem Anywhere, plus we'll phase in other features and new capabilities over time. In return, members will get a truly integrated mobile experience with even more personalized information to fit their unique needs. These changes will lead to a more personal experience, better engagement and improved health outcomes.

Beginning September 1, members enrolled in our commercial health benefit plans* (including those plans members purchase on or off the Health Insurance Marketplace) and Medicare health benefit plans will have, with Sydney, a personalized health assistant that connects questions to answers – and people to the right resources. It's all part of a more seamless digital experience, bringing together fully integrated benefit details, claims information, care finder tools, access to spending accounts and wellbeing programs. Members can download Sydney at the app stores starting September 1.

As part of our rollout efforts on September 1, Anthem will also launch – using a phased approach – a digital solution called My Family Health Record (MyFHR). MyFHR offers several benefits for members and providers. Members will be better able to manage their own health, address care gaps, and have the ability to download electronic medical records (EMR) from one or more providers. With MyFHR, members will also have the ability to share EMR information with family, caregivers, and providers.

Watch for information on future enhancements to Sydney and MyFHR in upcoming editions of *Provider News*.

*Excludes Medicaid health benefit plans.

URL: <https://providernews.anthem.com/connecticut/article/anthem-launches-sydney-on-september-1-new-app-offers-better-digital-health-care-support-to-members>

Reminder: Changes to timely filing requirements coming in October

Published: Sep 1, 2019 - Administrative

Anthem continues to look for ways to improve our processes and align with industry standards. With that in mind, it is also our goal to help providers receive their Anthem payments quickly and efficiently. Timely receipt of medical claims for your patients, our members, helps our chronic condition care management programs work most effectively, and also plays a crucial role in our ability to share information to help you coordinate patient care. In an effort to simplify processes, improve efficiencies, and better support coordination of care, we are changing all professional agreements to adopt a common time frame for the submission of claims to us. Notification was sent July 1, 2019 to providers of applicable networks and contracts.

Effective for all claims received by Anthem on or after October 1, 2019, all impacted contracts will require the submission of all professional claims within ninety (90) days of the date of service. This means claims submitted on or after October 1, 2019 will be subject to a ninety (90) day timely filing requirement, and Anthem will refuse payment if submitted more than ninety (90) days after the date of service¹.

If you have any questions, contact the [Provider Call Center](#).

¹ If Plan is the secondary payor, the ninety (90) day period will not begin until provider receives notification of primary payor's responsibility.

URL: <https://providernews.anthem.com/connecticut/article/reminder-changes-to-timely-filing-requirements-coming-in-october-1>

Reimbursement rate for non-participating providers of durable medical equipment to change

Published: Sep 1, 2019 - Administrative

Effective January 1, 2020, non-participating providers of durable medical equipment (DME) will be reimbursed at the same rate Anthem has negotiated with participating providers of DME. DME includes items such as wheelchairs, crutches, oxygen supplies, ostomy supplies, etc. This change does not change the network status of these providers.

It also does not represent a change to Anthem members' DME benefit and they can continue to use these out of network (OON) providers for DME services as long as they continue to have OON benefits. However, if you decide to refer an Anthem member to a non-participating DME provider, you will need to comply with our Advance Patient Notice (APN) Policy. As an Anthem participating provider you are obligated to refer members to Anthem participating providers to ensure a member is maximizing their benefit plan. If you decide to refer a member to a non-participating provider, you will need to have the member fill out the Non Par Authorization form as provided in the policy.

You can help your patients who are Anthem members maximize their benefits by encouraging them to use in-network (INN) DME providers. They can get details about INN DME providers at the [Find a Doctor tool](#) on anthem.com or by calling Member Services at the number on the back of their ID card.

On or about October 1, we will send a letter to Anthem members who have purchased DME from non-par providers in the last 12 months notifying them about this change and the possible impact to their out-of-pocket responsibility.

URL: <https://providernews.anthem.com/connecticut/article/reimbursement-rate-for-non-participating-providers-of-durable-medical-equipment-to-change>

Commercial Risk Adjustment (CRA) Reporting Update: Risk Adjustment Data Validation (RADV) Audit happening now

Published: Sep 1, 2019 - Administrative

Continuing our 2019 reporting CRA updates, we request your assistance with respect to our reporting processes.

The Centers for Medicare & Medicaid Services (CMS) is conducting a RADV Audit beginning June 2019 through January 2020. This audit is in accordance with the provisions of the Patient Protection and Affordable Care Act (PPACA) and its risk adjustment data validation standards.

For this audit, CMS will select a statistically valid sample of Anthem members enrolled in an Affordable Care Act (ACA) compliant plan. Providers whose patients during the benefit year 2018 were selected for this audit will receive requests and must provide copies of medical

record(s)/chart(s). This audit is to verify that diagnosis codes, which have been submitted on claims and reported to CMS, are accurate, properly documented, and coded with accurate levels of specificity.

In the event your patients are selected for this RADV audit, please note that we are working with several vendors to collect the needed medical records and signature attestations (if applicable). Representatives from Anthem or our vendors may reach out to you to request the required medical records and signature attestations. We appreciate your assistance and patience during this process.

Be advised that we are not requesting copies of “psychotherapy notes” as defined by the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, psychotherapy notes are defined as “notes recorded (in any medium) by a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical record. However, any data excluded from the definition of psychotherapy notes must be provided where applicable and pursuant to this request. The following list of items are not included in the definition of “Psychotherapy notes” and therefore, can be included pursuant to HIPAA:

- Medication prescription and monitoring
- Counseling session start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests; and
- Summary of the following:
 - Diagnosis
 - Functional status
 - Treatment plan
 - Symptoms
 - Prognosis; and
 - Progress to date

If you have any RADV audit questions/concerns, please contact Evelyn.Rey-Hipolito@anthem.com.

If you have any questions regarding our reporting process, please contact our CRA Network Education Representative Alicia.Estrada@anthem.com.

URL: <https://providernews.anthem.com/connecticut/article/commercial-risk-adjustment-cra-reporting-update-risk-adjustment-data-validation-radv-audit-happening-now>

Claim editing update for Excludes1 notes

Published: Sep 1, 2019 - Administrative

Beginning with claims processed on and after September 29, 2019, we will be implementing revised claims edit logic tied to Excludes1 notes from ICD-10 coding guidelines. We recognize that the editing tied to Excludes1 notations found in ICD-10-CM, which was implemented in March 2019, contained some conflicts between Excludes1 and Excludes2 notes which caused a need for claims to be re-adjudicated. We have taken steps to modify the logic and remove such conflicts.

To help ensure the accurate processing of claims, use ICD-10-CM Coding Guidelines when selecting the most appropriate diagnosis for patient encounters. ICD-10-CM has two types of excludes notes; each type has a different definition for use but they are similar since they indicate that codes excluded from each other are independent of each other. One of the unique attributes of the ICD-10 code set and coding conventions is the concept of Excludes1 notes. An Excludes1 note indicates that the excluded code identified in the note should not be used at the same time as the code or code range listed above the Excludes1 note. These notes are located under the applicable section heading or specific ICD-10-CM code to which the note is applicable. When the note is located following a section heading, it applies to all codes in the section.

Remember to review diagnosis code(s) for any Excludes1 notes prior to submitting your claims to help ensure proper adjudication of your claims.

Some examples of Excludes1 scenarios in ICD-10-CM, where both diagnosis codes should not be billed together include:

- Reporting both M54.2 (cervicalgia) with M50.XX (cervicalgia due to intervertebral disc disorder)
 - 2 has an Excludes1 note for M50.XX

- Reporting both M54.5 (low back pain) with S39.012X (strain of muscle, fascia and tendon of lower back)
 - 5 has an Excludes1 note for S93.012X
- Reporting both M54.5 (low back pain) with M54.4X (lumbago with sciatica)
 - 5 has an Excludes1 note for M54.4X
- Reporting J03.XX (acute tonsillitis) with J02.XX (acute sore throat), J02.0 (streptococcal sore throat), J02.9 (sore throat NOS), J35.1 (hypertrophy of tonsils) or J36 (peritonsillar abscess)
 - XX has an Excludes1 note for J02.XX, J02.0, J02.9, J35.1 and J36
- Reporting N89 (other inflammatory disorders of the vagina) with R87.62 (abnormal results from vaginal cytological exam), D07.2 (vaginal intraepithelial neoplasia), R87.623 (HGSIL of vagina), N76.XX (inflammation of the vagina), N95.2 (senile [atrophic] vaginitis) or A59.00 (trichomonal leukorrhea)
 - N89 has an Excludes1 note for R87.62, D07.2, R87.623, N76.XX, N95.2, D07.2 and A59.00

Finally, if you believe an Excludes1 note denial should be reviewed, please follow the normal claims dispute process and include medical records that support the usage of the diagnosis combination when submitting claims for consideration.

URL: <https://providernews.anthem.com/connecticut/article/claim-editing-update-for-excludes1-notes-2>

Provider transparency update

Published: Sep 1, 2019 - **Administrative**

A key goal of our provider transparency initiatives is to improve quality while managing health care costs. One of the ways this is done is by giving certain providers (payment innovation providers) in our various payment innovation programs (e.g., Enhanced Personal Health Care, Bundled Payments, Medical Home programs, etc.) (the programs) quality,

utilization and/or cost information about the health care providers (referral providers) to whom the payment innovation providers may refer their patients covered under the programs. If a referral provider is higher quality and/or lower cost, this component of the programs should result in their getting more referrals from payment innovation providers. The converse should be true if referral providers are lower quality and/or higher cost.

Providing this type of data, including comparative cost information, to payment innovation providers helps them make more informed decisions about managing health care costs and maintaining and improving quality of care. It also helps them succeed under the terms of the programs.

Additionally, employers and group health plans (or their representatives or vendors) may also be given quality/cost/utilization information about payment innovation providers and referral providers so that they can better understand how their health care dollars are being spent and how their health benefits plans are being administered. This will, among other things, give them the opportunity to educate their employees and plan members about the benefits of using higher quality and/or lower cost health care providers.

We will share data on which we relied in making these quality/cost/utilization evaluations upon request, and will discuss it with referral providers - including any opportunities for improvement. For questions or support, please refer to your local market representative or care consultant.

URL: <https://providernews.anthem.com/connecticut/article/provider-transparency-update-16>

Appointment access standards for primary care, specialty care and behavioral health practitioners

Published: Sep 1, 2019 - **Administrative**

As a participating provider, please be reminded of your contractual obligation to help ensure our members have prompt access to services. Please visit anthem.com to access our Provider Manual for our guidelines on access to care for primary care practitioners (PCPs), specialty care practitioners (SCPs) and behavioral health practitioners (BHPs). We use several methods to monitor adherence to these standards. Monitoring is accomplished by assessing the availability of appointments via phone calls by our staff or designated vendor

to the provider's office; analysis of member complaint data and analysis of member satisfaction surveys.

URL: <https://providernews.anthem.com/connecticut/article/appointment-access-standards-for-primary-care-specialty-care-and-behavioral-health-practitioners>

PCP after-hours access requirements

Published: Sep 1, 2019 - **Administrative**

As a participating provider, please be reminded of the requirement that your practice provide continuation of care for our members outside of regular business hours. Annually, we conduct after-hours access studies to assess how well practices are meeting this provision, and a high percentage of PCP offices do not have the basic messaging for our members for perceived emergency or urgent situations after regular office hours.

To be compliant, have your messaging or answering service include appropriate instructions.

- Emergency situations
 - The compliant response for an emergency instructs the caller/patient to hang up and call 911 or go to the ER, or connects the caller directly to the doctor.

- Urgent situations
 - The compliant response for an urgent situation would direct the caller to urgent care or the ER, to call 911 or directly connect the caller to their doctor or the doctor on call.

Messaging that only gives callers the option of contacting their health care practitioner (via transfer, cell phone, pager, text, email, voicemail, etc.) or to get a call back for urgent questions or instructions is not complaint, as there is no direct connection to their health care practitioner. Is your practice compliant?

URL: <https://providernews.anthem.com/connecticut/article/pcp-after-hours-access-requirements>

New Reimbursement Policies - Maternity Services and Multiple Delivery - professional

Published: Sep 1, 2019 - **Guideline Updates** / Reimbursement Policies

Beginning with dates of service on or after December 1, 2019, our current Routine Obstetrics policy will be retired and will be replaced by the new Maternity Services policy and the new Multiple Delivery policy. The new Multiple Delivery policy has the same reimbursement guidelines and requirements as the current Routine Obstetrics policy. The new Maternity Services policy has the same reimbursement guidelines for global billing as the current Routine Obstetrics policy with an update to the postpartum period. The postpartum period for CPT code 59430 (postpartum care only) will change from 45 days to a 90 day period.

For more information about this policy, visit the [Reimbursement Policy](#) page at [anthem.com/provider](https://www.anthem.com/provider).

URL: <https://providernews.anthem.com/connecticut/article/new-reimbursement-policies-maternity-services-and-multiple-delivery-professional>

New Reimbursement Policy - Intensity Modulated Radiation Therapy Planning and Delivery - professional

Published: Sep 1, 2019 - **Guideline Updates** / Reimbursement Policies

Beginning with dates of service on or after December 1, 2019, we will implement a new professional reimbursement policy, Intensity Modulated Radiation Therapy Planning and Delivery. This policy applies limitations to the Intensity Modulated Radiation Therapy (IMRT) planning, delivery, development and field setting services. For more information about this policy, visit the [Reimbursement Policy](#) page at [anthem.com/provider](https://www.anthem.com/provider).

URL: <https://providernews.anthem.com/connecticut/article/new-reimbursement-policy-intensity-modulated-radiation-therapy-planning-and-delivery-professional-1>

Claims requiring additional documentation facility reimbursement policy update

Published: Sep 1, 2019 - **Guideline Updates** / Reimbursement Policies

As we advised you in the April 2018 Network Update and September 2018 [Network eUpdate](#), in our efforts to improve payment accuracy and reduce post-payment recoveries, beginning with dates of service on or after July 13, 2018, we updated our Claims Requiring Additional Documentation policy to include the following requirement:

- Inpatient stay claims reimbursed at a percent of charge with billed charges above \$40,000 require an itemized bill to be submitted with the claim.

We continue to receive claims without the required itemized bill causing the claims to be returned for the itemization. To help ensure accuracy and eliminate delays in the adjudication of your claims, the itemized bill must be included with qualifying claim submissions.

For more information about this policy, visit the [Administrative, Billing and Reimbursement Policies](#) page at anthem.com/provider.

In addition, visit our anthem.com provider website to view the [instructions](#) on how to submit your itemized bill to us.

URL: <https://providernews.anthem.com/connecticut/article/claims-requiring-additional-documentation-facility-reimbursement-policy-update-4>

Medical policy updates are available on anthem.com

Published: Sep 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

The following new and revised medical policies were endorsed at the July 29, 2019 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com/providers > scroll down and select 'Find Resources for [state]' > [Medical Policies and Clinical UM Guidelines](#).

If you do not have access to the internet, you may request a hard copy of any updated policy by contacting the [Provider Call Center](#).

Please note that the Federal Employee Program® Medical Policy Manual may be accessed at www.fepblue.org > Benefit Plans > [Brochures and Forms](#) > Medical Policies.

Revised medical policy effective July 30, 2019

(The following policy was revised to expand medical necessity indications or criteria.)

MED.00129 - Gene Therapy for Spinal Muscular Atrophy

URL: <https://providernews.anthem.com/connecticut/article/medical-policy-updates-are-available-on-anthemcom-21>

Clinical guideline updates are available on anthem.com

Published: Sep 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

The following new and revised medical policies were endorsed at the June 6, 2019 Medical Policy & Technology Assessment Committee (MPTAC) meeting. These, and all Anthem medical policies, are available at anthem.com/providers > scroll down and select 'Find Resources for [state]' > [Medical Policies and Clinical UM Guidelines](#).

If you do not have access to the internet, you may request a hard copy of any updated policy by contacting the [Provider Call Center](#).

Archived clinical guideline effective October 1, 2019

(This policy is transitioning to be an AIM Clinical Guideline.)

CG-MED-80 - Positron Emission Tomography (PET) and PET/CT Fusion

Revised clinical guideline effective December 1, 2019

(The following guideline listed below might result in services that were previously covered now being considered either not medically necessary and/or investigational.)

CG-SURG-101 - Ablative Techniques as a Treatment for Barrett's Esophagus

URL: <https://providernews.anthem.com/connecticut/article/clinical-guideline-updates-are-available-on-anthemcom-22>

New Clinical Guideline: Pneumatic Compression Devices effective December 1, 2019

Published: Sep 1, 2019 - **Policy Updates** / Medical Policy & Clinical Guidelines

We will implement the following clinical guideline effective December 1, 2019, to support the review for outpatient pneumatic compression devices post-op outpatient orthopedic procedures.

CG-DME-46 - Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Lower Limbs

Visit our [website](#) to view the clinical guideline.

For questions, please contact the provider service number on the back of the member's ID card.

URL: <https://providernews.anthem.com/connecticut/article/new-clinical-guideline-pneumatic-compression-devices-effective-december-1-2019-2>

Electronic attachments coming soon

Published: Sep 1, 2019 - **State & Federal** / Medicare

As we prepare for the potential regulatory-proposed standards for electronic attachments, we will be implementing X12 275 electronic attachment transactions (version 5010) for claims.

Standard electronic attachments will bring value to you by eliminating the need for mailing paper records and reducing processing time overall.

Anthem and Availity will pilot electronic data interchange batch electronic attachments with previously selected providers. Both solicited and unsolicited attachments will be included in our pilots.

Attachment types

- **Solicited attachments:** The provider sends a claim and the payer determines there is not enough information to process the claim. The payer will then send the provider a request for additional information (currently done via letter). The provider can then send the solicited attachment transaction, with the documentation requested, to process the claim.
- **Unsolicited attachment:** When the provider knows that the payer requires additional information to process the claim, the provider will then send the X12 837 claim with the Paper Work Included segment tracking number. Then, the provider will send the X12 275 attachment transaction with the additional information and include the tracking number that was sent on the claim for matching.

What you can do

As we prepare for this change, you can help now by having conversations with your clearinghouse and/or electronic healthcare records vendor to determine their ability to set up the X12 275 attachment transaction capabilities.

In addition, you should be on the lookout for additional information and details about working with Anthem and Availity to send attachments via electronic batch.

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URL: <https://providernews.anthem.com/connecticut/article/electronic-attachments-coming-soon-1>

Clinical criteria updates

Published: Sep 1, 2019 - **State & Federal** / Medicare

On March 29, 2019, April 12, 2019 and May 1, 2019, the Pharmacy and Therapeutic (P&T) Committee approved clinical criteria applicable to Anthem's medical drug benefit. These policies were developed, revised or reviewed to support clinical coding edits.

The clinical criteria is publicly available on the provider website (www.anthem.com/medicareprovider), and the effective dates will be reflected in the [clinical](#)

[criteria Q2 update](#). Visit [clinical criteria](#) to search for specific policies.

For questions or additional information, email to druglist@ingenio-rx.com.

501734MUPENMUB

URL: <https://providernews.anthem.com/connecticut/article/clinical-criteria-updates-12>

Customizations to the 23rd edition of the MCG Care Guidelines

Published: Sep 1, 2019 - **State & Federal** / Medicare

Effective November 1, 2019, customizations will be implemented for chemotherapy and inpatient & surgical care (W0162) for adult patients. The customizations provide specific criteria and guidance on the following:

- Clinical indications for admission; examples will also be added for:
 - o Aggressive hydration needs that cannot be managed in an infusion center.
 - o Prolonged marrow suppression.
- Regimens that cannot be managed outpatient; examples will also be added.

Providers can view a summary of the 23rd edition of the MCG Care Guidelines customizations [online](#) by selecting Customizations to MCG Care Guidelines 23rd Edition.

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URL: <https://providernews.anthem.com/connecticut/article/customizations-to-the-23rd-edition-of-the-mcg-care-guidelines-2>

Changes to prior authorization requirements effective December 1, 2019

Published: Sep 1, 2019 - **State & Federal** / Medicare

Beginning December 1, 2019, we will update prior authorization (PA) requirements for certain services for our Medicare Advantage members. Federal and state law, state contract language and CMS guidelines (including definitions and specific contract provisions and exclusions) take precedence over these rules and must be considered first when determining coverage. We will deny claims that are noncompliant with the new rules.

In December, PA will be required for the following services/codes:

- T1019 — Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)
- C9740 — Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants
- E0953 — Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware
- E1031 — Rollabout chair, any and all types with castors 5 inches or greater
- E1090 — High-strength lightweight wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- E1130 — Standard wheelchair, fixed full-length arms, fixed or swing-away detachable footrests
- E1140 — Wheelchair, detachable arms, desk or full-length, swing-away detachable footrests
- E1260 — Lightweight wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- E1285 — Heavy-duty wheelchair, fixed full-length arms, swing-away detachable footrest
- E1290 — Heavy-duty wheelchair, detachable arms (desk or full-length) swing-away detachable footrest
- E2207 — Wheelchair accessory, crutch and cane holder
- E2378 — Power wheelchair component, actuator, replacement only
- K0039 — Leg strap, H style

Not all PA requirements are listed here; detailed PA requirements are available to contracted providers by accessing the provider self-service tool at <https://www.availability.com>.

Contracted and non-contracted providers who are unable to access the Availity Portal may call the number on the back of the member's ID card for PA requirements.

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URL: <https://providernews.anthem.com/connecticut/article/changes-to-prior-authorization-requirements-effective-december-1-2019>

Pharmacy benefit manager change to IngenioRx

Published: Sep 1, 2019 - **State & Federal** / Medicare

Effective January 1, 2020, IngenioRx will become our new pharmacy benefit manager (PBM) and will start managing prescription coverage for your Medicare Advantage individual and group retiree plan patients. IngenioRx PBM services will include handling your patients' prescriptions for mail order and specialty pharmacy medications.

Transferring prescriptions

We will automatically transfer prescriptions to IngenioRx Home Delivery Pharmacy for members currently using Express Scripts Mail Order Pharmacy. Members will receive instructions for initializing IngenioRx Home Delivery Pharmacy later this year. For members receiving specialty drugs from Accredo, we will automatically transfer prescriptions to IngenioRx Specialty Pharmacy. Most members will be able to fill their prescriptions at their same retail pharmacy outlet. If the member's pharmacy will not be available, we'll notify the member by letter and include a list of three alternative pharmacies near his or her home.

Prescriptions for controlled substances currently being filled at Express Scripts Mail Order Pharmacy or Accredo cannot be transferred to another pharmacy under federal law. Patients currently receiving these medications will need a new prescription sent to IngenioRx Home Delivery Pharmacy or IngenioRx Specialty Pharmacy.

- For providers who use ePrescribing:
 - There are no changes — simply select IngenioRx.
- For providers who do not use ePrescribing;

- Send your mail order and specialty prescriptions to IngenioRx. IngenioRx will begin accepting prescriptions January 1, 2020. Please consider the number of days' supply needed when making these requests.

IngenioRx Mail Order Pharmacy new prescriptions:

Phone: 833-203-1742

Fax: 800-378-0323

IngenioRx Specialty Pharmacy:

Prescriber phone: 833-262-1726

Prescriber fax: 833-263-2871

You can confirm whether your patient has transitioned to IngenioRx through the Availity Portal. The patient's PBM information can be located in the Patient Information section of their patient profile as part of the eligibility and benefits inquiry.

If you have questions, contact the Provider Service phone number on the back of the member's ID card or call the number you normally use for questions.

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URL: <https://providernews.anthem.com/connecticut/article/pharmacy-benefit-manager-change-to-ingeniorx-2>

Keep up with Medicare news

Published: Sep 1, 2019 - **State & Federal** / Medicare

Please continue to check [Important Medicare Advantage Updates](#) at [anthem.com/medicareprovider](https://www.anthem.com/medicareprovider) for the latest Medicare Advantage information, including:

- [Medicare Advantage Group Retiree PPO plans and National Access Plus FAQ](#)
- [Group Retiree members and National Access Plus](#)
- [Bill Medicare Part D for shingles or tetanus vaccination claims](#)

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URL: <https://providernews.anthem.com/connecticut/article/keep-up-with-medicare-news-80>
