September 2024 Provider Newsletter

Contents

Federal Employee Program (FEP) | Commercial | Jul 31, 2024

FEP Quality Reimbursement Program for providers

Long-Term Services and Supports | Commercial | Sep 1, 2024

The Power of the Blues: Introducing the Blue National Physician Performance Dataset

Pharmacy | Commercial | Aug 26, 2024

Specialty pharmacy updates — September 2024

Pharmacy | Commercial | Sep 1, 2024

Pharmacy information available on our provider website

Pharmacy | Medicare Advantage | Sep 1, 2024

Real-time prescription benefit

Pharmacy | Medicare Advantage | Aug 12, 2024

Anthem expands specialty pharmacy precertification list

Pharmacy | Medicare Advantage | Aug 27, 2024

Anthem expands specialty pharmacy precertification list

Quality Management | Commercial / Medicare Advantage | Aug 13, 2024

Announcing the new HEDIS documentation library supporting coding excellence

---

MOBCBS-CRCM-065291-24

To view this publication online:

Visit https://providernews.anthem.com/missouri/publications/september-2024-provider-newsletter-3348

Or scan this QR code with your phone

Administrative | Commercial / Medicare Advantage | Aug 1, 2023

Clinical Laboratory Improvement Amendments

Claims that are submitted for laboratory services subject to the *Clinical Laboratory Improvement Amendments* of *1988 (CLIA)* statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid *CLIA* certificate identification number must be reported on a *1500 Health Insurance Claim Form* (*CMS-1500*) or its electronic equivalent for clinical laboratory services. The *CLIA* certificate identification number must be submitted in one of the following manners:

Claim format and elements	***CLIA* number location options**	**Referring provider name and NPI number location options**	**Servicing laboratory physical location**
***CMS-1500* (formerly *HCFA-1500*)**	Must be represented in field 23	Submit the referring provider name and NPI number in fields 17 and 17b, respectively.	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not equal to the billing provider address. The servicing provider address must match the address associated with the *CLIA* ID entered in field 23.

HIPAA 5010 837 Professional	Must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	Physical address of servicing provider must be represented in the 2310C loop if not equal to the billing provider address and must match the address associated with the *CLIA* ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine non-referred or self-performed and referred services on the same *CMS-1500* claim form. Thus, when the referring laboratory bills for both non-referred and referred tests, it must submit two separate paper claims: one claim for non-referred tests and the other for referred tests. If submitted electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with qualifier of F4 in REF01.

Providers who have obtained a *CLIA Waiver* or *Provider Performed Microscopy Procedure* accreditation must include the QW modifier when any *CLIA* waived laboratory service is reported on a *CMS-1500* claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of *CLIA* accreditation for the particular test performed. Thus, any claim that does not contain the *CLIA* ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, does not have complete servicing provider demographic information and/or applicable reference laboratory provider demographic information, will be considered incomplete and rejected or denied.

If you have questions, please contact your Provider Relationship Management representative.

MULTI-BCBS-CRCM-029658-23-CPN29126, MULTI-BCBS-CRCM-066936-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/clinical-laboratory-improvement-amendments-6-14527

Or scan this QR code with your phone

Administrative | Medicare Advantage | Sep 1, 2024

Drug and biologic

Effective December 1, 2024, Anthem is enhancing its claim edits system to ensure claims billed with pharmaceutical drug procedure codes are reported with the appropriate 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 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 need to submit only 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-CR-063032-24-CPN62565

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/drug-and-biologic-21538

Or scan this QR code with your phone

Digital Solutions | Commercial / Medicare Advantage | Aug 28, 2024

Maximizing care with regular provider data attestation

At a glance:

- **Last month, we published information about the *Consolidated Appropriations Act (CAA)* data attestation process for Commercial providers here. This article provides additional information for Commercial and Medicare Advantage providers about updating your provider data with us.**
- **Care providers contracted with us must verify or update their demographic data every 90 days using the Provider Data Management (PDM) capability on Availity Essentials for efficient claims processing and timely reimbursement.**
- **Updating and attesting data are critical for maintaining accurate service directories for members. Non-compliance with these requirements may result in removal from the online provider directory.**
- **Availity Essentials not only allows for data attestation but also provides digital applications that enable users to monitor submitted demographic updates in real time, review the history of previously verified data, and manage multiple updates within one spreadsheet via the Upload Roster feature.**

What are the requirements for the attestation of demographic data?

We require our contracted care provider partners to attest to their demographic data every 90 days. Maintaining your provider data is critical as it results in improved connection to members seeking care, supports the accuracy of claims processing, and allows for timely reimbursement, while aligning to a bold purpose of improving the health of humanity.

How do I update and attest to my data?

We require the use of the PDM capability available on Availity Essentials to update your provider or facility data. There are two options within Availity Essentials PDM that are available at no cost to care providers:

- **Multi-payer platform, which includes Directory Verification and Core PDM:** allows care providers to make required updates using Directory Verification and changes using Core PDM
- **Roster upload:** allows care providers to submit multiple updates within one spreadsheet via the **Upload Roster** feature (*the Upload Roster feature is currently only available and shared with the health plan*)

Both the **Multi-payer Platform** and **Roster Upload** feature satisfy your 90-day attestation requirement.

To attest to your provider data:

1. Log in to Availity Essentials.
2. Navigate to **My Providers > Provider Data Management**.
3. Select the action menu next to the business whose information you want to verify.
4. Select **Verify Directory Listing**.
5. Review each set of data for accuracy.
6. Once complete, select **Submit Verified Profile**.

Organizations with no changes since their last submission may see a **Quick Verify** button that allows for directory verification in one click.

Individuals registered for their TIN within the Availity Manage My Organization application on Availity Essentials will receive periodic automated emails and notifications in the Notification Center on Availity reminding them when their attestation is due or overdue.

How do I access Availity Essentials and the PDM application?

To access 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.

Within PDM you also have the ability to:

- Monitor submitted demographic updates in real time with a digital dashboard.
- Review the history of previously verified data.

Why is updating and attesting to my data important?

Our members use **Find Care** to make informed decisions about their healthcare and find quality doctors and hospitals. Keeping your data up to date ensures members have access to you when they need it the most.

Failure to complete the 90-day attestation requirement puts your organization at risk of being non-compliant with the health plan's policies and procedures and may result in removal from the online provider directory.

What if I'm not registered for Availity yet?

If you aren't registered to use Availity Essentials, signing up is easy and secure. There is no cost to register or to use any of the 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 TIN, make sure to register all TINs associated with your account.

If you have questions regarding registration, reach out to Availity Client Services at **800-AVAILITY (282-4548)**.

How do I get training on the Availity PDM tool?

You can learn about the Availity PDC tool by attending one of our training opportunities **here**:

- For more information on Availity PDM, check out the *Quick Start Guide* **here** using your Availity Essentials user ID and password.
- For more information about the Roster Upload process:

- See the *Roster Submission Guide* on **Availity.com** > Payer Spaces > Select Payer Tile > Resources > *Roster Submission Guide* using PDM.
- Find training specifically for the *Standard Template* and *Rules of Engagement* by listening to our recorded webinar **here**.
- Take an on-demand class hosted by Availity to learn about Provider Data Management **here**.

What if I'm a behavioral health care provider?

If you are a behavioral health care provider and assigned to Carelon Behavioral Health, Inc., follow the Carelon Behavioral Health process for attestation. Council for Affordable Quality Healthcare (CAQH) care providers should attest, confirm, or update their data through the CAQH Provider Data Portal. Non-CAQH care providers and facilities should attest, confirm, or update their data directly through the Carelon Behavioral Health Provider Portal.

Contact us

Availity 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 Spaces tile from the drop-down. Then, select **Chat with Payer** and complete the pre-chat form to start your chat.

We are committed to finding solutions that help our care provider partners offer quality services to our members. For additional support, visit the *Contact Us* section of our provider website for the appropriate contact.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/maximizing-care-with-regular-provider-data-attestation-21681

Or scan this QR code with your phone

Digital Solutions | Commercial / Medicare Advantage | Aug 28, 2024

Advancing digital efficiency by discontinuing paper remittances

To advance our operations towards a more digitally efficient model, when a care provider registers for electronic remittance advice (ERA/835), we will cease issuing paper remittances 30 days after the effective registration date. Care providers will receive their remittance electronically through ERA with the option to print copies via Availity Essentials as needed in the Remit Inquiry application located in Payer Spaces.

Some care providers, despite successful registration, continue to receive remittances in both electronic and paper formats. We are actively addressing this redundancy by discontinuing the issuance of printed remittances. As a result, care providers who have enrolled for ERA/835 but are still receiving paper remittances will begin noticing a decrease in these paper transactions starting in late August.

If you have yet to register for ERA and wish to switch to electronic remittance reception, we recommend that you configure your ERA settings through Availity Essentials or by working with your existing clearinghouse vendor. In the interest of facilitating electronic transactions, care providers interested in receiving electronic payments are encouraged to visit the **EnrollSafe Enrollment Hub (payeehub.org)**.

This transition is part of our ongoing commitment to streamlining our procedures, enhancing customer experience, and promoting environmental sustainability.

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/advancing-digital-efficiency-by-discontinuing-paper-remittan-21666

Or scan this QR code with your phone

Digital Solutions | Commercial / Medicare Advantage | Sep 1, 2024

Save time and get better results with optimized CPT code search in Availity Essentials

Improvements in search capabilities in Availity Essentials now result in faster and more accurate results.

To help save you more time upfront while receiving more detailed eligibility & benefits information, we've expanded the Current Procedural Terminology® (CPT) code search capabilities in Availity Essentials' Eligibility and Benefit tool.

These optimizations enable the use of up to eight specific CPT or Healthcare Common Procedure Coding System (HCPCS) codes per transaction for faster, more accurate, and personalized search results, which include:

- Authorization requirement notifications — so you know up-front if an authorization is needed.
- Additional plan-level benefit limitations details.
- Cost-share information displayed by places of service and procedure codes.

Making these details available on the search results pages can help you save time and effort by giving you access to the right information you need when you need it. Additionally, it reduces the need to contact us, resulting in fewer calls and chats over time.

Watch the recorded training to see how you can start saving time today. Learning sessions show step-by-step how you can use the CPT code search capabilities in Availity Essentials to help increase your productivity. We're dedicated to supporting your success through digital solutions that help reduce your administrative burden and streamline your interactions with us.

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

MULTI-BCBS-CRCM-062285-24-CPN60904

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/save-time-and-get-better-results-with-optimized-cpt-code-sea-21257

Or scan this QR code with your phone

Digital Solutions | Medicare Advantage | Aug 8, 2024

Digital-only authorization case status notification coming to you

In our previous communications to you, we talked to you about using the Authorizations and Referrals application on Availity Essentials to get digital notification about your authorization cases and we mentioned the Preference Center where you can select your preferred method of communication for authorization cases. We are excited to share that we will launch the solution in mid-May.

Here we would like to give you a quick recap on how to get the digital notification for your authorization case status and related decision letters along with how to set your preference for mode of communication regarding authorization cases.

Navigating Availity Essentials for auth case status and digital auth decision letters:

1. Through Auth/Referral Inquiry, you can retrieve cases submitted by your organization via both digital and non-digital methods. You can also use the Pin to Dashboard feature to keep these cases on the Auth/Referral Dashboard, saving you from repeating the search in the future.
2. You can get the most recent status of cases submitted by your organization on Auth/Referral Dashboard and get the case details including decision letters via View Details in the Actions menu. For pinned cases, select the case card to get the latest status and case details.

Access the Preference Center and set your preferences

The Preference Center is located within Payer Spaces on Availity Essentials. Select the **payer tile** that corresponds to your market after selecting **Payer Spaces** from the top menu bar. Once in Payer Spaces, select the **Preference Center** application tile. Then you can select your organization and then set preference option for Authorization and Referrals. Adjust the

preference to fit your business needs (between Digital Access (Default) and Digital + Mail) for tax IDs and NPIs of your organization. Additionally, 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 in the Custom Learning Center, available in Payer Spaces on Availity Essentials.

After logging in to Availity Essentials, select **Payer Spaces** from the top menu bar, then select the **payer tile** that corresponds to your market. 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.

Through our shared health vision, we can affect real change.

MULTI-BCBS-CR-062610-24-CPN62607

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/digital-only-authorization-case-status-notification-coming-t-21335

Or scan this QR code with your phone

Education and Training | Commercial | Sep 1, 2024

New provider resource for family caregivers of members with cancer

Fifty-three million, or more than one in five Americans, are family caregivers. *Caregiving in the U.S. 2020* reports that caregivers face health challenges of their own, with nearly a quarter of caregivers finding it hard to take care of their own health and saying that caregiving has made their own health worse.

Now, we have made it easy for providers to help their patients who are family caregivers reduce their stress and improve their health. Help for Cancer Caregivers' new healthcare provider landing page has an easy-to-download flyer that can be given to patients to encourage them to visit Help for Cancer Caregivers. **This evidence-based, interactive website** allows family caregivers to take a brief survey to create a personal self-care guide, access social services, and browse topics like dealing with feelings, keeping health, day-to-day needs, working together, and long-distance caregiving.

Studies show that family caregivers suffer from poorer physical health than those who do not have additional caregiving responsibilities. Studies have found that:

- Caregivers show higher levels of depression.
- Caregivers suffer from high levels of stress and frustration, which can lead to burnout.
- Stressful caregiving situations may lead to harmful behaviors, such as abusing drugs or alcohol.
- Caregivers have an increased risk of heart disease.
- Caregivers have lower levels of self-care.
- Chronic diseases of caregivers are often more difficult to manage.
- Caregivers have an increased risk of sickness and premature death.

Evidence has also shown that education and intervention reduce caregiver strain, uncertainty, and helplessness and that information helps normalize the caregiver experience and enhances

a sense of control.

Access the healthcare provider landing page today. This website includes language and accessibility tools to support non-English speakers and people with accessibility needs.

MULTI-BCBS-CM-064165-24-CPN64037

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/new-provider-resource-for-family-caregivers-of-members-with-21304

Or scan this QR code with your phone

Medical Policies and *Clinical UM Guidelines* updates — September 2024

The following *Medical Policies and Clinical UM 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), please visit fepblue.org > Policies & Guidelines.

Below are the new medical policies and/or clinical guidelines that have been approved.

* Denotes prior authorization required

Policy/guideline	Information	Effective date
***MED.00148** Gene Therapy for Metachromatic Leukodystrophy	• Outlines the MN and NMN criteria for gene therapy for metachromatic leukodystrophy • New technology No specific code for Lenmeldy, listed NOC codes C9399, J3490, J3590	12/1/2024

Policy/guideline	Information	Effective date
***RAD.00069** Absolute Quantitation of Myocardial Blood Flow Measurement	• The use of absolute quantitation of myocardial blood flow testing is considered INV&NMN for all indications • Existing CPT® codes 0742T and 78434 and new CPT codes 0899T, 0900T effective 07/01/2024 will be considered INV&NMN	12/1/2024
***SURG.00011** Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting	• Revised ocular indications, including the addition of SurSight to MN and NMN section and added new MN criterion addressing non-healing or persistent corneal epithelial defects • Removed VersaWrap from INV&NMN statement • Removed Phasix Mesh from INV&NMN statement • Added Phasix Mesh and Phasix ST Mesh to MN and NMN statements • Revised coding section for ocular indications to considered MN when criteria are met; no specific code for Phasix, included in listed NOC codes; added new HCPCS codes Q4311-Q4333 effective 07/01/2024 considered INV&NMN and removed deleted codes Q4210, Q4277	12/1/2024

Below are the current clinical guidelines and/or medical policies we reviewed, and updates were approved.

* Denotes prior authorization required

Policy/guideline	Information	Effective date
***LAB.00019** Proprietary Algorithms for Liver Fibrosis	Added new CPT PLA code 0468U effective 07/01/2024 for the NASHnext test, considered INV&NMN	7/1/2024
***LAB.00042** Molecular Signature Test for Predicting Response to Tumor Necrosis Factor Inhibitor Therapy	Added new CPT PLA code 0456U effective 07/01/2024 for PrismRA test considered INV&NMN, replacing NOC codes	7/1/2024
***LAB.00046** Testing for Biochemical Markers for Alzheimer's Disease	Added new CPT PLA code 0459U effective 07/01/2024 for Elecsys® Total Tau CSF (tTau) and β-Amyloid (1-42) CSF II (Abeta 42) Ratio, considered INV&NMN	7/1/2024
***MED.00013** Parenteral Antibiotics for the Treatment of Lyme Disease	• Revised MN criteria related to heart blocks • Revised formatting in Clinical Indications section Added existing HCPCS codes J0688, J0689, J0744, J2184, J2281 and new codes J0687, J2183 effective 07/01/2024, for brand non-equivalent products considered INV&NMN for Lyme disease	7/1/2024
***MED.00140** Gene Therapy for Beta Thalassemia	Added HCPCS code J3393 effective 07/01/2024 for Zynteglo (replacing NOC codes for Zynteglo)	7/1/2024

Policy/guideline	Information	Effective date
***MED.00146** Gene Therapy for Sickle Cell Disease	Added HCPCS code J3394 effective 07/01/2024 for Lyfgenia (replacing NOC codes for Lyfgenia)	7/1/2024
***SURG.00052** Percutaneous Vertebral Disc Procedures Previously titled: Percutaneous Vertebral Disc and Vertebral Endplate Procedures	• Revised Title • Removed MN and NMN criteria for intraosseous basivertebral nerve ablation (BVNA) from Position Statement (other criteria available) Criteria for intraosseous basivertebral nerve ablation (BVNA) have been transitioned to Carelon Medical Benefits Management Musculoskeletal guidelines Removed CPT codes 64628, 64629 and associated ICD-10-PCS codes	9/1/2024
***TRANS.00039** Portable Normothermic Organ Perfusion Systems	Added new CPT Category III codes 0894T, 0895T, 0896T effective 07/01/2024 for liver perfusion systems MN when criteria are met, replacing NOC code	7/1/2024

MULTI-BCBS-CM-064737-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/medical-policies-and-clinical-um-guidelines-updates-septembe-21406

Or scan this QR code with your phone

Prior authorization requirement changes

Effective December 1, 2024

Effective December 1, 2024, prior authorization (PA) requirements will change for the following code(s). The medical code(s) listed below will require PA by Anthem for Medicare Advantage members. Federal and state law, as well as state contract language and Centers for Medicare & Medicaid Services guidelines, including definitions and specific contract provisions/exclusions take precedence over these precertification rules and must be considered first when determining coverage. **Non-compliance with new requirements may result in denied claims.**

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

Code	Description
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 Guardant360 Response™, Guardant Health, Inc, Guardant Health, Inc
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 Genomind® Pharmacogenetics Report – Full, Genomind®, Inc, Genomind®, Inc
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 Epic Sciences ctDNA Metastatic Breast Cancer Panel, Epic Sciences, Inc, Epic Sciences, Inc
0430U	Gastroenterology, malabsorption evaluation of alpha-1-antitrypsin, calprotectin, pancreatic elastase and reducing substances, feces, quantitative Malabsorption Evaluation Panel, Mayo Clinic/Mayo Clinic Laboratories, Mayo Clinic/Mayo Clinic Laboratories
0435U	Oncology, chemotherapeutic drug cytotoxicity assay of cancer stem cells (CSCs), from cultured CSCs and primary tumor cells, categorical drug response reported based on cytotoxicity percentage observed, minimum of 14 drugs or drug combinations ChemoID®, ChemoID® Lab, Cordgenics, LLC
0790T	Revision (eg, augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed
0810T	Subretinal injection of a pharmacologic agent, including vitrectomy and 1 or more retinotomies
0815T	Ultrasound-based radiofrequency echographic multi-spectrometry (REMS), bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine
0823T	Transcatheter insertion of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial

	angiography
0824T	Transcatheter removal of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography), when performed
0825T	Transcatheter removal and replacement of permanent single-chamber leadless pacemaker, right atrial, including imaging guidance (eg, fluoroscopy, venous ultrasound, right atrial angiography and/or right ventriculography, femoral venography, cavography) and device evaluation (eg, interrogation or programming), when performed
0826T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional, leadless pacemaker system in single-cardiac chamber
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only
0864T	Low-intensity extracorporeal shock wave therapy involving corpus cavernosum,

	low energy
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments
22838	Revision (eg, augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed
31242	Nasal/sinus endoscopy, surgical; with destruction by radiofrequency ablation, posterior nasal nerve
31243	Nasal/sinus endoscopy, surgical; with destruction by cryoablation, posterior nasal nerve
33276	Insertion of phrenic nerve stimulator system (pulse generator and stimulating lead[s]), including vessel catheterization, all imaging guidance, and pulse generator initial analysis with diagnostic mode activation, when performed
33279	Removal of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s) only
33281	Repositioning of phrenic nerve stimulator transvenous lead(s)

33287	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; pulse generator
33288	Removal and replacement of phrenic nerve stimulator, including vessel catheterization, all imaging guidance, and interrogation and programming, when performed; transvenous stimulation or sensing lead(s)
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms) [when specified as genicular artery embolization]
81517	Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years Enhanced Liver Fibrosis™ (ELF™) Test, Siemens Healthcare Diagnostics Inc/Siemens Healthcare Laboratory LLC
93150	Therapy activation of implanted phrenic nerve stimulator system, including all interrogation and programming
93151	Interrogation and programming (minimum one parameter) of implanted phrenic nerve stimulator system
93152	Interrogation and programming of implanted phrenic nerve stimulator system during polysomnography

93153	Interrogation without programming of implanted phrenic nerve stimulator system
E0746	Electromyograph Biofeedback
L5615	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control
Q4279	Vendaje ac, per square centimeter
Q4287	Dermabind dl, per square centimeter
Q4288	Dermabind ch, per square centimeter
Q4289	Revoshield + amniotic barrier, per square centimeter
Q4290	Membrane Wrap-Hydro TM, per sq cm
Q4291	Lamellas xt, per square centimeter
Q4292	Lamellas, per square centimeter
Q4293	Acesso dl, per square centimeter

Q4294	Amnio quad-core, per square centimeter
Q4295	Amnio tri-core amniotic, per square centimeter
Q4296	Rebound matrix, per square centimeter
Q4297	Emerge matrix, per square centimeter
Q4298	Amnicore pro, per square centimeter
Q4299	Amnicore pro+, per square centimeter
Q4300	Acesso tl, per square centimeter
Q4301	Activate matrix, per square centimeter
Q4302	Complete aca, per square centimeter
Q4303	Complete aa, per square centimeter
Q4304	Grafix plus, per square centimeter

Not all PA requirements are listed here. Detailed PA requirements are available to providers on **anthem.com/medicareprovider**. Choose the **Select a State** ribbon and then find on the

Resources tab. Contracted providers can also access Availity.com.

UM AROW A2024M1469

MULTI-BCBS-CR-057223-24-CPN56904

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/prior-authorization-requirement-21235

Or scan this QR code with your phone

FEP Quality Reimbursement Program for providers

The Federal Employee Program® (FEP) offers a quality reimbursement program for providers. Coding for CPT® II category codes for A1c results, blood pressure readings, and the first prenatal visit are reimbursed at $10 per code.

The program has been a success in improving HEDIS® scores and data collection. The FEP Quality Reimbursement Program for PPO providers **was revised as noted below effective May 12, 2023.**

Revisions to CPT II category II code requirements for $10 reimbursement:

- Only professional HCFA billing providers
- Only these six places of service codes are applicable:
  - 2 — telehealth not home
  - 10 — telehealth home
  - 11 — office
  - 12 — home
  - 17 — walk-in clinic
  - 20 — urgent care
- Only a specific diagnosis code that coordinates with the applicable CPT II code

Submitting the claim

Submit the CPT II code in field 24 of the HCFA *1500* with a charge of $10.

Use the applicable CPT II code, place of service code, and diagnosis code according to the information below.

Blood pressure — systolic and diastolic readings

Reimbursable DX codes: I10, I11.9, I12.9, I13.10, I15, I15.1, I15.8, I15.9, I16.0, I16.1, I16.9

3074F	Most recent systolic blood pressure less than 130 mm Hg
3075F	Most recent systolic blood pressure 130-139 mm Hg
3077F	Most recent systolic blood pressure greater than or equal to 140 mm Hg
3078F	Most recent diastolic blood pressure less than 80 mm Hg
3079F	Most recent diastolic blood pressure 80-89 mm Hg
3080F	Most recent diastolic blood pressure greater than or equal to 90 mm Hg

Hemoglobin A1c

Reimbursable DX codes: E10.8, E10.9, E11.8, E11.9

3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%
3046F	Most recent hemoglobin A1c (HbA1c) level greater than 9.0%

3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%

First prenatal visit

The first prenatal visit date of service must be on the claim (field 24A HCFA 1500) with the appropriate code.

Reimbursable DX codes: Maternity-related diagnosis code

0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit, and in a separate field, the date of the last menstrual period [LMP]) (Prenatal)
0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the LMP (Note: If reporting 0501F prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit) (Prenatal)

For additional information about the FEP Quality Reimbursement Program, email us at FEPproviderGIC@anthem.com.

MULTI-BCBS-CM-063827-24-SRS63786, MULTI-BCBS-CM-064143-24-SRS63773

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/fep-quality-reimbursement-program-for-providers-21224

Or scan this QR code with your phone

The Power of the Blues: Introducing the Blue National Physician Performance Dataset

Anthem is excited to announce the development of the Blue National Physician Performance Dataset. This initiative is a collaborative approach between Blue Cross Blue Shield Association, Blue Health Intelligence (BHI), and Motive Medical Intelligence (MMI) to develop a consistent national approach to evaluating physicians at the National Provider Identifier (NPI) level that incorporates measures of quality of care, appropriateness of care, and cost/efficiency of care.

Effective January 1, 2025, Anthem may incorporate the Blue National Physician Performance Dataset in various ways, including but not limited to:

- Providing special opportunities to participate in product offerings.
- When members contact Anthem with requests for referral options.
- Developing provider designations in provider directory (FindCare) tools.
- Enhancing existing tools in FindCare and Cost Finder, such as Personalized Match, that assist members with identifying or sorting providers.

For more information on how physicians are evaluated within each of the three categories (quality, appropriateness, and cost), you can view the ***Blue National Physician Performance Dataset Evaluation Method***.

If you have any questions about the Methodology or your score, contact your local provider relationship management representative

---

MULTI-BCBS-CM-059174-24-CPN57527, MULTI-BCBS-CM-059175-24-CPN57527

ATTACHMENTS (available on web): Blue National Physician Performance Dataset Evaluation Method (pdf - 0.11mb)

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/the-power-of-the-blues-introducing-the-blue-national-physici-21574

Or scan this QR code with your phone

Pharmacy | Commercial | Aug 26, 2024

Specialty pharmacy updates — September 2024

The 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.

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.

The 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 December 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-0264*	Anktiva (nogapendekin alfa inbekicept-pmln)	C9399, J9999

CC-0166*	Hercessi (trastuzumab-strf)	J3590
CC-0263*	Imdelltra (tarlatamab-dlle)	C9399, J9999

* Oncology use is managed by Carelon Medical Benefits Management.

Site of care updates

Update: In the May 2024 edition of *Provider News*, we announced the site of care review requirements for the following drugs would be effective August 1, 2024. Please be advised that the following drugs were not implemented to have SOC requirements added.

Access our *Clinical Criteria* to view the complete information for these site-of-care updates.

Clinical Criteria	**Drug**	**HCPCS or CPT code(s)**
CC-0042	Bimzelx (bimekizumab-bkzx)	C9399, J3590
CC-0256	Rivfloza (nedosiran)	J3490
CC-0257	Wainua (eplontersen)	C9399, J3490
CC-0254	Zilbrysq (zilucoplan)	J3490

Step therapy updates

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

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

Clinical Criteria	**Status**	**Drug**	**HCPCS or CPT code(s)**
CC-0166	Non-Preferred	Hercessi (trastuzumab-strf)	J3590

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

MULTI-BCBS-CM-065565-24-CPN65398

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-september-2024-21634

Or scan this QR code with your phone

Pharmacy | Commercial | Sep 1, 2024

Pharmacy information available on our provider website

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

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

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

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

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

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

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

MULTI-BCBS-CM-063546-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/pharmacy-information-available-on-our-provider-website-21102

Or scan this QR code with your phone

Pharmacy | Medicare Advantage | Sep 1, 2024

Real-time prescription benefit

Want to reduce administrative burden and help your patients save on prescription costs?

With real-time prescription benefit (RTPB), care providers can access *patient-specific* drug benefit information within the e-prescribing process. This functionality allows care providers to proactively identify barriers to cost and improve medication adherence.

"Prescription pickup rates have increased 3.2% and saved patients on average $40 per prescription with using real-time prescription benefit." — Surescripts.[2]

When using real-time prescription benefit during e-prescribing, care providers can see patient-specific benefit information including:

- Formulary status of selected medication.
- Patient cost share of medication at a retail and mail order pharmacy.
- Up to five formulary drug alternatives.
- Coverage alerts, including prior authorization and step therapy.

Benefits you and your patients will experience when using RTPB:

- Clearer, faster information
- Opportunity to lower cost barriers
- Decreased administrative burden
- Reduced time to therapy
- Enhanced patient experience

How real-time prescription benefit works:

1. Prescriber enters prescription information through e-prescribing.
2. The e-prescribing system triggers a data call to the pharmacy benefit manager (PBM).
3. The PBM receives the real-time prescription benefit request.
4. The PBM delivers cost, formulary, and utilization information for the selected pharmacy back to the prescriber's electronic health record (EHR).
5. Prescriber and patient make a choice together.

Help your patients save money on their prescriptions with EHR access to patient-specific drug coverage and out of pocket costs. Find out if your EHR vendor provides real-time prescription benefits information. There's no charge for the service; however, you will need the latest version of your EHR.

References:

1. Kleinsinger F. The Unmet Challenge of Medication Nonadherence. Perm J. 2018;22:18-033. doi: 10.7812/TPP/18-033. PMID: 30005722; PMCID: PMC6045499.
2. Giaquinto K. Prescription Pickup Rates 3.2 Percentage Points Higher with Surescripts Real-Time Prescription Benefit, Saving Patients an Average of $38 Per Prescription. *Surescripts*. September 2022.
3. Rodriguez S. Surescripts real-time prescription benefit drove medication adherence. EHRIntelligence. https://ehrintelligence.com/news/surescripts-real-time-prescription-benefit-drove-medication-adherence?_hsmi=226935530&_hsenc=p2ANqtz--HIMXEGIqFp9czAfA3_Z5V1uCL8ujtrmfRv3mTJ3EhaA0VCsVpQQmK9ifNmgQw4ApI_6rb1_AvlNFyilc9F Published September 21, 2022. Accessed November 2, 2022.

MULTI-BCBS-CR-065105-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/real-time-prescription-benefit-21356

Or scan this QR code with your phone

Pharmacy | Medicare Advantage | Aug 12, 2024

Anthem expands specialty pharmacy precertification list

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

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

HCPCS or CPT® codes	Medicare Part B drugs
J1599	Alyglo (immune globulin intravenous, human-stwk)

MULTI-BCBS-CR-064688-24-CPN64482

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/anthem-expands-specialty-pharmacy-precertification-list-21374

Or scan this QR code with your phone

Pharmacy | Medicare Advantage | Aug 27, 2024

Anthem expands specialty pharmacy precertification list

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

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

HCPCS or CPT® codes	Medicare Part B drugs
C9399, J9999	Anktiva (nogapendekin alfa inbekicept-pmln)
J3590	Hercessi (trastuzumab-strf)
C9399, J9999	Imdelltra (tarlatamab-dlle)

MULTI-BCBS-CR-064678-24-CPN64481

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/anthem-expands-specialty-pharmacy-precertification-list-21665

Or scan this QR code with your phone

Quality Management | Commercial / Medicare Advantage | Aug 13, 2024

Announcing the new HEDIS documentation library supporting coding excellence

To help make it as easy as possible to keep up with annual changes to HEDIS documentation, Anthem created a library of HEDIS content for you. You'll find tip sheets with coding information and more for many HEDIS measures and other documentation to help ensure accurate claims coding, which helps ensure accurate reimbursement.

Go to the ***Optimizing HEDIS & STARS* category** to view all the communications.

MULTI-BCBS-CRCM-064528-24-CPN64263

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/announcing-the-new-hedis-documentation-library-supporting-co-21424

Or scan this QR code with your phone