Anthem BlueCross BlueShield

November 2017

Provider Fall Newsletter 2017

Telehealth payment policy

Anthem Blue Cross and Blue Shield (Anthem) BadgerCare Plus follows ForwardHealth policy for services provided via telehealth, effective for dates of service on and after September 1, 2017, as described in *ForwardHealth Update No. 2017-25*. The health plan requires that the place of service (POS) where the member is located, referred to as the originating site, be one of the following: inpatient hospital (POS 21), outpatient hospital (POS 19 and 22), emergency room hospital (POS 23), office/clinic (POS 11 and 49) or skilled nursing facility (POS 31). An originating site facility fee may be billed using HCPCS code Q3014 (telehealth originating site facility fee). The distant site provider must report POS 2; only the provider types and CPT codes listed in the *ForwardHealth Update* are eligible for telehealth reimbursement.

Programs and services certified by the Department of Quality Assurance in accordance with Wis. Admin. Code chs. DHS 34, 35, 36, 40, 61, 63 or 75 to provide mental health and substance abuse treatment programs or services are required to meet telehealth certification requirements if they plan to provide services via telehealth.

Providers prohibited from collecting payment from Medicaid recipients

Providers are prohibited from collecting payment from BadgerCare Plus recipients for Anthem benefits. Providers may bill BadgerCare Plus recipients for noncovered services if the member accepts financial responsibility and the provider makes payment arrangements with the member prior to delivery of the service. Providers are strongly encouraged to obtain a written statement from the member before the service is provided documenting that the member has accepted responsibility for payment of the service.

Providers may inadvertently attempt to collect payment in situations where they're unaware the patient is a BadgerCare Plus recipient. It is recommended practice that the provider's front office staff check the patient's health insurance coverage at each patient visit. Under state and federal laws, a provider who inappropriately collects payment from a Medicaid recipient may be subject to program sanctions, including termination of Medicaid enrollment, fines or imprisonment. Additional information can be found in the ForwardHealth provider manual under Topic #227.

First- and second-level appeal deadlines

Providers may use the claims payment appeals process to challenge the outcome of a claim decision when they disagree. The first-level appeal, whether written or verbal, must be received by the health plan within 180 calendar days of the *Explanation of Payment* paid date or recoupment date, or the time limit set forth in the provider's Anthem contract. The second-level appeal must be received within the time frame indicated on the first-level appeal decision letter.

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Some recommendations or tips:

- Providers should **always** file a first- or second-level appeal within the time frame outlined below if there is any doubt or the Provider Relations representative has not gotten back to the provider.
- Add as much detail to the appeal summary notes as possible. Many first-level appeals could have been overturned had a more detailed explanation been provided. You can assist in the appeal process by providing clear and accurate information for the Anthem analyst.
- The second-level appeal must be in written form and must include [one] attachment. The attachment can include documentation explaining why the provider believes the first-level appeal should have been overturned, as well as medical records and any other supporting information.
- If a provider calls Anthem Customer Service to question a denial, be sure to advise the representative that you **do not** want an appeal initiated from the phone call. The Customer Service representative will read a script/agreement to the provider, which acknowledges that an appeal is about to be opened and the call recorded.

Reminder: AIM Specialty Health® managing review of sleep medicine, cardiology and radiation oncology services

We remind providers that, effective September 1, 2017, you should now contact AIM to obtain an order number for your Anthem patients before scheduling or performing the following services:

- Elective, outpatient home-based (unattended) diagnostic studies
- Facility-based diagnostic or titration study (freestanding or hospital)
- Sleep treatment equipment and related supplies

The following services are included:

- Home sleep test
- In-lab sleep study: polysomnography, Multiple Sleep Latency Test, Maintenance of Wakefulness Test
- Titration study
- Initial treatment order: automatic positive airway pressure (APAP), continuous positive airway pressure (CPAP), bilevel positive airway pressure (BPAP)
- Ongoing treatment order: APAP, CPAP, BPAP

Services performed in conjunction with emergency room services, inpatient hospitalization or urgent care facilities are excluded. For additional details about AIM requirements for sleep medicine order requests, please see the provider bulletin posted to the provider website at the link below. The bulletin also addresses AIM management of clinical appropriateness reviews of cardiology and radiation oncology services: **https://mediproviders.anthem.com/Documents/WIWI_CAID_PU_AIMInitiativeAnnouncement.pdf**.

Appointment access standards

The information below outlines Anthem's standards for timely and appropriate access to quality health care, following guidelines set by the National Committee for Quality Assurance, the American College of Obstetricians and Gynecologists, and the Wisconsin Department of Health Services. These standards help ensure that medical appointments and emergency services are provided fairly, reasonably and within specific time frames.

PCPs and specialists must make appointments for members according to the following scheduling standards:

- Emergency examinations: immediate access 24/7
- Urgent examinations: within 24 hours of request
- Routine exams: within 14 days of request
- Behavioral health (BH) emergency: immediately
- Outpatient treatment postpsychiatric inpatient care: within three days from the date of discharge from an inpatient psychiatric hospital stay
- Routine BH visits: within 10 days of request
- Routine dental appointment: within 90 days of request