Anthem

PROVIDER NEWS MISSOURI

November 2023 Provider Newsletter

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MOBCBS-CRCM-041565-23

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Administrative | Medicare Advantage | Nov 1, 2023

Updates to correct coding editing

Effective for claims processed December 1, 2023, the editing systems at Anthem Blue Cross and Blue Shield will be updated to align with the *American Medical Association (AMA) CPT® Manual*, *HPCPS Level II Manual*, and Centers for Medicare & Medicaid Services (CMS) correct coding guidelines, for the following services:

- **Ulcer debridement and ulcer staging:**
  - According to the *ICD-10 Diagnosis Coding Manual*, specific diagnosis codes that reflect the stage of the ulcer should be billed with the appropriate CPT code. For example, if billing a stage 3 pressure ulcer code, a stage 4 diagnosis code should not be reported.
  - According to the *AMA CPT Manual*, a debridement of an ulcer should be reported with the appropriate diagnosis code that reflects that service.
- **Billing of anatomical modifiers:**
  - According to the *AMA CPT* and *HCPCS Level II* manuals, the appropriate anatomical modifier is required to be appended to the appropriate procedure code. If not, the claim line will be denied. These modifiers designate the body part that a service is being performed on (for example, FA: Left hand, thumb, TA: Left foot, great toe).
- **Billing of interprofessional telephone/internet consultations:**
  - These billed procedure codes will follow the *AMA CPT Manual* coding guidelines.

Claim lines not billed in accordance with the correct coding guidance outlined above will be denied.

If you disagree with a claim reimbursement decision, please follow the claim dispute process (including submission of such documentation with the dispute) as outlined in the

Provider Manual.

If you have questions about this communication or need assistance with any other item, contact your provider relationship management representative.

With your help, we can continually build towards a future of shared success.

MULTI-BCBS-CR-038660-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/updates-to-correct-coding-editing-16269

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Administrative | Medicare Advantage | Oct 31, 2023

2024 Medicare Advantage service area and benefit updates

An overview of notable 2024 benefit changes and service area updates are now available at the link below:

Missouri 2024 Medicare Advantage plan changes

Please continue to check our **website** for the latest Medicare Advantage information.

MULTI-BCBS-CR-038967-23-CPN38918, MOBCBS-CR-038946-23-CPN38904

ATTACHMENTS (available on web): Missouri 2024 Medicare Advantage plan changes (pdf - 0.34mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/2024-medicare-advantage-service-area-and-benefit-updates-161-4

Or scan this QR code with your phone

Administrative | Medicare Advantage | Nov 1, 2023

Usage of liability modifiers

The Centers for Medicare and Medicaid Services (CMS) has provided specific guidance regarding the usage of the following modifiers:

Modifier	Description
GA	Waiver of Liability statement issued as required by payer policy.
GX	Notice of Liability issued, voluntary under payer policy.
GY	Item or Service Statutorily Excluded, does not meet the definition of any Medicare benefit.
GZ	Item or service expected to be denied as not reasonable and necessary.

It has been determined that these modifiers were used inappropriately for Medicare Advantage (MA) members.

Examples include:

- The member has an enhanced or supplemental benefit above what original Medicare covers and one or more of the above modifiers are applied to the claim:
  - Such as office calls billed by a chiropractor and the service is an enhanced benefit under the member's Medicare Advantage health plan.

- The item/service is a covered benefit but one or more of the above modifiers is applied to claim:
  - Such as **911** ambulance calls:
    - CMS guidance states that if the call is in accordance with a prudent layperson's definition of *emergency medical condition*, regardless of the final diagnosis.

An Advance Beneficiary Notice (ABN) is a written notice given to an original Medicare beneficiary by a provider (including physicians, practitioners, durable medical equipment (DME) companies, laboratories, etc.) when they believe that Original Medicare will deny some or all of the services or items because of medical necessity or the frequency of the service; however, the ABN is optional when original Medicare never covers a service or item. When a provider obtains an ABN along with the original Medicare requirements, the provider may indicate that they have obtained an ABN by billed with modifier GS, GX, GY and/or GZ. As published in the *Medicare Claims Processing Manual*, Chapter 30, Section 50, the ABN is provided to original Medicare beneficiaries for the above scenarios and is not used for items or services provided/denied under the MA program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). Under the MA program, MA members and their providers have the option to obtain a coverage decision prior to obtaining the item or service. This request for a pre-service coverage review is known as a request for an organizational determination.

Because a MA member can obtain a pre-service coverage decision through the pre-service organizational determination process, the use of the ABN for MA members is not appropriate. This means that the liability modifiers that denote that there is an ABN on file is not appropriate for MA members.

Providers (contracted and non-contracted providers as well as members) have the ability to request an organizational determination (prior authorization) prior to providing an item or service to determine if the item or service will be covered under the member's health plan benefits. Once an organizational determination has been made, if a denial is warranted, an Integrated Denial Notice (IDN) will be sent to the member and provider. This document provides important appeal rights guaranteed to the member.

If the service is denied, the member will be better informed to choose if they would still like to obtain the item or service at their own expense. Claims are not processed based on the **G** modifier, but rather on the benefit of the service rendered.

MULTI-BCBS-CR-040516-23-CPN39023

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/usage-of-liability-modifiers-16006

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Administrative | Commercial | Nov 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 webpage**. 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-040987-23-SRS40837

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/caa-maintain-your-online-provider-directory-information-1592-1

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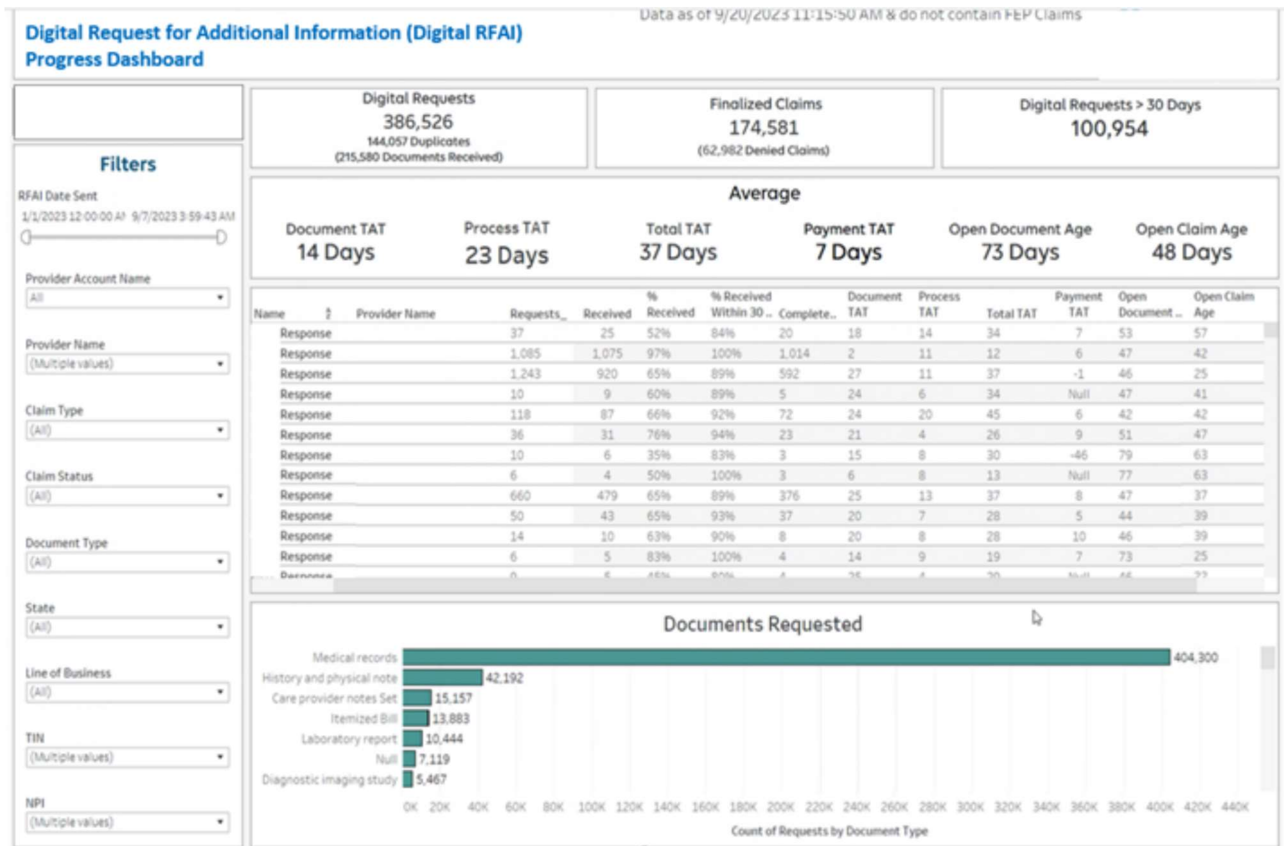
Digital Tools | Commercial | Nov 1, 2023

Digital RFAI process improvements

The Progress Dashboard is now available.

Care providers enrolled in the *Medical Attachments* applications on **Availity.com** are taking advantage of faster claims processing through Digital Request for Additional Information (Digital RFAI). They are receiving digital notifications when additional documents are needed to process our members' claims.

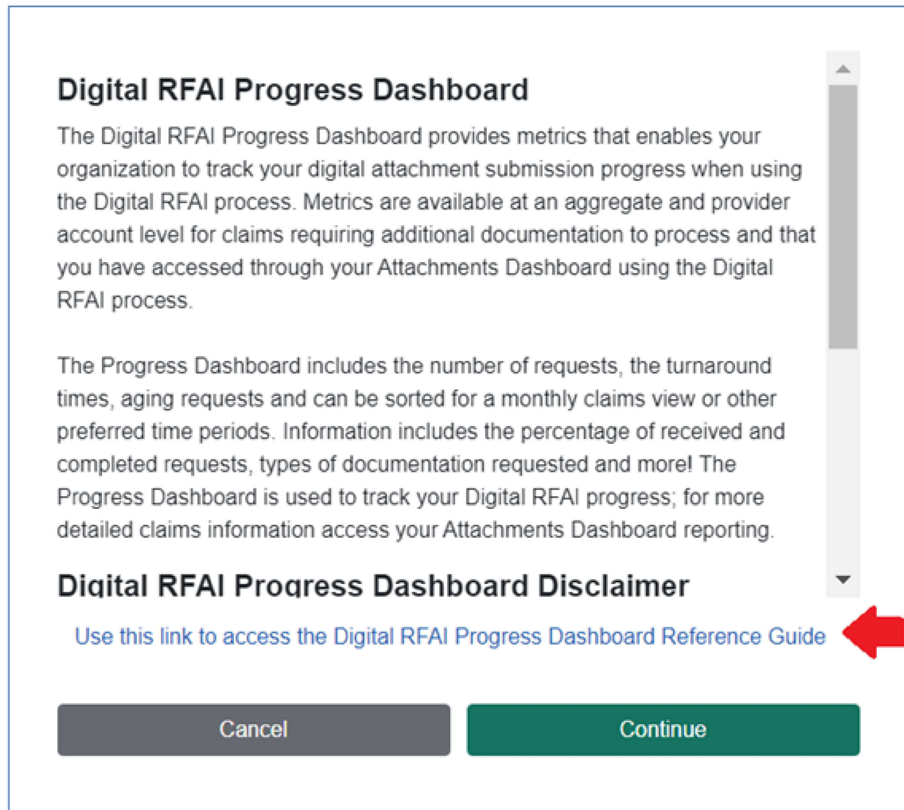


We receive the documentation faster, so the claim is processed faster.

Digital RFAI care providers will want to use the Digital RFAI Progress Dashboard right away. Track the number of document submissions, processing turn-around times, payment

turn-around times, types of documents requested, and more. Use filters to customize the report and reporting period.

Access the Digital RFAI Progress Dashboard from Availity.com through Payer Spaces. Use the link on the Digital RFAI Progress Dashboard disclaimer page to access the *Quick Reference Guide*.



Not a Digital RFAI care provider?

If you're not already using the Digital RFAI process and want to take advantage of faster claims processing, participation is easy.

1.	Registration	The organization's Availity administrator will register for Medical Attachments, which enables care provider organizations to receive notices from the payer and submit requested documents digitally.	All billing NPIs/TINs must be registered.

2.	User roles	The Availity administrator will be required to update or add new users with these specific role assignments through Availity: • Claims Status • Medical Attachments	Enable users to view the Availity Attachment Dashboard.
3.	Ready to go!	After the registration and user roles are completed on Availity, the Digital RFAI process is ready.	Requests will automatically appear on the Attachments Dashboard each morning (when documents are needed).

Learn more

Register for live training or view training on demand **here**.

Digital RFAI process improvements

Eliminating the Acknowledgement box to save steps and streamline processes

We've eliminated the Acknowledgement requirement when care providers access their Attachments Dashboard. You'll notice that notifications on your Attachments Dashboard have a *New* status.

Attachment due in 4 days
RFAI_FEP23215GA23108F00003000
MEDICAL CLAIM
NEW 08/03/2023
SMITH, DAVID
05/05/1966
R59613711
H101131804100

Saves you time: When you select the claim, you are no longer required to complete the Acknowledgement. You will be diverted directly to the notification information.

Adds transparency: If you upload your notification and select **Save**, you'll have access to a *Saved* status that dates your upload.

Attachment due in 4 days
RFAI_FEP23215GA23108F00003000
MEDICAL CLAIM
SAVED 09/28/2023

SMITH, DAVID
05/05/1966
R59613711
Patient Name 4100

Contact your provider relationship representative with any feedback. Your feedback is important to us and will help us create greater efficiencies for you and your practice.

Now accepting Medicaid and Medicare member claims

As a care provider taking advantage of Digital RFAI, you know it is the most efficient way to send the required documentation to process your Commercial member claims. **Beginning in mid-November, you will also receive Digital RFAI notifications for your Medicaid and Medicare member claims**.

The process will not change for Medicaid and Medicare member claims. You will still follow the same fast and easy process for our Medicaid and Medicare member claims as you do for your commercial member claims. The only change is that your Medicaid and Medicare member claims will not pend. Medicaid and Medicare member claims will deny when additional documentation is needed to process the claim.

Notifications will remain on your dashboard for up to 30 days as they do today. Submit the documentation at your convenience (most care providers submit documents within seven to 14 days).

Your notifications will continue to arrive on your dashboard each morning, making it convenient to plan your work; no need to check your dashboard throughout the day.

Learn more!

In collaboration with Availity, we've developed training for your organization's administrators about how to update the *Medical Attachment* registration:

Date	Time

November 14, 2023	10:30 to 11:45 a.m. ET
November 15, 2023	3 to 4:25 p.m. ET
December 4, 2023,	2:30 to 3:45 p.m. ET
December 11, 2023	2:30 to 3:45 p.m. ET
January 23, 2024	2:30 to 3:45 p.m. ET

Availity administrators can use **this link** to register for live training or to view the training on demand.

For associates who are responsible for sending attachments, we've developed an enhanced training session that walks through the Attachments Dashboard and many of the unique features that make it most efficient:

Date	**Time**
November 14, 2023	3 to 4 p.m. ET
November 15, 2023	3 to 4 p.m. ET
December 4, 2023,	12 to 1 p.m. ET
December 11, 2023	10:30 to 11:30 a.m. ET

January 23, 2024	2:30 to 3:30 p.m. ET

Availity users with the Medical Attachments and Claims Status role assignment can use this **link** to register for live training, or to view the live training on-demand.

Contact Availity Customer Support at **availity.com/Contact-Us** or your provider relationship representative if you have any questions.

We are committed to finding solutions that help our care provider partners offer quality services to our members.

MULTI-BCBS-CM-041237-23-CPN41100

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/digital-rfai-process-improvements-16458

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Digital Tools | Commercial | Nov 1, 2023

Filing digital claims disputes: Transparent and trackable

When you have more information to share about a claim that has been denied, filing the dispute digitally is a cost-effective and time-saving alternative to paper and fax. You can feel confident that we have received your claims dispute when you submit it through the digital workflow.

This Claim Status application feature, available on **Availity.com**, enables a fast, efficient, and streamlined process for filing claim disputes:

- Upload supporting documentation and attach it directly to the claim.
- Use the Appeals Dashboard:
  - To review digitally filed disputes.
  - To retrieve correspondence related to your disputes.
  - For a history of digitally filed disputes.

How to file a digital claim payment dispute:

1. Log onto **Availity.com**.
2. Select the *Claims & Payments* tab.
3. Select **Claim Status** and enter the information needed to retrieve your claim.
4. When you have found your claim, select the **Dispute** button to initiate a dispute (it will be visible when your claim is eligible for a dispute).
5. Access your Appeals Dashboard to upload the supporting documents, locate initiated dispute, and complete the dispute request:

- From the *Claims & Payments* tab select **Appeals** to access your Appeals Dashboard.

In the past, you may have used the **Attachment** button and selected the **Dispute** option to dispute a claim. We've eliminated that process to make disputing a claim more trackable and transparent.

Receive dispute determinations digitally from your *Appeals Dashboard*

We will review the dispute and communicate an outcome on **Availity.com**. Check the status of a digitally submitted dispute at any time from your Appeals Dashboard.

Learn more

Submitting a digital claim payment dispute is easy, but attending informative learning sessions provides a deep dive into the application and its search and filter functions. These tips are sure to make the submission process even easier.

Use this link to access on-demand training.

For more information about the claim payment dispute process, consult the provider manual or reach out to your provider relationship management representative.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/filing-digital-claims-disputes-transparent-and-trackable-164

Or scan this QR code with your phone

Digital Tools | Commercial / Medicare Advantage | Oct 31, 2023

Improvements to secure messaging through Availity Essentials

We are excited to announce improvements to secure messaging that will save time when checking claim status or when reaching out about a resolution to a previous inquiry.

What's new

In mid-November, the process for secure messaging will change:

- Through *Claims Status*:
  - When you select **Secure Messaging** from the *Claims Status* application, the screens will be updated, creating a better navigation and accessibility experience.
- Through *Payer Spaces*:
  - The process for submitting your secure message will stay the same through *Payer Spaces*. However, you will no longer need to use *Payer Resources* to access your replies.
  - You will send and receive secure messages through the *Payer Spaces* application.

As a reminder, to find your claims status fast, use the self-service *Claim Status* application on **Availity.com**.* Recent enhancements make it even easier and faster to get the information you are looking for.

If you have questions, contact your Provider Relationship Management representative.

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

MOBCBS-CRCM-041565-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/improvements-to-secure-messaging-through-availity-essentials-3

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Education and Training | Commercial | Oct 31, 2023

Practitioners’ rights during credentialing process

As part of our credentialing process, practitioners have certain rights as briefly outlined below.

Practitioners can request to:

- Review information submitted to support their credentialing application.
- Correct erroneous information regarding a credentialing application.
- Be notified of the status of credentialing or recredentialing applications.

We encourage practitioners to begin the credentialing process by going to **availity.com** as soon as possible when new physicians join a practice. Doing so will help minimize any disruptions to the practice and members’ claims.

MOBCBS-CM-035737-23-CPN33992

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/practitioners-rights-during-credentialing-process-16227

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Medical Policy & Clinical Guidelines | Medicare Advantage | Nov 1, 2023

Carelon Medical Benefits Management, Inc. updates — November 2023

Effective for dates of service on and after November 5, 2023, the following updates will apply to the *Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines* for medical necessity review for Anthem Blue Cross and Blue Shield:

- Musculoskeletal Guidelines:
  - Small Joint Surgery

Existing precertification requirements have not changed. Share this notice with other members of your practice and office staff.

Through our efforts, we can help our care provider partners deliver high quality, equitable healthcare.

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

MULTI-BCBS-CR-037766-23-CPN37065

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/carelon-medical-benefits-management-inc-updates-16265

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Medical Policies and *Clinical Guidelines* updates — November 2023

The following *Medical Policies* and *Clinical Guidelines* were reviewed for Indiana, Kentucky, Missouri, Ohio, and Wisconsin for Anthem Blue Cross and Blue Shield (Anthem).

To view *Medical Policies* and utilization management guidelines, go to **anthem.com** > select **Providers** > select your state > under *Provider Resources* > select **Policies, Guidelines & Manuals**.

To help determine if prior authorization is needed for Anthem members, go to **anthem.com** > select **Providers** > select your state > under *Claims* > select **Prior Authorization.** You can also call the prior authorization 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 Blue Cross and Blue Shield Service Benefit Plan (commonly referred to as the Federal Employee Program® [FEP®]), please visit **fepblue.org** > Policies & Guidelines.

Below are the current *Clinical Guidelines* and/or *Medical Policies* we reviewed, and updates were approved.

** Denotes prior authorization required*

Policy/guideline	Information	Effective date
***SURG.00005**	Add to PA	2/1/2024

Partial Left Ventriculectomy **Policy/guideline**	**Information**	**Effective date**
***SURG.00007** Vagus Nerve Stimulation	Add to PA	2/1/2024
***SURG.00010** Treatments for Urinary Incontinence	Add to PA	2/1/2024
***SURG.00011** Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting	Add to PA	2/1/2024
***SURG.00043** Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons	Add to PA	2/1/2024
***SURG.00045** Extracorporeal Shock Wave Therapy	Add to PA	2/1/2024
***SURG.00079** Nasal Valve Repair	Add to PA	2/1/2024
***SURG.00107** Prostate Saturation Biopsy	Add to PA	2/1/2024
***SURG.00113** Artificial Retinal Devices	Add to PA	2/1/2024

Policy/guideline	Information	Effective date
***SURG.00114** Facet Joint Allograft Implants for Facet Disease	Add to PA	2/1/2024
***SURG.00124** Carotid Sinus Baroreceptor Stimulation Devices	Add to PA	2/1/2024
***SURG.00126** Irreversible Electroporation	Add to PA	2/1/2024
***SURG.00132** Drug-Eluting Devices for Maintaining Sinus Ostial Patency	Add to PA	2/1/2024
***SURG.00135** Radiofrequency Ablation of the Renal Sympathetic Nerves	Add to PA	2/1/2024
***SURG.00139** Intraoperative Assessment of Surgical Margins During Breast-Conserving Surgery with Radiofrequency Spectroscopy or Optical Coherence Tomography	Add to PA	2/1/2024
***SURG.00141** Doppler-Guided Transanal Hemorrhoidal Dearterialization	Add to PA	2/1/2024

Policy/guideline	Information	Effective date
***SURG.00148** Spectral Analysis of Prostate Tissue by Fluorescence Spectroscopy	Add to PA	2/1/2024
***SURG.00156** Implanted Artificial Iris Devices	Add to PA	2/1/2024
***SURG.00157** Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis	Add to PA	2/1/2024
***SURG.00159** Focal Laser Ablation for the Treatment of Prostate Cancer	Add to PA	2/1/2024
***SURG.00160** Implanted Port Delivery Systems to Treat Ocular Disease	Add to PA	2/1/2024
***THER-RAD.00008 Neutron** Beam Radiotherapy	Add to PA	2/1/2024

MULTI-BCBS-CM-038927-23

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Prior Authorization | Medicare Advantage | Oct 19, 2023

Expansion of Carelon Medical Benefits Management, Inc. programs

Effective April 1, 2024, Carelon Medical Benefits Management, Inc. will expand multiple programs to perform medical necessity reviews for additional procedures for Anthem Blue Cross and Blue Shield members. Carelon Medical Benefits Management works to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments, helping to promote care that is appropriate, safe, and affordable.

The expansion will require clinical appropriateness review for additional procedures related to the Carelon Medical Benefits Management cardiology, genetic testing, radiology, musculoskeletal, surgical and radiation therapy programs.

Carelon Medical Benefits Management will follow the clinical hierarchy established by Anthem Blue Cross and Blue Shield for medical necessity determination. Anthem Blue Cross and Blue Shield makes coverage determinations based on CMS guidance, including national coverage determinations (NCDs), local coverage determinations (LCDs), other coverage guidelines and instructions issued by CMS, and legislative changes in benefits. When existing guidance does not provide sufficient clinical detail, Carelon Medical Benefits Management will determine medical necessity using an objective, evidence-based process.

Carelon Medical Benefits Management will continue to use criteria documented in Anthem Blue Cross and Blue Shield's *Medical Policies and Clinical Guidelines* listed in the table below. These *Clinical Guidelines* can be found at **Availity.com**.

Detailed prior authorization (PA) requirements are available online by accessing the **Precertification Lookup Tool** under *Payer Spaces* at **Availity.com**. Contracted and noncontracted care providers should call Provider Services at the phone number on the back of the member's ID card for PA requirements.

Prior authorization review requirements

Carelon Medical Benefits Management will begin accepting PA requests on March 18, 2024, for dates of service April 1, 2024 and after. For procedures scheduled to begin on or after April 1, 2024, care providers must contact Carelon Medical Benefits Management to obtain PA for the below non-emergency modalities. Refer to the *Clinical Guidelines* on the microsite resource pages for complete code lists.

Program	Services	Medical Policies or Clinical Guidelines
Cardiology	•Cardiac monitor device	CG-MED-74
	•Cardiac contractility modulation	SURG.00153
Genetic testing	•Chromosomal microarray analysis	CG-GENE-04
	•Gene expression profiling	CG-GENE-10
	•Gene mutation testing	CG-GENE-13
	•Gene sequencing	CG-GENE-14
	•DNA-based prenatal testing	CG-GENE-21
	•Panel and other multi-gene testing for polymorphisms	CG-GENE-22
		GENE.00010
	•Genetic testing for inherited diseases	GENE.00023
	•Molecular marker evaluation of thyroid nodules	GENE.00052
	•Hybrid personalized molecular residual disease testing for cancer	GENE.00053
		GENE.00056
		GENE.00057

		GENE.00059 TRANS.00025
Radiology	•Radiostereormetric analysis •Breast MRI	Breast MRI guideline RAD.00065
Musculoskeletal	•Percutaneous and endo spinal surgery •Open SI joint fusion •Ultrasound bone growth stimulation •Cryoablation for podiatric conditions •Nerve stimulation devices for pain	SURG.00071 SURG.00100 SURG.00147 SURG.00158
Surgical	•Tx of GE reflux, dysphagia, gastroparesis	SURG.00047
Radiation therapy	•Hyperthermia for cancer therapy	CG-MED-72

To determine if PA is needed for a member on or after April 1, 2024, call Provider Services using the phone number on the back of the member’s ID card. Care providers using the interactive care reviewer (ICR) tool on **Availity.com** for PA requests on an outpatient procedure will receive a message referring the provider to Carelon Medical Benefits Management. (Note: ICR cannot accept PA requests for services administered by Carelon Medical Benefits Management.)

How to place a review request

Care providers may place a PA request online to Carelon Medical Benefits Management via **providerportal.com**. ***Provider****Portal*$_{SM}$ is available 24/7, processing requests in real-time using clinical criteria.

For more information

For resources to help your practice get started with the radiology, cardiology, genetic testing, musculoskeletal, surgical, and radiation oncology programs, visit:

- **https://providers.carelonmedicalbenefitsmanagement.com/genetictesting**
- **https://providers.carelonmedicalbenefitsmanagement.com/cardiology/**
- **https://providers.carelonmedicalbenefitsmanagement.com/radiology/**
- **https://providers.carelonmedicalbenefitsmanagement.com/musculoskeletal/**
- **https://providers.carelonmedicalbenefitsmanagement.com/radoncology/**
- **https://providers.carelonmedicalbenefitsmanagement.com/surgicalprocedures/**

Our website helps you access information and tools such as order entry checklists, *Clinical Guidelines*, and FAQs.

Through genuine collaboration, we can simplify access to care and help you deliver high-quality, equitable healthcare.

Carelon Medical Benefits Management, Inc. is an independent company providing utilization management services on behalf of the health plan. Availity Essentials is an independent company providing prior authorization and billing services on behalf of the health plan.

MULTI-BCBS-CR-038666-23-CPN38554

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Prior Authorization | Medicare Advantage | Oct 16, 2023

Prior authorization requirement changes effective February 1, 2024 - codes 32274 and 32275

Effective **February 1, 2024**, prior authorization (PA) requirements will change for the following codes. The medical codes listed below will require PA by Anthem Blue Cross and Blue Shield for Medicare members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these precertification rules and must be considered first when determining coverage. **Non-compliance with new requirements may result in denied claims.**

Prior authorization requirements will be added for the following codes:

Codes	Description
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (such as fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (such as interrogation or programming), when performed
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular

Not all PA requirements are listed here. Detailed PA requirements are available to providers on **Medicare Advantage Providers | Anthem.com**, select your state > Providers > Claims > Prior Authorization. For contracted providers, access **Availity.com**.

Providers may also call number on the back of their patient's member ID card for Provider Services.

UM AROW 4290

MULTI-BCBS-CR-041041-23-CPN40476

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-february-1-12

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Prior Authorization | Commercial | Sep 28, 2023

Expansion of Carelon Medical Benefits Management, Inc. programs, effective April 1, 2024

Effective April 1, 2024, Carelon Medical Benefits Management, Inc.,* a specialty health benefits company, will expand multiple Carelon Medical Benefits Management to perform medical necessity reviews for additional procedures for Anthem Blue Cross and Blue Shield members, as further outlined below. Carelon Medical Benefits Management works with leading insurers to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments — helping to promote care that is appropriate, safe, and affordable.

The expansion will require clinical appropriateness review for additional procedures related to the Cardiology, Genetic Testing, Radiology, Musculoskeletal, Surgical, and Radiation Oncology programs for Carelon Medical Benefits Management. The *Clinical Guidelines* and *Medical Policies* that have been adopted by Anthem Blue Cross and Blue Shield to be used for medical necessity review are in the table below. Carelon Medical Benefits Management will begin accepting prior authorization requests on March 18, 2024, for dates of service April 1, 2024, and after.

Members included in the new program

All fully insured, self-funded (ASO), and National members currently participating in the Carelon Medical Benefits Management programs listed below are included. For ASO groups that currently do not participate in Carelon Medical Benefits Management, the program will be offered to ASO to add to their members' benefit package as of April 1, 2024. A separate notice will be published for Medicare Advantage, Medicare, and MA GRS. Members of the following products are excluded: Medicaid, Medicare supplement, and the Federal Employee Program® (FEP®).

Pre-service review requirements

For procedures that are scheduled to begin on or after April 1, 2024, all providers must contact Carelon Medical Benefits Management to obtain pre-service review for the services including but not limited to the following non-emergency modalities. Please refer to the *Clinical Guidelines* on the microsite resource pages for complete code lists.

Please note: All codes will be reviewed for medical necessity for the requested service and not for site of care at this time.

Program	**Services**	***Clinical Guidelines***
Cardiology	• Tx of varicose veins • Artery Stent Placement w/wo Angioplasty • Embolization procedure • Dialysis circuit procedure • EPS studies • Cardiac ablation • Card monitor. device • Cardiac contractility modulation • Wearable cardioverter defibrillators • Wireless CRT for left ventricular pacing • Venous angioplasty w/wo stent placement • Vein embolization tx for pelvic congestion syndrome and varicocele • PFO Closure devices	• CG-MED-74 • SURG.00153
Genetic Testing	• Topographic genotyping • Biomarker Tests • Pooled antibiotic sensitivity testing • Gene Expression Profiling • Gene Mutation Testing • Gene Sequencing • DNA-Based Prenatal Testing • Panel & other Multi-Gene Testing for Polymorphisms Genetic Testing for Inherited Diseases • Molecular Marker Evaluation of Thyroid Nodules • Hybrid Personalized Molecular Residual Disease Testing for Cancer	• CG-GENE-04 • CG-GENE-10 • CG-GENE-13 • CG-GENE-14 • CG-GENE-21 • CG-GENE-22 • GENE.00010 • GENE.00023 • GENE.00052 • GENE.00053 • GENE.00056

		• GENE.00057 • GENE.00059 • TRANS.00025
Radiology	• Radiostereormetric analysis • Quantitative ultrasound for tissue characterization • Myocardial sympathetic innervation & imaging w/wo spect. • Lumbar discography	• Carelon Breast MRI Guideline • MED.00004 • RAD.00065
Musculoskeletal	• Hip resurfacing • Extraosseous subtalar joint imp & arthroereisis • Genicular Nerve block & ablation- CHR knee pain • Percutaneous & Endo spinal surgery • Implanted devices for Spinal stenosis • Open SI joint fusion • Percutaneous vert disc & Endplate procedures • Cryoablation for podiatric conditions • Nerve stimulation devices for pain	• CG-DME-40 • SURG.00071 • SURG.00100 • SURG.00147 • SURG.00158
Surgical	• Wireless capsule endoscopy • Bariatric surgery • Paraoesophageal hernia repair • Ablation proc. – tx of Barrett's esophagus • Tx of GE reflux / Dysphagia / gastroparesis • Esophageal PH monitoring • Upper GI Endoscopy	• SURG.00047

Radiation Oncology	• Hyperthermia for cancer therapy	• CG-MED-72

To determine if prior authorization is needed for a member on or after April 1, 2024, contact the Provider Services phone number on the back of the member's ID card for benefit information. Providers using the Interactive Care Reviewer (ICR) tool on Availity Essentials* to pre-certify an outpatient procedure will receive a message referring the provider to Carelon Medical Benefits Management. (Note: ICR cannot accept prior authorization requests for services administered by Carelon Medical Benefits Management.)

Providers should continue to submit pre-service review requests to Carelon Medical Benefits Management using the convenient online service via the Carelon Medical Benefits Management ***Provider****Portal*SM. ***Provider****Portal* is available twenty-four hours a day, seven days a week, processing requests in real-time using clinical criteria. Go to **providers.carelonmedicalbenefitsmanagement.com** to register.

For resources to help your practice get started with the Radiology, Cardiology, Genetic Testing, Musculoskeletal, Surgical, and Radiation Oncology programs, visit:

- **Providers.carelonmedicalbenefitsmanagement.com/genetictesting**.
- **Providers.carelonmedicalbenefitsmanagement.com/cardiology**.
- **Providers.carelonmedicalbenefitsmanagement.com/radiology.**
- **Providers.carelonmedicalbenefitsmanagement.com/musculoskeletal.**
- **Providers.carelonmedicalbenefitsmanagement.com/surgicalprocedures.**
- **Providers.carelonmedicalbenefitsmanagement.com/radoncology**.

Our special websites help you learn more and access helpful information and tools such as order entry checklists, *Clinical Guidelines*, and FAQs. Additional information can also be found by calling your local Network Relations Representative.

We value your participation in our network and look forward to working with you to help improve the health of our members.

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

MULTI-BCBS-CM-038773-23-CPN38598

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program

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Prior Authorization | Medicare Advantage | Oct 3, 2023

Prior authorization requirement changes effective February 1, 2024 - code J1411

Effective February 1, 2024, prior authorization (PA) requirements will change for the following code(s). The medical code(s) listed below will require PA by Anthem Blue Cross and Blue Shield for Medicare Advantage members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines (including definitions and specific contract provisions/exclusions), take precedence over these precertification rules and must be considered first when determining coverage. **Non-compliance with new requirements may result in denied claims.**

Prior authorization requirements will be added for the following code(s):

Code	Description
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose

Not all PA requirements are listed here. Detailed PA requirements are available to providers on **https://www.anthem.com/medicareprovider** on the *Resources* tab or for contracted providers by accessing **Availity.com**.* Providers may also call Provider Services at the number on the back of the patient's member ID card for assistance with PA requirements.

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

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-february-1-7

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Reimbursement Policies | Commercial | Oct 31, 2023

Reimbursement policy update: *Pharmaceutical Waste – Professional and Facility*

Effective September 13, 2023, the *Related Coding* section of the *Pharmaceutical Waste – Professional and Facility* reimbursement policy was updated to include Modifier JZ (zero drug amount discarded or not administered to any patient) as a new informational modifier.

As a reminder, the intent of this policy is to require providers to use the most cost-effective vial or combination of vials of pharmaceutical when procuring and preparing a dose for administration to avoid pharmaceutical wastage. This applies to any non-self-administered drug or biologic dosage prepared from a single-dose vial (SDV).

For specific policy details, visit **anthem.com/provider/policies/reimbursement/?cnslocale=en_US_mo**

MULTI-BCBS-CM-040985-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-pharmaceutical-waste-professiona-5

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Federal Employee Program (FEP) | Commercial | Nov 1, 2023

FEP® Specialty Pharmacy prior authorization list

Effective with dates of service on or after February 1, 2024, the following pharmacy codes will be included in the Federal Employee® (FEP) plans (member IDs beginning with an *R*) ***prior authorization review*** process for specialty drugs. **As a result of this change, services provided on and after February 1, 2024, for these drugs without a prior authorization will be denied.**

FEP will review the FEP medical policy criteria for medical necessity, and the clinical guideline, Level of Care: Specialty Pharmaceuticals (CG-MED-83), will be used to review site-of-care criteria.

What's new beginning with dates of service on or after February 1, 2024, for the *new* drugs listed below?

- Prior to administering the drugs in any setting, a prior authorization must be completed to evaluate if the drugs meet clinical criteria. FEP will begin accepting prior authorization requests for these specialty drugs on January 15, 2024, for dates of service on and after February 1, 2024. **Request prior authorization review by calling the FEP Service Benefit Plan at 800-860-2156.**
- Outpatient hospital-based settings will require a site-of-care review for medical necessity as part of the prior authorization review. Hospital-based facilities contracted with Anthem Blue Cross and Blue Shield for lower drug and administration costs, non-hospital infusion clinics, provider offices, and home infusion providers will not require a site-of-care review:
    - A provider toolkit aligned to the clinical guideline (CG-Med83) will be updated with these additional drugs and provided to providers requiring a site-of-care review, either by fax or e-review. For outpatient hospital settings that do not meet clinical

    criteria, a dedicated clinical team will work with you to identify alternate lower level of care sites that can safely administer the drug.
    - If there are no infusion centers within 30 miles of the member's place of residence, or there are no home infusion providers able to service the member's residence, the hospital-based setting will be approved.
- If the prior authorization is denied for either the drugs not meeting medical necessity or the site-of-care not meeting medical necessity, providers should follow the disputed claim/service process. To obtain the current process, please contact the FEP Service Benefit Plan at **800-860-2156.**
- Services provided on or after February 1, 2024, without prior authorization will result in a denial of claims payment.

Additional Drugs requiring medical necessity and site-of-care review as of February 1, 2024:

Drug	Code	FEP Medical Policy
Avsola (infliximabe-axxq biosimilar)	Q5121	5.50.02
Cutaquig (immune globulin)	J1551	5.20.08 (Subq)
Xembify (immune globulin)	J1558	5.20.08 (Subq)

These changes apply to FEP members (member IDs beginning with an *R*) who are receiving the specialty drug listed above through their medical benefits. **These changes do not impact the approval process for these specialty drugs obtained through pharmacy benefits.** For more information, such as clinical criteria for specialty drugs and level of care, please contact the FEP Service Benefit Plan at **800-860-2156**.

MULTI-BCBS-CM-041501-23-CPN41102

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/fep-specialty-pharmacy-prior-authorization-list-16399

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Federal Employee Program (FEP) | Commercial | Nov 1, 2023

Federal Employee Program specialty pharmacy prior authorization review

Effective for dates of service on or after February 1, 2024, the Federal Employee Program® (FEP) will require prior authorization (PA) review for the specialty drugs listed below. This applies to member IDs beginning with an “R”.

Prior to administering the drug(s) at any setting, PA must be completed to evaluate if the drug(s) meets clinical criteria. Care providers can request PA by calling FEP at **800-860-2156**. Medications administered on or after February 1, 2024, without receiving PA will result in a denial of claims payment. If PA is denied for the drug not meeting medical necessity, care providers will follow the current disputed claim or service process.

FEP will continue to review the *Federal Employee Medical Policy* criteria for medical necessity on the drugs listed below. These changes do not impact the approval process for these specialty drugs obtained through pharmacy benefits.

For more information, contact Provider Services by calling the number on the back of your patient’s member ID card, or contact FEP at **800-860-2156.**

Product name	Codes	Therapeutic category
Alymsys	Q5126	Bevacizumab
Amvuttra	J0225	Amyloidosis

Avastin	J9035, C9257	Bevacizumab
Beovu	J0179	Ocular VEGF
Byooviz	Q5124	Ocular VEGF
Cimerli	Q5128	Ocular VEGF
Eylea	J0178	Ocular VEGF
Fulphila	Q5108	Pegfilgrastim
Fylnetra	Q5130	Pegfilgrastim
Givlaari	J0223	AHP (Acute Hepatic Porphyria)
Granix	J1447	Filgrastim
Herceptin	J9355	Trastuzumab
Herceptin Hylecta	J9356	Trastuzumab
Kanjinti	Q5117	Trastuzumab

Lucentis	J2778	Ocular VEGF
Mvasi	Q5107	Bevacizumab
Neulasta	J2506	Pegfilgrastim
Neulasta/Onpro	J2506	Pegfilgrastim
Neupogen	J1442	Filgrastim
Nivestym	Q5110	Filgrastim
Nyvepria	Q5122	Pegfilgrastim
Ogivri	Q5114	Trastuzumab
Onpattro	J0222	Amyloidosis
Ontruzant	Q5112	Trastuzumab
Oxlumo	J0224	Primary Hyperoxaluria Type 1
Procrit	J0885	Erythropoietin

Releuko	Q5125	Filgrastim
Retacrit	Q5106	Erythropoietin
Riabni	Q5123	Rituximab
Rituxan	J9312	Rituximab
Rituxan Hycela	J9311	Rituximab
Rolvedon	J1449	Eflapegrastim
Ruxience	Q5119	Rituximab
Skyrizi	J2327	Autoimmune
Soliris	J1300	Complement Inhibitors
Stelara IV	J3358	Autoimmune
Stelara SQ	J3357	Autoimmune
Stimufend	Q5127	Pegfilgrastim

Tegsedi	C9399, J3490, J3590	Amyloidosis
Truxima	Q5115	Trastuzumab
Udenyca	Q5111	Pegfilgrastim
Vabysmo	J2777	Ocular VEGF
Vegzelma	Q5129	Bevacizumab
Vyvgart	J9332	Antimyasthenic Agents
Vyvgart Hytrulo	C9399, J3490, J3590	Antimyasthenic Agents
Zarxio	Q5101	Filgrastim
Ziextenzo	Q5120	Pegfilgrastim
Zirabev	Q5118	Bevacizumab

MULTI-BCBS-CM-041497-23-CPN41103

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/federal-employee-program-specialty-pharmacy-prior-authorizat-1

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Pharmacy | Commercial | Nov 1, 2023

Specialty pharmacy updates

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., a separate company.

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.

Inclusion of 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 February 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-0247	Beyfortus (nirsevimab)	J3490, J3590, J9999, C9399

CC-0207	Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-gvfc)	J3490, C9399
CC-0072	Eylea HD (aflibercept)	J3490, J3590

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

Quantity limit updates

Effective for dates of service on and after February 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-0247	Beyfortus (nirsevimab)	J3490, J3590, J9999, C9399
CC-0207	Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-gvfc)	J3490, C9399
CC-0072	Eylea HD (aflibercept)	J3490, J3590

Site of care updates

Effective for dates of service on and after February 1, 2024, the following specialty pharmacy codes from current or new *Clinical Criteria* documents will be included in our site of care review process.

Access our ***Clinical Criteria*** to view the complete information for these site of care updates.

Clinical Criteria	**Drug**	**HCPCS or CPT code(s)**
CC-0065	Altuviiio (antihemophilic factor (recombinant)	J7214
CC-0227	Briumvi (ublituximab)	J2329
CC-0062	Cimzia (certolizumab pegol)	J0717
CC-0050	Skyrizi (risankizumab-rzaa)	J2327
CC-0229	Sunlenca (lenacapavir)	J1961

Effective for dates of service on and after February 1, 2024, the following specialty pharmacy codes from current or new *Clinical Criteria* documents will be removed from our site of care review process.

Access our ***Clinical Criteria*** to view the complete information for these site of care updates.

Clinical Criteria	**Drug**	**HCPCS or CPT code(s)**

CC-0111	Nplate (romiplostim)	J2796
CC-0007	Synagis (palivizumab)	90378

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

MULTI-BCBS-CM-041432-23-CPN41260

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-16396

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Pharmacy | Commercial | Nov 1, 2023

Pharmacy information available on our provider website

Visit the **Drug Lists** page on our provider website at **https://www.anthem.com/ms/pharmacyinformation/home.html** for more information about:

- Copayment/coinsurance requirements and their applicable drug classes.
- Drug lists and changes.
- Prior authorization criteria.
- Procedures for generic substitution.
- Therapeutic interchange.
- Step therapy or other management methods subject to prescribing decisions.
- Any other requirements, restrictions, or limitations that apply to using certain drugs.

The commercial and exchange drug lists are posted to the website quarterly on the first day of the month in January, April, July, and October.

To locate the exchange, select **Formulary and Pharmacy Information**, and scroll down to **Select Drug Lists**. This drug list is also reviewed and updated regularly as needed.

Federal Employee Program pharmacy updates and other pharmacy related information may be accessed at **www.fepblue.org** > Pharmacy Benefits.

MULTI-BCBS-CM-018448-23, MULTI-BCBS-CM-041071-23-CPN41054, MULTI-BCBS-CM-044369-23-CPN44369

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/pharmacy-information-available-on-our-provider-website-15875

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Quality Management | Commercial / Medicare Advantage | Oct 25, 2023

HEDIS measurement year 2023 documentation for Childhood Immunization Status (CIS)

Healthcare Effectiveness Data Information Set (HEDIS®) is a widely used set of performance measures developed and maintained by NCQA. These are used to drive improvement efforts surrounding best practices.

HEDIS 2023 documentation for Childhood Immunization Status (CIS) Measure description:

The percentage of children 2 years of age in the measurement year who had the following on or before their second birthday:

- **Four DTaP** (diphtheria, tetanus, and acellular pertussis)
- **Three IPV** (polio)
- **One MMR** (measles, mumps, and rubella)
- **Three HiB** (haemophilus influenza type B)
- **Three Hep B** (hepatitis B)
- **One VZV** (chicken pox)
- **Four PCV** (pneumococcal conjugate)
- **One Hep A** (hepatitis A)
- **Two or three RV** (rotavirus)
- **Two flu** (influenza)

The measure calculates a rate for each vaccine and three combination rates.

HEDIS 2023 documentation for Immunizations for Adolescents (IMA) Measure description: The percentage of adolescents 13 years of age in the measurement year

who had the following:

- **One MenACWY** (meningococcal)
- **One Tdap** (tetanus, diphtheria toxoids and acellular pertussis)
- **Two or three HPV** (human papillomavirus)

The measure calculates a rate for each vaccine and two combination rates.

HEDIS measurement year 2023 documentation for Lead Screening in Children (LSC) Measure description: The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

What we are looking for in provider medical records:

- Immunization records from birth (Department of Health immunization records are acceptable).
- If available, newborn inpatient records documenting Hep B.
- For those immunizations not recorded on the immunization record, provide progress notes for: Immunizations administered, patient's history of disease (chickenpox, Hep A, Hep B, measles, mumps, rubella).
- Anaphylaxis due to the Dtap, IPV, MMR, HIB, Hep B, VZV, PCV, Hep A, RV, or Influenza vaccines.
- Encephalitis due to the Dtap vaccine.
- Diagnosis of severe combined immunodeficiency, immunodeficiency, HIV, lymphoreticular cancer, multiple myeloma, leukemia, or intussusception.
- Meningococcal vaccine with a date of service on or between the member's 11th and 13th birthdays.
- Tdap vaccine with a date of service on or between the member's 10th and 13th birthdays.
- At least two HPV vaccines on or between the member's ninth and 13th birthdays and with dates of service at least 146 days apart, or at least three HPV vaccines with different dates of service on or between the member's ninth and 13th birthdays.

- Lead testing results and date (capillary or venous) on or before the child's second birthday.
- Evidence of hospice services in 2023.
- Evidence patient expired in 2023.

Helpful hints:

- Childhood immunizations and lead blood tests must be completed by the child's second birthday.
- Assess immunization needs at every clinical encounter, including sick visits and when indicated, immunize.
- Ensure immunization records include all vaccines that were ever given, including hospitals, health departments, all former providers, include refusals, and contraindications.
- FluMist (LAIV) vaccination (only approved for ages 2 to 49) may be used for the second vaccination, however it must be given **on** the child's second birthday to be compliant.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

MULTI-BCBS-CRCM-038697-23-CPN38591

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/hedis-measurement-year-2023-documentation-for-childhood-immu-16

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Quality Management | Medicare Advantage | Nov 1, 2023

Controlling high blood pressure and HEDIS®

The Controlling Blood Pressure (CBP) HEDIS measure can be challenging. It not only requires proof of a blood pressure reading, but also that the patient's blood pressure (BP) is adequately controlled. CBP care gaps can open and close throughout the year depending on if the patient's most recent BP reading is greater than 138/89 mmHG. As we approach the end of the year, it is important that we have record of your patients' BP readings and that you schedule any members who have not had a BP reading during 2023 or who have had high readings recorded this year.

Tips when scheduling members to close CBP care gaps:

- When scheduling appointments, have staff ask patients to avoid caffeine and nicotine for at least an hour before their scheduled appointment time.
- If possible, update your scheduling app or your reminder text message campaigns to include a reminder about abstaining from caffeine as well as a reminder to arrive early to avoid a sense of rushing.

Tips for lower BP readings during the appointment:

- Ask the patient if they tend to get nervous at appointments and have higher readings as a result. If they do, take their BP at both the start and end of the appointment. Document the lower reading.
- Readings could vary arm to arm. If slightly elevated in one arm, try the other and document the lower reading.

Getting credit for adequately CBP readings:

- Submit readings via Category II CPT® codes on claims:

Description	Code
Diastolic BP	CAT II: 3078F-3080F LOINC: 8462-4
Diastolic 80 to 89	CAT II: 3079F
Diastolic greater than/equal to 90	CAT II: 3080F
Diastolic less than 80	CAT II: 3078F
Systolic BP	CAT II: 3074F, 3075F, 3077F LOINC: 8480-6
Systolic greater than/equal to 140	CAT II: 3077F
Systolic less than 140	CAT II: 3074F, 3075F

- Ensure readings are carefully and appropriately documented within your electronic medical records (EMR) system.
- If you have questions on how to submit readings, speak to your care consultant or program manager.
- Be sure to adequately code patients who meet the exclusion criteria.

To learn more about our commitment to health equity visit **My Diverse Patients**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

MULTI-BCBS-CRCM-038111-23-CPN37873

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/controlling-high-blood-pressure-and-hedis-16311

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Quality Management | Commercial / Medicare Advantage | Sep 27, 2023

Be Antibiotics Aware: Protect your patients

Each year, the CDC encourages care providers and individuals to learn more about antibiotics by promoting antibiotic awareness in November. The CDC's *Be Antibiotics Aware* educational effort encourages care providers to:

- Prescribe antibiotics only when they are clinically indicated. Antibiotics are only needed to treat certain infections caused by bacteria, not viruses like those that cause COVID-19. Harm can be done by prescribing antibiotics that aren't needed.
- Talk to patients about why they don't need antibiotics for a viral respiratory infection, what to do to feel better, and when to seek care again if they don't feel better.
- Write a prescription for symptom relief, such as rest, fluids, cool mist vaporizers, and over-the-counter medicine.

CDC's *Be Antibiotics Aware* offers resources that help educate patients about antibiotic use at **Antibiotic Use | CDC**. This includes waiting/treatment room posters, pamphlets such as *Antibiotics Aren't Always the Answer*, prescription pads for cold relief, and more.

HEDIS® Measures that assess antibiotic prescribing

The following HEDIS measures assess appropriate antibiotic dispensing for bronchitis/bronchiolitis, upper respiratory infection, and pharyngitis. These measures are used to identify, monitor, and improve antibiotic prescribing practices.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB):

This measure assesses the percentage of episodes for patients ages three months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. If prescribing an antibiotic to patients with acute bronchitis, be sure to use the diagnosis code for the bacterial infection and/or comorbid condition.

Appropriate Treatment for Upper Respiratory Infection (URI):

This measure calculates the percentage of episodes for patients three months of age and older with a diagnosis of upper respiratory infection that did not result in an antibiotic dispensing event. Reducing unnecessary use of antibiotics is the goal of this measure. Educate patients on the difference between bacterial and viral infections. Refer to the viral illnesses as a common cold, sore throat, or chest cold.

Appropriate Testing for Pharyngitis (CWP):

This measure reports the percentage of episodes for patients three years of age and older where the patient was diagnosed with pharyngitis, dispensed an antibiotic, and received a group A strep test. When patients present with symptoms of pharyngitis, ensure proper testing (for strep) is performed to avoid the unnecessary prescribing of antibiotics. Record the results of the strep test.

For more information and coding guidelines, reference the HEDIS guides on the Anthem provider website.

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MULTI-BCBS-CRCM-037929-23-CPN37569

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Quality Management | Commercial / Medicare Advantage | Oct 15, 2023

HEDIS medical record submission made easier with our Remote EMR Access Service

Instead of submitting medical records for the HEDIS® hybrid project, use the Remote Electronic Medical Record (EMR) Access Service provided by Anthem. We offer providers the ability to grant access to your EMR system directly to pull the required documentation to aid your office in reaching compliance. Granting our team remote access to your EMR helps reduce the time and costs associated with medical record retrieval while improving efficiency and allowing your office to focus on patient care.

We have a centralized EMR team experienced with multiple EMR systems and extensively trained annually on HIPAA, EMR systems, and HEDIS measure updates. We complete medical record retrieval based on minimum necessary guidelines:

- We only access medical records of members pulled into the HEDIS sample using specific demographic data.
- We only retrieve the medical records that have claims evidence related to the HEDIS measures.
- We only access the least amount of information needed for a use, disclosure, or a request.
- We only save to file and do not physically print any PHI.

Getting started with Remote EMR Access is just one email away. Email Centralized_EMR_Team@anthem.com today. To learn more about our Remote EMR Access, view the frequently asked questions below.

Q. How do you retrieve our medical records?

A. We access your EMR using a secure website and retrieve only the necessary documentation by printing it to an electronic file we store internally, on our secure network drives.

Q. Is this process secure?

A. Yes, we only use secure internal resources to access your EMR systems. All retrieved records are stored on Anthem secure network drives.

Q. Why does Athem need full access to the entire medical record?

A. There are several reasons we need to look at the entire medical record of a member, including:

- HEDIS measures can include up to a 10-year look back of a member's information.
- Medical record data for HEDIS compliance may come from several different areas of the EMR system, including labs, radiology, surgeries, inpatient stays, outpatient visits, and case management.
- Compliant data may be documented or housed in a non-standard format, such as an in-office lab slip scanned into miscellaneous documents.

Q. What information do I need to submit to use your Remote EMR Access Service?

A. Email Centralized_EMR_Team@anthem.com with the following information:

Practice/facility demographic information (for example, address, National Provider ID, Taxpayer Identification Numbers, etc.)

- EMR system information (for example, type of EMR system, required access forms, access type, etc.)
- List of current providers/locations or a website for accessing this list.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Quality Management | Commercial / Medicare Advantage | Nov 1, 2023

HEDIS measurement year 2023 documentation for Transitions of Care (TRC)

HEDIS® is a widely used set of performance measures developed and maintained by the NCQA. These are used to drive improvement efforts surrounding best practices.

Measure description

The percentage of discharges for members 18 years of age and older who had each of the following:

- Notification of inpatient admission (can only be captured through medical record review)
- Receipt of discharge information (can only be captured through medical record review)
- Patient engagement
- Medication reconciliation post-discharge

What we are looking for in care provider records:

- **Notification of inpatient admission** — documentation in the outpatient medical record must include evidence of receipt for notification of inpatient admission on the day of admission through two days after the admission (three total days) with evidence of the date when the documentation was received. Any of the following examples meet criteria:
  - Communication about admission between inpatient care providers or ER and the member's PCP or ongoing care provider (for example, phone call, e-mail, fax, information exchange, automated alert system, shared electronic medical record, or from the member's health plan)

    - Indication that the PCP or ongoing care provider admitted the member to the hospital
    - Indication that a specialist admitted the member to the hospital and notified the member's PCP or ongoing care provider
    - Indication that the PCP or ongoing care provider placed orders for tests and treatments any time during the member's inpatient stay
    - Documentation that the PCP or ongoing care provider performed a preadmission exam or received communication about a planned inpatient admission. The time frame that the preadmission exam or planned inpatient admission must be communicated is not limited to the day of admission through two days after the admission (three total days)
- **Receipt of discharge information** — documentation in the outpatient medical record must include evidence of receipt of discharge information on the day of discharge through two days after the discharge (three total days) with evidence of the date when the documentation was received. Discharge information may be included in, but not limited to, a discharge summary or summary of care record, or in the structured fields in an electronic health record. At a minimum, the discharge information must include the following:
    - The practitioner responsible for the member's care during the inpatient stay
    - Procedures or treatments provided
    - Diagnoses at discharge
    - Current medication list
    - Testing results, or documentation of pending tests or no tests pending
    - Instructions for patient care post-discharge
- **Patient engagement** — documentation in the outpatient medical record must include evidence of patient engagement within 30 days after discharge. Any of the following meet criteria:
    - An outpatient visit, including office visits and home visits
    - A telephone visit

  - A synchronous telehealth visit where real-time interaction occurred between the member and care provider using audio and video communication
  - An e-visit or virtual check-in (asynchronous telehealth where two-way interaction, which was not real-time, occurred between the member and care provider)
- **Medication reconciliation** — documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Medication reconciliation must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. Any of the following meet criteria:
  - Documentation of the current medications with a notation that the care provider reconciled the current and discharge medications
  - Documentation of the current medications with a notation that references the discharge medications (for example, no changes in medications since discharge, same medication at discharge, discontinue all discharge medications)
  - Documentation of the member's current medications with a notation that the discharge medications were reviewed
  - Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service
  - Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review:
    - Evidence that the member was seen for post-discharge follow-up requires documentation that indicates the care provider was aware of the member's hospitalization or discharge
  - Documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record. There must be evidence the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
  - Notation that no medications were prescribed or ordered upon discharge
- **Exclusions:**
  - Evidence of hospice or palliative services in 2023

- Evidence patient expired in 2023

Helpful hints:

- Documentation of a procedure/surgery that is typically performed inpatient (such as, aortic bypass) does not indicate that the care provider is aware of the hospitalization. Documentation of *post-op/surgery follow-up* alone does not indicate the care provider was aware of the hospitalization or discharge. **Make sure documentation references the *hospitalization*, *admission*, or *inpatient stay*.**
- If performing a pre-admission exam, document that it is a pre-admission exam.
- If performing a pre-surgical, pre-operative, or surgical clearance exam, the date of the admission must be documented.
- Implement process to receive automated alerts when a member is admitted or discharged from an inpatient facility.
- Review discharge medications with the member.
- Schedule post-hospital discharge following appointments and have the office call the member to remind them.
- Document a received date for discharge summaries and notification of inpatient admissions.
- Use the appropriate billing codes for *Medication Reconciliation* and *Patient Engagement*.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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Quality Management | Medicare Advantage | Nov 1, 2023

Statin therapy end of year best practices

You may have patients who cannot tolerate moderate or high-dose statin therapy but appear in your HEDIS® denominator for Statin Use in Persons With Cardiovascular Disease (SPC). By properly submitting the required exclusion criteria for this measure, you can improve your quality scores before the end of the year. The **Statin Therapy Exclusion Guide** is a great resource to learn more on what qualifies as an exclusion and how to submit the proper criteria.

Tips for implementing best practices and improving your quality scores before the end of the year:

- Properly code and submit exclusion criteria for members who cannot tolerate moderate or high-dose statin therapy. Reference the **Statin Therapy Exclusion Guide**.
- Educate members on the importance of adhering to their statin therapy regime and educate them on potential side effects. If they start to experience muscle pain or weakness, have them contact you to discuss their options.
- Statin therapy should be accompanied by lifestyle modifications, such as a healthy diet and exercise. Work with your patients to proactively identify and overcome any barriers that may prevent lifestyle modifications:
- If they cannot make it to the gym, talk with them about exercising at home.
- Encourage a healthy diet based on the patient's culture and local availability:
  - Reference this **conversation guide** for more information on how to discuss lifestyle modifications if your patient is of a different culture than your own.
- For those patients who can tolerate moderate or high-dose statin therapy, encourage them to do 90-day prescriptions or mail order to eliminate barriers that may prevent them from getting their prescription on-time. As the SPC measure is reliant on

pharmacy claims to close the care gap, try to prescribe the lowest cost medication that will work for them to eliminate any undue financial burdens on the patient and discourage the use of pharmacy discount cards.

Patient care opportunities

You can find patient care opportunities within the Patient360 application located on Availity Essentials* Payer Spaces. To access the Patient360 application, you must have the Patient360 role assignment. From Availity's home page, select **Payer Spaces**, then choose the health plan from the menu. Select the **Patient360** tile from the *Payer Space Applications* menu and complete the required information on the screen. Gaps in care are located in the *Active Alerts* section of the **Member Summary**.

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

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