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MOBCBS-CRCM-038802-23-CPN38706

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

To view this publication online:

Visit https://providernews.anthem.com/missouri/publications/october-2023-provider-newsletter-30

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Administrative | Commercial | Oct 1, 2023

Enhanced outpatient facility editing for National Correct Coding Initiative: *Medically Unlikely Edits (MUEs)*

Beginning with claims processed on and after November 15, 2023, we will update our claims editing process for outpatient facility claims by applying the Medicare National Correct Coding Initiative (NCCI) Medically Unlikely Edits. NCCI edits are Centers for Medicare & Medicaid Services (CMS) developed guidelines to promote national correct coding based on industry standards for current coding practices.

These edits provide an opportunity to shift certain existing back-end reviews to front-end adjudication for outpatient facility claims. While this may facilitate quicker claim adjudication, it may also cause claims to deny frequency unit limits tied to Medically Unlikely Edits (MUEs) if correct coding guidelines are not followed. For additional information, please visit **CMS.gov** and select the *Medically Unlikely Edits page.*

If you have questions about this communication or need assistance with any other item, contact your Provider Relationship Management representative.

MULTI-BCBS-CM-036615-23-CPN36574

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/enhanced-outpatient-facility-editing-for-national-correct-co

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Administrative | Commercial | Oct 1, 2023

National Accounts 2024 Pre-certification list

The ***National Accounts 2024 Pre-certification list*** has been published. Please note, providers should continue to verify member eligibility and benefits prior to rendering services.

MULTI-BCBS-CM-035553-23-CPN35553

ATTACHMENTS (available on web): National Accounts 2024 Pre-certification list (pdf - 0.33mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/national-accounts-2024-pre-certification-list

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Administrative | Commercial | Oct 1, 2023

CAA: Maintain your online provider directory information

The *Consolidated Appropriations Act (CAA) of 2021* contains a provision that requires online provider directory information be reviewed and updated as needed at least every 90 days. Maintaining your online provider directory information is essential for members and healthcare partners to connect with you when needed. Please review your information frequently and let us know if any of your information we show in our online directory has changed.

Submit updates and corrections to your directory information by following the instructions on our **Provider Maintenance web page**. Online update options include:

- Add/change an address location.
- Name change.
- Provider leaving a group or a single location.
- Phone/fax number changes.
- Closing a practice location.

Reviewing your information helps us ensure your online provider directory information is current. Through genuine collaboration, we can simplify access to care and help you deliver high-quality, equitable healthcare.

MULTI-BCBS-CM-038049-23-SRS38044

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/icaai-maintain-your-online-provider-directory-informat-2

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Digital Tools | Commercial / Medicare Advantage | Oct 1, 2023

A way to help lower-income patients pay for internet service

Having reliable internet access is an important part of life. The internet helps us find information and connect with people, including finding and connecting with healthcare providers via virtual visits. However, not everyone can afford it. We share a health vision with our care provider partners that means real change for consumers. Making the internet more accessible is one way we can improve the whole health of our communities.

The Affordable Connectivity Program can help.

What is the Affordable Connectivity Program?

The Affordable Connectivity Program is a **government program that helps families who may need assistance** pay for internet access. Qualified households can receive:

- Up to a $30/month discount on internet service.
- Up to a $75/month discount on internet service if they live on **certain Tribal lands**.
- Up to a $100 one-time discount on a laptop, desktop, or tablet bought through a **participating internet provider**.

Who is eligible for the program?

A household is eligible for the Affordable Connectivity Program if:

- The household income is **200% or less than the Federal Poverty Guidelines**.
- Someone in the household (including a child or dependent):
    - Participates in certain government assistance programs such as the Supplemental Nutrition Assistance Program (SNAP), Medicaid, Social Security Income (SSI), the

Free and Reduced-Price School Lunch Program or School Breakfast Program, or **others**.

- Participates in certain Tribal assistance programs, such as Head Start, Tribal Temporary Assistance for Needy Families (TANF), or **others**.
- Received a Federal Pell Grant during the current award year.
- Already receives a **Lifeline** benefit (another government program providing discounts on internet and phone service).

How do my patients apply?

Your eligible patients can apply for the Affordable Connectivity Program online or by mail. They can also ask their current internet provider if they participate in the program. Please direct your patients to learn more at **AffordableConnectivity.gov**.

MULTI-BCBS-CRCM-036097-23-CPN34208

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/a-way-to-help-lower-income-patients-pay-for-internet-service-21

Or scan this QR code with your phone

Digital Tools | Commercial / Medicare Advantage / Medicaid | Oct 1, 2023

Introducing Claims Status enhancements for claim inquiries

We know one of the reasons you call us for claims status is because all the information you need isn't always available. We want to change that by making Availity Essentials'* claims status enhancements available for Anthem member inquiries. In November, enjoy the benefits of expanded search options, filters, and downloadable reports from the same Claims Status application you are using for other payers on **Availity.com**.

Claims Status application enhancements include:

- Improved search options (by patient account number and claim number).
- Customizable fields with sort options and exportable results.
- Details screen that includes interest and payment information.
- Remit Viewer (Electronic Remittance Advice — 835).
- Simplified layout that includes less scrolling and screens.

Enhancements will be rolled out, maximizing the effectiveness of the application. These updates are also available for claims submitted through clearinghouses or care providers using API transmissions.

The new claim status enhancements are in addition to the benefits you already enjoy:

- Submit documentation directly to your claim
- File a claim dispute
- Verify eligibility and benefits
- Send a secure message or chat with us directly from the application
- Chat with Payer available in all markets

Training and support

Learn how to optimize your experience using the Claims Status application on **Availity.com** by attending live or recorded webinar sessions. Visit the learning microsite **here** and register for training today.

Enhancing claims status results is one of the ways Anthem is collaborating for success. For questions or additional information, reach out to your Provider Relations Account Management Representative or use Chat with Payer.

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* Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

MULTI-BCBS-CDCRCM-034719-23-CPN34127

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/introducing-claims-status-enhancements-for-claim-inquiries-2

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Digital Tools | Medicare Advantage | Oct 1, 2023

Availity: Medicare provider-facing talking points and FAQ

Background:

We continue to focus and expand our consumer tools and content to assist members in making more informed and personalized healthcare decisions. Provider performance can vary widely in relation to efficiency, quality, and member experience. Our goal as your Medicare health plan partner is to ensure our members receive high-quality care that leads to improved member health outcomes across a wide range of variables.

Beginning January 1, 2023, we added a new sorting option on the FindCare tool for members to leverage when they are searching for a primary care provider. This sorting option, called Personalized Match Phase 1, is based on each provider's score relative to their peers in the patient's preferred mileage search radius. Providers are listed in order of their total score, though no individual scores appear within the tool or be visible to Medicare covered patients. The Personalized Match Phase 1 algorithm is based on quality and efficiency criteria to assist members in making more informed choices about their medical care. Other sorting options are still available on FindCare for our members.

Personalized Match Phase 1 highlights:

- We strive to make healthcare simpler, more affordable, and more accessible, and one of the ways to help achieve that goal is to ensure that consumers are connected with care providers who have strong track records delivering quality care.
- Beginning on November 10, 2023, we will upgrade the online FindCare tool for Medicare members with a new sorting option called Personalized Match Phase 1, to match consumers with providers who perform well in efficiency and quality metrics within a certain geographical distance.

- The new sorting option, known as Personalized Match Phase 1, will be the default for consumers who search for Medicare non-primary specialty care providers in FindCare.
- We currently offer *Personalized Match* to Commercial consumer members. *Personalized Match* seeks to match consumers with documented health conditions with provider ranked based on cost effectively managing quality care. For example, if a consumer who has been given a diagnosis of diabetes conducts a search, they will be matched with providers whose patients are more likely to cost effectively manage similar patients with diabetes (for example, consistently receive recommended A1c tests A consumer who is a 60-year-old male would receive different *Personalized Match* provider rank order than a consumer who is a 30-year-old female). The goal is to move to this full *Personalized Match* solution in Medicare in the future. *Personalized Match Phase 1* only analyzes providers' quality and efficiency performance regardless of member characteristics for generating the sort order.
- You may review a copy of the new sorting methodology which has been posted on Availity.*
- If you have general questions regarding this new sorting option, please submit an inquiry via the web on Availity.
- If you would like information about your scoring used for this sorting option or if you would like to request reconsideration of your score, you may do so by submitting an inquiry via the web on Availity.
- This change is part of a greater effort to help improve access to high quality, affordable healthcare, which is essential to our customers.

FAQ

Why are we reimagining the strategy for evaluating non-primary specialty care providers?

There is variability in provider performance (efficiency, quality, experience), and we want to ensure all members receive high-quality care that leads to improved patient outcomes. The strategy aligns with the future direction of our specialty provider care strategy. This phase of the Medicare FindCare improvement utilizes measures related to appropriate practice (for example, overuse and underuse measures). We utilize a vendor, Motive Medical, to

generate an overall Appropriate Practice Score at the NPI level, based on all CMS Fee-for-Service members.

How will I know my inquiry went through successfully once I submit?

An email will be sent to the inquirer acknowledging receipt of inquiry within two business days.

What is the turnaround time from when I submit my question to receiving an answer?

The goal is to have all questions answered within two business days. If further clarification is needed, or if detailed research is required, that time frame will be extended.

How will I receive my response?

An email will be sent with the required information back to the email address provided during the initial inquiry request.

How do I submit an inquiry?

Inquiries can be made at **Availity site**. There are three dropdown options for inquiry types. These are: 1) General Program Inquires, 2) Request a Copy of Your Provider Performance Scorecard, and 3) Provider Performance Scorecard Inquiries. An open text field is available to describe the nature of the inquiry in more detail.

What type of inquiries can I submit?

Any questions relating to Personalized Match Phase 1 that is not answered in this FAQ or by the Methodology document.

Do providers have any recourse if they feel their Provider Performance Scorecard is inaccurate?

If a provider disagrees with their Provider Performance Scorecard results, the provider can submit an inquiry at **Availity site** detailing their reasoning. We will determine the best course of action as needed, but potential outcomes could be a provider consultation, reanalysis, and potentially a rescoring of provider performance to be reflected in Personalized Match Phase 1 and the Provider Performance Scorecard.

What provider specialties are included in Personalized Match Phase 1?

For 2023, selected non-primary specialty care providers are included. We plan to potentially incorporate other provider specialties in future provider performance evaluations.

What measures are included in quality scoring and why were they included?

The quality measures selected for Personalized Match Phase 1 include underuse and overuse measures, within the appropriate practice domain. Measures vary by specialty and are available on request.

How are measures weighted?

Motive Medical considers three factors in weighting the importance of each measure as it impacts the overall NPI Appropriate Practice Score (APS):

- Measure volume (for example, the number of instances a provider is eligible for measurement)
- Cost differential (for example, the difference in cost between the inappropriate service chosen versus the cost of the appropriate alternative), and
- Patient harm (for example, measures weigh more heavily if they have a stronger negative impact on the patient).

What measurement year and source are used in quality scoring?

Motive Medical's Fall 2022 Refresh was used for quality scoring with varying claim periods by measure including dates from January 1, 2019, to December 31, 2021.

What are the inclusion criteria for quality scoring?

A non-primary specialist care provider must have at least three appropriateness measures with at least ten members in each measure (a few measures require 20 members) for the APS score to be calculated. If the provider does not meet this threshold, the APS score is not available.

The APS score can be described in the following steps:

- Within each specialty, calculate the mean Motive Medical APS score to be used as the national-specialty benchmark.
- For each non-primary care specialty provider, calculate an APS Observed to Expected (O/E) ratio, comparing the provider to the benchmark for the same specialty:
    - Provider's APS / national-specialty benchmark.
- The quality score is the provider's APS O/E percentile ranking at the national-specialty level.

What factors go into your efficiency target?

The factors going into our efficiency target are the episodes of the members are assigned to provider specialty who has the highest cost within the episode for Surgery and Evaluation costs. The *observed* cost of an episode is the sum of provider's total allowed costs. The *expected* or peer benchmark cost of an episode is the average cost of treating the same condition or procedure with the same severity level for all specialists in the same line of business, specialty and geographic area multiplied by number of provider's volume. For ETGs the measure is at the condition level (diabetes, asthma) and for PEGs it's the procedure level (knee replacement, lumbar fusions):

- Observed cost: Total provider cost
- Expected cost: Specialty average cost for same case mix * physician volume
- Efficiency index = observed / expected

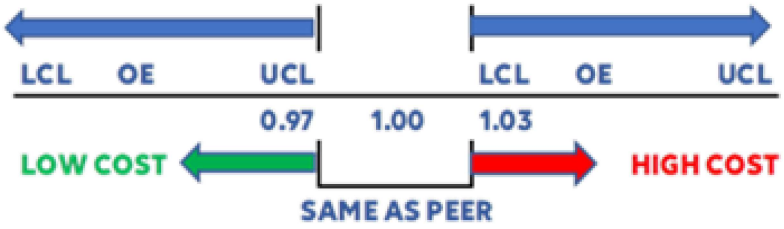
How is your efficiency target set?

Efficiency scores from the condition ETG and PEG procedure (observed/expected ratio scores) are blended into one final efficiency score by weighing the percentage of all the dollars that are tied to procedures vs conditions. This ensures that the efficiency scores for proceduralists (surgeons) are based more heavily on the procedure episodes. This is the final blended efficiency score for the provider:

- A minimum of 20 episodes that have benchmarks are required to calculate a condition efficiency or procedure efficiency score for the provider.

- A 90% statistical confidence interval is computed around the provider's final blended efficiency score to account for the level of statistical uncertainty around the point estimation. For example, a provider with a final blended efficiency score of 0.97 might have the following confidence interval: Upper confidence level (UCL) of 1.03, Lower Confidence level (LCL) of 0.91.

Cost ratings are then assigned to providers and provider groups using confidence intervals, as shown below. The provider group cost ratings are used for TIN Designation while individual provider cost ratings are used for the Provider composite score.



For high-cost cases, how do you normalize which can occur across different groups?

We exclude outlier episodes from the scoring, low cost and high-cost episodes are flagged by the software at Condition/Procedure, Severity, and Line of business level.

Provider specialties with quality measures:

- Cardiac electrophysiology
- Cardiac surgery
- Cardiology
- Colorectal surgery
- Endocrinology
- Gastroenterology
- General surgery
- Geriatric psychiatry
- Hand surgery
- Hematology
- Neurology
- Neurosurgery
- Obstetrics gynecology
- Ophthalmology
- Orthopedic surgery
- Otolaryngology
- Psychiatry
- Pulmonary disease
- Radiation oncology
- Rheumatology

- Hematology/oncology
- Interventional cardiology
- Medical oncology
- Nephrology
- Surgical oncology
- Thoracic surgery
- Urology
- Vascular surgery

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MULTI-BCBS-CR-032328-23-CPN32306

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/availity-medicare-provider-facing-talking-points-and-faq-5

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Digital Tools | Medicare Advantage | Oct 1, 2023

Personalized Match Phase 1

Find Care, the doctor finder and transparency tool in the Anthem Blue Cross and Blue Shield (Anthem) online directory, provides Anthem members with the ability to search for in-network providers using the secure member website. This tool currently offers multiple sorting options, such as sorting providers based on distance, alphabetical order, and provider name.

Beginning in the second quarter of 2024 or later, an additional sorting option will be available for our Medicare Advantage members to search by provider performance called Personalized Match Phase 1. This sorting option is based on provider efficiency and quality outcomes, alongside member search radius. Providers with the highest overall ranking within the member's search radius will be displayed first. Members will continue to have the ability to sort based on distance, alphabetical order, and provider name:

- You may review a copy of the Personalized Match Phase 1 methodology that has been posted on Availity* – our secure Web-based provider tool – using the following navigation: Go to Availity > Payer Spaces > Health Plan > Education & Reference Center > Administrative Support > Personalized Match Phase 1 Methodology.pdf.
- If you have general questions regarding this new sorting option, please submit an inquiry via the web at **Availity**.
- If you would like information about your quality or efficiency scoring used as part of this sorting option or if you would like to request reconsideration of those scores, you may do so by submitting an inquiry to **Availity**.

Anthem has expanded the scope of Personalized Match Phase 1 to include selected specialty providers and will continue to focus and expand our consumer tools and content to assist members in making more informed and personalized healthcare decisions.

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* Availity, LLC is an independent company providing administrative support serviceson behalf of the health plan.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/personalized-match-phase-1-2

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Digital Tools | Commercial / Medicare Advantage | Oct 1, 2023

Availity PDM application is now the intake channel for all demographic change requests, including roster uploads

As we communicated in July, August, and September, the Provider Data Management (PDM) application on Availity Essentials* is now the only intake application to verify and initiate care provider demographic change requests, including submitting roster uploads, for all professional and facility care providers.** **Previous intake channels are now retired as of October 1, 2023.**

If preferred, providers may continue to utilize the Provider Enrollment application in Availity to submit requests to add new practitioners under existing groups.

Training is available:

- PDM application specific trainings:
  - Learn about and attend one of our training opportunities by visiting **here**.
  - View the Availity PDM quick start guide **here**.

Note: An Availity account is required to access these training options. If not registered yet, see below for registration details.

- *Roster Automation Standard Template* and *Roster Automation Rules of Engagement* specific training:
  - Listen to our recorded webinar **here**.

Choice and flexibility to select the option that works best for you

Request data updates via either of the following options:

- Standard PDM experience
- Submitting a spreadsheet via a roster upload

Benefits to our care providers using Availity PDM

The Availity PDM application will ensure the following:

- Consistently updated data
- Decreased turnaround time for updates
- Compliance with federal and/or state mandates
- Improved data quality through standardization
- Increased provider directory accuracy

Want to submit a roster using Availity PDM?

Roster Automation is our new technology solution designed to streamline and automate provider data additions, changes, and terminations that are submitted using a standardized Microsoft Excel submission. Any provider, whether an individual provider/practitioner, group, or facility, can use Roster Automation:***

1. Utilize the *Roster Automation Standard Template*:
    - For your convenience, there is a standard roster Excel document. Find it online **here**.
2. Follow the *Roster Automation Rules of Engagement*:
    - A reference document, *Roster Automation Rules of Engagement,* is available to ensure error-free submissions, driving accurate and more timely updates through automation. Find it online **here**.
    - More detailed instructions on formatting and submission requirements can also be found on the first tab of the *Roster Automation Standard Template* (User Reference Guide).
3. Upload your completed roster via the Availity PDM application.

Availity PDM compatibility check for roster submissions

Availity PDM has been enhanced to incorporate a roster compatibility check. Providers can see if the roster was successfully submitted:

- If there is an error to the roster, providers will see an error rejection message with detailed reason for the rejection.
- Errors will need to be corrected. Then, the roster should be re-uploaded. Status will show as successfully submitted once corrected and re-submitted.
- After successful submission of the roster, all accepted elements of the roster will be processed and only errors/rejections will fall out.
- Any elements that fall out will require manual intervention.

How to access the Availity PDM application

Log onto **Availity.com** and select **My Providers** > **Provider Data Management** to begin the attestation process. If submitting a roster, find the TIN/business name for which you want to verify and update information. Before you select the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** (see screen shot below) and follow the prompts.

Availity administrators will automatically be granted access to PDM. Additional staff may be given access to **Provider Data Management** by an administrator. To find your administrator, go to **My Account Dashboard** > **My Account** > **Organization(s)** > **Administrator Information**.

Not registered for Availity yet?

If you aren't registered to use Availity Essentials, signing up is easy and 100% secure. There is no cost for your providers to register or to use any of our digital applications. Start by going to **Availity.com** and selecting **New to Availity? Get Started** at the top of the home screen to access the registration page. If you have more than one TIN, please ensure you have registered all TINs associated with your Availity account.

If you have questions regarding registration, reach out to Availity Client Services at **800-AVAILITY (282-4548)**.

** Exclusions:

- Behavioral health providers assigned to Carelon Behavioral Health, Inc.* will continue to follow the process for demographic requests and/or roster submissions, as outlined by Carelon Behavioral Health.
- Any specific state mandates or requirements for provider demographic updates.

*** If any roster data updates require credentialing, your submission will be routed appropriately for further action.

Note: The following requested adds, changes, or terminations will be routed to the Provider Contracting team for validation and impact to provider contracts and network adequacy:

- Change tax ID
- Change organization name
- Add a network to agreement
- Change provider specialty
- Terminate entire agreement

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* Availity, LLC is an independent company providing administrative support services on behalf of the health plan. Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

MULTI-BCBS-CRCM-035692-23-CPN35500

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/availity-pdm-application-is-now-the-intake-channel-for-all-d-9

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Education and Training | Commercial | Oct 1, 2023

New website for cancer caregivers

Fifty-three million Americans (more than one in five) are family caregivers. According to a new study, ***Caregiving in the U.S. 2020***, caregivers face health challenges of their own. Nearly a quarter of caregivers find it hard to take care of their own health and say that caregiving has made their own health worse.

Now, **helpforcancercaregivers.org** is here to help caregivers care for themselves. This interactive website, available 24/7, provides the information and resources that caregivers need to care for their own health and well-being. The website walks users through a brief survey and then provides a personalized *Self-Care Guide* to help them improve their health.

Studies show that family caregivers suffer from poorer physical health than those who do not have additional caregiving responsibilities. **Studies** have also found that:

- Caregivers show higher levels of depression.
- Caregivers suffer from high levels of stress and frustration — which can lead to burnout.
- Stressful caregiving situations may lead to harmful behaviors, such as abusing drugs or alcohol.
- Caregivers have an increased risk of heart disease.
- Caregivers have lower levels of self-care.
- Chronic diseases of caregivers are often more difficult to manage.
- Caregivers have an increased risk of sickness and premature death.

Evidence has also shown that education and intervention reduce caregiver strain, uncertainty, and helplessness and that information helps normalize the caregiver experience and enhances a sense of control.

Caregivers for your patients can access *Help for Cancer Caregivers* at **helpforcancercaregivers.org**.

MULTI-BCBS-CM-036949-23-CPN36922

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/new-website-for-cancer-caregivers

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Webinars | Medicare Advantage | Jun 30, 2023

Required training - Model of Care

As a contracted provider for Special Needs Plan (SNP) from Anthem Blue Cross and Blue Shield (Anthem), you are required to participate in an annual training on Model of Care for Anthem. This training includes a detailed overview of SNPs and program information — highlighting cost sharing, data sharing, participation in the Interdisciplinary Care team (ICT), where to access the member's health risk assessment results, plan of care, and benefit coordination.

Training for SNP product for Anthem is self-paced and available at **availity.com**.*

The training must be completed by December 31, 2023.

How to access the *Custom Learning Center* on the Availity website:

1. Log in to Availity website at **availity.com**.
    - At the top of Availity website, select Payer Spaces and select the appropriate payer.
2. On the *Payer Spaces* landing page, select Access Your Custom Learning Center from *Applications*.
3. In the *Custom Learning Center*, select Required Training.
4. Select **Special Needs Plan and Model of Care Overview**.
5. Select **Enroll**.
6. Select Start.
7. Once the course is completed, select Begin Attestation and complete.

Not registered for Availity Essentials?

Have your organization's designated administrator register your organization for the Availity website:

1. Visit **availity.com** to register.
2. Select Register.
3. Select your organization type.
4. In the *Registration* wizard, follow the prompts to complete the registration for your organization.

Refer to these PDF documents: **https://apps.availity.com/availity/Demos/Registration/index.htm** for complete registration instructions.

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* Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

MULTI-BCBS-CR-022628-23, CPN22400, MULTI-BCBS-CR-039458-23-CPN39408

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/required-training-model-of-care-6

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Webinars | Commercial / Medicare Advantage | Sep 22, 2023

You're invited: Thriving, not just surviving: Youth mental health in today's world

This forum has moved from the original date of September 27, 2023 to October 19, 2023

Register today for the youth mental health forum hosted by Anthem Blue Cross and Blue Shield (Anthem) and Motivo* for Anthem providers on October 19, 2023.

Thursday, October 19, 2023
3:30 to 5 p.m. Eastern time

This important event will address the critical need to engage young people in leading their mental health. By deepening the discussion on youth mental health, we can do our part to foster a culture of understanding and support for youth and young adults. Authentic conversations lead to reducing implicit bias and improving the health and wellbeing of all Americans and the communities in which we live and serve.

Please join us to hear from a diverse panel of experienced professionals and young leaders as we explore the challenges experienced by today's youth, amplify the experiences and ideas of young people, and equip attendees with practical tools and innovative approaches to create meaningful change.

Each forum will continue the exploration of ways we can reduce disparities in healthcare, demonstrate cultural humility, address, and deconstruct bias, have difficult and productive conversations, learn about valuable resources, increase inclusion, advance equity in healthcare.

Please register for this event by visiting this **link**.

* Motivo is an independent company providing a virtual forum on behalf of the health plan.

MULTI-BCBS-CRCM-039386-23-CPN39367

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/youre-invited-thriving-not-just-surviving-youth-mental-h-16

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Webinars | Commercial / Medicare Advantage | Oct 1, 2023

Looking to earn CME credits? Check out the CME Engagement Hub!

Overview

We're committed to being actively involved with our care provider partners and going beyond the contract to create a real impact on the health of our communities. That's why we offer care providers free continuing medical education (CME) sessions to learn best practices to overcoming barriers in achieving clinical quality goals and improved patient outcomes.

Engagement Hub objectives:

- Learn strategies to help you and your care team improve your performance across a range of clinical areas.
- Apply the knowledge you gain from the webinars to improve your organization's clinical quality.
- Offer care providers a convenient way to earn CME credits at a time that works best for them.
- Each session in this series is approved for one American Academy of Family Physicians credit:
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    - Open the CME webinars in **Google Chrome**

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Clinical Criteria updates - June 2023

Medical drug benefit *Clinical Criteria* updates

On August 19, 2022, September 12, 2022, November 18, 2022, February 24, 2023, May 19, 2023, June 12, 2023, and July 11, 2023, the Pharmacy and Therapeutic (P&T) Committee approved the following *Clinical Criteria* applicable to the medical drug benefit for Anthem Blue Cross and Blue Shield (Anthem). These policies were developed, revised, or reviewed to support clinical coding edits.

Visit ***Clinical Criteria*** to search for specific policies. If you have questions or would like additional information, use this **email**.

Please see the explanation/definition for each category of *Clinical Criteria* below:

- New: newly published criteria
- Revised: addition or removal of medical necessity requirements, new document number
- Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive

Please share this notice with other providers in your practice and office staff.

Note:

- **The *Clinical Criteria* listed below applies only to the medical drug benefits contained within the member's medical policy. This does not apply to pharmacy services.**
- **This notice is meant to inform the provider of new or revised criteria that has been adopted by Anthem only. It does not include details regarding any authorization requirements. Authorization rules are communicated via a separate notice.**

Effective date	Document number	*Clinical Criteria* title	New or revised
October 18, 2023	*CC-0243	Vyjuvek (beremagene geperpavec)	New
October 18, 2023	*CC-0242	Epkinly (epcoritamab-bysp)	New
October 18, 2023	*CC-0241	Elfabrio (pegunigalsidase alfa-iwxj)	New
October 18, 2023	CC-0228	Leqembi (lecanemab)	Revised
October 18, 2023	*CC-0061	Gonadotropin Releasing Hormone Analogs for the Treatment of Non-Oncologic Indications	Revised
October 18, 2023	*CC-0015	Infertility and HCG Agents	Revised
October 18, 2023	*CC-0062	Tumor Necrosis Factor Antagonists	Revised
October 18, 2023	CC-0151	Yescarta (axicabtagene ciloleucel)	Revised

Effective date	Document number	*Clinical Criteria* title	New or revised
October 18, 2023	*CC-0177	Zilretta (triamcinolone acetonide extended-release)	Revised
October 18, 2023	CC-0149	Select Clotting Agents for Bleeding Disorders	Revised
October 18, 2023	CC-0032	Botulinum Toxin	Revised
October 18, 2023	*CC-0002	Colony Stimulating Factor Agents	Revised
October 18, 2023	*CC-0001	Erythropoiesis Stimulating Agents	Revised
October 18, 2023	*CC-0174	Kesimpta (ofatumumab)	Revised
October 18, 2023	*CC-0209	Leqvio (inclisiran)	Revised
October 18, 2023	*CC-0011	Ocrevus (ocrelizumab)	Revised
October 18,	*CC-0005	Hyaluronan Injections - Medicare	Revised

Effective date	Document number	*Clinical Criteria* title	New or revised
2023		Only	

MULTI-BCBS-CR-036939-23-CPN36113

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Transition to Carelon Medical Benefits Management, Inc. site of care guidelines

Effective December 30, 2023, Anthem Blue Cross and Blue Shield (Anthem) will transition the *Clinical Criteria* for site of care reviews to the following Carelon Medical Benefits Management* (Caralon) site of care guidelines to perform medical necessity and clinical appropriateness reviews for the requested site of care for certain procedures.

Program	Services	Carelon Guideline	CPT® code list links
Surgical	Routine outpatient surgical procedures across the following specialty services: gastroenterology (including upper and lower endoscopy), ophthalmology (such as cataract surgery), gynecology, dermatology, urology, pulmonary and musculoskeletal	**Surgical Appropriate Use Criteria: Site of Service**	**https://tinyurl.com/8bruffkj**
Radiology	Routine outpatient CT and MRI imaging such as head, chest, and extremity imaging.	**Advanced Imaging Appropriate Use Criteria: Site of Care**	**https://tinyurl.com/y45hsv5h**

Musculoskeletal	Select musculoskeletal and pain procedures, including shoulder and knee arthroscopies and epidural injections.	Surgical Appropriate Use Criteria: Site of Care	https://tinyurl.com/3xujthte
Rehabilitative Services	Routine outpatient speech, occupational, and physical therapy services	Outpatient Rehabilitative and Habilitative Services Appropriate Use Criteria: Site of Care	https://tinyurl.com/5dz92sp4

Note: These reviews do not apply to procedures performed on an emergent basis.

Carelon Medical Benefits Management also manages the musculoskeletal level of care review using The **Carelon Musculoskeletal Appropriate Use Criteria: Level of Care for Musculoskeletal Surgery and Procedures** guideline.

Members included in the program

The new review criteria apply to all Anthem members currently participating in the above mentioned Carelon Medical Benefits Management programs. To determine if prior authorization by Carelon Medical Benefits Management is required for a member, contact the Provider Services phone number on the back of the member's ID card.

The following members are excluded: Medicare Advantage (individual and group),

Medicare, Medicare supplement, and the Federal Employee Program® (FEP).

Prior authorization requirements

Prior authorization requirements remain the same. For services scheduled to begin on or after December 29, 2023, care providers must contact Carelon Medical Benefits Management to obtain prior authorization. Requested services received on or after December 29, 2023, will be reviewed with the new *Clinical Criteria*.

Care providers may submit prior authorization requests to Carelon Medical Benefits Management at **providerportal.com**. Initiating a request and entering all the requested clinical information will provide an immediate determination 24/7.

For questions related to guidelines, please contact Carelon Medical Benefits Management via email at MedicalBenefitsManagement.guidelines@Carelon.com. Additionally, you may download a copy of the current and upcoming guidelines **here**.

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* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

MULTI-BCBS-CM-038847-23

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Visit https://providernews.anthem.com/missouri/articles/transition-to-carelon-medical-benefits-management-inc-site-2

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Medical Policies and *Clinical Guidelines* updates

Anthem Blue Cross and Blue Shield (Anthem) *Medical Policies* and *Clinical Guidelines* were reviewed for Indiana, Kentucky, Missouri, Ohio, and Wisconsin. The chart below contains the current *Clinical Guidelines* and *Medical Policies* reviewed, and the updates that were approved.

Policy or Guideline	Information	Effective date
DME.00032 Automated External Defibrillators for Home Use	Add to prior authorization	1/1/2024
LAB.00003 In Vitro Chemosensitivity Assays and In Vitro Chemoresistance Assays	Add to prior authorization	1/1/2024
LAB.00011 Selected Protein Biomarker Algorithmic Assays	Add to prior authorization	1/1/2024
LAB.00019 Proprietary Algorithms for Liver Fibrosis in the Evaluation and Monitoring of Chronic Liver Disease	Add to prior authorization	1/1/2024

Policy or Guideline	Information	Effective date
LAB.00024 Immune Cell Function Assay	Add to prior authorization	1/1/2024
LAB.00027 Selected Blood, Serum and Cellular Allergy and Toxicity Tests	Add to prior authorization	1/1/2024
LAB.00035 Multi-biomarker Disease Activity Blood Tests for Rheumatoid Arthritis	Add to prior authorization	1/1/2024
LAB.00036 Multiplex Autoantigen Microarray Testing for Systemic Lupus Erythematosus	Add to prior authorization	1/1/2024
LAB.00037 Serologic Testing for Biomarkers of Irritable Bowel Syndrome (IBS)	Add to prior authorization	1/1/2024
LAB.00041 Machine Learning Derived Probability Score for Rapid Kidney Function Decline	Add to prior authorization	1/1/2024
LAB.00046 Testing for Biochemical Markers for Alzheimer's Disease	Add to prior authorization	1/1/2024

Policy or Guideline	Information	Effective date
LAB.00048 Pain Management Biomarker Analysis	Add to prior authorization	1/1/2024
GENE.00057 Gene Expression Profiling for Idiopathic Pulmonary Fibrosis	Add to prior authorization	1/1/2024
MED.00004 Technologies for the Evaluation of Skin Lesions (including Dermatoscopy, Epiluminescence Microscopy, Video microscopy, Ultrasonography)	Add to prior authorization	1/1/2024
GENE.00052 Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling	Add to prior authorization	1/1/2024
SURG.00092 Implanted Devices for Spinal Stenosis	Add to prior authorization	1/1/2024
LAB.00031 Advanced Lipoprotein Testing	Adding Code **0052U** to prior authorization - Lipoprotein, blood, high resolution fractionation and quantitation of lipoproteins, including all five major lipoprotein classes and subclasses of HDL, LDL, and VLDL by vertic	1/1/2024

Policy or Guideline	Information	Effective date
LAB.00033 Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer	Adding Code **0228U** to prior authorization - Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morni	1/1/2024
LAB.00015 Detection of Circulating Tumor Cell	Adding Code **0337U** to prior authorization - Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells ba	1/1/2024
LAB.00015 Detection of Circulating Tumor Cell	Adding Code **0091U** to prior authorization - Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive o	1/1/2024
LAB.00033 Protein Biomarkers for the Screening, Detection and Management of Prostate Cancer	Adding Code 0359U to prior authorization - Oncology (prostate cancer), analysis of all prostate-specific antigen (PSA) structural isoforms by phase separation and immunoassay, plasma, algorithm reports risk of cancer	1/1/2024

* Denotes prior authorization required

To view *Medical Policies* and utilization management guidelines, visit **Anthem.com** and select *Providers,* then select your state. Under *Provider Resources*, select *Policies, Guidelines, and Manuals*.

To help determine if prior authorization is needed for Anthem members, visit **Anthem.com** and select *Providers*, then select your state. Under **Claims**, select *Prior Authorization*. You can also call the phone number on the back of the member's ID card.

To view medical policies and utilization management guidelines applicable to members enrolled in the Federal Employee Program® (FEP), visit **fepblue.org** and select **Policies and Guidelines**.

MULTI-BCBS-CM-038398-23

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Reimbursement policy update: After-Hours, Emergency, and Miscellaneous E/M Services – Professional

Beginning with dates of service on or after January 1, 2024, the *After-Hours, Emergency, and Miscellaneous E/M Services – Professional* reimbursement policy will also apply to facility providers**.** The intent of this policy is to reimburse professional providers for rendering urgent services outside of regular hours ("after hours" services) when such services are:

- Billed on a *CMS-1500* form.
- Billed with an office place of service (*POS 11*).
- Rendered between 5:00 p.m. and 8:00 a.m. on weekdays or anytime on weekends based on arrival time and not the actual time the service commenced.

The policy will not allow separate reimbursement for "after hours" codes 99050 or 99051 when:

- Billed by facility providers.
- Billed with *POS 20* (urgent care facility).

The policy will be retitled *After-Hours, Emergency, and Miscellaneous E/M Services – Professional and Facility*.

For specific policy details, visit **anthem.com** and select For Providers. Under the *Provider Resources* heading, select Policies, Guidelines & Manuals. On the next screen, select the Select a State. Next, under the *Reimbursement Policies* heading, select Access policies.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-after-hours-emergency-and-miscel

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Genetic Tests: Once per Lifetime

New Reimbursement Policy

Genetic Tests: Once per Lifetime

(Policy G-23002, effective 01/01/2024*)*

Beginning with dates of service on or after January 1, 2024, Anthem Blue Cross and Blue Shield (Anthem) will implement a new reimbursement policy titled *Genetic Tests: Once per Lifetime*. This policy identifies specific genetic tests allowed once in a member's lifetime. During the member's lifetime, the germline genotype will not change. However, the interpretation of the gene sequence may change due to recategorization of variants, or other factors. Repeat sequencing is not required for future interpretation of germline genotype, or re-analysis of previously sequenced data.

The Related Coding section includes a *Once per Lifetime Genetic Test* coding list, which describes the genetic procedures that are limited to once per lifetime sequencing. Reinterpretation of the original results are not separately reimbursable.

For additional information, please review the *Genetic Tests: Once per Lifetime* reimbursement policy at **https://www.anthem.com/medicareprovider**.

MULTI-BCBS-CR-033765-23-CPN29184

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Pharmacy | Commercial | Oct 1, 2023

Specialty pharmacy updates — October 2023

Specialty pharmacy updates for Anthem Blue Cross and Blue Shield (Anthem) are listed below.

Prior authorization clinical review of **non-oncology** use of specialty pharmacy drugs is managed by Anthem's medical specialty drug review team. Review of specialty pharmacy drugs for **oncology** use is managed by Carelon Medical Benefits Management, Inc.*

Important to note: Currently, your patients may be receiving these medications without prior authorization. As of the effective date below, you may be required to request prior authorization review for your patients' continued use of these medications.

Including the National Drug Code (NDC) code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

Prior authorization updates

Effective for dates of service on and after January 1, 2024, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

Access our ***Clinical Criteria*** to view the complete information for these prior authorization updates.

Clinical Criteria	**Drug**	**HCPCS or CPT® code(s)**
CC-0244*	Columvi (glofitamab-gxbm)	C9399, J3490, J3590, J9999

CC-0245	Izervay (avacincaptad pegol)	C9399, J3490, J3590, J9999
CC-0246	Rystiggo (rozanolixizumab-noli)	C9399, J3490, J3590, J9999

* Oncology use is managed by Carelon Medical Benefits Management.

Note: Prior authorization requests for certain medications may require additional documentation to determine medical necessity.

Step therapy updates

Courtesy notice — Effective for dates of service on and after October 1, 2023, updated step therapy criteria for iron agents found in the clinical criteria document for CC-0182 will be implemented. The preferred product list is being expanded to include Infed. Please refer to the clinical criteria document for details.

Access our ***Clinical Criteria*** to view the complete information for these step therapy updates.

Quantity limit updates

Effective for dates of service on and after January 1, 2024, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our quantity limit review process.

Access our ***Clinical Criteria*** to view the complete information for these quantity limit updates.

Clinical Criteria	**Drug**	**HCPCS or CPT code(s)**
CC-0245	Izervay (avacincaptad pegol)	C9399, J3490, J3590, J9999

CC-0246	Rystiggo (rozanolixizumab-noli)	C9399, J3490, J3590, J9999

* Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan.

MULTI-BCBS-CM-038617-23-CPN38572

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Pharmacy | Medicare Advantage | Sep 19, 2023

Medicare Part B precert expansion: Adstiladrin, Altuviiio, Idacio, Lamzede, Lunsumio, Rebyota, Signifor LAR, Syfovre, and Vivimusta

Anthem Blue Cross and Blue Shield expands specialty pharmacy precertification list

The previous effective date was previously listed in error as October 1, 2023, this correct effective date is December 1, 2023.

Effective for dates of service on and after **December 1, 2023**, the specialty Medicare Part B drugs listed in the table below will be included in our precertification review process.

Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

HCPCS or CPT® codes	Medicare Part B drugs
J9029	Adstiladrin (nadofaragene firadenovec-vncg)
C9399, J7199	Altuviiio (antihemophilic factor (recombinant)
C9399, J3490	Lamzede (velmanase alfa-tycv)

J9350	Lunsumio (mosunetuzumab-axgb)
J1440	Rebyota (fecal microbiota, live – jslm)
J2502	Signifor LAR (pasireotide)
C9151, C9399, J3490	Syfovre (pegcetacoplan)
J9056	Vivimusta (bendamustine)

MULTI-BCBS-CR-023557-23-CPN23416

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Pharmacy | Medicare Advantage | Sep 22, 2023

Medicare Part B precert expansion: Elfabrio, Epkinly, Qalsody, Vyjuvek, and Zynyz

Expanded specialty pharmacy precertification list

Effective for dates of service on and after January 1, 2024, the specialty Medicare Part B drugs listed in the table below will be included in our precertification review process.

Federal and state law, as well as state contract language and CMS guidelines, including definitions and specific contract provisions/exclusions, take precedence over these precertification rules and must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

HCPCS or CPT® codes	Medicare Part B drugs
J3490, J3590	Elfabrio (pegunigalsidase alfa-iwxj)
C9399, J3490, J3590, J9999	Epkinly (epcoritamab-bysp)
J3490, J3590	Qalsody (tofersen)
J3490, J3590	Vyjuvek (beremagene geperpavec)
J9999	Zynyz (retifanlimab-dlwr)

MULTI-BCBS-CR-037831-23-CPN37401

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