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MOBCBS-CRCM-061280-24

To view this publication online:

Visit https://providernews.anthem.com/missouri/publications/july-2024-provider-newsletter-3031-3031

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Administrative | Commercial | Jul 1, 2024

Drugs and biologic

Effective October 1, 2024, Anthem is enhancing its claims editing system to ensure that claims billed with pharmaceutical drug procedure codes are reported with the appropriate Federal Drug Administration (FDA) approved indicators for on- and off-label use.

These enhanced claim edits provide an opportunity for Anthem to evaluate submitted claims for drug quality, safety, and effectiveness. The enhancement is to have the claims deny if not billed with the FDA indicator for on-/off-label use.

If you believe a claim reimbursement decision should be reviewed, please follow the normal claims dispute process outlined in the provider manual and include medical records that clarify whether the indication was approved through the governing agencies. You will only need to submit the portion(s) of the medical record that is relevant to the drug provided.

If you have questions about this notification, contact your contract manager or provider relationship management account representative.

MULTI-BCBS-CM-061244-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/drugs-and-biologic-20657

Or scan this QR code with your phone

Administrative | Commercial | Jul 1, 2024

Timely receipt of other carrier *EOB* or rejection helps avoid timely filing denials

When working with another carrier, submit documentation from the other carrier when you send the claim to Anthem to help avoid the claim from denying for timely filing. You can submit the documentation and the claim through Availity Essentials using the Claims and Payments application.

If we are the secondary payer, we will need to receive an *Explanation of Benefits* (*EOB*) along with the claim submission to determine our payment amount. To avoid a timely filing denial, the documentation must demonstrate that submission to the other insurer was within Anthem's timely filing limit and must reflect that it was received within the timely filing limit starting from the date of the remittance advice or *Explanation of Payments*.

If you submit to the other carrier first and receive a rejection, submit the denial letter from the other insurance carrier along with the claim. To avoid a timely filing denial, the denial letter must be dated and printed on letterhead, and the claim and documentation must be submitted to Anthem within the timely filing limit starting from the date of the denial letter.

When a claim is submitted to us as the primary payer, and we are the secondary payer, our claims system will deny the claim because we don't have the *EOB*. This can delay your receiving payment and can also cause you to miss the timely filing guideline.

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

Resource

Coordination of benefits — how to avoid timely filing denial

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-061117-24

ATTACHMENTS (available on web): Coordination of benefits — how to avoid timely filing denials (pdf - 0.32mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/coordination-of-benefits-how-to-avoid-timely-filing-denials-20502

Or scan this QR code with your phone

Administrative | Commercial | Jul 1, 2024

Anesthesia modifiers — professional editing update

Effective for all claims received on and after August 1, 2024, Anthem is updating its professional claims editing system to deny anesthesia services billed without the required anesthesia modifiers. According to industry-standard coding resources including the American Society of Anesthesiologists and AMA CPT® coding manuals, and the Anthem current commercial professional anesthesia services reimbursement policy, anesthesia modifiers are necessary to identify whether a procedure was personally performed, medically directed, or medically supervised.

The required modifiers to be reported by provider type are as follows:

Provider type	Required modifier(s)
Anesthesiologist	AA, AD, QK, or QY
CRNA or anesthesiologist assistant — medically directed	QX
CRNA — not medically directed	QZ

If you believe you have received a claim denial in error, follow the Anthem claim dispute process.

MULTI-BCBS-CM-061114-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/anesthesia-modifiers-professional-editing-update-20381

Or scan this QR code with your phone

Administrative | Commercial | Jul 1, 2024

Recovery room — facility editing update

Effective for all claims received on and after August 1, 2024, Anthem is updating its outpatient facility editing system to deny revenue code 0710 (recovery room services) when billed without revenue code 037X (anesthesia services), on the same claim. Per industry-standard coding resources, including the UB04 editor and the National Uniform Billing Committee (NUBC), “an anesthesia charge (revenue code category 037X) should be billed with a revenue code from category 071X, recovery room charge.”

If you believe you have received a denial in error, follow the Anthem claim dispute process.

MULTI-BCBS-CM-061118-24-SRS60998

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/recovery-room-facility-editing-update-20360

Or scan this QR code with your phone

Administrative | Commercial / Medicare Advantage | Jun 18, 2024

Phoenix Sepsis Criteria for coding and billing pediatric sepsis

To ensure compliance with the coding and billing of a claim submitted with the diagnosis of sepsis for our pediatric members, we review clinical information (including treatment and medical management) and laboratory and diagnostic procedure findings in the medical records submitted for review. To conduct the review accurately and consistently, our review process for pediatric sepsis applies coding and documentation guidelines.

Beginning with admission dates of July 1, 2024, and later for members aged 29 days through 17 years of age, we will also apply the updated and most recent publication of the Society of Critical Care Medicine Pediatric Sepsis Definition Task Force criteria known as the *Phoenix Sepsis Criteria*, published in the *Journal of the American Medical Association (JAMA)* in January 2024.

Clinicians and facilities should apply the *Phoenix Sepsis Criteria* when determining at discharge if the pediatric patient's clinical course supports the coding and billing of a diagnosis of sepsis. The claim may be subject to an adjustment in reimbursement when sepsis is found to be unsupported based on the *Phoenix Sepsis Criteria*.

Together, we can work towards improved outcomes.

jamanetwork.com/journals/jama/article-abstract/2814297

MOBCBS-CRCM-056033-24-CPN55116

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/phoenix-sepsis-criteria-for-coding-and-billing-pediatric-sep-20329

Or scan this QR code with your phone

Administrative | Commercial | Jul 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/provider**. Then at the top of the webpage, choose ***Find Care***. Review your information and let us know if any of your information has changed.

Updating your information

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

PDM features include:

- Updating care provider demographic information for all assigned payers in one location.
- Attesting to and managing current care 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:

- Log on to Availity.com to learn about and attend one of our training opportunities.
- On Availity.com, you can view the Availity PDM quick start guide.
- *Roster Automation Standard Template* and *Roster Automation Rules of Engagement* training:
    - Listen to our recorded webinar on Availity.com.

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 care 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, reach out to Availity Client Services at **800-AVAILITY**.

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

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/caa-maintain-your-online-provider-directory-information-20248

Or scan this QR code with your phone

Digital Solutions | Medicare Advantage | Jul 1, 2024

Admission, discharge, and transfer information is now available for Medicare Advantage members

If you and your organization are focused on promoting evidence-based medicine and clinical quality performance, our Alerts Hub clinical notification tool, accessed through Availity Essentials, can help drive your success.

Our clinical notification application, Alerts Hub, offers admission, discharge, and transfer (ADT) notifications for Medicare Advantage members. For those members, Alerts Hub offers a simple way to view a list of patients who have been admitted to the hospital or visited the emergency room.

Discover what users across the country already know.

Alerts Hub offers timely, actionable information to help your organization reach out to patients who can benefit from transitions in care planning or other interventions following inpatient or emergency care.

Viewing and responding to ADT notifications with outreach to patients can help drive your organizations' clinical quality and cost of care performance in value-based care arrangements —More importantly, it helps drive better outcomes for your patients.

Get started today.

We are committed to finding solutions that help our care provider partners offer quality services to our members. To access Alerts Hub, log on to Availity Essentials, select **Payer Spaces**, then select **Alerts Hub**. New users will need to register and set preferences. Registered users will receive daily notification emails with a summary of relevant alerts and

a reminder to view details in Alerts Hub. Be sure to check your junk or spam folders if you aren't receiving messages in your inbox.

Need more help? The Availity Custom Learning Center offers a range of training materials that can help you get up to speed quickly so that you can take advantage of all Alerts Hub has to offer.

Contact us.

Chat with Payer is available during normal business hours. Get answers to your questions about eligibility, benefits, authorizations, claims status, and more. To access Availity Essentials, go to **Availity.com** and select the appropriate payer space tile from the drop-down. Then, select **Chat with Payer** and complete the pre-chat form to start your chat.

For additional support, visit the *Contact Us* section of our provider website.

MULTI-BCBS-CR-060650-24-CPN59897

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/admission-discharge-and-transfer-information-is-now-availabl-20573

Or scan this QR code with your phone

Digital Solutions | Commercial | Jul 1, 2024

Adopting digital member ID cards

Anthem has a continued mission to leverage digital technology to provide enhanced services for both members and care providers. We encourage the support of care providers in accepting digital ID cards instead of a physical member ID card. As members increasingly use digital ID cards, care providers may need to implement changes in their processes to accept this format.

Due to recent enhancements, care providers can bypass the request for cards by accessing Availity.com. If a copy of a physical member identification card is needed, a member can email, fax, or access card details saved in their digital wallet. As a reminder, care providers can also access eligibility and benefit information without the health care identification (HCID). This makes both check-ins and submitting claims easier and faster.

Anthem is dedicated to providing digital solutions that transform both care provider and payer interactions. Thank you in advance for your continued partnership and support in empowering our members to use their digital ID cards. With your help, we can continually build towards a future of shared success.

MULTI-BCBS-CM-061102-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/adopting-digital-member-id-cards-20509

Or scan this QR code with your phone

Digital Solutions | Commercial | Jun 20, 2024

Digital-only authorization case status notification coming to you

In our previous communications, we shared information about using the Authorizations and Referrals application on Availity Essentials to receive digital notifications for your authorization cases and related decision letters, and we introduced the Preference Center for Authorization and Referrals where you can select your preferred method of communication. We are excited to announce that we launched the Preference Center for Authorization and Referrals in April and will start using your preferences there in July.

Here is a quick recap on how to receive digital notifications and set your preferred communication method for the status of your authorization cases.

Use the Authorizations and Referrals application for digital notifications:

- Retrieve cases submitted digitally and non-digitally by your organization through Auth/Referral Inquiry; use the Pin to Dashboard feature to keep these cases on the Auth/Referral Dashboard, saving you from repeating the search in the future.
- Find the most recent statuses of cases submitted by your organization on the Auth/Referral Dashboard — Select View Details in the *Actions* menu for case details, including decision letters. For pinned cases, select the case card to get the latest status and case details.

Access the Preference Center and set your preferences:

- After logging in to **Availity Essentials**, select **Payer Spaces** from the top menu bar, then select the **Anthem payer tile**. Once in *Payer Spaces*, select the **Preference Center** application tile.
- Select your organization and then set your communication preference (your default is **Digital Access** (Default) or if you prefer to receive paper surface mail, you can select **Digital + Mail**) for Authorization and Referrals:

- Adjust the preference for the tax IDs and NPIs of your organization to fit your business needs.
- You can add more NPIs to your current registration and set the preferred communication mode for the new NPIs under the selected tax IDs.

Manage preferences (Availity administrators)

Availity Administrators can learn more about managing preferences related to Authorization Decision letters. After logging in to **Availity Essentials**, select **Payer Spaces** from the top menu bar, then select the **Anthem payer tile**. Once in *Payer Spaces*, select the **Custom Learning Center** application, then select the **Resources section** to view or download the *Reference Guide* on managing receipt of Authorization Decision letters.

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

MULTI-BCBS-CM-060250-24-CPN60234

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/digital-only-authorization-case-status-notification-coming-t-20446

Or scan this QR code with your phone

Education and Training | Commercial / Medicare Advantage | Jul 1, 2024

July is Disability Awareness Month

We hope you are finding our monthly observance articles helpful and informative. We will continue to feature these monthly articles to keep you informed about our resources that are here to support you in caring for all of our members.

We strive to advance health equity so everyone has a fair opportunity to be at their healthiest. As we reduce barriers to whole health — physical, behavioral, and social — and personalize the healthcare journey, we can more effectively advance health equity. While focusing on understanding member needs, we actively develop educational tools for providers.

In recognition of July as Disability Awareness Month, and to commemorate the signing of the *Americans with Disabilities Act* (*ADA*) in 1990 that promotes equal rights and accessibility for people with disabilities, we are introducing three eLearning resources and tools on My Diverse Patients. This site offers a comprehensive repository of resources for providers to help support the needs of diverse patients and address disparities. Availability of multiple free continuing medical education (CME) courses with CMEs are offered through the American Academy of Family Physicians (AAFP).

For the month of July, our featured eLearning Resources & Tools are:

- Health Equity Framework for People with Disabilities:
    - This policy brief provides the rationale for the need for an all-of-government approach to achieve health equity in the United States and its territories for the largest unrecognized minority group in this country — the over 61 million people with disabilities — and sets forth a framework to achieve health equity for all people with disabilities. Disability is a natural part of the human condition, which occurs across all ages, genders, races, ethnicities, languages, and social groups.
- Health Equity for People with Disabilities:

    - The CDC's Division of Human Development and Disability (DHDD) works to promote health and reduce health inequities for people with disabilities of all ages so they can participate fully in all aspects of their communities throughout their lives and have the opportunity to achieve all they set out to do.
- Connections Between Health Equity and Disability:
    - When it comes to healthcare, significant disparities abound between people with disabilities and able-bodied people. From physical barriers and discrimination to financial hurdles and a lack of available resources, access to healthcare is alarmingly inequitable for people with disabilities around the world.

We're pleased to offer these resources as we work together to deliver high-quality, equitable healthcare.

MULTI-ALL-CRCM-060725-24-CPN60345

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/july-is-disability-awareness-month-20491

Or scan this QR code with your phone

Education and Training | Commercial | Mar 12, 2024

Important reminder: The correct original claim number must be included if submitting a corrected claim

When we receive a corrected claim and it doesn't have the original claim number, or the original claim number is not correctly entered, we are not able to process it because we're not able to connect it to the original claim.

1. **For providers and their vendors (clearinghouses or billing services) submitting a corrected claim through EDI**, we will send you a *277CA EDI Response Report* acknowledging that we've received the submission, but are not able to process it:

    a. In this instance, you can either submit a **new corrected claim** with the original claim ID number or **submit the corrected claim as an original claim** if you do not have the original claim ID number.

    b. It is important that you **submit proof of timely filing** when resubmitting the correction or the original claim so we can ensure the claim is processed according to the timely filing guidelines.

2. **For providers using Claims Status application on Availity.com**, you will not be able to access the corrected claim if it was rejected on the *277CA EDI Response Report*:

    a. In this instance, you can either submit a **new corrected claim** with the original claim ID number or **submit the corrected claim as an original claim** if you do not have the original claim ID number.

    b. It is important that you **submit proof of timely filing** when resubmitting the correction or the original claim so we can ensure the claim is processed according to the timely filing guidelines.

We've also developed a training video that can help you reduce duplicate claims along with a training guide called *Making the Claims Process Work for You* to help you properly submit a corrected claim. Access the video and download the guide **here**. **Provider information is required to view this training; however, you will only be prompted to enter this information the first time viewing this training.**

If you have questions about submitting a corrected claim, reach out to your provider representative or work with your EDI vendor to ensure you are receiving the *277CA Response Report*.

MULTI-BCBS-CM-049145-23-CPN48099, MULTI-BCBS-CM-061597-24-CPN61590

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/important-reminder-the-correct-original-claim-number-must-be-1-18665

Or scan this QR code with your phone

Faster notification of EDI corrected claims errors

For those providers and their corresponding vendors (either billing services or clearinghouses) who submit corrected claims through EDI, we're enhancing the 277CA to notify you of submission errors discovered during our claims processing. Although you'll continue to receive physical mail notifications related to claims processing issues, the 277CA notifications can expedite the turnaround time by highlighting submission issues upfront.

Now, the 277CA will also communicate the following messages:

- Tax ID and NPI are not registered.
- Billed place of treatment doesn't correspond with the place of service.
- Rendering provider isn't valid for the service date.
- Billing NPI doesn't align with the claim's tax ID.

Despite the addition of this new feature, there will be no reductions in the services we already provide. Our hope is that this change will augment the speed and communication of our service.

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-060850-24-CPN59863

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/faster-notification-of-edi-corrected-claims-errors-20366

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Clinical Criteria updates

Effective July 6, 2024

Summary

On November 17, 2023, and March 21, 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**.

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
July 6, 2024	*CC-0261	Winrevair (sotatercept-csrk)	New
July 6, 2024	*CC-0125	Opdivo (nivolumab)	Revised
July 6, 2024	*CC-0003	Immunoglobulins	Revised
July 6, 2024	CC-0033	Xolair (omalizumab)	Revised
July 6, 2024	*CC-0062	Tumor Necrosis Factor Antagonists	Revised
July 6, 2024	CC-0121	Gazyva (obinutuzumab)	Revised
July 6, 2024	CC-0201	Rybrevant (amivantamab-ymjw)	Revised
July 6, 2024	*CC-0251	Ycanth (cantharidin)	Revised

MULTI-BCBS-CR-059942-24-CPN59599

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-20049

Or scan this QR code with your phone

Policy Updates | Medicare Advantage | Jun 3, 2024

Clinical Criteria updates — November 2023

Summary: On February 24, 2023, September 11, 2023, and November 17, 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.

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- **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
July 7, 2024	*CC-0252	Adzynma (ADAMTS13, recombinant-krhn)	New
July 7, 2024	*CC-0253	Aphexda (motixafortide)	New
July 7, 2024	*CC-0254	Zilbysq (zilucoplan)	New
July 7, 2024	CC-0130	Imfinzi (durvalumab)	Revised
July 7, 2024	CC-0223	Imjudo (tremelimumab-actl)	Revised
July 7, 2024	*CC-0059	Selected Injectable NK-1 Antiemetic Agents	Revised
July 7, 2024	CC-0074	Akynzeo (fosnetupitant and palonosetron) for injection	Revised
July 7, 2024	*CC-0065	Agents for Hemophilia A and von Willebrand Disease	Revised
July 7, 2024	CC-0124	Keytruda (pembrolizumab)	Revised
July 7, 2024	CC-0150	Kymriah (tisagenlecleucel)	Revised

Effective Date	*Clinical Criteria* Number	*Clinical Criteria* Title	New or Revised
July 7, 2024	CC-0187	Breyanzi (lisocabtagene maraleucel)	Revised
July 7, 2024	CC-0133	Aliqopa (copanlisib)	Revised
July 7, 2024	CC-0205	Fyarro (sirolimus albumin bound)	Revised
July 7, 2024	CC-0127	Darzalex (daratumumab) and Darzalex Faspro (daratumumab and hyaluronidase-fihj)	Revised
July 7, 2024	*CC-0226	Elahere (mirvetuximab)	Revised
July 7, 2024	CC-0125	Opdivo (nivolumab)	Revised
July 7, 2024	CC-0058	Sandostatin and Sandostatin LAR (Octreotide) / Octreotide Agents	Revised
July 7, 2024	*CC-0009	Lemtrada (alemtuzumab) for the Treatment of Multiple Sclerosis	Revised
July 7, 2024	*CC-0014	Beta Interferons and Glatiramer Acetate for Treatment of Multiple Sclerosis	Revised

Effective Date	*Clinical Criteria* Number	*Clinical Criteria* Title	New or Revised
July 7, 2024	*CC-0011	Ocrevus (ocrelizumab)	Revised
July 7, 2024	*CC-0174	Kesimpta (ofatumumab)	Revised
July 7, 2024	*CC-0020	Natalizumab Agents (Tysabri, Tyruko)	Revised
July 7, 2024	*CC-0032	Botulinum Toxin	Revised
July 7, 2024	*CC-0068	Growth Hormone	Revised
July 7, 2024	*CC-0173	Enspryng (satralizumab-mwge)	Revised
July 7, 2024	*CC-0170	Uplizna (inebilizumab-cdon)	Revised
July 7, 2024	*CC-0199	Empaveli (pegcetacoplan)	Revised
July 7, 2024	*CC-0041	Complement Inhibitors	Revised
July 7, 2024	*CC-0071	Entyvio (vedolizumab)	Revised

Effective Date	*Clinical Criteria* Number	*Clinical Criteria* Title	New or Revised
July 7, 2024	*CC-0064	Interleukin-1 Inhibitors	Revised
July 7, 2024	*CC-0042	Monoclonal Antibodies to Interleukin-17	Revised
July 7, 2024	*CC-0066	Monoclonal Antibodies to Interleukin-6	Revised
July 7, 2024	*CC-0050	Monoclonal Antibodies to Interleukin-23	Revised
July 7, 2024	*CC-0078	Orencia (abatacept)	Revised
July 7, 2024	*CC-0063	Ustekinumab Agents	Revised
July 7, 2024	*CC-0062	Tumor Necrosis Factor Antagonists	Revised
July 7, 2024	CC-0003	Immunoglobulins	Revised
July 7, 2024	*CC-0002	Colony Stimulating Factor Agents	Revised
July 7, 2024	CC-0247	Beyfortus (nirsevimab)	Revised

Effective Date	*Clinical Criteria* Number	*Clinical Criteria* Title	New or Revised
July 7, 2024	CC-0072	Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised
July 7, 2024	CC-0010	Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors	Revised
July 7, 2024	CC-0209	Leqvio (inclisiran)	Revised
July 7, 2024	*CC-0182	Iron Agents	Revised
July 7, 2024	*CC-0086	Spravato (esketamine) Nasal Spray	Revised

MULTI-BCBS-CR-050483-24-CPN49884

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-november-2023-20069

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Policy Updates | Medicare Advantage | May 29, 2024

Carelon Medical Benefits Management, Inc. updates

Effective September 1, 2024, Anthem will transition to the following ***Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines*** for medical necessity/clinical appropriateness reviews for requested interventions:

- Site of Care Guidelines:
  - Site of Care for Advanced Imaging
  - Rehabilitative Site of Care
  - Surgical Site of Care

Please share this notice with other members of your practice and office staff.

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

Effective for dates of service on and after October 20, 2024, the following updates will apply to the Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines. As part of the Carelon Medical Benefits Management guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable healthcare services.

Radiology:

- **Brain Imaging:**
  - Added indications for MRI and amyloid beta PET imaging in Alzheimer disease to address patients considering or receiving lecanemab
- **Spine Imaging:**
  - Changed *Perioperative and Periprocedural Imaging* to *Postoperative and Postprocedural Imaging*; pre-procedure requests should be reviewed based on more specific indication
- **Extremity Imaging:**
  - Separated criteria for osteomyelitis and septic arthritis into separate indications; US or arthrocentesis as preliminary tests were placed only in the *septic arthritis* indication
- **Vascular Imaging:**
  - CTA/MRA Head addition for chronic posterior circulation Stroke/TIA presentations (CTA/MRA neck already allowed, intracranial eval needed for full extent of

anatomy)

- Lower Extremity PAD: Updated physiologic testing parameters and added allowance for ischemic signs/symptoms at presentation, in alignment with ACR Appropriateness Criteria
- Suboptimal imaging option downgrades/removals in Brain, Head and Neck, and Abdomen/Pelvis

Cardiovascular:

- **Imaging of the Heart:**
  - Resting Transthoracic Echocardiography (TTE)
  - Expanded frequency of echocardiographic evaluation in patients on mavacamten for treatment of hypertrophic obstructive cardiomyopathy (HOCM)
  - Expanded criteria for echocardiographic evaluation to allow a single screening for cardiac disease in patients undergoing evaluation for solid organ or hematopoietic cell transplant
- **Cardiac Resynchronization Therapy:**
  - Exclusion added for Wireless CRT
- **Diagnostic Coronary Angiography:**
  - Criteria reaffirmed — no changes
- **Endovascular Revascularization:**
  - Added indication for endovascular venous arterialization of the tibial or peroneal veins
  - Exclusions added for endovenous femoral-popliteal arterial revascularization with transcatheter placement of intravascular stent and intravascular lithotripsy
  - Also exclusion added for atherectomy (clarification)
- **Implantable Cardioverter Defibrillators:**
  - Transvenous ICD placement

    - Expanded criteria for transvenous ICD to include phospholamban, filamin-C, and lamin A/C cardiomyopathies
- **Percutaneous Coronary Intervention:**
    - Exclusion added for percutaneous transluminal coronary lithotripsy
- **Permanent Implantable Pacemakers:**
    - Device replacement
    - Added criteria for permanent implantable pacemaker device replacement
    - Single chamber leadless pacemakers
    - Clarified that criteria for single chamber leadless pacemaker apply to the right ventricle
    - Exclusion added for right atrial single chamber leadless pacemakers
    - Dual chamber leadless pacemakers
    - Exclusion added for dual chamber leadless pacemakers

Genetic Testing:

- **Chromosomal Microarray Analysis:**
    - Clarified recommendations for Genetic Counseling
    - Clarified requirements for postnatal evaluation of individuals with:
    - Congenital or early onset epilepsy (before age 3 years) without suspected environmental causes
    - Autism spectrum disorder, developmental delay, or intellectual disability with no identifiable cause (idiopathic)
    - Clarified prenatal evaluation of a fetus with a structural fetal anomaly noted on ultrasound
- **Pharmacogenomic Testing:**
    - Added APOE testing
- **Polygenic Risk Scores renamed Predictive and Prognostic Polygenic Testing:**

- Broadened guideline scope to include polygenic expression prognostic testing and multivariable prognostic genetic testing (essentially clarifications), and moved these tests to exclusions as they are considered not medically necessary
- Retitled guideline to Predictive and Prognostic Polygenic Testing to address this change in scope.

- **Somatic Testing of Solid Tumors:**
  - Breast Cancer
  - Clarified gene expression profiling is to guide adjuvant therapy for localized Breast Cancer
- **Whole Exome and Whole Genome Sequencing:**
  - Expanded WES criteria to include congenital or early onset epilepsy (before age 3) without suspected environmental etiology and added other clarifications.
  - Clarified well-delineated genetic syndrome in criterion for multiple anomalies
  - Clarified Genetic Counseling details for WES

MSK:

- **Sacroiliac Joint Fusion:**
  - New medical necessity criteria for open SI joint fusion
  - As an adjunct to sacrectomy or partial sacrectomy related to tumors involving the sacrum
  - As an adjunct to the medical treatment of sacroiliac joint infection/sepsis (for example, osteomyelitis, pyogenic sacroiliitis)
  - For severe traumatic injuries associated with pelvic ring disruption (for example, pelvic ring fractures, acetabular fracture, spinopelvic dissociation)
  - During multi-segment spinal constructs (for example, correction of deformity in scoliosis or kyphosis surgery) extending to the ilium as part of medically necessary lumbar spine fusion procedures

    - Open SI joint fusion is not medically necessary for poorly defined low back pain and sacral insufficiency fractures.
- **Spine Surgery:**
    - Lumbar Discectomy, Foraminotomy, and Laminotomy
    - Added exclusion for annular closure device
    - Lumbar Laminectomy
    - Expanded timeframe for imaging lumbar disc herniation (9 months) and lumbar spinal stenosis (12 months)

Radiation Oncology:

- Removed criteria for hyperthermia
- Clarified inclusion criteria of the RTOG 1112 protocol.

Sleep Disorder Management:

- Expanded definitions and terminology
- Expanded documentation of hypoventilation
- Expanded criteria for home and in-lab sleep studies
- Added contraindication to APAP titration for use of supplemental oxygen
- Removed home sleep apnea testing (HSAT) as an option in medical necessity of MSLT/MWT for suspected narcolepsy
- Management of OSA using Implanted Hypoglossal Nerve Stimulators — Narrowed age range (raised lower limit to 13) for HNS in individuals with Down syndrome and OSA to align with age range suggested by FDA
- Miscellaneous Devices section added: electronic positional therapy and neuromuscular electrical training of the tongue musculature are considered not medically necessary due to lack of high-quality evidence

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

- Access Carelon Medical Benefits Management's provider portal 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.

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

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Medical Policies and *Clinical Guidelines* updates for July 2024

The following Anthem *Medical Polices* and *Clinical Guidelines* were reviewed for Indiana, Kentucky, Missouri, Ohio, and Wisconsin.

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

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

To view *Medical Policies* and utilization management guidelines applicable to members enrolled in the Blue Cross and Blue Shield Service Benefit Plan (commonly referred to as the Federal Employee Program® (FEP®)), visit fepblue.org > *Policies & Guidelines*.

Below are the new *Medical Policies* and/or *Clinical Guidelines* that have been approved:

Policy/guideline	Information	Effective date
CG-SURG-118 Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	• Moved content from SURG.00103 to new *Clinical UM Guideline* with the same title • INV&NMN changed to NMN as a result of MP to *CUMG* transition	10/1/2024

Policy/guideline	Information	Effective date
CG-SURG-119 Treatment of Varicose Veins (Lower Extremities)	• Moved content from SURG.00037 to new *Clinical UM Guideline* with the same title • INV&NMN changed to NMN as a result of MP to *CUMG* transition	10/1/2024
CG-SURG-120 Vagus Nerve Stimulation	• Moved content from SURG.00007 to new *Clinical UM Guideline* with the same title • INV&NMN changed to NMN as a result of MP to *CUMG* transition	10/1/2024
OR-PR.00008 Osseointegrated Limb Prostheses	• Outlines the MN and NMN criteria for the use of osseointegrated (bone-anchored) prosthetic devices for improving the mobility and function of people who have had limb loss	10/1/2024
SURG.00162 Implantable Shock Absorber for Treatment of Knee Osteoarthritis	• Use of an implantable shock absorber device for treatment of osteoarthritis of the knee is considered **INV&NMN**	10/1/2024

** Denotes prior authorization required*

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

Policy/guideline	Information	Effective date
ANC.00008 Cosmetic and Reconstructive Services of the Head and Neck	Added existing codes 21086, L8045 related to auricular prostheses considered MN or REC when criteria are met	4/10/2024
CG-BEH-02 Adaptive Behavioral Treatment	Criteria for these services have been transitioned to *MCG* guidelines	6/1/2024
CG-DME-31 Powered Wheeled Mobility Devices	Added new HCPCS code E2298 effective 4/1/2024 replacing deleted code E2300 for power seating system, also added K0108 NOC code	4/1/2024
CG-MED-68 Therapeutic Apheresis	Added erythropoietic protoporphyria, liver disease to the plasmapheresis and RBC exchange and heart transplantation, desensitization /rejection prophylaxis to the plasmapheresis MN sections Added ICD-10-CM codes E80.0, K77 considered MN when criteria are met for plasmapheresis and cytapheresis	4/10/2024
LAB.00025 Topographic Genotyping	Added existing NOC code 89240 which may be used for this service	4/10/2024
LAB.00039 Combined Pathogen Identification and Drug Resistance Testing	• Revised title • Revised Position Statement to address “combined pathogen identification and drug resistance” testing Added existing CPT® PLA codes 0141U,	4/10/2024

Policy/guideline	Information	Effective date
Previously Titled: Pooled Antibiotic Sensitivity Testing	0142U, 0321U & 0370U, 0369U previously addressed in CG-LAB-17 (MN criteria), and 0373U previously addressed in CG-LAB-14 (was NMN), all considered INV&NMN; removed 81479 NOC	
LAB.00046 Testing for Biochemical Markers for Alzheimer's Disease	Added CPT PLA code 0445U effective 4/1/2024 for Elecsys® PhosphoTau (181P) CSF (pTau181) and βAmyloid (1-42) CSF II (Abeta 42) Ratio, considered **INV&NMN**	4/1/2024
MED.00125 Biofeedback and Neurofeedback	Added new HCPCS code S9002 effective 4/1/2024 for home biofeedback device, considered **INV&NMN**	4/1/2024
RAD.00059 Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver	Added new HCPCS code C9797 effective 4/1/2024 for embolization, considered **INV&NMN** for specific diagnoses	4/1/2024
SURG.00011 Gene Mutation Testing for Cancer Susceptibility and Management	• Revised **MN** statement to include Cortiva and Surgimend for breast reconstruction • Revised **MN** statement to include EPICEL, Integra Omnigraft Dermal Regeneration Template, and ReCell for the treatment of partial and deep thickness burns • Revised **MN** statement to include Biovance and Oasis for the treatment of diabetic foot ulcers • Revised **NMN** statement to align with	4/1/2024

Policy/guideline	Information	Effective date
	revisions to **MN** statements • Added new products to the **INV&NMN** statement	
SURG.00105 Bicompartmental Knee Arthroplasty	Criteria for these services have been transitioned to Carelon Medical Benefits Management, Inc. Musculoskeletal guidelines	6/1/2024
SURG.00126 Irreversible Electroporation	Added new ICD-10-PCS code 02583ZF for irreversible electroporation of cardiac conduction mechanism, considered **INV&NMN**	4/1/2024
SURG.00145 Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)	• Revised pVAD criteria to include ECMO as concomitant therapy • Revised Total Artificial Heart criteria for simplification	4/10/2024
SURG.00154 Microsurgical Procedures for the Prevention or Treatment of Lymphedema	Added ICD-10-PCS codes 0DXU0ZV, 0DXU0ZW, 0DXU0ZX, 0DXU0ZY, 0DXU4ZV, 0DXU4ZW, 0DXU4ZX, 0DXU4ZY effective 4/1/2024 for omentum transfer, considered **INV&NMN** for lymphedema diagnoses	4/1/2024
SURG.00157 Minimally Invasive Treatment of the	Added note regarding CPT code 30117 when used for posterior nasal nerve	4/1/2024

Policy/guideline	Information	Effective date
Posterior Nasal Nerve to Treat Rhinitis	ablaton	
SURG.00158 Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain	Added new HCPCS code A4438 effective 4/1/2024 for a component of the NALU device, considered **INV&NMN** when specified for peripheral nerve	4/1/2024
TRANS.00028 Hematopoietic Stem Cell Transplantation for Hodgkin Disease and non-Hodgkin Lymphoma	• Updated formatting in **Position Statement** section • In the MN **Position Statement** section for NHL, created criterion B3 • In the INV&NMN section for NHL, updated bullet “A” by adding “when criteria above are not met, including” • Added ICD-10-CM diagnosis codes C91.50-C91.52 MN when criteria are met for lymphoma	4/10/2024
TRANS.00033 Heart Transplantation	Added CPT 33929 previously addressed in SURG.00145, considered **MN** when criteria are met	4/10/2024
TRANS.00038 Thymus Tissue Transplantation	Added endocrine procedure NOC code 60699	4/10/2024

** Denotes prior authorization required*

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Medical Policies and *Clinical Utilization Management Guidelines* update

Effective July 1, 2024

The *Medical Policies*, *Clinical Utilization Management (UM) Guidelines* and *Third-Party Criteria* below were developed and/or revised during Q4 2023. Note, several policies and guidelines were revised to provide clarification only and are not included. Some may have expanded rationales, medical necessity indications or criteria and some may involve changes to policy position statements that might result in services that previously were covered being found to be not medically necessary.

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

To view a guideline, visit **anthem.com/medicareprovider** > Providers > Provider Resources > Policies, Guidelines & Manuals.

Notes/updates:

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

- MED.00146 - Gene Therapy for Sickle Cell Disease
  - Outlines the Medically Necessary and Investigational & Not Medically Necessary criteria for Gene therapy for sickle cell disease
- RAD.00068 - Myocardial Strain Imaging
  - Myocardial strain imaging in considered Investigational & Not Medically Necessary for all indications

- SURG.00026 - Deep Brain, Cortical, and Cerebellar Stimulation
  - Reformatted Position Statement and added headers
  - Reformatted Medically Necessary statements to move target treatment areas into criteria
  - Revised Medically Necessary statement for primary dystonia to remove dystonia manifestation types
  - Reformatted Medically Necessary statements for DBS for Parkinson's, primary dystonia, and OCD
  - Reformatted Medically Necessary statements for epilepsy
  - Revised DBS for epilepsy Medically Necessary statement regarding non-epileptic seizures
  - Revised Position Statement to add revision/replacement Medically Necessary and Investigational & Not Medically Necessary statements for DBS, cortical stimulation, and battery
  - Revised and reformatted Investigational & Not Medically Necessary statements
- SURG.00097 - Scoliosis Surgery
  - Revision to Position Statement formatting
  - Added Medically Necessary and Investigational & Not Medically Necessary criteria for revision, replacement, or removal of vertebral body tethering to Position Statement
- SURG.00142 - Genicular Procedures for Treatment of Knee Pain
  - Previously titled: Genicular Nerve Blocks and Ablation for Chronic Knee Pain
  - Revised title
  - Added genicular artery embolization to the scope of document
  - Revised Position Statement to add genicular artery embolization as Investigational & Not Medically Necessary
- CG-DME-42 - Continuous Glucose Monitoring Devices

    - Previously titled: Continuous Glucose Monitoring Devices and External Insulin Infusion Pumps
    - Revised title
    - Moved content related to external insulin pumps to new document CG-DME-51 and automated insulin delivery systems to new document CG-DME-50
    - Revised existing Medically Necessary and Not Medically Necessary statements
- CG-DME-52 - Continuous Passive Motion Devices in the Home Setting
    - Use of a continuous passive motion (CPM) device in the home setting is considered Not Medically Necessary for all indications
- CG-MED-94 - Vestibular Function Testing
    - Outlines the Medically Necessary and Not Medically Necessary criteria for vestibular function testing
- CG-SURG-09 - Temporomandibular Disorders
    - Revised formatting of Medically Necessary statement
    - Revised surgical procedures criteria
    - Added MIRO Therapy to Not Medically Necessary statement
- CG-SURG-70 - Gastric Electrical Stimulation
    - Added Medically Necessary and Not Medically Necessary criteria to Clinical Indications for removal, revision, or replacement of a gastric electrical stimulator

Medical Policies

On November 9, 2023, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Anthem. These medical policies take effect July 1, 2024.

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
1/3/2024	LAB.00026	Systems Pathology and Multimodal Artificial Intelligence Testing for Prostate Cancer **Previously titled:** Systems Pathology Testing for Prostate Cancer	Revised
1/3/2024	LAB.00046	Testing for Biochemical Markers for Alzheimer's Disease	Revised
1/3/2024	LAB.00050	Metagenomic Sequencing for Infectious Disease in the Outpatient Setting	Conversion new
1/3/2024	MED.00057	MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications	Revised
1/18/2024	*MED.00146	Gene Therapy for Sickle Cell Disease	New
1/3/2024	*RAD.00068	Myocardial Strain Imaging	New
1/3/2024	SURG.00010	Treatments for Urinary Incontinence	Revised

Publish date	*Medical Policy* number	*Medical Policy* title	New or revised
12/28/2023	*SURG.00026	Deep Brain, Cortical, and Cerebellar Stimulation	Revised
12/28/2023	*SURG.00097	Scoliosis Surgery	Revised
1/3/2024	*SURG.00142	Genicular Procedures for Treatment of Knee Pain **Previously titled:** Genicular Nerve Blocks and Ablation for Chronic Knee Pain	Revised
1/3/2024	TRANS.00027	Hematopoietic Stem Cell Transplantation for Pediatric Solid Tumors	Revised

Clinical UM Guidelines

On November 9, 2023, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. These guidelines were adopted by the medical operations committee for Medicare Advantage members on January 4, 2024. These guidelines take effect July 1, 2024.

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
1/3/2024	*CG-DME-42	Continuous Glucose Monitoring Devices **Previously titled:** Continuous Glucose Monitoring Devices and External Insulin Infusion Pumps	Revised
1/3/2024	CG-DME-44	Electric Tumor Treatment Field (TTF)	Revised
1/3/2024	CG-DME-50	Automated Insulin Delivery Systems	Conversion new
1/3/2024	CG-DME-51	External Insulin Pumps	Conversion new
1/3/2024	*CG-DME-52	Continuous Passive Motion Devices in the Home Setting	New
1/3/2024	CG-LAB-25	Outpatient Glycated Hemoglobin and Protein Testing	Revised
1/3/2024	CG-MED-92	Foot Care Services	Revised
1/3/2024	*CG-MED-94	Vestibular Function Testing	New

Publish date	*Clinical UM Guideline* number	*Clinical UM Guideline* title	New or revised
1/3/2024	*CG-SURG-09	Temporomandibular Disorders	Revised
12/28/2023	*CG-SURG-70	Gastric Electrical Stimulation	Revised
1/3/2024	CG-SURG-94	Keratoprosthesis	Revised
12/28/2023	CG-SURG-95	Sacral Nerve Stimulation and Percutaneous or Implantable Tibial Nerve Stimulation for Urinary and Fecal Incontinence, Urinary Retention	Revised

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Prior Authorization | Commercial | Jun 19, 2024

Carelon Medical Benefits Management, Inc. genetic testing code updates

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

CPT® code	Description
81457	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability
81458	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability
81459	Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements
81462	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements

81463	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis, copy number variants, and microsatellite instability
81464	Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (eg, plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements
0420U	Oncology (urothelial), mRNA expression profiling by real-time quantitative PCR of MDK, HOXA13, CDC2, IGFBP5, and CXCR2 in combination with droplet digital PCR (ddPCR) analysis of 6 single-nucleotide polymorphisms (SNPs) genes TERT and FGFR3, urine, algorithm reported as a risk score for urothelial carcinoma
0422U	Oncology (pan-solid tumor), analysis of DNA biomarker response to anti-cancer therapy using cell-free circulating DNA, biomarker comparison to a previous baseline pre-treatment cell-free circulating DNA analysis using next-generation sequencing, algorithm reported as a quantitative change from baseline, including specific alterations, if appropriate
0423U	Psychiatry (eg, depression, anxiety), genomic analysis panel, including variant analysis of 26 genes, buccal swab, report including metabolizer status and risk of drug toxicity by condition
0424U	Oncology (prostate), exosome-based analysis of 53 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RT-qPCR), urine, reported as no molecular evidence, low-, moderate- or elevated-risk of prostate cancer

0425U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis, each comparator genome (eg, parents, siblings)
0426U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), ultra-rapid sequence analysis
0428U	Oncology (breast), targeted hybrid-capture genomic sequence analysis panel, circulating tumor DNA (ctDNA) analysis of 56 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutation burden
0434U	Drug metabolism (adverse drug reactions and drug response), genomic analysis panel, variant analysis of 25 genes with reported phenotypes
0438U	Drug metabolism (adverse drug reactions and drug response), buccal specimen, gene-drug interactions, variant analysis of 33 genes, including deletion/duplication analysis of CYP2D6, including reported phenotypes and impacted gene-drug interactions

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*$_{SM}$ for Carelon Medical Benefits Management 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 **Availity.com**.

If you have any 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**.

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Reimbursement Policies | Commercial | Jul 1, 2024

Reimbursement policy update: Incident to Services — Professional

Beginning with dates of service on or after October 1, 2024, Anthem will update the *Incident to Service — Professional* policy. The intent of the policy is to identify the reimbursement guidelines for incident to services.

This reimbursement policy identifies the following two different types of incidents:

- **Incident to Billing:** When Incident to billing services are rendered and billed in accordance with this policy, the incident to services are eligible for reimbursement based on a 15% reduction of the maximum allowance of the applicable supervising provider's fee schedule.
- **Incident to Services or Supplies:** Incident to services or supplies that are essential to the performance of professional service are considered bundled in the primary service and are not allowed for separate reimbursement.

The Related Coding section of the policy includes Modifier SA which must be appended when the supervising physician is billing on behalf of non-physician practitioner (NPP) for non-surgical services.

The policy has been renamed to *Incident to Services and Billing — Professional* to define incident to services from incident to billing guidelines.

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

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Reimbursement Policies | Commercial | Jul 1, 2024

Reimbursement policy update: Frequency Editing — Professional

Beginning with dates of service on or after October 1, 2024, Anthem will update the Related Coding section of the Frequency Editing — Professional reimbursement policy.

This policy identifies reimbursement for a procedure or service that is billed for a single member, on a single date of service by the same provider and/or provider group, up to the maximum number of units allowed. In addition to using claims processing logic to determine when the use of multiple units is appropriate, we use the nomenclature for a particular CPT® or HCPCS level II code, the CMS's medically unlikely edits (MUEs) designation, industry standards, or the ability to clinically perform or report a specific service more than one time on a single date of service or within a specific date span per member, per provider in making these determinations.

In the Related Coding section of the policy, the following updates will be made:

CPT maximum frequency code list:

- Remove 36415 and 36416 (refer to laboratory and venipuncture C-10001)
- Remove 96158-96159, 96164-96165 (refer to health and behavioral assessment/intervention C-11003)
- Delete 76942, 77002, 77003, 77012, 77021, 77338, 77600, 77605, 80320-80377, 81479, 86160, 87483, 87491, 87591, 88305, 87529, 90378, 92250, 92273, 92274, 92326, 93325, 95925, 95926, 95938, 95927, 95928, 95929, 95939, 96900, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 93792, and 93793

HCPCS maximum frequency code list:

- Remove S9529 (refer to laboratory and venipuncture C-10001)

- Remove G0480, G0481, G0482, and G0483 (refer to drug screen testing — professional C-12004)
- Remove C9257, G0480, G0481, G0482, and G0483
- Add A4238, A4239, A6520-A6529, A6552-A6589, A6593-A6610, and Q0509

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

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

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New reimbursement policy: Diagnostic Radiopharmaceuticals and Contrast Materials — Professional and Facility

Beginning with dates of service on or after October 1, 2024, Anthem will implement a new reimbursement policy titled *Diagnostic Radiopharmaceuticals and Contrast Materials — Professional and Facility*.

Under this policy, when radiopharmaceuticals and contrast materials are billed by the facility, such services are not reimbursed as they are considered included in the facility fee. In addition, the following statement was removed from the *Place of Service — Professional* reimbursement policy and added to this policy:

> *The health plan does not allow separate reimbursement for diagnostic radiopharmaceutical and contrast materials by professional providers when reported in a facility place of service.*

The Related Coding section contains specific codes with guidelines for both professional and facility providers.

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

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-061235-24

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Visit https://providernews.anthem.com/missouri/articles/new-reimbursement-policy-diagnostic-radiopharmaceuticals-and-20336

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Antidepressant Medication Management (AMM)

The National Committee Quality Assurance (NCQA) develops and collects HEDIS® measurements to set performance and drive improvement in quality-of-care outcomes.

The Federal Employee Program® (FEP) for Anthem is continuously working to improve clinical quality of care and performance outcomes. To comply with the NCQA standards and improve HEDIS AMM performance rate, FEP takes this opportunity to remind providers to document every service rendered in an accurate, timely manner and use the appropriate ICD-10-CM, CPT®, and HCPCS codes when billing services rendered for patients who are receiving antidepressant medications. Below is a description of the AMM measure, why it is important, exclusions, and helpful tips (such as medical records documentation and best practices).

HEDIS AMM measure description

This HEDIS measure evaluates the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported:

- **Effective acute phase treatment:** the percentage of members who remained on antidepressant medication for at least 85 days (12 weeks)
- **Effective continuation phase treatment:** the percentage of members who remained on an antidepressant medication for at least 180 days (6 months)

Members with any diagnosis of major depression who are seen in any of the care settings are included in the AMM measure.

Place of services	
• Outpatient visit • Telehealth visit • ED visit • Acute or nonacute inpatient stay	• Intensive outpatient encounter or partial hospitalization • Community mental health center • E-Visit or virtual check-in (online assessment)

Why is the HEDIS AMM measure important?

Major depression is a serious mental illness with a significant burden of symptoms and the most common psychiatric disorder in individuals who die from suicide.[1] Integrating the right antidepressant medication with appropriate behavioral therapy leads to positive benefits and outcomes for members. Compliance with antidepressant medication is an essential component in treatment guidelines for major depression.[2]

Exclusions

Enrollees who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the index prescription start date (IPSD) through the IPSD and the 60 days after the IPSD

Common behavioral health codes used with any diagnosis of major depression that trigger patients into the HEDIS AMM measure are:

Description	Behavioral health codes (ICD-10-CM, CPT, HCPCS, POS)
Major depression	ICD-10-CM: F32.0–F32.4, F32.9, F33.0–F33.3, F33.41, F33.42, F33.9. F34.1
BH outpatient visit	CPT: 98960–98962, 99078, 99202–99205, 99211–99215, 99242–99245,

	99341–99345, 99347–99350, 99381–99387, 99391–99397, 99401–99404, 99411, 99412, 99483, 99492–99494, 99510 HCPCS: G0155, G0176, G0177, G0409, G0463, G0512, H0002, H0004, H0031, H0034, H0036, H0037, H0039, H0040, H2000, H2010, H2011, H2013 - H2020, T1015
Place of service (POS)	POS: 02, 10, 52, 53
Telehealth visit	POS: 10 CPT: 98966–98968, 99441–99443
ED visit	CPT: 99281–99285
E-visit or virtual check-in (online assessment)	CPT: 98970–98972, 98980, 98981, 99421–99423, 99457, 99458 HCPCS: G0071, G2010, G2012, G2250, G2251, G2252

Helpful tips

Medical record documentation:

- Diagnosis of major depression
- Date of services
- Date of dispensing
- Evidence of antidepressant medication prescription

Best practices:

- Educate members that most antidepressants take four to six weeks to work.

- Encourage members to continue any prescribed medication even if they feel better. Inform them of the danger of discontinuing suddenly. If they take the medication for less than six months, they are at a higher risk of recurrence.
- Assess members within 30 days from when the prescription is first filled for any side effects and their response to treatment.
- When patients are making a follow-up visit, educate and encourage patients to bring their discharge instructions and medications list to their first appointment.
- Coordinate care between behavioral health and primary care physicians by sharing progress notes and updates.
- Educate members on what to do in an emergency, such as when having suicidal thoughts.
- Focus on member preferences for treatment, allowing the member to take ownership of their health and treatment plan.

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1. https://pubmed.ncbi.nlm.nih.gov/23411024: Accessed January 21, 2020.
2. https://ncqa.org/hedis/measures/antidepressant-medication-management

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/antidepressant-medication-management-amm-20391

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Pharmacy | Commercial | Jul 1, 2024

Specialty pharmacy updates — July 2024

Specialty pharmacy updates for Anthem are listed below.

Prior authorization clinical review of **non-oncology** use of specialty pharmacy drugs is managed by the medical specialty drug review team for Anthem. Review of specialty pharmacy drugs for **oncology** use is managed by CareIon Medical Benefits Management, Inc., a separate company.

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

Inclusion of the national drug code (NDC) on your claim will help expedite claim processing of drugs billed with a not otherwise classified (NOC) code.

Prior authorization updates

Effective for dates of service on or after October 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* at **anthem.com/ms/pharmacyinformation/clinicalcriteria.html** to view the complete information for these prior authorization updates.

Clinical Criteria	Drug	HCPCS code(s)
CC-0003*	Alyglo (immune globulin intravenous, human-stwk)	J1599

CC-0062	Simlandi (adalimumab-ryvk)	J3590
CC-0261	Winrevair (sotatercept-csrk)	C9399, 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.

Step therapy updates

Effective for dates of service on or after October 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* at **anthem.com/ms/pharmacyinformation/clinicalcriteria.html** to view the complete information for these step therapy updates.

Clinical Criteria	Status	Drug	HCPCS code(s)
CC-0003	Non-preferred	Alyglo (immune globulin intravenous, human-stwk)	J1599
CC-0062	Non-preferred	Cimzia (certolizumab pegol)	J0717
CC-0042	Non-preferred	Cosentyx intravenous (secukinumab)	C9399, J3490, J3590, C9166

CC-0050	Non-preferred	Ilumya (tildrakizumab)	J3245
CC-0050	Non-preferred	Omvoh (mirkizumab-mrkz)	C9168, J3590

Quantity limit updates

Effective for dates of service on or after October 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* at **anthem.com/ms/pharmacyinformation/clinicalcriteria.html** to view the complete information for these quantity limit updates.

Clinical Criteria	Drug	HCPCS code(s)
CC-0062	Simlandi (adalimumab-ryvk)	J3590
CC-0261	Winrevair (sotatercept-csrk)	C9399, J3590

MULTI-BCBS-CM-060687-24-CPN60563

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Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-july-2024-20649

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Pharmacy | Medicare Advantage | Jun 20, 2024

Anthem expands specialty pharmacy precertification list

Effective for dates of service on and after October 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. They must be considered first when determining coverage. Noncompliance with new requirements may result in denied claims.

HCPCS codes	Medicare Part B drugs
J3490, J3590	Amtagvi (lifleucel)
J3490, J3590	iDoseTR (travoprost implant)

MULTI-BCBS-CR-058746-24-CPN58434

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Visit https://providernews.anthem.com/missouri/articles/anthem-expands-specialty-pharmacy-precertification-list-20461

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Quality Management | Medicare Advantage | Jul 1, 2024

Understanding your role in the Health Outcomes Survey

The Centers for Medicare & Medicaid Services (CMS) Health Outcomes Survey (HOS) gathers patient-reported health outcomes from members enrolled in Medicare Advantage plans to support quality improvement activities and improve the overall health of members.

Increased awareness of all HOS measures can help guide your provider interactions with your patients and positively impact HOS results and can help impact your Star rating.

Refer to attachment to view full details

MULTI-BCBS-CR-055932-24-CPN55629

ATTACHMENTS (available on web): Understanding your role in the Health Outcomes Survey (pdf - 0.88mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/understanding-your-role-in-the-health-outcomes-survey-19398

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