February 2024 Provider Newsletter

Contents

Prior Authorization | Medicare Advantage | Nov 8, 2023

Prior authorization requirement changes effective May 1, 2024

Prior Authorization | Medicare Advantage | Nov 15, 2023

Prior authorization requirement changes effective May 1, 2024

Prior Authorization | Medicare Advantage | Nov 15, 2023

Prior authorization requirement changes effective May 1, 2024

Reimbursement Policies | Commercial | Feb 1, 2024

New reimbursement policy: Modifier Usage — Facility

Reimbursement Policies | Commercial | Feb 1, 2024

Reimbursement policy update: Facility Guidelines for Claims Related to Professional Services — Facility

Pharmacy | Commercial | Feb 1, 2024

Updated requirements to obtain certain specialty drugs from CVS Specialty Pharmacy

Pharmacy | Commercial | Jan 24, 2024

Specialty pharmacy updates — February 2024

Pharmacy | Medicare Advantage | Jan 18, 2024

Expansion of specialty pharmacy precertification list

Quality Management | Medicare Advantage | Feb 1, 2024

Improving Hispanic heart health

Quality Management | Commercial | Feb 1, 2024

Improving Hispanic heart health

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To view this publication online:

Visit https://providernews.anthem.com/missouri/publications/february-2024-provider-newsletter-2392

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Administrative | Commercial | Feb 1, 2024

Home Health Agency Capabilities Survey

To help inform referrals and placements, we are asking all home health agencies to complete this survey, which will allow us to have the most up-to-date information about your facility and allow us to provide the best possible service to you and to our members.

With your help, we can continually build towards a future of shared success. Please complete the survey **here**. It should only take about 10 minutes of your time.

MOBCBS-CM-048851-23-CPN45030

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/home-health-agency-capabilities-survey-17851

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Administrative | Commercial | Feb 1, 2024

CAA: Have you reviewed your online provider directory information lately?

Please review your online provider directory information on a regular basis to ensure it is correct. Access your online provider directory information by visiting **anthem.com**, then at the top of the webpage, select **Find Care**.

Submit updates and corrections to your directory information by following the instructions on the ***Provider Maintenance Form*** online. Update options include:

- add/change an address location
- name change
- phone/fax number change
- provider leaving a group or a single location
- closing a practice location

The Consolidated Appropriations Act (CAA) implemented in 2021 contains a provision that requires online provider directory information be reviewed and updated as needed at least every 90 days. By reviewing your information regularly, you help us ensure your online provider directory information is current.

We share a health vision with our care providers that means real change for consumers.

MULTI-BCBS-CM-049338-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/caa-have-you-reviewed-your-online-provider-directory-informa-1

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Digital Tools | Commercial | Feb 1, 2024

Beginning in March 2024, you can submit Behavioral Health prior authorizations through the Authorization application on Availity.com

You may submit all your prior authorizations in one application on Availity.com.

You may already be submitting your prior authorizations through the Availity multi-payer Authorization application — taking advantage of the time savings and speed to care through digital authorization submissions. Beginning in March, you can submit both your physical health and behavioral health prior authorizations through one Authorization application on **Availity.com**.

You can still access the Interactive Care Reviewer (ICR) to review cases that were submitted through that application. You will also continue to use ICR to submit an appeal or authorization for medical specialty Rx.

Using the Availity Authorization application to submit your behavioral health prior authorizations will not be much different from the process you follow today. You may enjoy more intuitive screens or learn sooner if an authorization is required — but the digital submission process is still the very best way to submit your prior authorization and the fastest way to care for our members.

Training is available

If you aren't already familiar with Availity Authorization, training is available. Select **Availity Authorization Training** to enroll for an upcoming live webcast or to access an on-demand recording.

Now, give it a try!

Accessing the Availity for authorization is easy. Ask your organization's Availity administrator to ensure you have the Authorization role assignment. Without the role assignment, you will not be able to access the Authorization application. Then, log on to **Availity.com** to access the app through the *Patient Registration* tab by selecting **Authorizations and Referrals**.

MULTI-BCBS-CM-049149-23-CPN48082

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/beginning-in-march-2024-you-can-submit-behavioral-health-pri

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Digital Tools | Commercial | Feb 1, 2024

Update: 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 February, 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 difference 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 for pended claims as they do today and 45 days for denied claims. After that, those notifications will move to the history tab of your dashboard.. 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.

* Claims for providers under pre-payment review will pend for 30 days.

Learn more!

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

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.

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 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).

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

MULTI-BCBS-CM-049152-23-CPN48758

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/training-for-digital-requests-for-additional-information-dig-4

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Policy Updates | Commercial | Feb 1, 2024

MCG care guidelines 27th edition update

Effective June 1, 2024, Anthem will transition from CG-BEH-02 (Adaptive Behavioral Treatment) and MCG W0153 (Behavioral Health Care Applied Behavioral Analysis), to MCG B-806-T Behavioral Health Care Applied Behavioral Analysis (Original MCG Guideline), for medical necessity/clinical appropriateness reviews.

If you have questions, please contact the provider service number on the back of the member's ID card.

MULTI-BCBS-CM-047274-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/mcg-care-guidelines-27th-edition-update-17867

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Clinical Criteria updates — September 2023

Summary

On September 21, 2023, and October 4, 2023, the Pharmacy and Therapeutic (P&T) Committee approved the following *Clinical Criteria* applicable to the medical drug benefit for 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.

Please 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
February 19, 2024	*CC-0248	Elrexfio (elranatamab-bcmm)	New
February 19, 2024	*CC-0249	Talvey (talquetamab-tgvs)	New
February 19, 2024	*CC-0250	Veopoz (pozelimab-bbfg)	New
February 19, 2024	*CC-0251	Pompe Disease	New
February 19, 2024	*CC-0018	Pompe Disease	Revised
February 19, 2024	*CC-0021	Fabrazyme (agalsidase beta)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
February 19, 2024	*CC-0046	Zinplava (bezlotoxumab)	Revised
February 19, 2024	CC-0182	Iron Agents	Revised
February 19, 2024	*CC-0068	Growth Hormones	Revised
February 19, 2024	CC-0156	Reblozyl (luspatercept)	Revised
February 19, 2024	*CC-0233	Rebyota (fecal microbiota, live – jslm)	Revised
February 19, 2024	*CC-0020	Natalizumab Agents (Tysabri, Tyruko)	Revised
February 19, 2024	CC-0064	Interleukin-1 Inhibitors	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
February 19, 2024	CC-0026	Testosterone Injectable	Revised
February 19, 2024	*CC-0247	Beyfortus (nirsevimab)	Revised

MULTI-BCBS-CR-047335-23-CPN47070

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-september-2023-17735

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Carelon Medical Benefits Management, Inc. genetic testing code updates

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

CPT® code	Description
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
0306U	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
0307U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-free DNA, initial (baseline) assessment to determine a patient specific panel for

0356U	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, ZNF132 and TWIST1), multiplex quantitative polymerase chain reaction (qPCR), circulating cell-free DNA (cfDNA), plasma, report of risk score for advanced adenoma or colorectal cancer
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 amplifications, gene rearrangements, microsatellite instability and tumor mutational burden

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

- Access 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.
- Access via **Availity.com**.

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

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

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-CM-048270-23-CPN48141

To view this article online:

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

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Prior Authorization | Commercial | Feb 1, 2024

Claims Match Enhancement for Carelon Medical Benefits Management, Inc. Genetic Testing

As part of our ongoing quality improvement efforts, we will be implementing a new Genetic Testing (GT) claim to authorization match enhancement that will ensure GT panels billed have a corresponding authorization. This enhanced match logic will be effective by May 1, 2024. Labs that bill panels with codes in excess of what has been authorized may receive a full claim denial. The goal of this enhanced match logic is to ensure tests performed are authorized and meet medical necessity requirements.

MULTI-BCBS-CM-047632-23-CPN47301

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/claims-match-enhancement-for-carelon-medical-benefits-manage-2

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Prior Authorization | Medicare Advantage | Nov 8, 2023

Prior authorization requirement changes effective May 1, 2024

> UPDATE: This article was originally published as being effective March 1, 2024. The effective date has been delayed to May 1, 2024.

Effective **May 1, 2024,** prior authorization (PA) requirements will change for the following code(s). The medical code(s) listed below will require PA for Anthem Blue Cross and Blue Shield 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
E0761	Non-Thermal Pulsed High Frequency Radiowaves, High Peak Power Electrom

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

UM AROW #: A2023M0415

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-CR-044184-23-CPN43845, CPN-CRMMP-049296-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-march-1-20-9

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Prior Authorization | Medicare Advantage | Nov 15, 2023

Prior authorization requirement changes effective May 1, 2024

> UPDATE: This article was originally published as being effective March 1, 2024. The effective date has been delayed to May 1, 2024.

Effective **May 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 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
0738T	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination

0739T	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and int

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

UM AROW #: A2023M0443

MULTI-BCBS-CR-044235-23-CPN43832, CPN-CRMMP-049296-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-march-1-20-32

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Prior Authorization | Medicare Advantage | Nov 15, 2023

Prior authorization requirement changes effective May 1, 2024

> UPDATE: This article was originally published as being effective March 1, 2024. The effective date has been delayed to May 1, 2024.

Effective **May 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 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
Q4272	Esano a, per square centimeter
Q4273	Esano aaa, per square centimeter
Q4274	Esano ac, per square centimeter

Q4275	Esano aca, per square centimeter
Q4276	Orion, per square centimeter
Q4277	Woundplus membrane or e-graft, per square centimeter
Q4278	Epieffect, per square centimeter
Q4280	Xcell amnio matrix, per square centimeter
Q4281	Barrera sl or barrera dl, per square centimeter
Q4282	Cygnus dual, per square centimeter
Q4283	Biovance tri-layer or biovance 3l, per square centimeter
Q4284	Dermabind sl, per square centimeter

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

UM AROW #: A2023M0417

MULTI-BCBS-CR-044198-23-CPN43849, CPN-CRMMP-049296-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-march-1-20-23

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New reimbursement policy: Modifier Usage — Facility

Beginning with dates of service on or after May 1, 2024, Anthem will implement a new reimbursement policy titled Modifier Usage — Facility based on the code-set combinations submitted with the correct modifiers. This reimbursement policy identifies the following three different types of facility modifiers:

- **Reimbursement modifiers** affect payment and denote circumstances when an increase or reduction is appropriate for the service provided.
- **Informational modifiers impacting reimbursement** determine if the service provided will be reimbursed or denied.
- **Informational modifiers not impacting reimbursement** are used for documentation purposes.

The *Related Coding* section of the policy includes a Facility Modifier code list which identifies the modifier, the modifier description, and any related reimbursement policies. The Facility Modifier code list also includes six modifiers that do not have associated reimbursement policies. These modifiers indicate a reduced service or different equipment was used for the service. These modifiers will result in a reduction when billed on a facility claim.

For specific policy details, visit the **reimbursement policy page** at **anthem.com**.

MULTI-BCBS-CM-047155-23-SRS47155

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/new-reimbursement-policy-modifier-usage-facility-18012

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Reimbursement Policies | Commercial | Feb 1, 2024

Reimbursement policy update: Facility Guidelines for Claims Related to Professional Services — Facility

Beginning with dates of service on or after April 1, 2024, Anthem will not reimburse for the following when billed on a *UB-04*:

- Consultation CPT® codes 99242–99245, 99251–99255
    - Prolonged Services codes 99354–99359, 99415–99417 and G2212

For appropriate billing guidelines of Consultation and Prolonged Services CPT codes, please refer to the corresponding professional *Reimbursement Policies*:

- Prolonged Services
- Consultation Services

For specific policy details, visit the **reimbursement policy page** at **anthem.com**.

MULTI-BCBS-CM-047188-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/new-reimbursement-policy-modifier-usage-facility-update-1799-4

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Pharmacy | Commercial | Feb 1, 2024

Updated requirements to obtain certain specialty drugs from CVS Specialty Pharmacy

As previously communicated, Anthem developed a policy requiring facilities to acquire certain select specialty pharmacy medications administered in the hospital outpatient setting through CVS Specialty Pharmacy.

Updates

Effective for dates of service on and after May 1, 2024, the following specialty pharmacy medications will be **removed** from the *Designated Medical Specialty Pharmacy Drug List*:

HCPCS	Description	Brand name
J2503	Injection, pegaptanib sodium, 0.3 mg	MACUGEN
J9023	INJECTION AVELUMAB 10 MG	BAVENCIO
J9225	HISTRELIN IMPLANT VANTAS 50 MG	VANTAS
J9266	INJ PEGASPARGASE SINGLE DOSE VIAL	ONCASPAR

J0887 J0888	INJECTION EPOETIN BETA 1 MICROGRAM ESRD INJECTION EPOETIN BETA 1 MICROGRAM NON-ESRD	MIRCERA
J0885	INJECTION, EPOETIN ALFA, (FOR NON-ESRD USE), 1000 UNITS	EPOGEN/PROCRIT
J0881 J0882	INJ DARBEPOETIN ALFA 1 MCG NON-ESRD INJ DARBEPOETIN ALFA 1 MCG FOR ESRD	ARANESP
Q5106	INJ EPOETIN ALFA-EPBX NON-ESRD BIOSIMLR 1000 UNIT	RETACRIT

To access the current *Designated Medical Specialty Pharmacy Drug List*, please visit **anthem.com/provider**, select **Providers**, select **Forms and Guides** (under the Provider Resources column), select your state, scroll down, and select **Pharmacy** in the *Category* drop down. The *Designated Medical Specialty Pharmacy Drug List* may be updated periodically by Anthem.

If you have questions or would like to discuss the terms and conditions for providing certain specialty medications, please contact your contract manager with Anthem. Thank you for your continued participation in the Anthem networks and for the services you provide to our members. Beyond simply signing a contract, care providers are part of a genuine collaboration aimed at improving the lives of real people.

MOBCBS-CM-048765-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/updated-requirements-to-obtain-certain-specialty-drugs-from

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Pharmacy | Commercial | Jan 24, 2024

Specialty pharmacy updates — February 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.

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

Update: In the May 2023 edition of *Provider News*, we announced prior authorization for Adstiladrin will be effective August 2023. Review of Adstiladrin is managed by Carelon Medical Benefits Management.

Effective for dates of service on and after May 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-0252	Adzynma (ADAMTS13, recombinant-krhn)	C9399
CC-0253*	Aphexda (motixafortide)	J3490, J3590, J9999
CC-0042	Bimzelx (bimekizumab-bkzx)	J3490
CC-0032	Daxxify (daxibotulinumtoxinA-lanm)	C9160
CC-0050	Omvoh (mirikizumab-mrkz)	J3590
CC-0066*	Tofidence (tocilizumab-bavi)	J3490, J3590
CC-0254	Zilbysq (zilucoplan)	J3490
CC-0062	Zymfentra (infliximab-dyyb)	J3590

* Oncology use is managed by Carelon Medical Benefits Management.

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 May 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-0042	Bimzelx (bimekizumab-bkzx)	J3490
CC-0032	Daxxify (daxibotulinumtoxinA-lanm)	C9160
CC-0050	Omvoh (mirikizumab-mrkz)	J3590
CC-0066	Tofidence (tocilizumab-bavi)	J3490, J3590
CC-0254	Zilbysq (zilucoplan)	J3490
CC-0062	Zymfentra (infliximab-dyyb)	J3590
CC-0066	Spravato (esketamine)	G2082, G2083, S0013

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-048938-24-CPN48884

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-february-2024-17873

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Pharmacy | Medicare Advantage | Jan 18, 2024

Expansion of specialty pharmacy precertification list

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

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

HCPCS or CPT® codes	Medicare Part B drugs
J3490, J3590, J9999, C9399	Elrexfio (elranatamab-bcmm)
J3490, J3590	Eylea HD (aflibercept)
J3490, J3590	Pombiliti (cipaglucosidase alfa-atga)
J3490, J3590, J9999, C9399	Talvey (talquetamab-tgvs)
J3490, J3590	Tyruko (natalizumab-sztn)

J3590, C9399	Veopoz (pozelimab-bbfg)
J3490	Ycanth (cantharidin)

MULTI-BCBS-CR-046706-23-CPN45768

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/expansion-of-specialty-pharmacy-precertification-list-17737

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Quality Management | Medicare Advantage | Feb 1, 2024

Improving Hispanic heart health

Hispanics are the largest ethnic minority group in the United States, making it vital that we recognize the unique health needs of the population. Take time in February to support American Heart Health Month and explore how your practice can help improve your Hispanic patients' heart health.

What can your practice do to help improve health outcomes for Hispanic patients with heart disease?

- Be proactive about asking if the patient requires interpretation services. No one wants to feel like a burden. By asking and preparing for an interpreter in advance, you are creating a welcoming atmosphere for the patient during their appointment. If you would like to request an interpreter, including sign language, on behalf of your Anthem Blue Cross and Blue Shield patients, call Provider Services. Free interpreter services are also available to members by calling the Member's Services number on the back of their ID card (TTY/TTD **711**) and through the 24/7 NurseLine.
- According to a study by the American Heart Association (**link**), Hispanic persons had similar rates of heart disease compared to Caucasian adults but lower rates of awareness and control. To help increase awareness of their condition, you can ask questions such as:
    - "Have you ever been told that you have high blood pressure or high cholesterol?"
    - "Has a healthcare provider ever discussed with you or prescribed you medication to control your blood pressure or cholesterol levels?"
- Once awareness of the condition is properly understood, educate the patient on any increased health risk factors they might have, especially if they have other conditions like diabetes or obesity.

- Use culturally appropriate examples when discussing lifestyle changes. Select **here** for our conversation guide for tips on how to engage patients who may be from a culture different from your own.
- Encourage scheduling follow-up appointments for blood pressure rechecks or lab work to check cholesterol levels before the patient leaves the office.
- Submit all blood pressure readings using Category II codes on claims or through your practice's preferred supplemental data submission method. Blood pressure care gaps can open and close through the year and are based on the last recorded blood pressure reading of the year. The goal for every patient is a reading below 140/90 mmHg.
- Properly code statin therapy exclusions and prescribe low-cost medications to discourage the use of discount cards.

To learn more about our commitment to health equity, visit **MyDiversePatients.com**. Your patients can also learn more about the unique health needs of Hispanic persons by visiting **takingactionforourhealth.org/**.

Patient care opportunities

If you have questions on improving your quality scores, contact your care consultant or program manager to discuss your opportunities. You also 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. Choose the *Patient360* tile from the **Payer Space Applications** menu and complete the required information on the screen. Gaps in care are in the **Active Alerts** section of the *Member Summary*.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local provider relationship management associate or call Provider Services on the back of your patient's member ID card.

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

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Quality Management | Commercial | Feb 1, 2024

Improving Hispanic heart health

Hispanics are the largest ethnic minority group in the United States, making it vital that we recognize the unique health needs of the population. Take time in February to support American Heart Health Month and explore how your practice can help improve your Hispanic patients' heart health.

What can your practice do to help improve health outcomes for Hispanic patients with heart disease?

- Be proactive about asking if the patient requires interpretation services. No one wants to feel like a burden. By asking and preparing for an interpreter in advance, you are creating a welcoming atmosphere for the patient during their appointment. If you would like to request an interpreter, including sign language, on behalf of your Anthem Blue Cross and Blue Shield patients, call Provider Services. Free interpreter services are also available to members by calling the Member's Services number on the back of their ID card (TTY/TTD **711**) and through the 24/7 NurseLine.
- According to a study by the American Heart Association (**link**), Hispanic persons had similar rates of heart disease compared to Caucasian adults but lower rates of awareness and control. To help increase awareness of their condition, you can ask questions such as:
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