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Administrative | Commercial | Aug 1, 2024

CAA: Providers required to verify their online provider directory information

Previously titled: Enhance patient trust by verifying your online directory info every 90 days

Summary:

- The *Consolidated Appropriations Act (CAA)* obliges care providers to validate their online directory details every 90 days to remain listed, effective November 1, 2024.
- Anthem's provider data management (PDM) on Availity Essentials enables care providers to verify and update their information efficiently.
- Care providers can submit data updates through the PDM's Roster Automation solution using a standard Microsoft Excel document.

The *CAA* of 2021 requires care providers to review and verify the accuracy of the following information in the online provider directory every 90 days:

- Care provider/facility name
- Address
- Specialty
- Phone number
- Digital contact information

Effective November 1, 2024, care providers who fail to verify their information every 90 days may be removed from the online provider directory.

Care providers will be reinstated to the online provider directory once verification is complete.

Review, verify, and update your directory information

To review, verify, and update your online directory information, Anthem uses the provider data management (PDM) capabilities of Availity Essentials to update care provider or facility data. Using the Availity PDM tool meets the verification requirement to validate care provider demographic data set by the *CAA*.

PDM features include:

- Updating care provider demographic information for all assigned payers in one location.
- Verifying 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.

To access the PDM tool, log on to Availity.com and go to My Providers > Provider Data Management. Administrators are automatically 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. View the Availity PDM quick start guide here (PDF).

Use Roster Automation to submit care provider demographic changes

Within the PDM tool, care providers also have the choice and flexibility to request data updates using our Roster Automation solution by submitting a spreadsheet via a roster upload.

Care provider data additions, changes, and terminations are submitted on a standardized Microsoft Excel document. The resources for this process are available on our website.

Visit **anthem.com** > For Providers > Forms and Guides. The following two resources appear under the Digital Tools category:

- *Roster Automation Rules of Engagement:* This is a reference document available to ensure error-free submissions for accurate and timely updates through automation.
- *Roster Automation Standard Template:* Use this template to submit your information. More detailed instructions on formatting and submission requirements can be found on the first tab of the template, the tab named *User Reference Guide.*

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To view this article online:

Visit https://providernews.anthem.com/missouri/articles/caa-providers-required-to-verify-their-online-provider-direc-21179

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Administrative | Commercial | Aug 1, 2024

Incidental services — facility editing update

Effective for all claims received on or after November 1, 2024, Anthem is updating its outpatient facility editing system to deny claim lines billed with general revenue code 0250 when billed on the same claim with a radiology or diagnostic revenue code. Claims billed with surgical revenue codes 036X or 049X are not subject to this edit.

Per industry standard coding resources, including the Uniform Billing Editor and the National Uniform Billing Committee, care providers should use the more detailed revenue code subcategory when applicable and available rather than revenue codes that end in 0 (General) or 9 (Other). Claims must be coded to the highest level of specificity. As a reminder, unclassified CPT® code J3490 should only be submitted when there is no specific HCPCS or CPT code for the submitted National Drug Code.

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

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Visit https://providernews.anthem.com/missouri/articles/incidental-services-facility-editing-update-21093

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Administrative | Commercial | Aug 1, 2024

Device-dependent procedures — facility editing update

Effective for all dates of service on and after November 1, 2024, Anthem is updating its outpatient facility editing system to implement a device-dependent procedure edit.

When a device is necessary to perform a specific procedure, both the device and the device-dependent procedure code must be submitted on the same claim and rendered on the same service date. Please visit the Centers for Medicare & Medicaid Services (CMS) Outpatient Code Editor at cms.gov for the most current lists of device-dependent procedure codes and device category codes. These lists may also be found in Appendix 3A and 3B of the Uniform Billing Editor. These lists may be updated to align with CMS changes.

In addition to the CMS-provided device-dependent procedure codes, we are adding CPT® codes 52441 and 52442 to the device-dependent procedure list for this edit.

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

MULTI-BCBS-CM-063147-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/device-dependent-procedures-facility-editing-update-21092

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Administrative | Medicare Advantage | Aug 1, 2024

ICD-10-CM Excludes1 notes

Beginning with claims processing on or after August 31, 2024, Anthem will implement revised claims editing logic tied to Excludes1 notes from ICD-10-CM 2020 coding guidelines. To help ensure the accurate processing of claims, care providers are encouraged to use ICD-10-CM coding guidelines when selecting the most appropriate diagnosis for member encounters. Please remember to code to the highest level of specificity. For example, if there is an indication at the category level that a code can be billed with another range of codes, it is imperative to look for Excludes1 notes that may prohibit billing a specific code combination.

The concept of Excludes1 notes is one of the unique attributes of the ICD-10-CM code set and coding conventions. An Excludes1 note indicates that the excluded code identified in the note should not be billed with the code or code range listed above the Excludes1 note. These notes appear below the affected codes; if the note appears under the category (the first three characters of a code), it applies to the entire series of codes within that category. If the Excludes1 note appears beneath a specific code (three, four, five, six, or seven characters in length) then it applies only to that specific code.

In ICD-10-CM, when a category includes an Excludes1 note, it outlines what codes should **not** be billed together. Examples of this code scenario would include but are not limited to the following:

- Reporting Z01.419 with Z12.4:
    - 41X (encounter GYN exam w/out abnormal findings) has an Excludes1 note below that includes Z12.4 (encounter for screening malignant neoplasm cervix).
- Reporting Z79.891with F11.2X:
    - 891 (long-term use of opiates) has an Excludes1 note after it for F11.2X (opioid dependence).

- Reporting M54.2 with M50.XX:
    - 2 (cervicalgia) has an Excludes1 note below it for M50.XX (cervicalgia due to intervertebral disc disorder).
- Reporting M54.5 with S39.012X and/or M54.4x:
    - 5 (low back pain) has an Excludes1 note below it, which includes S93.012X (strain of muscle, fascia and tendon of lower back), M54.4X (low back pain), and M51.2X (lumbago due to intervertebral disc disorder).
- Reporting J03.XX with J02.XX, J35.1, J36, J02.9:
    - Acute tonsillitis has an Excludes1 note below it, which includes J02.- (acute sore throat), J35.1 (hypertrophy of tonsils), and J36 (peritonsillar abscess).
    - Reporting N89 with R87.62X, D07.2, R87.623, N76.XX, N95.2N89 (other inflammatory disorders of the vagina) has an Excludes1 note below the category for R87.62X (abnormal results from vaginal cytological exam), D07.2 (vaginal intraepithelial neoplasia), R87.623 (HGSIL of vagina), N76.XX inflammation of the vagina), N95.2 (senile [atrophic] vaginitis), and A59.00 (trichomonal leukorrhea).

Finally, if you believe an Excludes1 note denial is incorrect, please consult the ICD-10-CM code book to verify appropriate use of the billed codes and provide supporting documentation through the normal dispute process to indicate why the billed diagnoses codes are appropriately used together.

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

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/icd-10-cm-excludes1-notes-21020

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Administrative | Commercial | Aug 1, 2024

Personalized Match update

Find Care, the doctor finder and transparency tool in the Anthem online directory, provides Anthem members with the ability to search for in-network providers using the secure member website. This tool currently offers multiple sorting options such as sorting providers based on distance, alphabetical order, and provider name.

In our November 2022 newsletter, we provided an update regarding Personalized Match, an additional Find Care sorting option for Commercial members. We informed you that this provider sorting option was based on provider efficiency and quality outcomes described in a methodology document linked in the newsletter article, in addition to member search radius.

We want to inform you that, beginning in September 2024 or later, we will be enhancing Personalized Match. This will expand upon the existing program. Newer components of the provider personalization metrics will contain up to 10 times as many features as compared to existing metrics such as gaps in care and additional types of service cost and utilization. Personalized Match will continue to display providers with the highest overall ranking within the member's search radius, first. Members will continue to have the ability to sort based on distance, alphabetical order, and provider name.

Helpful resources on Availity

You may review a copy of the Personalized Match methodology that has been posted on Availity, our secure web-based provider tool, using the following navigation:

- Go to Availity > Payer Spaces > Health Plan > Education & Reference Center > Administrative Support > Personalized Match Methodology.pdf.

If you have general questions regarding these upcoming changes, please submit an inquiry via the web at **Availity.com**. If you would like information about your quality or

efficiency scoring used as part of this sorting option or if you would like to request reconsideration of those scores, you may do so by submitting an inquiry to **Availity.com**.

Anthem will continue to focus and expand our consumer tools and content to assist members in making more informed and personalized healthcare decisions.

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To view this article online:

Visit https://providernews.anthem.com/missouri/articles/personalized-match-update-20717

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Administrative | Commercial | Aug 1, 2024

Provider manual update available — effective November 1, 2024

Anthem reviews and updates our provider manuals annually so that our care provider partners have the current information needed to work with us. The updated manual effective November 1, 2024, is available now on our public provider website at anthem.com.

To view the updated manual, visit the provider webpage on anthem.com. Select **Missouri**, if needed. Scroll down and select **Policies, Guidelines & Manuals**. Scroll to **Provider Manual** and select **Download the Manual**. On the *Provider Manual* page, scroll down to the green section, **Looking for Our Upcoming Provider Manual** and select **Preview the upcoming manual**.

Select **Access previous versions and other manuals** to view our Provider Manual Library for all current and historical provider manuals available.

MOBCBS-CM-062979-24

To view this article online:

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Digital Solutions | Medicare Advantage | Jul 16, 2024

Expansion of Carelon Medical Benefits Management, Inc. programs

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

The expansion will require clinical appropriateness review for additional procedures related to Carelon Medical Benefits Management programs, including cardiology, radiation oncology, radiology, musculoskeletal, sleep, surgical, and additional outpatient services.

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

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

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

Prior authorization review requirements

Carelon Medical Benefits Management will begin accepting PA requests on September 24, 2024, for dates of service October 1, 2024, and after. For procedures scheduled to begin on or after
October 1, 2024, care providers must contact Carelon Medical Benefits Management to obtain PA for the non-emergency modalities below. Refer to the clinical guidelines on the microsite resource pages for complete code lists.

Program	Services	*Medical Policies* or *Clinical Guidelines*
Cardiovascular	• OP cardiac hemodynamic monitoring w/wireless sensor for heart failure management • Non-invasive heart failure & arrhythmia monitoring system • Vascular-carotid sinus device (effective 3/1/2025)	• *MED.00115* • *MED.00134* • *SURG.00124* (Effective 3/1/2025)
Additional outpatient utilization management	• Therapeutic apheresis • Hyperbaric oxygen therapy • Physiologic record of tremor • Home enteral and parenteral nutrition • Ambulance services • Virtual reality-assisted therapy systems • Home visual field monitor • Colonic irrigation • Automated evacuation of meibomian gland	• *CG-MED-68* • *MED.00101* • *CG-MED-08* • CG-MED-89 • CG-DME-30 • *CG-MED-73* • *DME.00048* • *DME.00048* • *MED.00103* • *MED.00131* • *MED.00141* • *CG-ANC-06*

Program	Services	*Medical Policies* or *Clinical Guidelines*
	• Prothrombin time self-monitoring devices	• *CG-SURG-08* • *SURG.00052* • *SURG.00158* • *SURG.00112*
Musculoskeletal	• Peripheral nerve blocks for Tx of neuropathic pain • Implant of nerve stim. devices • Percutaneous vertebral disc and vertebral endplate procedures	• *CG-SURG-08* • *SURG.00052* • *SURG.00158* • *SURG.00026* • *SURG.00112*
Surgical	• Surg. Tx of hyperhidrosis • Skin related cosmetic and reconstructive services • Cochlear and auditory brainstem implants • Implantable hearing aids • Surg. Tx for OSA and snoring • Drug-eluting devices to maintain sinus ostial patency • Minimally invasive Tx of posterior nasal nerve for rhinitis • Temporomandibular disorders • Nasal valve repair • Gastric electrical stim. • Penile prosthesis implantation • Diaphragmatic/phrenic nerve stim. and pacing systems	• *SURG.00045* • *SURG.00112* • CMS criteria only • *SURG.00129* • *SURG.00047* • *ANC.00007* • *CG-MED-79* • *CG-SURG-08* • *CG-SURG-09* • *CG-SURG-116* • *CG-SURG-118* • *CG-SURG-12* • *CG-SURG-120* • *CG-SURG-30* • *CG-SURG-36*

Program	Services	*Medical Policies* or *Clinical Guidelines*
	• Radiofrequency ablation of renal sympathetic nerves • Respiratory assist devices • Tonsillectomy/adenoidectomy • Uterine fibroid ablation • Sacral nerve stim. Tx of neurogenic bladder secondary to spinal cord injury • Vagus nerve stim. • Ablation for solid tumors outside the liver • Intraocular telescope • Automated evacuation of meibomian gland • Intraocular anterior segment aqueous drainage devices • Extracorporeal shock wave therapy • Implant of nerve stim. devices • Implanted artificial iris devices • Implantable infusion pumps • Tx for urinary and fecal incontinence • Panniculectomy and abdominoplasty • Regenerative cell therapy and soft tissue • Augmentation • Products for wound healing and soft tissue grafting • Surg. and ablative Tx for chronic headaches	• *CG-SURG-61* • *CG-SURG-70* • *CG-SURG-79* • *CG-SURG-81* • *CG-SURG-82* • *CG-SURG-84* • *CG-SURG-95* • *CG-SURG-96* • *CG-SURG-99* • *MED.00103* • *MED.00132* • *MED.00132* • *SURG.00010* • *SURG.00011* • *SURG.00077* • *SURG.00079* • *SURG.00096* • *SURG.00129* • *SURG.00132* • *SURG.00135* • *SURG.00139* • *SURG.00156* • *SURG.00157*

Program	Services	*Medical Policies* or *Clinical Guidelines*
	• Intraoperative assess. of surgical margins during breast-conserving surg. • Mandibular/maxillary surg.	
Sleep	• Electronic positional devices for Tx of OSA • Neuromuscular electrical training for Tx of OSA • Respiratory assist device	• *DME.00042* • *DME.00043* • *SURG.00007* • CMS criteria

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

How to place a review request

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

For more information

For resources to help your practice get started with the cardiology, musculoskeletal, surgical, and programs, visit:

- Cardiovascular Solution | Carelon Insights

- Musculoskeletal (MSK) Solution | Carelon Insights (AIM)
- Sleep Solution | Sleep Healthcare | Carelon Insights
- Surgical Procedures Solution | Carelon Insights
- Radiation Oncology Solution | Carelon Insights

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

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

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To view this article online:

Visit https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program-20928

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Digital Solutions | Commercial | Jul 24, 2024

Expansion of Carelon Medical Benefits Management, Inc. programs

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

The continued migration will expand clinical appropriateness review for procedures related to the following existing Carelon Medical Benefits Management programs: cardiovascular, musculoskeletal, radiation oncology, radiology, sleep, and surgical. In addition, some codes will migrate into a new Carelon Medical Benefits Management solution — additional outpatient utilization management (UM) that will include some transportation (including ambulance) and fertility procedures as set forth below. Transportation may include emergency post-service reviews.

The *Clinical UM Guidelines* and *Medical Policies* (also known as coverage guidelines in Virginia) by Anthem for medical necessity review are listed in the table below. Carelon Medical Benefits Management will begin accepting prior authorization requests on September 23, 2024, for dates of service on or after October 1, 2024.

Members included in the new program

Updates to Carelon Medical Benefits Management programs apply to select local fully insured Anthem members and select members who are covered under self-insured (ASO) benefit plans with services medically managed by Carelon Medical Benefits Management. This notice does not apply to certain HMO, BlueCard®, Medicare Advantage, Medicaid, Medicare Supplemental, or Federal Employee Program® (FEP®). For more information, please contact the phone number on the back of the member ID card.

Pre-service review requirements

For procedures that are scheduled to begin on or after October 1, 2024, all care 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* at **anthem.com** > Providers > Provider Resources > Policies, Guidelines & Manuals for complete code lists.

Note: All codes will be reviewed for medical necessity for the requested service and not for site of care. Please note some services below are effective March 1, 2025.

Program	Services	*Medical Policies* or *Clinical Guidelines*
Cardiovascular	• Intracardiac ischemia monitoring • OP cardiac hemodynamic monitoring w/wireless sensor for heart failure management • Non-invasive heart failure and arrhythmia monitoring system	• *MED.00111* • *MED.00115* • *MED.00134*

Musculoskeletal	• US bone growth stim • Manipulation under anesthesia • Anesthesia for interventional pain procedures • Facet joint allograft implants for facet disease • Electrothermal shrinkage of joint capsules, ligaments, and tendons • Implant of nerve stim. devices • Radiofrequency neurolysis and pulsed radiofrequency therapy for trigeminal neuralgia	• *CG-DME-45* • *CG-MED-65* • *SURG.00043* • *CG-MED-78* • *CG-SURG-08* • *CG-SURG-89* • *SURG.00114*
Radiology	• Magnetic source imaging and magnetoencephalography • Dynamic spinal visualization (including digital motion X-ray and cineradiography/ videofluoroscopy) • Cervical and thoracic discography	• *CG-MED-76* • *RAD.00034* • *RAD.00053*
Radiation oncology	• Neutron beam radiotherapy	• *THER-RAD.00008*
Sleep	• Electronic positional devices for Tx of OSA • Neuromuscular electrical training for Tx of OSA	• *DME.00042* • *DME.00043*
Surgical GI	• High resolution anoscopy screening	• *SURG.00116*

	• Doppler-guided transanal hemorrhoidal de-arterialization	• *SURG.00141*

Update to previous notice: The services additional outpatient utilization management and base surgical below are effective March 1, 2025.

Program	Services	*Medical Policies* or *Clinical Guidelines*
Additional outpatient utilization management services (effective 3/1/2025)	• Fertility • Therapeutic apheresis • Hyperbaric oxygen therapy • Physiologic record of tremor • Home parenteral nutrition • Imaging evaluation of skin lesions • Ambulance services (not applicable to Connecticut) • Virtual reality-assisted therapy systems • Quantitative sensory testing • Automated nerve conduction testing • Bioimpedance spectroscopy • Autonomic testing • Continuous monitoring of intraocular pressure • Seizure monitoring • Electronic home visual field monitoring • Eye movement analysis for diagnosis of concussion • High-volume colonic irrigation	• *CG-MED-68* • *MED.00101* • *CG-MED-89* • *CG-MED-73* • *CG-MED-73* • *DME.00011* • *DME.00048* • *MED.00011* • *MED.00082* • *MED.00092* • *MED.00103* • *MED.00105* • *MED.00112* • *MED.00118* • *MED.00130* • *MED.00131* • *MED.00137* • *MED.00141* • *MED.00002* • *MED.00004*

	• Electrical stimulation as a treatment for pain and other conditions • Sensory stimulation for brain-injured individuals in coma or vegetative state • Automated evacuation of meibomian gland • Selected sleep testing	• *CG-MED-66* • *CG-MED-88* • *CG-SURG-35* • *LAB.00045* • *CG-ANC-04* • *CG-ANC-06*
Cardiovascular services effective 3/1/2025	• Intravascular stent • Angioplasty • Central venous access device • Sclerotherapy • Endovenous therapy • Vascular embolization/occlusion organ/venous • Echosclerotherapy • Balloon dilatation • Balloon angioplasty • Transcath stent • Dialysis circuit with angiography • Carotid sinus procedures • Carotid sinus neurostimulator	• *CG-SURG-106* • *CG-SURG-119* • *CG-SURG-28* • *CG-SURG-76* • *CG-SURG-83* • *CG-SURG-93* • *RAD.00059* • *SURG.00062* • *SURG.00124*
Base surgical effective 3/1/2025	• Anesthesia for dental services • Skin-related cosmetic and reconstructive services • Balloon dilation of eustachian tubes • Functional endoscopic sinus surgery • Bronchial thermoplasty	• *ANC.00007* • *CG-MED-41* • *CG-MED-79* • *CG-MED-81* • *CG-SURG-03* • *CG-SURG-08*

	• Balloon sinus ostial dilation • Cochlear and auditory brainstem implants • Implantable hearing aids • Surgical treatment for obstructive sleep apnea and snoring • Drug-eluting devices to maintain sinus ostial patency • Minimally invasive treatment of posterior nasal nerve for rhinitis • MRI guided high-intensity focused ultrasound ablation for non-oncologic indications • Uterine fibroid ablation • Sacral nerve stimulation as a treatment of neurogenic bladder secondary to spinal cord injury • Vagus nerve stimulation • Ablation for solid tumors outside the liver • Irreversible electroporation • Corneal collagen cross linking • Intraocular telescope • Automated evacuation of meibomian gland • Presbyopia and astigmatism-correcting intraocular lenses • Viscocanalostomy and canaloplasty • Intraocular anterior segment aqueous drainage devices • Implanted artificial iris devices • Implanted port delivery systems for ocular disease	• *CG-SURG-09* • *CG-SURG-105* • *CG-SURG-12* • *CG-SURG-117* • *CG-SURG-118* • *CG-SURG-120* • *CG-SURG-18* • *CG-SURG-24* • *CG-SURG-61* • *CG-SURG-71* • *CG-SURG-73* • *CG-SURG-79* • *CG-SURG-81* • *CG-SURG-82* • *CG-SURG-83* • *CG-SURG-84* • *CG-SURG-88* • *CG-SURG-95* • *CG-SURG-96* • *CG-SURG-99* • *MED.00057* • *MED.00103* • *MED.00132* • *SURG.00010* • *SURG.00011* • *SURG.00118* • *SURG.00061* • *SURG.00077* • *SURG.00079*

	• Implantable infusion pumps • Treatments for urinary and fecal incontinence, urinary retention • Reduction mammaplasty • Mastectomy for gynecomastia • Panniculectomy and abdominoplasty • Adipose-derived regenerative cell therapy and soft tissue augmentation • Products for wound healing and soft tissue grafting • Surgical and ablative treatments for chronic headaches • Intraoperative assessment of surgical margins during breast-conserving surgery with radiofrequency spectroscopy or optical coherence tomography • Mandibular/maxillary surgery • Blepharoplasty, repair, and brow lift • Internal rib fixation systems • Prostate saturation biopsy • Focal laser ablation for the treatment of prostate cancer • Penile prosthesis implantation • Diaphragmatic/phrenic nerve stimulation and pacing systems • High intensity focused ultrasound ablation for oncologic indications • Renal sympathetic nerve ablation • Hysterectomy • Laparoscopic gynecologic surgery • Myomectomy	• *SURG.00084* • *SURG.00095* • *SURG.00096* • *SURG.00107* • *SURG.00116* • *SURG.00120* • *SURG.00126* • *SURG.00129* • *SURG.00132* • *SURG.00135* • *SURG.00139* • *SURG.00141* • *SURG.00156* • *SURG.00157* • *SURG.00159* • *SURG.00160* • *MCG: ISC: S-660/660-RRG: Hysterectomy, Vaginal* • *MCG: ISC: S-450/450-RRG/5450: Laparotomy for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy* • *MCG: ISC: S-660/660-RRG: Hysterectomy, Vaginal*

	• Transurethral destruction, prostate tissue • Temporomandibular disorders (*SURG-09*) • Septoplasty (*SURG-18*) • Bariatric surgery and other treatment for clinically severe obesity (*SURG-81*) • Nasal valve repair (*SURG.00079*) • Bone-anchored and bone conduction hearing aids (*SURG-82*)	• *MCG: ISC: S-665/665-RRG: Hysterectomy, Laparoscopic* • *MCG: ISC: S-775/775-RRG: Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy*

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

Care providers should continue to submit pre-service review requests to Carelon Medical Benefits Management using the convenient online service via the Carelon Medical Benefits Management provider portal. The provider portal is available 24 hours a day, seven days a week, processing requests in real-time using *Clinical Criteria*. Go to providerportal.com to register.

For more information

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

- **Cardiovascular Solution | Carelon Insights**
- **Radiology Solution | Carelon Insights**

- **Sleep Solution | Sleep Healthcare | Carelon Insights**
- **Surgical Procedures Solution | Carelon Insights**
- **Radiation Oncology Solution | Carelon Insights**
- **Additional Outpatient Utilization Management**

Our website at anthem.com helps you access information and tools such as order entry checklists, *Clinical Guidelines*, and FAQ. You can also contact your local network relations representative if you have any questions.

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

MULTI-BCBS-CM-063152-24-CPN62856

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Digital Solutions | Commercial | Aug 1, 2024

Coming soon: View your fee schedule in Availity Essentials Payer Spaces

Soon you will be able to request your specific fee schedule via the Provider Enrollment application in Availity Essentials. Enter your organizational information in the **My Fee Schedule** option, where you will be able to request and download your contracted rate(s) at one centralized location:

- Care providers can download the complete fee schedule — both standard and negotiated rates — within minutes.
- Care providers will be able to pull historic fee schedules (up to three years), current, and future rate(s).
- Rates are updated daily and will be available the following day.

To locate Provider Enrollment, log in to Availity Essentials, select your state, then select **Payer Spaces** and **payer tile**. Look for future communications as to when this feature will be live.

MULTI-BCBS-CM-061987-24-CPN61632

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/coming-soon-view-your-fee-schedule-in-availity-essentials-pa-20810

Or scan this QR code with your phone

Digital Solutions | Medicare Advantage | Jul 9, 2024

Coming soon — digital-only authorization case status notifications for Medicare

We previously communicated to you that we are digitizing authorization case notifications, including status and decision letters, for Commercial health plans, eliminating paper notifications, with the commercial health plans. We are happy to share that we are expanding the digitization of authorization case notifications and eliminating paper notifications for Medicare health plans in your state.

Just as you have with Commercial health plans, you have 24/7 access to authorization case information in one location through Availity Essentials. The digital authorization case status notifications are available under the *Authorizations and Referrals** application once you have logged in to Availity Essentials and selected *Patient Registration*. By eliminating the redundancy of receiving both a digital and paper letter, you'll see fewer errors associated with manual processes in handling the paper letters while reducing cost and our carbon footprint.

* Note: to access this application, your Availity Essentials administrator must assign you the role of Authorization & Referral Inquiry or Request.

Care providers will be able to choose different options to receive Medicare authorization decision notifications via the Provider Preference Center under *Availity Payer Spaces*. Look for details on the Provider Preference Center options and ways to access authorization case status in an upcoming communication.

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

(HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

MULTI-BCBS-CR-053243-24-CPN51281

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/coming-soon-digital-only-authorization-case-status-notificat-20785

Or scan this QR code with your phone

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

Coming soon: Provider e-Learning Resource Center for Payment Integrity

We are thrilled to announce the upcoming launch of Payment Integrity's new innovative tool, the Provider e-Learning Resource Center (PeRC). This is an exciting upgrade exemplary of our ongoing commitment to providing the best resources for your billing and coding success. PeRC is an educational platform:

- Dedicated to accurate coding initiatives, with the goal of resulting in reduced errors.
- That promotes a well-informed care provider community, enhances healthcare services, and improves outcomes.

Stay tuned for the official launch date and more details about the Provider e-Learning Resource Center from the Provider Education team.

We are committed to a future of shared success.

MULTI-BCBS-CRCM-061035-24-CPN60941

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/coming-soon-provider-e-learning-resource-center-for-payment-21122

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

August is National Breastfeeding Month

On August 6, 2011, the U.S. Breastfeeding Committee (USBC) officially declared August as National Breastfeeding Month.[1]

In recognition of August as National Breastfeeding Month, we are introducing resources published by numerous trusted sources, including My Diverse Patients. The first is an eLearning experience, developed for care providers, nurses, office staff, and other healthcare professionals. It is titled *Promoting Birth Equity*. You can find it on the Maternal Health Disparities page. In addition, within the *Current Trends* section, we offer access to an education resource via an externally published special series called *Lost Mothers: Maternal Mortality In The U.S.* It includes a resource by the National Public Radio entitled *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*.

Further and in accordance, the U.S. Centers for Disease Control and Prevention (CDC) offers these key points about breastfeeding:

- Breastfeeding is the best source of nutrition for most infants.
- Breastfeeding can reduce the risk of certain health conditions for both infants and mothers.
- Only one in four infants are exclusively breastfed as recommended until they are six months old.
- CDC supports and promotes breastfeeding across the United States.

Infants who are breastfed and mothers who breastfeed have reduced risk of:

- Asthma and severe lower respiratory disease.
- Obesity.
- Type 1 diabetes.

- Acute otitis media (ear infections).
- Sudden infant death syndrome (SIDS).
- Gastrointestinal infections, which can cause diarrhea and vomiting.
- Necrotizing enterocolitis (NEC) (death of intestinal tissue) for preterm infants.

Mothers who breastfeed also have reduced risk of high blood pressure, Type 2 diabetes, ovarian cancer, and breast cancer.[2]

Whole health

We are taking a holistic view that can transform health. Maternal-child health includes the entire pre-pregnancy, pregnancy, delivery, and postpartum journey of a parent and child up to one year after birth.[3]

Healthy babies start with healthy pregnancies. The United States has a robust healthcare infrastructure, spending more per capita on healthcare than any other nation, but maternal health in the U.S. has lagged behind that of other developed countries.[4]

Certified doula care can help improve maternal and infant health outcomes

Research shows that doulas — trained professionals who counsel pregnant people before, during, and after their babies are born — can help improve maternal health outcomes by offering information and education, as well as physical, social, and emotional support. Such care has been found to reduce the rate of cesarean births, preterm births, and postpartum depression, while also improving breastfeeding rate.[4]

We look forward to working together to deliver high-quality, equitable healthcare. If you have any questions about this communication, visit the *Contact Us* section of our provider website.

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1. National Breastfeeding Month. U.S. Breastfeeding Committee. (n.d.). https://www.usbreastfeeding.org/national-breastfeeding-month.html

2. Centers for Disease Control and Prevention. (2023, December 18). *About breastfeeding*. Centers for Disease Control and Prevention. https://www.cdc.gov/breastfeeding/php/about/index.html
3. *Maternal Health.* Elevance Health. (n.d.). https://www.elevancehealth.com/our-approach-to-health/maternal-health
4. Elevance Health Impact. (2023, April 30). *Certified Doula Care Can Help Improve Maternal and Infant Health Outcomes* Video. Elevance Health. https://www.elevancehealth.com/our-approach-to-health/whole-health/certified-doula-care-can-help-improve-maternal-and-infant-health-outcomes

MULTI-ALL-CRCM-062148-24-CPN61848

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/august-is-national-breastfeeding-month-20838

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Clinical Criteria updates

Effective August 12, 2024

Summary: On May 17, 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. If you have questions or for 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
August 12, 2024	*CC-0262	Tevimbra (tislelizumab-jsgr)	New
August 12, 2024	*CC-0162	Tepezza (teprotumumab-trbw)	Revised
August 12, 2024	*CC-0111	Nplate (romiplostim)	Revised
August 12, 2024	CC-0165	Trodelvy (sacituzumab govitecan)	Revised
August 12, 2024	*CC-0002	Colony Stimulating Factor Agents	Revised
August 12, 2024	CC-0128	Tecentriq (atezolizumab)	Revised
August 12, 2024	*CC-0098	Doxorubicin Liposome (Doxil, Lipodox)	Revised
August 12, 2024	*CC-0101	Torisel (temsirolimus)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
August 12, 2024	*CC-0107	Bevacizumab for Non-Ophthalmologic Indications	Revised
August 12, 2024	CC-0143	Polivy (polatuzumab vedotin-piiq)	Revised
August 12, 2024	*CC-0092	Adcetris (brentuximab vedotin)	Revised
August 12, 2024	CC-0106	Erbitux (cetuximab)	Revised
August 12, 2024	*CC-0105	Vectibix (panitumumab)	Revised
August 12, 2024	CC-0145	Libtayo (cemiplimab-rwlc)	Revised
August 12, 2024	CC-0160	Vyepti (eptinezumab)	Revised
August 12, 2024	CC-0102	GNRH Analogs for Oncologic Indications	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
August 12, 2024	CC-0201	Rybrevant (amivantamab-ymjw)	Revised
August 12, 2024	*CC-0188	Imcivree (setmelanotide)	Revised
August 12, 2024	*CC-0124	Keytruda (pembrolizumab)	Revised
August 12, 2024	CC-0041	Complement C5 Inhibitors	Revised
August 12, 2024	CC-0199	Empaveli (pegcetacoplan)	Revised
August 12, 2024	*CC-0130	Imfinzi (durvalumab)	Revised
August 12, 2024	CC-0240	Zynyz (retifanlimab-dlwr)	Revised
August 12, 2024	CC-0123	Cyramza (ramucirumab)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
August 12, 2024	CC-0187	Breyanzi (lisocabtagene maraleucel)	Revised
August 12, 2024	CC-0158	Enhertu (fam-trastuzumab deruxtecan-nxki)	Revised
August 12, 2024	CC-0226	Elahere (mirvetuximab)	Revised
August 12, 2024	CC-0043	Monoclonal Antibodies to Interleukin-5	Revised
August 12, 2024	*CC-0066	Monoclonal Antibodies to Interleukin-6	Revised
August 12, 2024	CC-0221	Spevigo (spesolimab-sbzo)	Revised
August 12, 2024	CC-0071	Entyvio (vedolizumab)	Revised
August 12, 2024	*CC-0063	Ustekinumab Agents	Revised

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

MULTI-BCBS-CR-061721-24-CPN61521

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

Effective for dates of service on and after November 17, 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.

Genetic testing

Cell-free DNA Testing (Liquid Biopsy) for the Management of Cancer:

- Expanded criteria to include a wider scope of testing for metastatic disease: AKT1 and PTEN (related to capivasertib/fulvestrant therapy)

Prenatal Testing [changed to Screening] using cell-free DNA:

- Expanded criteria to include follow-up screening for abnormal maternal serum screen results in viable singleton/twin pregnancies when diagnostic testing is declined
- Expanded criteria to include screening for pregnancies with multiple anomalies when diagnostic testing is not possible

Somatic Testing of Solid Tumors:

- Tissue-agnostic testing for patients with advanced solid tumors:
    - Clarification about TMB testing by FDA-approved test with reporting threshold ≥ 10 mutations/megabase (mut/Mb)
- Bladder cancer:

    - Expansive changes for microsatellite instability/mismatch repair deficiency (MSI/dMMR)
- Brain cancer:
    - New clinical criteria considered clarifications for what may have otherwise been reviewed using general (umbrella) criteria
- Breast cancer, metastatic:
    - Expanded criteria to include a wider scope of testing for metastatic disease: AKT1 and PTEN (related to capivasertib/fulvestrant therapy)
- Colorectal cancer, localized and metastatic:
    - Newly diagnosed localized or metastatic CRC — Expanded criteria for MSI/dMMR testing to allow in individuals with de novo metastatic disease
    - Metastatic CRC — Expanded POLE/POLD1 testing
- Endometrial carcinoma:
    - Expanded routine testing for MSI/dMMR; also expanded POLE and p53 testing
    - Panel size limited to ≤ 50 genes
- Non-small cell lung cancer, metastatic:
    - New criteria for metastatic squamous cell carcinoma
    - Allowance for repeat NGS testing in the setting of progressive disease, if a progressing lesion is being used for the repeat testing
- Ovarian (epithelial):
    - Added statement that HRD testing must include evaluation of genomic instability through an FDA approved test
- Pancreatic adenocarcinoma:
    - Added criteria for targeted (50 or fewer genes) somatic testing beyond MSI/dMMR in locally advanced, metastatic, or recurrent pancreatic adenocarcinoma
- Prostate cancer, metastatic:

    - Specified appropriateness of MSI/dMMR testing is in metastatic prostate cancer
    - Moved ATM from required to "may be included" genes in approvable NGS panels
- Thyroid cancer:
    - Testing of indeterminate thyroid nodules (ITN) — Afirma GSC added as a gene expression classifier that may be used
    - Somatic testing of thyroid malignancy — Modified language so that BRAF V600E, ALK, NTRK, and RET testing can be done in anaplastic thyroid cancer at any stage, or in unresectable, locally advanced, recurrent, or metastatic thyroid cancer

Somatic Testing of Hematologic Malignancies:

- Acute Lymphocytic Leukemia:
    - Added statement about NGS testing on bone marrow specimen which specifies time points where testing is appropriate (such as, end of initial induction, end of initial consolidation)
- Acute Myelogenous Leukemia:
    - Added an indication for focused testing using RT-qPCR to measure minimal residual disease (MRD)
- Chronic Myeloid Leukemia:
    - Modified the timing for BCR-ABL1 quantification for monitoring in the first year after completion of tyrosine kinase inhibitor (TKI) therapy
    - Added allowance for BCR-ABL1 quantification for monitoring patients at three-month intervals beyond one year after completion of TKI therapy
- Myeloproliferative Neoplasms:
    - Added allowance for additional focused testing for initial risk stratification if a specific myeloproliferative neoplasm is diagnosed on initial diagnostic workup
- Myelodysplastic Syndrome:

- Clarified that testing can be pursued for diagnosis or risk stratification and clarified the list of genes that may be associated with MDS

Musculoskeletal

Joint Surgery:

- Reverse Shoulder Arthroplasty:
  - Added a requirement for impaired function for six months for consistency with total shoulder arthroplasty
  - Removed requirement for conservative management when there is severe osteoarthritis for consistency with other joint replacements
- Shoulder Arthroscopy and Open Procedures:
  - Removal of loose body — Removed requirement for specific findings on exam
  - Rotator cuff repair and revision — Added an exclusion for subacromial balloon spacer due to lack of supporting evidence
  - Labrum Repair — Removed Bankart lesion broadening MRI findings to allow for any labral tear
  - Chronic shoulder instability or laxity — Broadened exam findings to include any evidence of instability rather than just the apprehension/relocation test
  - Tendinopathy of the long head of the biceps — Removed specific exam findings related to long head of biceps pathology
- Primary Total Hip Arthroplasty:
  - Removed the requirements for conservative management and three-month duration of symptoms when radiographs show severe osteoarthritis
- Primary Partial Hip Arthroplasty:
  - Combined criteria for partial hip arthroplasty and partial hip resurfacing
- Hip Arthroscopy:
  - Removal of loose body — Removed requirement for specific findings on exam

- Knee Arthroplasty:
    - Added exclusion for the use of an implantable shock absorber due to lack of supporting evidence
- Knee Arthroscopy:
    - ACL reconstruction — Removed standalone scenario of physically demanding occupation/pattern of activities
    - Excision of popliteal cyst — Added imaging requirement
    - Repair of subchondral bone defects (subchondroplasty) — Added exclusion for use of engineered calcium phosphate mineral or similar compounds due to lack of supporting evidence
- Osteochondral Grafts:
    - Juvenile Osteochondritis Dissecans — Expanded allowances to include either failed conservative management or unstable lesion
    - Added exclusion for use of particulated juvenile articular cartilage due to lack of evidence supporting its use

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

MULTI-BCBS-CR-061759-24-CPN61577

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Updates to Carelon Medical Benefits Management Clinical Appropriateness Guidelines

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adenocarcinoma

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  - Added allowance for BCR-ABL1 quantification for monitoring patients at three-month intervals beyond one year after completion of TKI therapy
- Myeloproliferative neoplasms:

    - Added allowance for additional focused testing for initial risk stratification if a specific myeloproliferative neoplasm is diagnosed on initial diagnostic workup
- Myelodysplastic syndrome (MDS):
    - Clarified that testing can be pursued for diagnosis or risk stratification and clarified the list of genes that may be associated with MDS

Musculoskeletal

Joint surgery:

- Reverse shoulder arthroplasty:
    - Added a requirement for impaired function for six months for consistency with total shoulder arthroplasty
    - Removed requirement for conservative management when there is severe osteoarthritis for consistency with other joint replacements
- Shoulder arthroscopy and open procedures:
    - Removal of loose body — removed requirement for specific findings on exam
    - Rotator cuff repair and revision — added an exclusion for subacromial balloon spacer due to lack of supporting evidence
    - Labrum repair — removed Bankart lesion broadening MRI findings to allow for any labral tear
    - Chronic shoulder instability or laxity — broadened exam findings to include any evidence of instability rather than just the apprehension/relocation test
    - Tendinopathy of the long head of the biceps — removed specific exam findings related to long head of biceps pathology
- Primary total hip arthroplasty:
    - Removed the requirements for conservative management and three-month duration of symptoms when radiographs show severe osteoarthritis
- Primary partial hip arthroplasty:

    - Combined criteria for partial hip arthroplasty and partial hip resurfacing
- Hip arthroscopy:
    - Removal of loose body — removed requirement for specific findings on exam
- Knee arthroplasty:
    - Added exclusion for the use of an implantable shock absorber due to lack of supporting evidence
- Knee arthroscopy:
    - Anterior cruciate ligament (ACL) reconstruction — removed standalone scenario of physically demanding occupation/pattern of activities
    - Excision of popliteal cyst — added imaging requirement
    - Repair of subchondral bone defects (subchondroplasty) — added exclusion for use of engineered calcium phosphate mineral or similar compounds due to lack of supporting evidence
- Osteochondral grafts:
    - Juvenile osteochondritis dissecans — expanded allowances to include either failed conservative management or unstable lesion
    - Added exclusion for use of particulated juvenile articular cartilage due to lack of evidence supporting its use

Small joint surgery:

- Hallux rigidus surgery:
    - First metatarsophalangeal joint arthrodesis — removed three-month requirement for conservative management (not needed with severe osteoarthritis)
    - First metatarsophalangeal joint arthroplasty — removed three-month requirement for conservative management; added allowance for failed prior hallux rigidus surgery
- Ankle arthritis:

- Ankle arthrodesis and total ankle arthroplasty — removed requirement for conservative management when there is severe osteoarthritis for consistency with other joint replacements
- Revision total ankle arthroplasty — added requirement for reconstruction after the management of periprosthetic infection to be consistent for staged reconstructions of infected total ankle

Surgical site of care:

- Criteria have been reformatted to align with general categories that are used across all Carelon Medical Benefits Management Site of Care Guidelines.
- Background, Scope, and Rationale sections have been updated and aligned with all Carelon Medical Benefits Management Site of Care Guidelines.
- Clinical comorbidities have been broadened to include any American Society of Anesthesiologists (ASA) Class III or greater condition with specific examples updated as below:
  - The following cardiac comorbidity examples were removed and replaced with "documented history of myocardial infarction or acute coronary syndrome":
    - "Acute coronary syndrome within the prior three months"
    - Currently taking dual antiplatelet therapy which cannot be temporarily discontinued safely for the proposed surgical procedure
    - Ongoing ischemic symptoms
  - The cerebrovascular example was changed from "Stroke or transient ischemic attack (TIA) within the prior three months" to "Documented history of stroke or transient ischemic attack (TIA)."
- The criteria "mental status change" was removed due to redundancy with existing criteria of "intellectual disability or cognitive impairment."
- Criteria added for "when performing a procedure outside the Hospital Outpatient Department (HOPD) would reasonably be expected to create clinically significant delays in care."

- Criteria added for “Absence of a geographically accessible alternative non-HOPD facility capable of performing the requested procedure.”

Advanced imaging site of care:

- Background, Scope, and Rationale sections have been updated and aligned with all Carelon Medical Benefits Management Site of Care Guidelines.
- Criteria was added for “Additional resources required to establish and/or maintain IV access in patients with previous difficulty.”

How to submit prior authorization requests, ask questions, or get more information

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

- Access the Carelon Medical Benefits Management provider portal directly at **providerportal.com**:
    - Online access is available seven days a week, 24 hours a day 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** on the Carelon Medical Benefits Management website.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/updates-to-carelon-medical-benefits-management-clinical-appr-20608

Or scan this QR code with your phone

MCG Care Guidelines 28th edition

Effective September 1, 2024, Anthem will upgrade to the 28th edition of MCG Care Guidelines. Along with this upgrade, there will be some changes as to how transcranial magnetic stimulation (TMS) will be approved.

A specific change will be noted for *Behavioral Health Care (BHG): Transcranial Magnetic Stimulation B-801-T*. An annotation for **motor threshold redetermination after initiation of treatment** has been added to the *Inconclusive or non-supportive evidence* section of the evidence summary with new references to support it.

Any requests for CPT® code 90869 will be referred for peer clinical review to determine medical necessity.

If you have questions, please contact Provider Services by calling the number on the back of the member's ID card.

MULTI-BCBS-CM-062483-24-SRS62339

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/mcg-care-guidelines-28th-edition-20910

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Medical Policies and *Clinical Guidelines* updates — August 2024

The following *Medical Policies* and *Clinical Guidelines* were reviewed for Anthem for the following states: Indiana, Kentucky, Missouri, Ohio, and Wisconsin.

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

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

Policy/guideline	Information	Effective date
CG-DME-45 *Ultrasound Bone Growth Stimulation*	Addresses the medical necessity of use of low-intensity pulsed ultrasound devices as a non-invasive treatment to promote healing of some fresh fractures and to accelerate healing for nonunion of other fracture sites.	10/1/24

Policy/guideline	Information	Effective date
	Transitioned to Carelon Medical Benefits Management, Inc. guidelines.	
CG-MED-65 *Manipulation Under Anesthesia*	Addresses the medical necessity of use of manipulation under anesthesia of the spine. Also addresses the use of manipulation under anesthesia of joints other than the knee and shoulder. Anesthesia types may include local, regional, intravenous (IV) monitored sedation, and general. **Transitioned to Carelon Medical Benefits Management guidelines.**	10/1/24
CG-MED-76 *Magnetic Source Imaging and Magnetoencephalography*	Addresses the medical necessity of magnetic source imaging (MSI) and magnetoencephalography (MEG). **Transitioned to Carelon Medical Benefits Management guidelines.**	10/1/24
CG-MED-78 *Anesthesia Services for Interventional Pain Management Procedures*	Addresses the medical necessity of anesthesia services, including monitored anesthesia care (MAC), for interventional pain management procedures. Interventional pain management procedures include, but are not limited to, diagnostic or therapeutic nerve blocks, diagnostic or therapeutic injections, and percutaneous image guided procedures. **Transitioned to Carelon Medical Benefits Management guidelines.**	10/1/24

Policy/guideline	Information	Effective date
CG-SURG-89 *Radiofrequency Neurolysis and Pulsed Radiofrequency Therapy for Trigeminal Neuralgia*	Addresses the use of radiofrequency (RF) neurolysis and pulsed radiofrequency (PRF) therapy for the treatment of trigeminal neuralgia. Updated MN criteria to remove criteria referencing other surgical options. **Transitioned to Carelon Medical Benefits Management guidelines.**	10/1/24

MULTI-BCBS-CM-061943-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/medical-policies-and-clinical-guidelines-updates-august-2024-20880

Or scan this QR code with your phone

Medical Policies and *Clinical Utilization Management Guidelines* update

Effective August 8, 2024

The *Medical Policies*, *Clinical Utilization Management (UM) Guidelines* and *Third-Party Criteria* below were developed and/or revised during Q1 2024. 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** and select **Change State** and pick appropriate state. Then Providers > Policies, Guidelines & Manuals.

Notes/Updates:

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

- LAB.00039 - Combined Pathogen Identification and Drug Resistance Testing; Previously Titled: Pooled Antibiotic Sensitivity Testing
  - Revised title
  - Revised Position Statement to address “combined pathogen identification and drug resistance” testing
- OR-PR.00008 - Osseointegrated Limb Prostheses

    - Outlines the Medically Necessary and Not Medically Necessary criteria for the use of osseointegrated (bone-anchored) prosthetic devices for improving the mobility and function of people who have had limb loss
- SURG.00052 - Percutaneous Vertebral Disc and Vertebral Endplate Procedures
    - Revised Medically Necessary criteria for basivertebral nerve ablation (BVNA)
- 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 Investigational & Not Medically Necessary
- CG-DME-53 - Biomechanical Footwear Therapy
    - Biomechanical footwear therapy is considered Not Medically Necessary for all indications
- CG-LAB-32 - Cancer Antigen 125 Testing
    - Outlines the Medically Necessary and Not Medically Necessary criteria for the tumor marker cancer antigen 125 (CA-125) testing
- CG-MED-94 - Vestibular Function Testing
    - Revised Medically Necessary and Not Medically Necessary statements to include vestibular-evoked myogenic potential tests
- CG-MED-96 - Prefabricated External Infant Ear Molding Systems
    - Outlines the Medically Necessary, Reconstructive and Cosmetic & Not Medically Necessary criteria for the use of prefabricated external infant ear molding systems to treat external ear malformations and deformations

Medical Policies

On March 28, 2024, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Anthem. These medical policies take effect August 8, 2024.

Publish Date	*Medical Policy* Number	*Medical Policy* Title	New or Revised
4/10/2024	*LAB.00039	Combined Pathogen Identification and Drug Resistance Testing Previously Titled: Pooled Antibiotic Sensitivity Testing	Revised
2/22/2024	MED.00140	Gene Therapy for Beta Thalassemia	Revised
4/10/2024	*OR-PR.00008	Osseointegrated Limb Prostheses	New
4/1/2024	SURG.00011	Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
4/10/2024	*SURG.00052	Percutaneous Vertebral Disc and Vertebral Endplate Procedures	Revised
4/10/2024	SURG.00145	Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)	Revised
4/10/2024	*SURG.00162	Implantable Shock Absorber for Treatment of Knee Osteoarthritis	New

Publish Date	*Medical Policy* Number	*Medical Policy* Title	New or Revised
4/10/2024	TRANS.00028	Hematopoietic Stem Cell Transplantation for Hodgkin Disease and non-Hodgkin Lymphoma	Revised

Clinical UM Guidelines

On March 28, 2024, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. These guidelines were adopted by the medical operations committee for Medicare members on March 28, 2024. These guidelines take effect August 8, 2024.

Publish Date	*Clinical UM Guideline* Number	*Clinical UM Guideline* Title	New or Revised
4/10/2024	CG-DME-50	Automated Insulin Delivery Systems	Revised
4/10/2024	*CG-DME-53	Biomechanical Footwear Therapy	New
4/10/2024	*CG-LAB-32	Cancer Antigen 125 Testing	New
4/10/2024	CG-MED-68	Therapeutic Apheresis	Revised
4/10/2024	*CG-MED-94	Vestibular Function Testing	Revised

4/10/2024	*CG-MED-96	Prefabricated External Infant Ear Molding Systems	New
4/10/2024	CG-SURG-118	Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)	Conversion New
4/10/2024	CG-SURG-119	Treatment of Varicose Veins (Lower Extremities)	Conversion New
4/10/2024	CG-SURG-120	Vagus Nerve Stimulation	Conversion New
4/10/2024	CG-SURG-121	Fetal Surgery for Prenatally Diagnosed Malformations	Conversion New
4/1/2024	CG-SURG-78	Locoregional Techniques for Treating Primary and Metastatic Liver Malignancies	Revised

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/medical-policies-and-clinical-utilization-management-guideli-20759

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Prior Authorization | Commercial | Aug 1, 2024

Notification of authorization fax number changes

Anthem is in the process of shutting down specific authorization fax channels. This is to notify you the below fax numbers will be decommissioned as of August 30, 2024.

Look for additional notifications as other authorization fax lines are retired.

Availity Authorizations is the preferred method for authorization intakes. If you cannot use Availity Authorizations, call our contact center at **833-545-9102**, and we will work with you to determine the best submission method.

Available resources

Registering and accessing Availity is easy. If your organization is not registered for Availity, start here.

If you are not already familiar with Availity Authorization, training is available. Register for training today and learn about the simple workflow for submitting digital authorizations.

These fax numbers will be turned off as of August 30, 2024.

800-722-7427	**866-447-1341**	**877-332-8239**	**877-539-3856**	**888-620-0306**
804-678-7943	**866-487-3757**	**877-381-8696**	**877-539-3860**	**888-656-5721**
866-444-8162	**866-487-7453**	**877-381-8698**	**877-539-9588**	**866-447-1273**
866-445-6507	**866-553-8823**	**877-476-9175**	**877-539-9589**	**866-993-5966**
866-445-7207	**866-787-8503**	**877-476-9176**	**877-549-3987**	**877-539-3855**
866-446-0030	**866-959-1394**	**877-539-3851**	**877-825-8419**	**888-438-7081**

MULTI-BCBS-CM-063748-24-CPN63063

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/notification-of-authorization-fax-number-changes-21163

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Reimbursement Policies | Commercial | Aug 1, 2024

New reimbursement policy: Intraoperative Neuromonitoring — Professional

Beginning with dates of service on or after November 1, 2024, Anthem will implement a new reimbursement policy titled *Intraoperative Neuromonitoring — Professional* based on guidelines from the American Academy of Neurology. This reimbursement policy will allow reimbursement for intraoperative neuromonitoring (IONM) when billed by a professional provider with a place of service 19, 21, 22, or 24.

When reporting IONM, providers are required to bill on a *CMS-1500* form and use the appropriate place of service. Services must be performed in a hospital setting using the place of service where the member is located even if the monitoring physician is in an office. The following place of service codes are appropriate for use by the monitoring physician:

- Off campus-outpatient hospital (19)
- Inpatient hospital (21)
- On campus-outpatient hospital (22)
- Ambulatory surgical center (24)

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

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/new-reimbursement-policy-intraoperative-neuromonitoring-prof-21192

Or scan this QR code with your phone

Reimbursement Policies | Commercial | Aug 1, 2024

Reimbursement policy update: Bundled Services and Supplies — Facility

Beginning with dates of service on or after November 1, 2024, Anthem will update the *Bundled Services and Supplies — Facility* reimbursement policy as follows:

- Addition of categories of services considered integral to the primary service, or included in the facility fee that are not allowed for separate reimbursement when billed by a facility provider
- Addition of the following code to the Related Coding section:
    - G2211 — visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition

For specific policy details, visit the reimbursement policy page and select the appropriate state.

MULTI-BCBS-CM-062760-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-bundled-services-and-supplies-fa-21154

Or scan this QR code with your phone

Reimbursement Policies | Commercial | Aug 1, 2024

Reimbursement policy update: Professional Anesthesia Service

Beginning with dates of service on or after November 1, 2024, Anthem will update the *Anesthesia Modifiers* list in the *Related Coding* section of the *Professional Anesthesia Service* reimbursement policy as follows:

- Updated modifier QZ reimbursement from 100% to 85%.
- Added modifiers QK, QX, or QY language (removed from the policy body section).
- Removed diagnosis codes not eligible for reimbursement when reported with add-on code 99140 code list.
- Added the following statement to the *Comments* column for modifiers G8, G9, and QS column:
    - May be reported in a subsequent modifier field when the service rendered is monitored anesthesia care (MAC).
- Updated physical status modifiers P3, P4, and P5 language to indicate reimbursement for the applicable additional time unit.

Section V., Qualifying Circumstances for Anesthesia will be updated to indicate that Anthem will consider qualifying circumstances to be always bundled when reported in addition to the anesthesia procedure or service provided.

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

MULTI-BCBS-CM-063134-24-SRS62776

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-professional-anesthesia-service-21151

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Reimbursement policy update: Modifier 78

(Policy G-06016, effective 07/01/2024)

Past system limitations prevented us from reimbursing Modifier 78 in complete alignment with Centers for Medicare & Medicaid Services (CMS). New system updates will now allow Anthem to closer align with the CMS Medicare Physician Fee Schedule Data Base (MPFSDB).

For claims processed on and after 07/01/2024, you may see a slight adjustment in reimbursement which will reflect this configuration update.

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

MULTI-BCBS-CR-048996-23-CPN45239

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-provider-newsletter-article-20961

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Reimbursement Policies | Commercial | Aug 1, 2024

Reimbursement policy update: Modifiers 26 and TC — Professional

Anthem updated the *Modifiers 26 and TC — Professional* reimbursement policy in October 2023. The statement below was inadvertently removed from the *Nonreimbursable* section of the policy, but remained in the policy *Definition* section:

- *There is a separate standalone code that describes the professional component only, technical component only, or global test only of a selected diagnostic test.*

No claims were impacted by the omission of this statement. The *Nonreimbursable* section of the policy has been updated to include this statement.

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

MULTI-BCBS-CM-061251-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-modifiers-26-and-tc-professional-20919

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Reimbursement Policies | Commercial | Aug 1, 2024

Reimbursement policy update: Outpatient Facility Revenue Code Billing Requirements — Facility

Beginning with dates of service on or after November 1, 2024, Anthem will update the related coding section of the *Outpatient Facility Revenue Code Billing Requirements — Facility reimbursement policy.* The policy requires HCPCS or CPT® codes to be submitted for reimbursement when submitted with certain revenue codes. The policy is updated to include the following revenue codes that require a corresponding HCPCS or CPT code:

- 0270 Medical/Surgical Supplies and Devices — General
- 0271 Medical/Surgical Supplies and Devices — Nonsterile
- 0272 Medical/Surgical Supplies and Devices — Sterile
- 0273 Medical/Surgical Supplies and Devices — Take-home supplies
- 0274 Medical/Surgical Supplies and Devices — Prosthetic/orthotic devices
- 0275 Medical/Surgical Supplies and Devices — Pacemaker
- 0276 Medical/Surgical Supplies and Devices — Intraocular lens
- 0277 Medical/Surgical Supplies and Devices — Take-home oxygen
- 0279 Medical/Surgical Supplies and Devices — Other supplies/devices
- 0280 Oncology — General
- 0920 Other diagnostic services — General
- 0940 Other therapeutic services — General

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

MULTI-BCBS-CM-062881-24-SRS62741

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-outpatient-facility-revenue-code-20825

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Reimbursement policy update: Nurse Practitioner and Physician Assistant Services

(Policy G-20002, effective 11/01/2024)

Beginning with dates of service on or after 11/01/2024, Anthem will update the *Nurse Practitioner and Physician Assistant Services* reimbursement policy as indicated below.

The following services will be removed as physicians' services:

- Preventive Services
- Radiology Services

The following services will be included as physicians' services:

- Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS)
- Laboratory Services and Screening Services

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

MULTI-BCBS-CR-050463-24-CPN49984

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/policy-update-nurse-practitioner-and-physician-assistant-ser-20682

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Specialty pharmacy updates — February 2024

Note: This article corrects the *Clinical Criteria* for Spravato (esketamine), which was incorrectly listed in a February 2024 article.

Specialty pharmacy updates for Anthem are listed below

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

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

Inclusion of National Drug Code (NDC) code on your claim will help expedite claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

Prior authorization updates

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

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

Access our *Clinical Criteria* to view the complete information for these prior authorization updates.

Clinical Criteria	Drug	HCPCS or CPT® code(s)
CC-0252	Adzynma (ADAMTS13, recombinant-krhn)	C9399
CC-0253*	Aphexda (motixafortide)	J3490, J3590, J9999
CC-0042	Bimzelx (bimekizumab-bkzx)	J3490
CC-0032	Daxxify (daxibotulinumtoxinA-lanm)	C9160
CC-0050	Omvoh (mirikizumab-mrkz)	J3590
CC-0066*	Tofidence (tocilizumab-bavi)	J3490, J3590
CC-0254	Zilbysq (zilucoplan)	J3490
CC-0062	Zymfentra (infliximab-dyyb)	J3590

* Oncology use is managed by Carelon Medical Benefits Management.

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

Quantity limit updates

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

Access our *Clinical Criteria* to view the complete information for these quantity limit updates.

Clinical Criteria	Drug	HCPCS or CPT code(s)
CC-0042	Bimzelx (bimekizumab-bkzx)	J3490
CC-0032	Daxxify (daxibotulinumtoxinA-lanm)	C9160
CC-0050	Omvoh (mirikizumab-mrkz)	J3590
CC-0086	Spravato (esketamine)	G2082, G2083, S0013
CC-0066	Tofidence (tocilizumab-bavi)	J3490, J3590
CC-0254	Zilbysq (zilucoplan)	J3490
CC-0062	Zymfentra (infliximab-dyyb)	J3590

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

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

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

MULTI-BCBS-CM-061803-24-CPN61620

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-february-2024-21150

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Pharmacy | Commercial | Aug 1, 2024

Specialty pharmacy updates — August 2024

Specialty pharmacy updates for Anthem are listed below.

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

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

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

Prior authorization updates

Effective for dates of service on or after November 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 or CPT® code(s)
CC-0262*	Tevimbra (tislelizumab-jsgr)	J3590, J9999

CC-0066*	Tyenne (tocilizumab-aazg)	C9399, J3590
CC-0063	Wezlana (ustekinumab-auub)	Q5137, Q5138]

* 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 or after November 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 or CPT code(s)
CC-0066	Tyenne (tocilizumab-aazg)	C9399, J3590
CC-0063	Wezlana (ustekinumab-auub)	Q5137, Q5138

MULTI-BCBS-CM-063401-24-CPN63195

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-august-2024-21213

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