Reporting Taxonomy codes

Taxonomy codes are standard code sets used to provide information about provider type and specialty for the provider's certification. Providers are required to report a Taxonomy code in Box 33b on claims submitted to Anthem Blue Cross and Blue Shield (Anthem) for BadgerCare Plus members when the billing NPI entered on the claim form corresponds to multiple Medicaid certifications.

Reporting the corresponding Taxonomy code for the service performed is required in order for Anthem to process claims and apply the appropriate benefit. The importance of accurate Taxonomy code reporting is based on the need for complete Medicaid encounter data that managed care plans submit to the state. Health plan encounters are rejected by ForwardHealth when the claim is submitted with an inappropriate Taxonomy code/CPT code combination.

Sterilization consent form

Medicaid reimbursement for sterilizations is dependent upon providers fulfilling all federal and state requirements and thorough completion of the Consent for Sterilization form. The form completion instructions for element 22 require that one of the alternative final paragraphs is struck in order to indicate whether the minimum waiting period of 30 days was met. If one of the paragraphs is not crossed out, the health plan will deny the claim. The provider may appeal this action to the state. Refer to the provider online manual for complete ForwardHealth requirements and to access the Consent for Sterilization form.

After-hours standards for PCP availability

Anthem standards for primary care providers (PCP) state that the PCP is to be available 24 hours a day, 7 days per week. The objective is for members to have access to PCP offices after normal business hours and to ensure that offices are providing proper instructions to members for emergency care.

Anthem considers the standards to be satisfied if the following are met:

- Office or answering service answers the call, directs the caller appropriately for life-threatening situations, **and** has a way of reaching a PCP or on-call provider for non-emergency situations, or directs the caller to another number to reach a PCP or on-call provider;
- Answering machine or automated response directs the caller to contact 911 or directs the caller to the nearest emergency department for life-threatening situations **and** has contact information for the PCP or on-call provider
- PCP was reached directly

Anthem standards are not met by the PCP if:

- The answering machine or automated response does not direct the caller appropriately for life-threatening situations or does not properly direct the caller for non-emergency issues

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- There is no answer on the office phone.

New benefit for behavioral treatment

ForwardHealth will initiate coverage for behavioral treatment services, including services for treatment of autism spectrum disorder (ASD), beginning in 2016. Information regarding provider enrollment and coverage requirements for this new benefit can be accessed from the ForwardHealth website at: https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/html/btb/Behavioral_Treatment_Benefit.htm.spage

Providers are reminded that claims for behavioral treatment services are submitted to Medicaid fee-for-service, not to the member's managed care plan. Claims submitted to Anthem for BadgerCare Plus members will be denied as state responsibility.

Post-service claims review for high-cost drugs

Effective **February 1, 2016**, Anthem will begin a post-service claims review for high-cost drugs that also have been identified as those most frequently billed to the health plan. These drugs currently do not require prior authorization when administered in the facility setting and submitted on the UB-04 claim form. Drugs subject to review can be identified on the health plan's provider website using the precertification tool. The following message will be returned to providers for drugs subject to the review process:

This drug is managed directly by ForwardHealth except when the rendering provider is billing the services on a UB-04 claim form. When this occurs, Anthem will manage the drug via the Post Service Clinical Claims Review (PSCCR) process.

Professional claims for drugs will continue to be submitted to ForwardHealth fee-for-service according to the current drug carve-out policy. The complete provider notification of the PSCCR process can be accessed from the health plan's provider website at the following link: https://mediproviders.anthem.com/WI/Pages/communications-updates.aspx

Tobacco use disorder counseling

Tobacco use disorder is one of the key initiatives the state of Wisconsin is focusing on for HMO patients. The state is measuring the percentage of BadgerCare Plus members who are 12 years of age and older, and identified as tobacco users receiving tobacco counseling.

The goals are for patients with tobacco use disorder to receive tobacco counseling and be identified through the claims submission process with an appropriate diagnosis code. The CPT and diagnosis codes to report for this measurement are:

- Behavioral Health and Medical Services Providers may report the following codes, as appropriate for their Provider Type: **96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387,**

99394, 99397, 99401-99404, 90832-90834, 90836-90838, 90845, 90847, 90849, 90875, 90876, 90880, 90899.

- ICD-9-CM Code: **305.1 – primary, secondary, tertiary, or fourth placement**
- ICD-10-CM Codes**: F17200, F17201, F17208-211, F17213**, **F17218-21, F17223, F17228, F17229, F17290, F17291. F17293, F17289, F17299, Z720.**

Please take the time to identify tobacco use disorder patients and submit your claims using the codes noted above.

Member grievance and appeals process

Anthem is committed to resolving any issues that our BadgerCare Plus members may have with the health plan. To facilitate this process, the health plan employs a member advocate who works with both members and providers to ensure the provision of member benefits. The member advocate monitors formal and informal grievances to identify trends or specific problem areas of access and care delivery and is charged with making recommendations to the health plan on any changes needed to improve the care provided or the way care is delivered. A brief summary of the member grievance and appeals processes is include here; however, a more detailed description of the process is in chapter 12 of the provider manual located on the Medicaid provider website at this link: https://mediproviders.anthem.com/WI/Pages/manuals-directories-training.aspx

Grievance Process

All members are entitled to a grievance and appeals process in a timely manner and in accordance with state and federal regulations. Members are encouraged to discuss their concerns with Anthem staff, who can resolve most verbal complaints. However, if the issue is not resolved to the member's satisfaction, the member can contact the member advocate who coordinates the formal grievance process, initiates investigations, and ensures that appropriate follow-up occurs. The member advocate can be reached by calling **1-855-690-7800** and requesting the member advocate for Wisconsin.

As part of the formal grievance process, medical records or other information may be requested from the provider involved. Providers are expected respond to these requests within 10 days.

Appeals Process

When the member is dissatisfied with the resolution of the grievance process (for example: the decision not to approve the service for which their doctor has asked), they may file an appeal, either standard or expedited. Members and providers have the opportunity to submit written comments and documentation relevant to the appeal. If Anthem requests medical records or an explanation of the issues raised in the appeal, providers are expected to respond within 10 days for a standard appeal and 24 hours for an expedited appeal.

When the appeal is the result of a medical necessity determination, the case is reviewed by a physician clinical reviewer of the same or similar specialty who was not involved in the initial decision. The provider may be contacted by the clinical reviewer to discuss possible alternatives.

The resolution timeframe may be extended for 10 business days upon member request, or if Anthem demonstrates a need for additional information that would be in the member's best interest.

Refer to the provider manual for other member options for filing grievances and appeals:
https://mediproviders.anthem.com/WI/Pages/manuals-directories-training.aspx