Anthem

Provider Bulletin
September 2020

Electronic visit verification notification

Electronic visit verification

The *Federal Cures Act* requires State Medicaid Departments to implement electronic visit verification (EVV). The Wisconsin Department of Health Services (DHS) established Sandata as their vendor for electronic visits and will train providers on this system. Providers are expected to have all of their staff use the EVV program to validate visits for personal care services. All claims must have a valid visit for the date, time, provider, member and units for which the provider is authorized.

DHS reported a soft-launch date for EVV in November 2, 2020. HMOs will work with providers to ensure they have valid visits in place when they submit a claim. DHS will then establish the hard launch date. When that date is set, the HMO will deny any claim that does not have a valid visit. Providers must ensure that visits are valid through the Sandata system and resubmit any claims denied for not having a valid visit.

Please ensure submitted claims are completed accurately to assist with visit validation. DHS has required HMOs to match the EVV visit and claim on several indicators including: member Medicaid ID, provider Medicaid ID, date and time of visit, units of visit, and procedure code.

Live-in caregiver

Wisconsin DHS has indicated HMOs are able to make the determination related to live-in workers. Anthem Blue Cross and Blue Shield (Anthem) has made the decision to subject live-in workers to the requirements of EVV.

Prior authorization

Prior authorization (PA) is required before personal care services can be performed. Services must meet authorization and medical necessity guidelines as established by the HMO. You must include all clinical documentation to assist in making a medically necessary decision. Per the Personal Care Screening Tool (PCST) instructions, assessment for durable medical equipment should be completed prior to the administration of the PCST. It is required that this assessment by an occupational/physical therapist (OT/PT) be included in the request for new personal care services. Furthermore, durable medical equipment should be in place for the member prior to the administration of the PCST to determine true functional deficits that need personal care services and cannot be replaced by a more appropriate service such as durable medical equipment.

You must submit all proper documentation for personal care services including:

- Medical doctor order.
- Physician plan of care.
- Clinical documentation noting functional deficits and diagnosis that align with requested services.
- PT/OT evaluations demonstrating functional abilities.
- PCST (completed within the last 90 days).
- Supervisory RN and determination of anticipated duration of services per *Wisconsin Admin Code DHS 107.112(3)(b)2*.

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If appropriate documentation is not included, your request will be returned, and you will be asked to submit an updated PA with the appropriate documentation. If you do not re-submit within 14 days, you will be required to submit a new request.

Please ensure you are updating your contact information with Anthem's Provider Services at **1-855-558-1443** so that we are able to update you if any changes are needed to your PA.

COVID-19 emergency health order

During the emergency health order, DHS established some policy and procedure changes. Anthem follows provider notification 2020-15, allowing telehealth visits to be completed in lieu of face-to-face visits. Face-to-face visits are expected to be re-established upon notification from DHS that 2020-15 is no longer applicable.

Billing

Proper billing and submission guidelines must be followed to ensure services provided to members are paid. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Anthem reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations. Anthem reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy

Wisconsin DHS – 2018-18, Section 12006(a) of the *21st Century Cures Act:* PA policy for Anthem follows *Wisconsin Admin. Code DHS 107.02(3), 107.03(5), 107.03(9), 107.112*, and ForwardHealth topics #2472, #2479 and ForwardHealth update no. 2009-08.

Anthem follows the instruction tool F11133A for the PCST in guidance for determining allocation of time. The initial claim must be received and accepted in compliance with federal and/or state mandates regarding claims timely filing requirements to be considered for reimbursement. Anthem follows the standard of:

- 180 days for participating providers and facilities.
- 365 days for nonparticipating providers and facilities.

Timely filing is determined by subtracting the date of service from the date we receive the claim and comparing the number of days to the applicable federal or state mandate. If there is no applicable federal or state mandate, then the number of days is compared to the company standard.