January 2024 Provider Newsletter

Contents

Medical Policy & Clinical Guidelines | Commercial / Medicare Advantage | Jan 1, 2024

Updates to *Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines*

Medical Policy & Clinical Guidelines | Commercial / Medicare Advantage | Dec 28, 2023

Transition to Carelon Medical Benefits Management, Inc. cardiology guidelines

Medical Policy & Clinical Guidelines | Commercial | Jan 1, 2024

Carelon Medical Benefits Management, Inc. genetic testing CPT® code list update

Prior Authorization | Commercial | Jan 1, 2024

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

Prior Authorization | Medicare Advantage | Nov 22, 2023

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

Dental | Commercial | Jan 1, 2024

January Dental newsletter communications

Pharmacy | Commercial | Dec 28, 2023

Specialty pharmacy updates — January 2024

Quality Management | Medicare Advantage | Jan 1, 2024

Boost annual planned visit rates

Quality Management | Commercial / Medicare Advantage | Jan 1, 2024

HEDIS diabetes documentation

Quality Management | Commercial | Nov 20, 2023

Annual preventive care visits

MOBCBS-CRCM-047207-23

To view this publication online:

Visit https://providernews.anthem.com/missouri/publications/january-2024-provider-newsletter-2416

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Administrative | Commercial | Jan 1, 2024

Introducing Paytient: a new interest-free way for your patients to pay for out-of-pocket costs

As your partner in health, Anthem is here to help your patients more easily access and pay for the care they need, while also reducing your administrative burden of collections.

We're excited to announce that we've partnered with Paytient, a Health Payment Account (HPA) that makes paying for medical and pharmacy expenses easier with interest-free flexible payment plans. Paytient offers many benefits, which include allowing your patients the ability to focus on what matters most — improving their health and wellness.

Giving you and your patients peace of mind

Paytient gives your patients with Anthem individual and family Affordable Care Act (ACA)-compliant plans the power to pay for out-of-pocket healthcare costs over time, interest-free, and with no fees or credit check. They can just choose a payment plan that works for them.

Removing you and your staff from the debt equation

Paytient pays you as soon as your patients swipe their card — taking you out of the debt equation and ensuring you get paid faster. You don't need to assume any of the debt risk to your balance sheet, as the card allows you to reliably receive payment at the point of care or on the first billing cycle. Your eligible patients can also use their Paytient card to pay for late or unpaid bills, so long as they're not with a collection agency. This means you won't have to go through the burden of collections — saving you and your staff time and money.

Paytient is only available to those with an individual or family ACA-compliant plan offered by Anthem in Virginia, Georgia, and Missouri.

Share this information with your office staff to help support your patients in need. To learn more, visit **paytient.com/anthem** or contact your local provider relationship management representative.

Through our efforts, we are committed to reducing administrative burden and ensuring timely payments because we value you, our care provider partners.

MULTI-BCBS-CM-046901-23-CPN45514

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/introducing-paytient-a-new-interest-free-way-for-your-patien

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Inappropriate primary diagnosis

According to ICD-10-CM guidelines for coding and reporting, it is inappropriate to bill certain diagnosis codes as a primary or first listed diagnosis. Instead, these codes should always be sequenced as a secondary or subsequent diagnosis. Effective for claims processed on or after April 1, 2024, Anthem will apply these correct coding ICD-10-CM guidelines and deny:

- Professional claims submitted on a *CMS-1500* form that report inappropriate primary diagnosis codes as the only diagnosis on the claim or claim line; and facility claims submitted on a *CMS-1450* form that report inappropriate primary diagnosis codes as the principal diagnosis or only code on the claim.

As provided by ICD-10-CM guidelines, inappropriate primary diagnosis codes **include but are not limited to:**

- **External Cause Codes of Morbidity** (V, W, X, or Y codes [ICD-10-CM]) describes an environmental event causing an injury, not the nature of the injury, and therefore should not be used as a principal diagnosis. These codes are intended to be supplemental to the principal or primary diagnosis code indicating the nature of the condition. In addition, based on this guideline, a diagnosis code of external causes cannot be the only diagnosis on the claim.
- **Manifestation Codes:** Certain conditions contain both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD Manual coding guidelines have established a coding convention that requires the underlying condition to be sequenced first followed by the manifestation. According to the ICD Manual coding guidelines, the primary, first listed, or principal diagnosis cannot be a manifestation code. In addition, based on this guideline, a manifestation code cannot be the only diagnosis on the claim.

- **Sequela Codes:** a sequela (7th character "S") code cannot be listed as the primary, first listed, or principal diagnosis on a claim. Coding of a sequela requires reporting of the condition or nature of the sequela sequenced first, followed by the sequela (7th character "S") code. In addition, based on this guideline, a sequela (7th character "S") code cannot be the only diagnosis on a claim.
- **Secondary Diagnosis:** According to ICD guidelines, a secondary diagnosis code can only be used as a secondary diagnosis. Since these codes are only for use as supplemental codes, any procedure or service received with a secondary diagnosis code as the principal or primary diagnosis will be denied as incorrectly coded.

EOB Message: We denied this service since it was reported incorrectly. Per CMS (Federal) correct coding guidelines, specific Supplementary Classification ICD-10 codes cannot be used as the primary diagnosis or as the only diagnosis on the claim.

Ex-Codes: 00V16 and v16

MULTI-BCBS-CR-035113-23-CPN34788

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/inappropriate-primary-diagnosis-17237

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Administrative | Commercial | Jan 1, 2024

CAA: Maintain your online provider directory information

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:

- Adding/changing an address location.
- Changing a name.
- Changing a phone/fax number.
- Provider leaving a group or a single location.
- Closing a practice location.

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. Reviewing your information helps us ensure your online provider directory information is current.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/caa-maintain-your-online-provider-directory-information-1729

Or scan this QR code with your phone

Administrative | Commercial | Jan 1, 2024

Important Changes for Active Members of Northrop Grumman Corporation

Effective January 1, 2024, Northrop Grumman Corporation will contract with Quantum Health to perform health care navigation and care coordination services for their active member population only. As part of this contract, Quantum Health will support member healthcare and benefit needs, including member and care provider services and medical utilization review and submission to Anthem. Northrup Grumman Corporation active members may be identified by the group number beginning with 174022 on the member ID card. A sample ID card is below.

Anthem will remain responsible for claims adjudication and certain services as described below. Anthem will also remain the administrator of Behavioral Health Utilization Management, inclusive of retrospective reviews, and Case Management.

Quantum Health is the point of contact for member and care provider inquiries.

Quantum Health will be the point of contact for members and healthcare providers to verify:

- Benefit coverage information.
- Eligibility inquiries.
- Prior-authorization submission and review (as stated above).

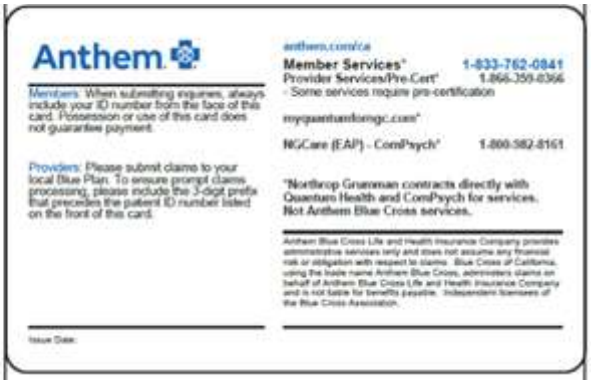
Anthem will remain the point of contact for care providers for the following:

- Behavioral Health Utilization Management, inclusive of retrospective reviews and Case Management.

- Quantum Health will redirect care provider questions/inquiries to Anthem or local Blue for Medical and Behavioral Health Services for the following:
    - Care provider contracting.
    - Remittances.
    - Fee schedule.
    - Value Based Programs.
    - Network status.
    - Demographic information updates.

Sample Member ID card

Based on the information outlined above, there are changes in the Member Services and Provider Services/pre-certification phone numbers. These two new phone numbers are located on the back of the Medical Member ID card.



If you have any questions, please contact your provider relationship management representative. We are committed to a future of shared success.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/important-changes-for-active-members-of-northrop-grumman-cor

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Administrative | Commercial | Jan 1, 2024

Using and billing air ambulance services appropriately

When using or billing air ambulance services, please remember:

- To facilitate timely and accurate claim processing of air ambulance services, include the facility's record (emergency department record, or if an inpatient, the discharge or transfer summary) along with your run sheet. Providing this information will greatly facilitate timely review of medical necessity.
- Regarding the practice of using air ambulance services solely because use of ground transport would temporarily deplete local area Emergency Medical Services (EMS) availability, while EMS availability is always a local EMS concern, please understand that this reason alone does not meet medical necessity criteria for our members.
- Lastly, excess miles flown to keep a patient within the sending facility's health system, when another closer capable receiving hospital has capacity, does not meet medical necessity criteria. Determination of medical necessity, including mode of transportation, is determined in accordance with Anthem's clinical guidelines and medical necessity criteria. These determining guidelines include only approving the distance to the closest capable facility with capacity.

Taking the above into consideration will result in faster processing and lower denials of your air ambulance service claims. For your reference, see **CG-ANC-04 Ambulance Services: Air and Water**.

If you have questions, contact your local provider relationship management representative.

We look forward to working together to achieve improved outcomes.

MULTI-BCBS-CM-047454-23-CPN47431

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/using-and-billing-air-ambulance-services-appropriately-17445

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Digital Tools | Commercial | Dec 26, 2023

Training for digital requests for additional information (Digital RFAI)

Now accepting Medicaid and Medicare member claims

As a care provider taking advantage of digital requests for additional information (Digital RFAI), you know it is the most efficient way to send the required documentation to process your Commercial member claims. As of mid-November, you also can 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

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
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.

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	All billing NPIs/TINs must be registered.

		notices from the payer and submit requested documents digitally.	
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).

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

MULTI-BCBS-CM-047947-23-CPN47121

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/training-for-digital-requests-for-additional-information-dig-1

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Education and Training | Commercial | Jan 1, 2024

Important information about your Anthem patients' specialty prescriptions

Effective January 1, 2024, most specialty prescriptions will transfer to BioPlus, CarelonRx specialty pharmacy that services Anthem members. This migration is taking place in multiple waves throughout the next year.

What happens next?

- If you have patients affected by this pharmacy change, BioPlus will contact you to request new prescriptions, refills, or prior authorizations. You will also receive a letter from CarelonRx.
- Current specialty prescriptions with open refills will automatically transfer to BioPlus.
- Impacted patients will receive a letter and a phone call, explaining this transition.
- There is nothing you or your patients need to do except speak with BioPlus when they call.

What is the benefit to you and your patients?

CarelonRx and BioPlus work together to deliver patients an unparalleled level of high-tech, high-touch service that focuses on their whole health.

As a care provider, you will receive fast and easy benefit confirmation and prior authorizations for expedited time to therapy. BioPlus also offers comprehensive infusion services that include dedicated nurse concierges, patient advocates, and disease-specific education and clinical reminders.

If you have any questions, please call your Anthem representative. We're here to help.

CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of the health plan.

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

MULTI-BCBS-CM-047443-23-CPN47164

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Visit https://providernews.anthem.com/missouri/articles/important-information-about-your-anthem-patients-specialty-p

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Clinical Criteria updates — August 2023

On August 18, 2023, and August 30, 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. For questions or 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	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
January 8, 2024	*CC-0244	Columvi (glofitamab-gxbm)	New
January 8, 2024	*CC-0245	Izervay (avacincaptad pegol)	New
January 8, 2024	*CC-0246	Rystiggo (rozanolixizumab-noli)	New
January 8, 2024	*CC-0247	Beyfortus (nirsevimab)	New
January 8, 2024	CC-0001	Erythropoiesis Stimulating Agents	Revised
January 8, 2024	CC-0124	Keytruda (pembrolizumab)	Revised
January 8, 2024	CC-0104	Levoleucovorin Agents	Revised
January 8, 2024	CC-0100	Romidepsin	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
January 8, 2024	*CC-0182	Iron Agents	Revised
January 8, 2024	CC-0075	Rituximab Agents for Non-Oncologic Indications	Revised
January 8, 2024	CC-0176	Beleodaq (belinostat)	Revised
January 8, 2024	CC-0180	Monjuvi (tafasitamab-cxix)	Revised
January 8, 2024	CC-0107	Bevacizumab for non-ophthalmologic indications	Revised
January 8, 2024	CC-0216	Opdualag (nivolumab and relatlimab-rmbw)	Revised
January 8, 2024	CC-0196	Zynlonta (loncastuximab tesirine-lpyl)	Revised
January 8, 2024	CC-0197	Jemperli (dostarlimab-gxly)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
January 8, 2024	CC-0203	Ryplazim (plasminogen, human-tvmh)	Revised
January 8, 2024	CC-0193	Evkeeza (evinacumab)	Revised
January 8, 2024	*CC-0034	Hereditary Angioedema Agents	Revised
January 8, 2024	*CC-0041	Complement Inhibitors	Revised
January 8, 2024	*CC-0207	Vyvgart (efgartigimod alfa-fcab) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-gvfc)	Revised
January 8, 2024	CC-0028	Benlysta (belimumab)	Revised
January 8, 2024	*CC-0243	Vyjuvek (beremagene geperpavec)	Revised
January 8, 2024	CC-0165	Trodelvy (sacituzumab govitecan)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
January 8, 2024	*CC-0125	Opdivo (nivolumab)	Revised
January 8, 2024	*CC-0119	Yervoy (ipilimumab)	Revised
January 8, 2024	CC-0143	Polivy (polatuzumab vedotin-piiq)	Revised
January 8, 2024	*CC-0072	Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised

MULTI-BCBS-CR-044412-23-CPN44137

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-august-2023-17138

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Genetic testing code list update

Effective for dates of service on and after April 1, 2024, the following codes will require prior authorization through Carelon Medical Benefits Management, Inc.

CPT® code	Description
0378U	RFC1 (replication factor C subunit 1), repeat expansion variant analysis by traditional and repeat-primed PCR, blood, saliva, or buccal swab
0364U	Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (PCR) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (MRD) with quantitation of disease burden, when appropriate
0380U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis, 20 gene variants and CYP2D6 deletion or duplication analysis with reported genotype and phenotype
0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)

0131U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)
0132U	Hereditary ovarian cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)
0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)
0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)
0379U	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA (523 genes) and RNA (55 genes) by next-generation sequencing, interrogation for sequence variants, gene cop
0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite insta
0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic predict

0392U	Drug metabolism (depression, anxiety, attention deficit hyperactivity disorder [ADHD]), gene-drug interactions, variant analysis of 16 genes, including deletion/duplication an
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations
0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number a
0333U	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement
0368U	Oncology (colorectal cancer), evaluation for mutations of APC, BRAF, CTNNB1, KRAS, NRAS, PIK3CA, SMAD4, and TP53, and methylation markers (MYO1G, KCNQ5, C9ORF50, FLI1, CLIP4,
0388U	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and struct

0391U	Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for single nucleoti
0397U	Oncology (non-small cell lung cancer), cell-free DNA from plasma, targeted sequence analysis of at least 109 genes, including sequence variants, substitutions, insertions, del
0400U	Obstetrics (expanded carrier screening), 145 genes by nextgeneration sequencing, fragment analysis and multiplex ligationdependent probe amplification, DNA, reported as carrie
0401U	Cardiology (coronary heart disease [CAD]), 9 genes (12 variants), targeted variant genotyping, blood, saliva, or buccal swab, algorithm reported as a genetic risk score for a

As a reminder, ordering and servicing care providers may submit prior authorization requests to Carelon Medical Benefits Management in one of several ways:

- Access the Carelon Medical Benefits Management ***Provider****Portal*$_{SM}$ directly at **providerportal.com**:
    1. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Access Carelon Medical Benefits Management via Availity Essentials at **Availity.com**

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

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

MULTI-BCBS-CR-041252-23-CPN40788

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/genetic-testing-code-list-update-16420

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Updates to *Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines*

Effective for dates of service on and after April 14, 2024, the following updates will apply to the *Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines*. As part of the Carelon Medical Benefits Management guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable health care services.

Refer to attachment to view full details.

MULTI-BCBS-CRCM-043720-23-CPN42002

ATTACHMENTS (available on web): Updates to Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines (pdf - 0.11mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/updates-to-carelon-medical-benefits-management-inc-clinical-7

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Medical Policy & Clinical Guidelines | Commercial / Medicare Advantage | Dec 28, 2023

Transition to Carelon Medical Benefits Management, Inc. cardiology guidelines

Effective April 1, 2024, Anthem will transition to the following Carelon Medical Benefits Management, Inc. guidelines to perform medical necessity/clinical appropriateness reviews for requested cardiology interventions. Applicable CPT® codes lists are included in each guideline linked below:

- **Endovascular Revascularization**
- **Cardiac Resynchronization Therapy**
- **Implantable Cardioverter Defibrillators**
- **Permanent Implantable Pacemakers**

Preapproval requirements remain the same. The requested services received on or after April 1, 2024, will be reviewed with the new *Clinical Criteria*.

As a reminder, ordering and servicing care providers may submit preapproval requests to Carelon Medical Benefits Management using the ***Provider***Portal$_{SM}$ directly at **providerportal.com**. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.

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

We are focused on reducing administrative burdens, so you can do what you do best – care for our members.

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

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

MULTI-BCBS-CRCM-042161-23-CPN41724

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Visit https://providernews.anthem.com/missouri/articles/transition-to-cardiology-guidelines-from-carelon-medical-ben-6

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Carelon Medical Benefits Management, Inc. genetic testing CPT® code list update

Effective for dates of service on and after April 1, 2024, the following codes will require prior authorization through Carelon Medical Benefits Management, Inc.

CPT code	Description
0378U	RFC1 (replication factor C subunit 1), repeat expansion variant analysis by traditional and repeat-primed PCR, blood, saliva, or buccal swab
0364U	Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (PCR) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (MRD) with quantitation of disease burden, when appropriate
0380U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis, 20 gene variants and CYP2D6 deletion or duplication analysis with reported genotype and phenotype
0130U	Hereditary colon cancer disorders (such as Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in

CPT code	Description
0131U	Hereditary breast cancer-related disorders (such as hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)
0132U	Hereditary ovarian cancer-related disorders (such as, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)
0134U	Hereditary pan cancer (such as, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)
0135U	Hereditary gynecological cancer (such as, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)
0379U	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA (523 genes) and RNA (55 genes) by next-generation sequencing, interrogation for sequence variants, gene cop
0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite insta

CPT code	Description
0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic predict
0392U	Drug metabolism (depression, anxiety, attention deficit hyperactivity disorder [ADHD]), gene-drug interactions, variant analysis of 16 genes, including deletion/duplication an
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements
0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number
0333U	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement

CPT code	Description
0388U	Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and struct
0391U	Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for single nucleoti
0397U	Oncology (non-small cell lung cancer), cell-free DNA from plasma, targeted sequence analysis of at least 109 genes, including sequence variants, substitutions, insertions, del
0400U	Obstetrics (expanded carrier screening), 145 genes by nextgeneration sequencing, fragment analysis and multiplex ligationdependent probe amplification, DNA, reported as carrie
0401U	Cardiology (coronary heart disease [CAD]), 9 genes (12 variants), targeted variant genotyping, blood, saliva, or buccal swab, algorithm reported as a genetic risk score

As a reminder, ordering and servicing providers may submit prior authorization requests to Carelon Medical Benefits Management in one of the following ways:

- Access Carelon's ***Provider****Portal*$_{SM}$ directly at **providerportal.com:**
  - Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Access Carelon Medical Benefits Management via the Availity platform at **Availity.com**.

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

MULTI-BCBS-CM-041131-23-CPN40786

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/carelon-medical-benefits-management-inc-genetic-testing-cpt-3

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Prior Authorization | Commercial | Jan 1, 2024

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

As communicated in the October 2023 provider newsletter, effective April 1, 2024, Carelon Medical Benefits Management, Inc., a specialty health benefits company, will expand multiple Carelon Medical Benefits Management programs to perform medical necessity reviews for additional procedures for Anthem 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 Carelon Medical Benefits Management expanded cardiology, genetic testing, radiology, musculoskeletal, surgical and radiation oncology programs. The *Clinical Guidelines* and *Medical Policies* that have been adopted by Anthem 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), HealthLink, and National members currently participating in the Carelon Medical Benefits Management programs listed below are included. For self-funded (ASO) groups that currently do not participate in the Carelon Medical Benefits Management programs, the program will be offered to self-funded accounts (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, Federal Employee Program® (FEP®).

Pre-service review requirements

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 the Availity Essentials website 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).

For procedures that are scheduled to begin on or after April 1, 2024, all providers with the following programs 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.

Note: The procedure list has been updated since the November notification. All codes will only be reviewed for medical necessity for the requested service and not for site of care at this time.

Program	Services	*Clinical Guidelines*
Expanded cardiology	• Treatment of varicose veins • Artery stent placement w/wo angioplasty • Embolization procedure • Dialysis circuit procedure • EPS studies • Cardiac ablation • Cardiac monitor device	• CG-MED-64 • CG-MED-74 • CG-SURG-28 • CG-SURG-55 • CG-SURG-76 • CG-SURG-83 • CG-SURG-93

	• Cardiac contractility modulation • Wearable cardioverter defibrillators • Wireless CRT for left ventricular pacing • Venous angioplasty w/wo stent placement • Vein embolization treatment for pelvic congestion syndrome and varicocele • PFO closure devices	• CG-SURG-106 • MED.00055 • RAD.00059 • SURG.00032 • SURG.00037 • SURG.00062 • SURG.00152 • SURG.00153 • THER-RAD.00012
Genetic testing	• Topographic genotyping • Chromosomal microarray analysis • Gene expression profiling • Gene mutation testing • Gene sequencing • Panel and other multi-gene test for polymorphisms • Genetic test for inherited diseases • Molecular marker evaluation of thyroid nodules • Hybrid personalized molecular residual disease test for cancer • BRCA gene test • Cell-free DNA test to aid in monitoring of kidney transplant rejection • Laboratory test to aid in dx of heart transplant rejection	• Carrier Screening in the Prenatal Setting and Preimplantation Genetic Testing • Cell-free DNA Testing (Liquid Biopsy) for the Management of Cancer • Chromosomal Microarray Analysis • Genetic Testing for Inherited Conditions • Hereditary Cancer Testing • LAB.00025 • LAB.00050 • Pharmacogenomic Testing • Polygenic Risk Scores • Somatic Tumor Testing • Whole Exome Sequencing and Whole Genome Sequencing
Radiology	• Radiostereometric analysis	• CG-SURG-29 • RAD.00064

	• Quantitative ultrasound for tissue characterization • Myocardial sympathetic innervation and imaging w/wo spect. • Lumbar discography	• RAD.00065 • RAD.00067
Musculoskeletal	• Extraosseous subtalar joint imp and arthroereisis • Genicular Nerve block and ablation — CHR knee pain • Percutaneous and endo spinal surgery • Implanted devices for spinal stenosis • Percutaneous vert disc and endplate procedures • Cryoablation for podiatric conditions	• SURG.00052 • SURG.00071 • SURG.00092 • SURG.00100 • SURG.00104 • SURG.00142
Surgical	• Wireless capsule endoscopy • Bariatric surgery • Paraoesophageal hernia repair • Ablation proc. — treatment of Barrett's esophagus • Transendoscopic therapy for GE reflux/dysphagia/gastroparesis • Lower esophageal sphincter augmentation devices	• CG-SURG-83 • CG-SURG-92 • CG-SURG-101 • MED.00090 • SURG.00047 • SURG.00131
Radiation oncology	• Hyperthermia for cancer therapy	• CG-MED-72

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 *ProviderPortal*$_{SM}$. *ProviderPortal* is available 24 hours a day, seven days a week, processing requests in real-time using *Clinical Criteria*. Go to **providers.carelonmedicalbenefitsmanagement.com** to register.

For more information

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

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

These websites include helpful information and tools such as order entry checklists, *Clinical Guidelines*, and FAQs. You can also call your local provider relationship management representative if you have any questions.

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

MULTI-BCBS-CM-047241-23

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

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Prior Authorization | Medicare Advantage | Nov 22, 2023

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

As communicated in the November 2023, provider newsletter, effective April 1, 2024, Carelon Medical Benefits Management, Inc., a specialty health benefits company, will expand multiple Carelon Medical Benefits Management programs 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 Carelon Medical Benefits Management Expanded Cardiology, Genetic Testing, Radiology, Musculoskeletal, Surgical, and Radiation Therapy programs.

Refer to attachment to view full details

ATTACHMENTS (available on web): Expansion of Carelon Medical Benefits Management, Inc. programs effective April 1, 2024 (pdf - 0.73mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program-16

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Dental | Commercial | Jan 1, 2024

January Dental newsletter communications

Welcome to our monthly provider newsletter: stay informed

We are thrilled to include our dental providers in our monthly provider newsletter. In these monthly publications, we will communicate important updates, informative educational articles, and more.

New articles are published on the first business day of each month, so be sure to bookmark **this location** and visit this page regularly for updates. Our dedicated team is committed to making important information easy for you to find, so that you can continue providing excellent care to your patients.

Consolidated Appropriations Act provider directory federal mandate – provider directories effective January 1, 2022

As required by the *Consolidated Appropriations Act (CAA)* and several state laws, we must ensure our provider directories are accurate. Your patients, our members, need the most up-to-date information to reach you. Please keep us informed of any changes impacting you or your office, especially those changes impacting the directory.

We will reach out to our contracted providers as required by Federal and State laws to verify contact information. As a contracted provider, you must respond to the notification by providing updated contact information.

We appreciate your due diligence in keeping us informed of any changes impacting you or your office. Working together, we ensure your patients, our members, can reach you quickly while we meet our compliance obligations.

MULTI-BCBS-DEN-047183-23-CPN47030

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Pharmacy | Commercial | Dec 28, 2023

Specialty pharmacy updates — January 2024

Specialty pharmacy updates for 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.

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 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

Correction: In the August 2023 edition of *Provider News*, we announced prior authorizations for Zynyz would be effective November 2023. In the September 2023 edition of *Provider News*, we announced prior authorizations for Epkinly would be effective December 2023.

Please be advised that the prior authorization effective date for Epkinly and Zynyz is **January 1, 2024.**

Clinical Criteria	**Drug**	**HCPCS or CPT® code(s)**
CC-0242*	Epkinly (epcoritamab-bysp)	C9155, J3490, J3590, J9999

CC-0240*	Zynyz (retifanlimab-dlwr)	J9345

* Oncology use is managed by Carelon Medical Benefits Management.

Effective for dates of service on and after April 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-0068	Ngenla (somatrogon-ghla)	J3590, C9399
CC-0018	Pombiliti (cipaglucosidase alfa-atga)	J3490, J3590
CC-0020	Tyruko (natalizumab-sztn)	J3490, J3590
CC-0248*	Elrexfio (elranatamab-bcmm)	C9165, J3590, J9999, C9399
CC-0249*	Talvey (talquetamab-tgvs)	C9163, J3590, J9999, C9399
CC-0250	Veopoz (pozelimab-bbfg)	C9399, J3590
CC-0251	Ycanth (cantharidin)	C9164, J3490

* 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

Effective for dates of service on and after April 1, 2024, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process.

The preferred product in the Tyruko step therapy is generic dimethyl fumarate.

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

Clinical Criteria	**Status**	**Drug**	**HCPCS or CPT code(s)**
CC-0020	Non-preferred	Tyruko (natalizumab-sztn)	J3490, J3590

Courtesy notice

Effective on or after October 30, 2023, step therapy criteria for vascular endothelial growth factor (VEGF) inhibitors found in *Clinical Criteria* document CC-0072 expands the preferred product list to include Eylea HD. Please refer to *Clinical Criteria* document for details.

Quantity limit updates

Effective for dates of service on and after April 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-0018	Pombiliti (cipaglucosidase alfa-atga)	J3490, J3590
CC-0020	Tyruko (natalizumab-sztn)	J3490, J3590
CC-0250	Veopoz (pozelimab-bbfg)	C9399, J3590
CC-0251	Ycanth (cantharidin)	C9164, J3490

Site of care updates

Effective for dates of service on and after April 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-0189	Amondys 45 (casimersen)	J1426
CC-0241	Elfabrio (pegunigalsidase alfa-iwxj)	J2508

Clinical Criteria	Drug	HCPCS or CPT code(s)
CC-0193	Evkeeza (evinacumab)	J1305
CC-0044	Exondys 51 (eteplirsen)	J1428
CC-0154	Givlaari (givosiran)	J0223
CC-0231	Lamzede (velmanase alfa-tycv)	J0217
CC-0209	Leqvio (inclisiran)	J1306
CC-0013	Mepsevii (vestronidase alfa)	J3397
CC-0185	Oxlumo (lumasiran)	J0224
CC-0073	Prolastin (alpha 1 proteinase inhibitor)	J0256
CC-0049	Radicava (edaravone)	J1301
CC-0246	Rystiggo (rozanolixizumab-noli)	J9333
CC-0225	Tzield (teplizumab-mzwv)	J9381

Clinical Criteria	Drug	HCPCS or CPT code(s)
CC-0170	Uplizna (inebilizumab-cdon)	J1823
CC-0172	Viltepso (viltolarsen)	J1427
CC-0160	Vyepti (eptinezumab-jjmr)	J3032
CC-0152	Vyondys 53 (golodirsen)	J1429
CC-0207	Vyvgart Hytrulo (efgartigimod alfa 2 mg and hyaluronidase-qvfc)	J9334

MULTI-BCBS-CM-047322-23

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Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-january-2024-17549

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Quality Management | Medicare Advantage | Jan 1, 2024

Boost annual planned visit rates

We're committed to ensuring every eligible member receives an Annual Planned Visit (APV) this year and appreciate your help to make this happen.

Tips to help your practice boost APV rates early in the year:

- Members do not need to wait a full calendar year between wellness visits. Coverage resets on January 1 and we encourage all eligible members to schedule wellness visits with their care provider.
- Outreach to members within their first year of Medicare to schedule their Welcome to Medicare Exam (or Initial preventive physical exam, IPPE) and explain its importance.
- Know who your hard-to-engage members are and start contacting them earlier in the year.
- The **Provider News Quality Management** page is a great resource to learn more about optimizing your quality scores and staying up to date on our latest communications.
- While everyone is eligible for an annual wellness visit, some of the topics discussed during the visit may require additional follow-up to close a care gap. Be aware of scheduling lead times with other facilities for certain visit types, like mammograms, DEXA scans, and colonoscopies. Try to prioritize these patients who need these services for wellness visits.
- The AWV is a hands-off appointment that can be conducted via telehealth. This may be a great option for patients with mobility or access issues or compromised immune systems. See our guide for how to facilitate these exams via telehealth **here**.

APV coding guidelines:

Verify member's benefits and eligibility prior to scheduling

Initial preventive physical exam (IPPE)	Annual wellness visit (AWV)	Annual routine physical (ARP)
G0402, G0468[1] • Service is limited to new beneficiaries during the first 12 months of Medicare enrollment • Face-to-face visit • Includes a preventive evaluation and management service • Once per beneficiary, per lifetime **Note:** This is a preventive service and not a comprehensive physical checkup.	**G0438, G0468 Initial AWV** • Services limited to beneficiary during the second year of Medicare Part B eligibility • Face-to-face visit • Includes a personalized prevention plan of services • Once per beneficiary, per lifetime **G0439, G0468 Subsequent AWV** • Face-to-face visit • Includes a personalized prevention plan of services • Once per calendar year	**99381-99397** • Service is coded based on beneficiary's age • Face-to-face visit • Comprehensive, multi-system physical exam based on the patient's age, gender, and identified risk factors • Includes system review, family and social history, comprehensive assessment • Is not problem-oriented and does not involve a chief complaint or present illness. • Once per calendar year

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HEDIS diabetes documentation

HEDIS® 2023 documentation for Blood Pressure Control for Patients With Diabetes (BPD)

Measure description

The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) during the measurement year.

What we are looking for in provider records:

- Last BP documented in 2023 regardless of reading
- Evidence of hospice or palliative services in 2023
- Evidence patient expired in 2023
- Documentation of polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes

Helpful hints:

- Take a second BP at the end of the office visit if initial BP was ≥ 140/90 and document new BP.
- Consider taking BP at every visit.
- Remind medical staff not to round results. Results must be precise (such as, 139/89).
- Compliance is greater than 139/89.
- Counsel on healthy habits for managing high blood pressure.
- Encourage antihypertensive and other medication adherence.

- Member reported BPs during a telehealth visit are acceptable and should be documented in the members health record
- Review diabetic services needed at each office visit.
- For members who have not been diagnosed with diabetes but take a diabetes medication for off-label use, document why they are taking medication (for example, weight loss, congestive heart failure, chronic kidney disease, etc.).

HEDIS 2023 documentation for Hemoglobin A1c Control for Patients With Diabetes (HBD)

Measure description

The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c control (< 8.0%)
- HbA1c poor control (> 9.0%)

What we are looking for in provider records:

- Last HbA1c documented in 2023 regardless of result
- Evidence of hospice or palliative services in 2023
- Evidence patient expired in 2023
- Documentation of polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes

Helpful hints:

- Counsel on healthy habits for managing diabetes.
- If appropriate, set an HbA1c goal of less than 7%.
- Encourage timely HbA1c testing.
- Encourage medication adherence.
- Encourage continuous glucose monitoring.

- In progress notes when documenting HbA1c value include date the test was performed.
- Review diabetic services needed at each office visit.
- For members who have not been diagnosed with diabetes but take a diabetes medication for off-label use, document why they are taking medication (for example, weight loss, congestive heart failure, chronic kidney disease, etc.).

HEDIS 2023 documentation for Eye Exam for Patients With Diabetes (EED)

Measure description

The percentage of members 18 to 75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

What we are looking for in provider records:

- Evidence of a retinal eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or year prior with results
- Bilateral eye enucleation any time during the member's history
- Evidence of hospice or palliative services in 2023
- Evidence patient expired in 2023
- Documentation of polycystic ovarian syndrome, gestational diabetes, or steroid induced diabetes

Helpful hints:

- Refer patients to an optometrist or ophthalmologist for a dilated or retinal eye exam annually.
- Fundus/retinal photography is considered imaging and is eligible for use, must be dated and interpreted by an eye care professional.
- Counsel on healthy habits for managing diabetes.

- In progress notes when documenting a retinal eye exam include the name of eye care provider or optometrist/ophthalmologist credentials, date performed, and result.
- Encourage medication adherence.
- Review diabetic services needed at each office visit.
- For members who have not been diagnosed with diabetes but take a diabetes medication for off-label use, document why they are taking medication (for example, weight loss, congestive heart failure, chronic kidney disease, etc.).

MULTI-BCBS-CRCM-041667-23-CPN41092

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/hedis-diabetes-documentation-16438

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Quality Management | Commercial | Nov 20, 2023

Annual preventive care visits

With the New Year, people often make resolutions or set goals for themselves. Let this be the year that you see all your patients for their annual preventive care visit.

As you know, annual visits are mutually beneficial to both you and your patients. These visits help establish a strong provider-patient relationship, which is essential in achieving the best healthcare outcomes. Establishing baseline measurements, knowing family history, and understanding unique risk factors and concerns can help you provide appropriate and culturally sensitive guidance on reducing risk for disease. Patients who report positive interactions with their healthcare providers demonstrate greater self-management and quality of life, as well as a reduction in emergency room visits and inpatient admissions.

Start the new year on the right foot:

- If you are seeing a patient for the first time, ask them to have their previous provider send their medical records.
- Begin reaching out to harder to engage patients early in the year.
- Reach out to patients at least [two months] prior to their birthday to schedule an appointment.
- Remind patients of their upcoming appointment via phone, text, and/or email as it approaches to avoid no shows.
- Remember to verify your patient's benefits and eligibility prior to scheduling appointments.
- Screen for social needs that may be a barrier for care.
- If you need to refer a patient for a test or to a specialist, manage their expectations and follow-up with both the patient and provider.

Make sure to get the credit you deserve by reporting all services provided and use all appropriate billing codes:

- The annual visit service is coded based on the patient's age.
- Use CPT® Category II codes with your claims encounters to maximize HEDIS® data collection and reduce the burden of HEDIS medical record review. Go to the American Medical Association website at **ama-assn.org** for a complete list of CPT codes.
- If you are using an electronic medical record system, consider electronic data sharing with the health plan to capture all coded elements to facilitate HEDIS data collection and more accurate gap in care reports.

MULTI-BCBS-CM-045214-23-CPN44820

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