March 2024 Provider Newsletter

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MOBCBS-CRCM-051142-24

To view this publication online:

Visit https://providernews.anthem.com/missouri/publications/march-2024-provider-newsletter-2766

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Administrative | Medicare Advantage | Mar 1, 2024

CAA: Maintain your online provider directory information

Maintaining your online provider directory information is essential for member and healthcare partners to connect with you when needed. Access your online provider directory information by visiting **anthem.com** then at the top of the webpage, choose **Find Care**. Review your information and let us know if any of your information we show in our online directory has changed.

Updating your information

Anthem uses the provider data management (PDM) capability available on Availity Essentials to update your provider or facility data. Using the Availity PDM capability meets the quarterly attestation requirement to validate provider demographic data set by the *Consolidated Appropriations Act (CAA)*.

PDM features include:

- Updating provider demographic information for all assigned payers in one location.
- Attesting to and managing current provider demographic information.
- Monitoring submitted demographic updates in real-time with a digital dashboard.
- Reviewing the history of previously verified data.

Accessing the PDM application

Log on to **Availity.com** and select **My Providers > Provider Data Management** to begin using PDM. Administrators will automatically be granted access to PDM. Additional staff may be given access to PDM by an administrator. To find your administrator, go to **My Account Dashboard > My Account > Organization(s) > Administrator Information**.

PDM training

PDM training is available:

- Learn about and attend one of our training opportunities by visiting **here**.
- View the Availity PDM quick start guide **here**.
- For Roster Automation Standard Template and Roster Automation Rules of Engagement specific training, listen to our recorded webinar **here**.

Not registered for Availity yet?

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

If you have questions regarding registration, contact Availity Client Services at **800-AVAILITY**.

MULTI-BCBS-CM-050672-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/caa-maintain-your-online-provider-directory-information-1823

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Digital Solutions | Medicare Advantage | Feb 29, 2024

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

> This article, originally announced in the January 2024 Provider News, was updated as of **February 29, 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 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.

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

Carelon Medical Benefits Management will continue to use criteria documented in Anthem *Medical Policies* and *Clinical Guidelines* listed in the table below. These clinical guidelines can be reviewed online at **Availity.com**.

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

Prior authorization review requirements

Carelon Medical Benefits Management will begin accepting prior authorization requests on March 18, 2024, for dates of service April 1, 2024, and after. For procedures that are scheduled to begin on or after April 1, 2024, all providers must contact Carelon Medical Benefits Management to obtain prior authorization for the following non-emergency modalities. 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.

Program	Services	*Medical Policies/Clinical Guidelines*
Expanded Cardiology	• Card monitor device • Cardiac contractility modulation • Endovascular revascularization • Cardiac Resynchronization Therapy • Implantable Cardioverter Defibrillators • Permanent Implantable Pacemakers	CG-MED-74 SURG.00153 CAR07-0623.2 CAR05-0423 CAR06-0923.1 CAR08-1023.2
Genetic Testing	• Somatic Tumor Testing • Chromosomal Microarray Analysis • Pharmacogenomic Testing	GEN02-0324.1 GEN07-0223.1 GEN09-0223.1

	• Carrier Screening in the Prenatal Setting and Preimplantation Genetic Testing • Cell-free DNA Testing for the Management of Cancer • Genetic Testing for Inherited Conditions • Hereditary Cancer Testing • Polygenic Risk Scores • Prenatal Testing using cell-free DNA • Whole Exome Sequencing and Whole Genome Sequencing	GEN05-0124.1 GEN03-0124.1 GEN06-0124.1 GEN01-1123.2 GEN10-0124.1 GEN04-1123.3
Radiology	• Radiostereormetric analysis • Breast MRI	Carelon Medical Benefits Management Imaging of the Chest RAD.00065
Musculoskeletal	• Percutaneous and endo spinal surgery • Open SI joint fusion • Ultrasound bone growth stimulation • Cryoablation for podiatric conditions • Nerve stimulation devices for pain	SURG.00071 SURG.00100

To determine if prior authorization is needed for a member on or after April 1, 2024, contact the Provider Services phone number on the back of the member's ID card for benefit information. Providers using the Interactive Care Reviewer (ICR) tool on Availity Essentials for prior

authorization requests on 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.

How to place a review request

Providers may place a prior authorization request online to Carelon Medical Benefits Management using the convenient online service via the *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, 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/**

Our special websites will help you learn more and will allow you to access helpful information and tools such as order entry checklists, clinical guidelines, and FAQs.

For additional help, you can also call your local provider relationship management representative.

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

MULTI-BCBS-CR-045225-23-CPN44885, MULTI-BCBS-CR-051238-24-CPN50727

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program-26

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Digital Solutions | Commercial | Mar 1, 2024

Expansion of Carelon Medical Benefits Management, Inc. programs

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 FI, 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

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

Please note: 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. *Vascular procedures will not require prior authorization for National members currently participating in the Carelon Medical Benefits Management Cardiology program.*

Program	**Services**	***Clinical Guidelines***
Expanded Cardiology	• Tx of varicose veins • Artery Stent Placement w/wo Angioplasty • Embolization procedure • Dialysis circuit procedure • EPS studies • Cardiac ablation • Card monitor. device • Cardiac contractility modulation • Wearable cardioverter defibrillators • Wireless CRT for left ventricular pacing • Venous angioplasty w/wo stent placement • Vein embolization tx for pelvic congestion syndrome and varicocele • PFO Closure devices • Endovascular revascularization • Cardiac Resynchronization Therapy • Implantable Cardioverter Defibrillators • Permanent Implantable Pacemakers	• CG-MED-64 • CG-MED-74 • CG-SURG-28 • CG-SURG-55 • CG-SURG-76 • CG-SURG-83 • CG-SURG-93 • CG-SURG-106 • MED.00055 • RAD.00059 • SURG.00032 • SURG.00037 • SURG.00062 • SURG.00152 • SURG.00153 • THER-RAD.00012 • CAR07-0623.2 • CAR05-0423

		• CAR06-0923.1 • CAR08-1023.2
Genetic Testing	• Somatic Tumor Testing • Chromosomal Microarray Analysis • Pharmacogenomic Testing • Carrier Screening in the Prenatal Setting and Preimplantation Genetic Testing • Cell-free DNA Testing for the Management of Cancer • Genetic Testing for Inherited Conditions • Hereditary Cancer Testing • Polygenic Risk Scores • Prenatal Tesing using cell-free DNA • Whole Exome Sequencing and Whole Genome Sequencing	• GEN02-0324.1 • GEN07-0223.1 • GEN09-0223.1 • GEN05-0124.1 • GEN03-0124.1 • GEN06-0124.1 • GEN01-1123.2 • GEN10-0124.1 • GEN04-1123.3
Radiology	• Radiostereormetric analysis • Quantitative ultrasound for tissue characterization • Myocardial sympathetic innervation & imaging w/wo spect. • Lumbar discography	• CG-SURG-29 • RAD.00064 • RAD.00065 • RAD.00067
Musculoskeletal	• Extraosseous subtalar joint imp & arthroereisis • Genicular Nerve block & ablation- CHR knee pain • Percutaneous & Endo spinal surgery • Implanted devices for Spinal stenosis	• SURG.00052 • SURG.00071 • SURG.00092 • SURG.00100 • SURG.00104 • SURG.00142

	• Percutaneous vert disc & Endplate procedures • Cryoablation for podiatric conditions	
Surgical	• Wireless capsule endoscopy • Bariatric surgery • Paraoesophageal hernia repair • Ablation proc. – tx 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]

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

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

For more information

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/**; for

resources to help your practice get started with the Radiology, Expanded Cardiology, Genetic Testing, Musculoskeletal, Surgical, and Radiation Oncology programs. Our special websites help you learn more and access helpful information and tools such as order entry checklists, clinical guidelines, and FAQs, or you can call your local Network Relations representative.

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

MULTI-BCBS-CM-050934-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program-19

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Digital Solutions | Commercial | Feb 21, 2024

Beginning February 2024, you can submit Physical 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 February, you can submit your physical 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 Behavioral Health.

Using the Availity Authorization application to submit your physical 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 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, MULTI-BCBS-CM-052246-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/beginning-february-2024-you-can-submit-physical-health-prior

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Education and Training | Commercial | Mar 1, 2024

Congenital syphilis intervention opportunities for neonatal and pediatric providers

Problem: Incidence of Congenital Syphilis (CS) is increasing exponentially nationwide:

- In 2021, a total of 2,677 cases were reported rising to a rate of 74.1 per 100,000 live births.
- From 2012-2021, the number of cases increased 701.5% from 334 to 2,677 cases.

Refer to attachment to view full details

MOBCBS-CM-041189-23-CPN40661

ATTACHMENTS (available on web): Congenital syphilis intervention opportunities for neonatal and pediatric providers (pdf - 0.14mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/congenital-syphilis-intervention-opportunities-for-neonatal-14

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Policy Updates | Medicare Advantage | Feb 16, 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 (BHG) Applied Behavioral Analysis), to *MCG B-806-T* (Behavioral Health Care (BHG) Applied Behavioral Analysis (Original MCG Guideline), for medical necessity and clinical appropriateness reviews.

For questions, contact the care provider service number on the back of the member's ID card.

MULTI-BCBS-CR-046987-23-CPN46745

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/mcg-care-guidelines-27th-edition-update-18225

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Clinical Criteria updates — December 2023

Summary: On December 11, 2023, and January 5, 2024, 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**.

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

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
March 22, 2024	*CC-0255	Loqtorzi (toripalimab-tpzi)	New
March 22, 2024	*CC-0256	Rivfloza (nedosiran)	New
March 22, 2024	*CC-0257	Wainua (eplontersen)	New
March 22, 2024	*CC-0185	Oxlumo (lumasiran)	Revised
March 22, 2024	*CC-0107	Bevacizumab for Non-ophthalmologic Indications	Revised
March 22, 2024	*CC-0002	Colony Stimulating Factor Agents	Revised
March 22, 2024	CC-0075	Rituximab Agents for Non-Oncologic Indications	Revised
March 22, 2024	CC-0213	Voxzogo (vosoritide)	Revised
March 22, 2024	CC-0124	Keytruda (pembrolizumab)	Revised
March 22, 2024	*CC-0110	Perjeta (pertuzumab)	Revised

MULTI-BCBS-CR-051461-24-CPN50533

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Visit https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-december-2023-18291-6

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Prior Authorization | Medicare Advantage | Jan 24, 2024

Prior authorization requirement changes effective 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 for Medicare Advantage members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these precertification rules and must be considered first when determining coverage. **Non-compliance with new requirements may result in denied claims.**

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

Code	Description
C1825	Generator, neurostimulator (implantable), non-rechargeable with carotid sinus baroreceptor stimulation lead(s)

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 Provider Services at the number on the back of the patient's member ID card for assistance with PA requirements.

MULTI-BCBS-CR-047346-23-CPN47107

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-may-1-2024-6

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Prior Authorization | Medicare Advantage | Feb 1, 2024

Prior authorization requirement changes effective 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 for Medicare Advantage members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines (including definitions and specific contract provisions/exclusions), take precedence over these precertification rules and must be considered first when determining coverage. **Non-compliance with new requirements may result in denied claims.**

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

Code	Description
G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem)

	and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed

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 Provider Services at the number on the back of the patient's member ID card for assistance with PA requirements.

UM AROW A2023M0821

MULTI-BCBS-CR-048505-23-CPN48212

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-changes-effective-may-1-2024-12

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Reimbursement Policies | Commercial | Mar 1, 2024

Reimbursement policy update: Ambulance Transportation – Professional

Beginning with dates of service on or after June 1, 2024, the Related Coding section of Anthem's Ambulance Transportation – Professional reimbursement policy will be updated to specify that Modifier X, which is used to indicate an intermediate stop at the physician's office enroute to a hospital, will only apply as a destination modifier.

Modifier X should only be used as a destination code in the second position of the modifier designated field.

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

MULTI-BCBS-CM-050524-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-ambulance-transportation-profess-5

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Pharmacy | Commercial | Feb 22, 2024

Specialty pharmacy updates — March 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 medically 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 January 2024 edition of Provider News, we announced prior authorizations for the following drugs would be effective April 1, 2024. Please be advised that the prior authorization effective date for the drugs listed below will be **May 1, 2024**.

Clinical Criteria	Drug	HCPCS or CPT® code(s)
CC-0248*	Elrexfio (elranatamab-bcmm)	C9165, J3590, J9999, C9399
CC-0018	Pombiliti (cipaglucosidase alfa-atga)	J3490, J3590

CC-0249*	Talvey (talquetamab-tgvs)	C9163, J3590, J9999, C9399
CC-0020	Tyruko (natalizumab-sztn)	J3490, J3590
CC-0250	Veopoz (pozelimab-bbfg)	C9399, J3590
CC-0251	Ycanth (cantharidin)	C9164, J3490

* Oncology use is managed by Carelon Medical Benefits Management.

Effective for dates of service on and after June 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-0107*	Avzivi (bevacizumab-tnjn)	J3490, J3590
CC-0255*	Loqtorzi (toripalimab-tpzi)	C9399, J3490, J3590
CC-0256	Rivfloza (nedosiran)	J3490
CC-0002*	Ryzneuta (efbemalenograstim alfa-vuxw)	J3490, J3590
CC-0257	Wainua (eplontersen)	C9399, 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.

Quantity limit updates

Effective for dates of service on and after June 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-0002	Ryzneuta (efbemalenograstim alfa-vuxw)	J3490, J3590
CC-0256	Rivfloza (nedosiran)	J3490
CC-0257	Wainua (eplontersen)	C9399, J3490

Step therapy updates

Effective for dates of service on and after June 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.

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

Clinical Criteria	Status	Drug	HCPCS or CPT code(s)
CC-0107	Non-preferred	Avzivi (bevacizumab-tnjn)	J3490, J3590
CC-0002	Non-preferred	Ryzneuta (efbemalenograstim alfa-vuxw)	J3490, J3590

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-march-2024-18385

Or scan this QR code with your phone

Pharmacy | Commercial | Mar 1, 2024

Important information about your Anthem patients' Botox prescriptions

Effective March 1, 2024, prescriptions for Botox currently filled by Accredo Specialty Pharmacy will transfer to BioPlus, which is CarelonRx, Inc.'s new specialty pharmacy that services Anthem members.

What happens next:

- If you have patients affected by this pharmacy change, BioPlus will contact you to request a new prescription, refill, or prior authorization.
- Current specialty prescriptions for Botox 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.
- Any new Botox medication you prescribe for Anthem members must be submitted to BioPlus Specialty Pharmacy, to their MedScripts Medical Pharmacy location, as follows:
  - Medscripts Medical Pharmacy
    1325 Mille Road Suite K
    Greenville, SC 29607
  - NPI: 1780958744
  - Phone: **866-840-4067**
  - Fax: **833-670-2942**
- If you prefer, you still have the option to purchase and supply the Botox. In this case, you would bill Anthem for the drug and administration of the drug.

If you have any questions, please call your Anthem representative. With your help, we can continually build towards a future of shared success.

MULTI-BCBS-CM-050675-24-CPN50521

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/important-information-about-your-anthem-patients-botox-presc-1

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Pharmacy | Commercial | Mar 1, 2024

Pharmacy information available on our provider website

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

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

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

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

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

Please call provider services to request a copy of the pharmaceutical information available online if you do not have internet access.

Through our efforts, we are committed to reducing administrative burden because we value you, our care provider partner.

MULTI-BCBS-CM-050732-24-CPN50598

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/pharmacy-information-available-on-our-provider-website-18291-1

Or scan this QR code with your phone

Pharmacy | Commercial | Feb 20, 2024

Prior authorization updates for therapeutic duplication of specialty drugs

Therapeutic duplications are defined as concurrent use of two or more drugs in the same therapeutic class for the same indication. Anthem's prior authorization criteria does not allow for certain drugs to be used in combination with each other if the drugs are in the same therapeutic class.

Starting June 1, 2024, if multiple drugs are prescribed in the same therapeutic class for the therapeutic classes listed in the *Therapeutic duplication category* column in the table below, providers will be required to obtain a prior authorization for each drug.

Example drugs for each therapeutic class are listed below. For a complete list for drugs that may not be used in combination, you can access our drug lists and formulary policies by visiting **Pharmacy Information for Providers | Anthem.com**.

Therapeutic duplication category	Example drugs — This list is not exclusive.
PCSK9	Repatha, Praluent
Hereditary angioedema prophylaxis agents	Takhzyro, Orladeyo, Cinryze, Haegarda
Asthma biologics	Nucala, Fasenra, Cinqair, Dupixent, Xolair, Tezspire
Targeted immunomodulators	Rinvoq, Xeljanz, Xeljanz XR, Olumiant, Cibinqo, Sotyktu, Zeposia, Velsipity, Cimzia, Zymfentra, adalimumab agents, etanercept agents, infliximab agents, Simponi, Simponi Aria, Omvoh, Ilumya, Skyrizi, Tremfya, Bimzelx, Cosentyx, Siliq, Taltz, Entyvio,

	ustekinumab agents, Orencia, Opzelura, Arcalyst, Kineret, Ilaris, tocilizumab agents, Kevzara, rituximab agents
Phenylketonuria agents	Palynziq, Kuvan
Multiple sclerosis disease modifying agents	Aubagio, Avonex, Bafiertam, Betaseron, Briumvi, Copaxone/Glatiramer/Glatopa, Extavia, Gilenya, Kesimpta, Lemtrada, Mavenclad, Mayzent, Ocrevus, Plegridy, Ponvory, Rebif, Tascenso ODT, Tecfidera, Tysbari, Vumerity, Zeposia
Atopic dermatitis	Dupixent, Rinvoq, Adbry, Cibinqo, Opzelura

As a reminder, prior authorizations may be submitted through any of the following ways:

- **Online:** Submit the prior authorization requests online through the CoverMyMeds website (**covermymeds.com**). Electronic submission will allow care providers to check the status of the prior authorization request in real time.
- **Fax:** Download prior authorization forms from **anthem.com** and fax the completed forms to the number on the fax form.
- **Phone:** Call Provider Services at the number on the back of your patient's member ID card. Submitting requests online or via fax is preferred.

If you have any questions regarding this notice, please contact Provider Services at the number on the back of your patient's member ID card.

MULTI-BCBS-CM-047326-23

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-updates-for-therapeutic-duplication-of-s-1

Or scan this QR code with your phone

Pharmacy | Medicare Advantage | Feb 16, 2024

Anthem expands specialty pharmacy precertification list

Update: In the February 2024 edition of *Provider News*, we announced prior authorizations for the following drugs would be effective May 1, 2024. Please be advised that the prior authorization effective date for the drugs listed below will be **June 1, 2024**.

HCPCS or CPT® codes	Medicare Part B drugs
C9399	Adzynma (ADAMTS13, recombinant-krhn)
J3490, J3590, J9999	Aphexda (motixafortide)
C9160	Daxxify (daxibotulinumtoxinA-lanm)
J3490	Focinvez (fosaprepitant)
J3590	Omvoh (mirikizumab-mrkz)
J3490, J3590	Tofidence (tocilizumab-bavi)

Effective for dates of service on and after **June 1, 2024**, the specialty Medicare Part B drug 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	Avzivi (bevacizumab-tnjn)

C9399, J3490, J3590	Loqtorzi (toripalimab-tpzi)
J3490	Rivfloza (nedosiran)
J3490, J3590	Ryzneuta (efbemalenograstim alfa-vuxw)
C9399, J3490	Wainua (eplontersen)

Notification of specialty pharmacy medical step therapy updates

Effective **June 1, 2024**, the following Part B medications from the current *Clinical Criteria Guidelines* will be included in our medical step therapy precertification review process. Step therapy review will apply upon precertification initiation in addition to the current medical necessity review (as is current procedure). Step therapy will not apply for members who are actively receiving medications listed below.

Clinical UM Guidelines are publicly available on the provider website. Visit the ***Clinical Criteria page*** to search for specific criteria.

Clinical UM Guidelines	Preferred drug(s)	Nonpreferred drug(s)
CC-0107	Avastin Mvasi	Avzivi Alymsys Vegzelma Zirabev
CC-0002	Neulasta Neulasta OnPro Udenyca	Ryzneuta Fulphila Fylnetra Nyvepria Rolvedon Stimufend Ziextenzo

MULTI-BCBS-CR-051073-24-CPN50794

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/anthem-expands-specialty-pharmacy-precertification-list-1826-1

Or scan this QR code with your phone

Overview of Medicare risk adjustment in-office prospective programs

Anthem's in-office prospective programs are designed to encourage the comprehensive annual assessment of patients' health and support the complete and accurate documentation and coding of active, present conditions assessed. Collecting accurate and complete diagnosis information helps to support proper treatment, care management, and patient care. Providers participating in these programs may have the opportunity to receive reimbursement for the additional administrative time associated with their participation.

Key takeaways:

- Enhanced provider-patient engagement through comprehensive annual assessments and individual care planning
- Streamlined workflows designed to reduce administrative time spent by a provider at the point of care, allowing the provider to focus their time on their patients
- Patient-specific insights to support a comprehensive assessment and improvement in the accuracy and completeness of diagnosis data collected

In-office prospective programs	
In-office assessment program	**Point of care technology**
In-office patient assessment program that uses a form to message potential conditions,[1] recommended screenings, and other health information to the providers; this program is designed to support complete and comprehensive annual exams and promote earlier detection of chronic conditions	Technology solution designed to streamline the Medicare Annual Wellness Visit (AWV) and other preventive services to improve provider workflow efficiency, support the continued delivery of quality care, and improve the accuracy and completeness of diagnosis data collected during a face-to-face encounter

Additional information about the in-office prospective program based on last year's data:

- Patients who did not receive an in-office prospective program had, on average, an MLR increase of 2% YoY.
- Patients who received a comprehensive in-office assessment via the in-office prospective programs had, on average, 0.3 HCCs[2] reported based on that encounter.
- Providers who actively participated in the in-office prospective programs received, on average, 2%–5% increase to their Persistent Condition Validation (PCV).

We are committed to active involvement with our care provider partners and going beyond the contract to create a real impact on the health of our communities.

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1 Potential conditions include previously reported conditions and/or conditions suspected based on clinical and/or statistical indicators. Potential conditions should be assessed by the provider during a face-to-face encounter with a patient; only those conditions the provider determines, based on their assessment of the patient for the condition(s) and independent clinical judgment, to be active and present should be documented, coded, and reported.
2 Hierarchical Condition Categories (HCCs) are groupings of clinically related diagnoses with similar medical costs; each HCC is assigned a risk factor value by CMS. Only ICD-10-CM codes that map the CMS-HCC risk adjustment model are used in risk score calculation.

MULTI-BCBS-CR-051061-24-CPN50903

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/overview-of-medicare-risk-adjustment-in-office-prospective-p-1

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Pharmacy | Medicare Advantage | Jan 31, 2024

Notification of specialty pharmacy medical step therapy updates

This is a courtesy notice as there is no change to current status of Eylea HD in the Medical Step Therapy Program. The step criteria for anti-vascular endothelial growth factor (VEGF) inhibitors found in *Clinical Criteria* document CC-0072 will formally list Eylea HD as a preferred product.

Clinical UM Guidelines are publicly available on the provider website. Visit the ***Clinical Criteria page*** to search for specific criteria.

Clinical UM Guidelines	Preferred drug(s)	Nonpreferred drug(s)
CC-0072	Avastin Byooviz Cimerli Eylea Eylea HD Lucentis Vabysmo	Beovu Macugen

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

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/notification-of-specialty-pharmacy-medical-step-therapy-upda-11

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Encourage Cervical Cancer Screening (CCS)

Cervical cancer is one of the most preventable and successfully treatable forms of cancer if it is detected and diagnosed early. Although Cervical Cancer Screening (CCS) has dramatically reduced new cases and deaths from the disease over the past 50 years, a National Cancer Institute study found that the percentage of people who are overdue for screening has increased from 14% in 2005 to 23% in 2019.[1]

What can I do?

One of the most important things you can do is to recommend a routine CCS for your patients, per preventive care guidelines published by the U.S. Preventive Services Task Force and the National Institutes of Health: every three years for people 21 to 64 years with a cervical cytology (Pap test) and every five years for people 30 to 64 years of age with a cervical high-risk human papillomavirus (hrHPV) test or hrHPV and Pap co-testing. People who have been vaccinated against HPV should still be screened for cervical cancer.

How can I encourage my patients to get a CCS?

When encouraging your patients to get their cervical cancer screening, be sensitive and use culturally appropriate messaging. Regardless of a person's background, many people might be sensitive or embarrassed to discuss or have the screening. High levels of modesty among some people might create barriers in their interactions, especially when there is a lack of cultural congruence. As a result, encouraging your patients to be screened for cervical cancer may be part of a continued conversation conducted with your patients in their preferred language and in simple terms until they feel more comfortable and understand the benefits of completing the screening.

It is important to start these conversations early in the year so the appropriate screenings can be completed in a timely manner before the end of the calendar year.

How can I report data for HEDIS?

NCQA strongly encourages the electronic collection of CCS HEDIS® data. Data sources for HEDIS Electronic Clinical Data System (ECDS) may come from the electronic health record (EHR)/personal health record (PHR) and administrative data from claims. ECDS reporting can reduce the measurement and data exchange burden on your practices and can be more efficient and more sensitive. Contact your Healthy Blue provider relationship management representative for additional details and questions.

Cervical cancer screening HEDIS data may also be collected through medical record review. As you review and screen your patients based on the guidance and their personal risk factors, be sure to clearly document the screening in your patient's medical chart and in submitted claims. Additionally, be sure to clearly document any applicable exclusions such as an absence of a cervix, a hysterectomy, or assignment of male at birth.

In addition, it is becoming increasingly important to identify the population served by race, ethnicity, preferred language, and socioeconomic status to help measure and address health disparities.

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[1] Winstead, Edward. "Why are many Women Overdue for Cervical Cancer Screening?" **https://www.cancer.gov/news-events/cancer-currents-blog/2022/overdue-cervical-cancer-screening-increasing**. Published 2/22/2022. Accessed 12/21/2023.

MULTI-BCBS-CM-048593-23-CPN48423

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/encourage-cervical-cancer-screening-17834

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Cervical Cancer Screening (CCS) and Prenatal and Postpartum Care (PPC) for HEDIS

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

HEDIS 2024 Documentation for Cervical Cancer Screening (CCS)

Measure description: The percentage of women 21 to 64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last 3 years.
- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30 to 64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last 5 years.

What we are looking for in provider records:

- Documentation in the medical record indicating the date when the cervical cytology was performed and result or finding (2022 to 2024)
- Documentation in the medical record indicating the date when the hrHPV test was performed and result or finding (2020 to 2024)
    - Documentation of *HPV test* can be counted as hrHPV testing along with result or finding
- Documentation of *complete*, *total*, *or radical* hysterectomy (abdominal, vaginal, or unspecified anytime in the member's history through 12/31/2024).
- Documentation of *vaginal hysterectomy* (anytime in the member's history through 12/31/2024).

- Evidence of hospice services in 2024
- Evidence patient expired in 2024

Please note: Documentation of hysterectomy alone does not meet the criteria, because it is not sufficient evidence that the cervix was removed.

Helpful Hints:

- Educate patient on importance of regular cervical cancer screening.
- OB/GYN and PCP should share cervical cancer screening results.
- Document date and result of member reported cervical cancer or HPV screenings.

HEDIS 2024 Documentation for Prenatal and Postpartum Care (PPC)

Measure description: The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year (2023) and October 7 of the measurement year (2024). For these women, the measure assesses the following facets of prenatal and postpartum care.

- *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment with the Healthy Blue plan.
- *Postpartum Care.* A postpartum visit on or between 7 and 84 days after delivery.

What we are looking for in provider records for a prenatal care visit with a PCP or OB/GYN or other prenatal practitioner:

- Documentation in the medical record for deliveries of live births on or between October 8 of the year prior to the measurement year (2023) and October 7 of the measurement year (2024) must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following:
    - Documentation indicating the woman is pregnant or references to the pregnancy for example:
        - Documentation in a standardized prenatal flow sheet
        - Documentation of LMP, EDD, or gestational age
        - Documentation of a positive pregnancy test result

    - Documentation of gravidity and parity
    - Documentation of complete obstetrical history
    - Documentation of prenatal risk assessment and counseling/education
- Documentation of a basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed such as:
    - Screening test in the form of an obstetrical panel (must include all the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing)
    - Torch antibody panel alone
    - A rubella antibody test/titer with an Rh incompatibility (ABO/blood typing)
- Ultrasound of a pregnant uterus
- Evidence of nonlive birth
- Evidence of hospice services in 2024
- Evidence patient expired in 2024

What We Are Looking For In Provider Records For A Postpartum Care Visit With A PCP Or OB/GYN or other prenatal practitioner:

- Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following:
    - Pelvic exam
    - Evaluation of weight, BP, breasts, and abdomen
    - Notation of postpartum care
    - Perineal or cesarean incision/wound check
    - Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders
    - Glucose screening for women with gestational diabetes

    - Documentation of any of the following: Infant care or breastfeeding, resumption of intercourse, birth spacing or family planning, sleep/fatigue, resumption of physical activity, attainment of healthy weight
- Evidence of nonlive birth
- Evidence of hospice services in 2024
- Evidence patient expired in 2024

Helpful Hints:

- Educate members on the importance of timely prenatal care.
- Schedule postpartum visit during final prenatal appointment or prior to discharge from hospital.
- Reach out to members to remind them of scheduled prenatal and postpartum appointments.

MULTI-BCBS-CM-048368-23-CPN48274

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/cervical-cancer-screening-ccs-and-prenatal-and-postpartum-ca-7

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HEDIS 2024 documentation for Controlling High Blood Pressure (CBP) and Statin Therapy for Patients with Cardiovascular Disease (SPC)

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

HEDIS 2024 documentation for Controlling High Blood Pressure (CBP)

Measure description: The percentage of members 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose BP (blood pressure) was adequately controlled (< 140/90 mm Hg) during the measurement year.

What we are looking for in provider records:

- Last BP documented in 2024 regardless of reading

Documentation below could be used to exclude the patient:

- Evidence of hospice or palliative services in 2024
- Evidence patient expired in 2024
- Documentation of pregnancy any time during 2024
- Documentation of end stage renal disease, dialysis, nephrectomy, or kidney transplant any time in the member's history on or prior to December 31, 2024

Helpful hints:

- Take BP at every visit.
- Take a second BP before the end of the office visit if the BP was ≥ 140/90.

- Counsel on healthy habits for managing high blood pressure.
- BPs cannot be taken:
    - On the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests.
    - From member-reported BPs if taken with a non-digital device such as with a manual blood pressure cuff and a stethoscope.

HEDIS 2024 documentation for Statin Therapy for Patients with Cardiovascular Disease (SPC)

Measure description: The percentage of males 21 to 75 years of age and females 40 to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and received statin therapy and remained on the statin for at least 80% of the treatment period.

What we are looking for in provider records

Documentation in the medical record indicating the date the patient was dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

All of the following must be present with a dispensed medication:

- Name of the drug (generic or brand name)
- Strength/dose
- Route
- Date when the medication was **dispensed**, **filled**, or **shipped** to the patient

Documentation below could be used to exclude the patient:

- Evidence of hospice services in 2024
- Evidence patient expired in 2024
- Evidence patient received palliative care in 2024

- Evidence patient was pregnant or underwent IVF treatment in 2023 or 2024
- Evidence of ESRD or dialysis in 2023 or 2024
- Evidence of cirrhosis in 2023 or 2024
- Evidence of a dispensed prescription for Clomiphene in 2023 or 2024
- History of myalgia, myositis, myopathy, muscle pain or rhabdomyolysis documented in 2024

Helpful hints:

- Recommended that if the patient has a reaction to statins, record the specific reaction (myalgia, myositis, myopathy, muscle pain or rhabdomyolysis) in the patient's chart annually.
- Recommended to also include drug quantity and directions with the dispensed medication so that days' supply can be calculated for the measure.

MULTI-BCBS-CRCM-048400-23-CPN48275

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/hedis-2024-documentation-for-controlling-high-blood-pressure-10

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HEDIS Breast Cancer Screening (BCS) update

Background

The U.S. Preventive Services Task Force (USPSTF) has joined other medical organizations in recommending that members of average risk for breast cancer begin routine screening at 40 years of age. Breast cancer screening in the form of screening mammography is recommended by the USTPSTF every other year beginning at age 40 and continuing until the age of 74.

Research has shown that more members are being diagnosed with breast cancer in their 40s.[1] Members who are diagnosed with early-stage breast cancer may be cured with fewer and/or less intense treatment and surgeries.

African American/Black members and members of Ashkenazi Jewish ancestry are at higher risk and are more likely to be diagnosed in their 40s with more aggressive breast cancer as referenced by the Breast Cancer Research Foundation (BCRF) and the American College of Radiology. However, there is a risk of more false positives among younger members who might have more dense breast tissue, making it harder to distinguish between normal and suspicious breast tissue on a screening mammogram.[2]

One option for members with dense breasts and others with a higher-than-normal risk for breast cancer is 3D mammography. Studies have found that 3D mammography reduces the chances of needing to return for more images when compared to a standard 2D mammogram. It also appears to find more breast cancers, and several studies have shown it can be helpful in members with more dense breasts.

How will NCQA collect data for HEDIS?

NCQA requires Breast Cancer Screening (BCS) HEDIS® data to be collected electronically. Data sources for HEDIS Electronic Clinical Data System (ECDS) may come from the electronic health record (EHR)/personal health record (PHR) and administrative data from claims. ECDS

reporting can reduce the measurement rate and data exchange burden on your practices and may be more efficient and sensitive. Contact your provider relationship management representative for more information and assistance with establishing this connection.

As you review and screen your patients based on the guidance and their personal risk factors, be sure to clearly document the screening in your patient's medical chart and in submitted claims, as well as clearly document any applicable exclusions such as bilateral or unilateral mastectomy or care-prohibitive conditions like living in a long-term care institution or advanced illnesses.

In addition, it is becoming increasingly important to identify the population served by race, ethnicity, preferred language, and socioeconomic status to help measure and address health disparities. **MyDiversePatients.com** and **communityresources.elevancehealth.com** are free resources that might help you with your diverse patient population.

Impact to patients

Unequal access to and utilization of screening mammography often leads to delays in the detection, diagnosis, and treatment, thus amplifying disparities in patient outcomes.[3] Therefore, it is important to meet your patients where they are when discussing screening options; addressing barriers to care including beliefs, concerns, and issues of access and availability; and scheduling timely appointments and follow-ups.

Questions?

We're committed to active involvement with our care provider partners and going beyond the contract to create a real impact on the health of our communities. Contact your provider relationship management representative for additional details and questions.

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[1] "What to Know about New Breast Cancer Screening Recommendations." *Breast Cancer Research Foundation (BCRF).* **https://www.bcrf.org/blog/uspstf-new-breast-cancer-screening-guidelines-2023?utm_source=google&utm_medium=cpc&gclid=EAIaIQobChMIo_qw8dPxgwMVU2BHAR2jawgHEAAYA** Published June 6, 2023; Accessed December 4, 2023.

[2] Grimm, Lars J., et al. "Benefits and Risks of Mammography Screening in Women ages 40 to 49 Years." *Journal of Primary Care and Community Health.* Jan-Dec; 13: 21501327211058322. Published online 2022 Jan 22. doi: **10.1177/21501327211058322**. **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8796062/**.

Accessed December 4, 2023.
[3] Makurumidze G, Lu C, Babagberni K. “Addressing Disparities in Breast Cancer Screening: A Review.” *Applied Radiology.* **https://appliedradiology.com/articles/addressing-disparities-in-breast-cancer-screening-a-review.** Published November 2, 2022; Accessed December 4, 2023.

MULTI-BCBS-CRCM-048624-23-CPN48418

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/hedis-breast-cancer-screening-bcs-update-17953

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HEDIS® 2024 documentation for Care of Older Adults (COA)

Measure description: The purpose is to document the percentage of adults, 66 years and older, who had each of the following during the measurement year:

- *Medication Review*
- *Functional Status Assessment*
- *Pain Assessment*

What we are looking for in provider records:

- ***Medication Review:*** Members with both of the following during the same visit in the measurement year:
  - At least one medication review by a prescribing practitioner, or clinical pharmacist, and the date it was performed, along with the presence of a medication list in the medical record.
  - Notation that the member is not taking any medication, and the date it was noted.
- ***Functional Status Assessment:*** Members who had at least one *Functional Status Assessment* during the measurement year (2024):
  - *Notation of Activities of Daily Living (ADL)* were assessed, or that at least five of the following were assessed (bathing, dressing, eating, transferring, toileting, walking).
  - Notation that *Instrumental Activities of Daily Living (IADL)* were assessed, or at least four of the following were assessed (shopping for groceries, driving or using public transportation, using the telephone, cooking or meal prep, housework, home repair, laundry, taking medicines, handling finances).
  - Result of assessment using a standardized functional status assessment tool.

- ***Pain Assessment:*** Members who had at least one *Pain Assessment* during the measurement year:
  - Documentation that the patient was assessed for pain (positive or negative).
  - Result of an assessment using a standardized pain assessment tool or scale.
- Evidence of hospice services in 2024.
- Evidence patient expired prior to January 1, 2025.

Helpful hints:

- Encourage at least yearly visits. Older adults, many of whom have multiple, complex chronic conditions, require regular care addressing their physical, mental, cognitive, and behavioral needs.
- Most older adults take multiple drugs. A medication review to check safety and potential savings is recommended.
- Many older adults believe that pain is a normal part of aging. Regular screening for pain is recommended. Utilization of a standardized pain tool may assist in evaluating and adjusting care.
- Document, at least annually, *ADL* or *IADL* assessment:
  - Use the appropriate codes for *Medication Review, Functional Status Assessment,* and *Pain Assessment* whenever possible.

MULTI-BCBS-CR-050131-24-CPN49876

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/hedis-2024-documentation-for-care-of-older-adults-coa-18162

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Quality Management | Commercial | Mar 1, 2024

Boost annual preventive care visits: Tips and resources: An ounce of prevention is worth a pound of cure

As you know, annual visits help establish and enhance a strong partnership with your patients which is essential in getting the best healthcare outcomes. Preventive care visits give you an opportunity to:

- Check in with your patients when they are not sick.
- Establish a baseline and monitor health.
- Learn about your patient's family history, unique risk factors, and concerns.
- Ensure that appropriate screenings and tests are completed.
- Understand social and cultural factors that might impact their physical and mental health and subsequent disease management.
- Educate, counsel, and address health issues and manage chronic conditions.

Refer to **attachment** to view full details

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ATTACHMENTS (available on web): Boost annual preventive care visits: Tips and resources: An ounce of prevention is worth a pound of cure (pdf - 0.29mb)

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