Anthem

PROVIDER NEWS MISSOURI

October 2024 Provider Newsletter

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MOBCBS-CRCM-067873-24

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To view this publication online:

Visit **https://providernews.anthem.com/missouri/publications/october-2024-provider-newsletter-3438**

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Administrative | Commercial | October 1, 2024

National Accounts 2025 precertification list

The **National Accounts 2025 Pre-certification List** has been published. Please note, care providers should continue to verify member eligibility and benefits prior to rendering services.

MULTI-BCBS-CM-066138-24-SRS64578

ATTACHMENTS (available on web): **National Accounts 2025 Pre-certification List (pdf - 1.52mb)**

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/national-accounts-2025-precertification-list-21713**

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MOBCBS-CRCM-067873-24

Digital Solutions | Commercial / Medicare Advantage | September 4, 2024

Digital Provider Enrollment now available for additional provider types in Availity Essentials

On September 23, 2024, Anthem will add new specialties to the Provider Enrollment tool hosted on Availity Essentials to further automate and improve your online enrollment experience.

Who can use this new tool?

- Therapy providers (physical therapist, occupational therapist, and speech therapist)
- Audiologists and hearing aid fitters
- Registered dieticians (Independent providers should enroll through American Specialty Health (ASH) at **ashcompanies.com/Contact** or **800-972-4226**)
- Acupuncturists

What does the tool provide?

- Enroll as an individual provider.
- Enroll a new group of providers.
- Apply and request a contract. After review, a contract can be sent back to you digitally for an electronic signature. This eliminates the need for paper applications or paper contracts.
- Use a dashboard for real time status on the submitted applications.
- Experience streamlined complete data submission.

Reviewing how the online enrollment application works

Availity's online application will guide you throughout the enrollment process and provide status updates using a dashboard. As a result, you will know where each provider is in the application process without having to call or email for a status update.

Please note: *For any* ***changes*** *to your practice profile, adding or deleting practitioners, and updating demographics, use the Provider Data Management (PDM) application on Availity Essentials that allows you to electronically submit any changes to your practice profile and demographics. Availity administrators and assistant administrators can access PDM by going to Availity > My Providers > Provider Data Management.*

Accessing the Provider Enrollment application

Log on to Availity Essentials and select **Payer Spaces** > **Anthem** > **Applications** > **Provider Enrollment** to begin the enrollment process.

If your organization is not currently registered for Availity Essentials, the person in your organization designated as the Availity administrator should go to **Availity.com** and select **Register**.

For organizations already using Availity Essentials, your organization's Availity administrator should go to **My Account Dashboard** from the Availity home page to register new users and update or unlock accounts for existing users. Staff who need access to the Provider Enrollment tool need to be granted the role of **Provider Enrollment**. *Availity administrators and user administrators will automatically be granted access to Provider Enrollment.*

If you are using Availity Essentials today and need access to Provider Enrollment, please work with your organization's administrator to update your Availity Essentials role. To determine who your administrator is, you can go to **My Account Dashboard** > **My Administrators**.

Need assistance with registering for Availity Essentials?

Contact Availity Client Services at **800-282-4548**.

MOBCBS-CRCM-067873-24

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MULTI-BCBS-CRCM-059932-24-CPN59787

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MOBCBS-CRCM-067873-24

Digital Solutions | Commercial / Medicare Advantage | September 12, 2024

Roster Automation updates effective November 15, 2024: enhanced reporting to increase data accuracy

At a glance:

- **Care providers will use the Error Report function in Availity Essentials to identify, rectify, and resubmit errors in rosters.**
- **The new Results Report is available to view.**
- **Both the Error and Results Reports can be found on the Upload Roster File page of Availity, with additional guidance available in the *Roster Submission Guide*.**

Error Report an essential tool to identify and correct mistakes

As previously communicated, we introduced an Error Report to the Upload Roster File screen in Availity Essentials Provider Data Management (PDM). Care providers can use this Error Report to understand where errors occurred (specifically which sheet, tab, and row), the cause of the issue, and how to fix it.

As a reminder, you will need to correct any errors submitted in a roster (for example, missing data or incorrectly formatted data) in the future. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems.

Effective November 15, 2024, care providers are responsible for using the Error Report to identify errors in a roster, correct them, and resubmit the roster rows that contain errors. Rows in a roster that contain an error will not be processed and the addition, change, or termination will not be updated in our systems.

New Results Report identifies added and updated records

For better transparency for our care providers, we've now introduced a new Results Report that allows care providers to see the number of unique records that were added or updated based on a specific roster. The Results Report also contains data elements associated with the records, including NPI, TIN, name, address, and effective date. Think of it as a receipt of the actions taken to keep your demographic information accurate. A Results Report has been created for rosters received on and after June 15, 2024.

Both reports are on the Upload Roster File page of Availity

You can find the Results Report, as well as the Error Report, on the Upload Roster File page of Availity PDM. Future informational webinars are coming soon — Watch for updates in the *Provider Newsletter*.

Use the *Roster Submission Guide*

Additional information about the Results Report and Error Report can be found in our *Roster Submission Guide*. Find it online at **Availity.com** > Payer Spaces > Select Payer Tile > Resources > *Roster Submission* Guide using Provider Data Management.

Access our previous communications below

Colorado
Connecticut
Georgia
Missouri
New Hampshire
Ohio
Virginia

We look forward to working together to achieve improved outcomes.

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To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/roster-automation-updates-effective-november-15-2024-enhance-21877**

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MOBCBS-CRCM-067873-24

Digital Solutions | Medicare Advantage | October 1, 2024

Introducing the Care Provider Recognition Program from Anthem

Celebrating extraordinary impacts on health:

- **The new Care Provider Recognition Program honors excellence in Medicare patient care.**
- **The annual program launching in the fall of 2024 will award top healthcare providers.**
- **Winners will be chosen based on quality measures and good standing with health plans.**

We're committed to going beyond the contract to make a real impact on health together with our care providers. To celebrate and appreciate our care provider partners for outstanding performance in patient care, we're excited to announce our new Care Provider Recognition Program.

This program honors successes and highlights those who are driving toward better outcomes. It provides care providers with an opportunity to thank and celebrate teams for going above and beyond to deliver high-quality, cost-efficient care, while driving health equity and exceptional patient experiences, and outcomes.

Launching in the fall of 2024, this annual program will recognize care providers who deliver excellence in care to their Medicare patients, our members — which makes it different from other distinctions in the industry. Winners of the 2024 Care Provider Recognition Award will be announced in mid--December.

Winners will be selected based on the following criteria:

- Top 5% of care providers based on quality measured through our internal Medicare data based on current performance and three-year average, including medical best practices such as preventive care screenings, immunizations, chronic disease management, and medication adherence
- In-network and contract in good standing with an affiliated health plan

Driving toward better health outcomes is a critical shared goal with our care provider partners, and results like these are worthy of the spotlight.

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

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/introducing-the-care-provider-recognition-program-from-anthe-21977**

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Education and Training | Medicare Advantage | September 16, 2024

Seamless advance care: MyDirectives digital tool for D-SNP members

At a glance:

- **Members enrolled in Dual Eligible Special Needs Plan (D-SNP) can have free access to MyDirectives to manage advance directives digitally.**
- **Providers should discuss the importance of advance directives with patients during annual wellness visits.**
- **Members can access MyDirectives through their member website to easily create, upload, and share advance directives.**

Anthem is providing all Medicare Advantage members enrolled in a Dual Eligible Special Needs Plan (D-SNP) with free access to **MyDirectives**, an advance directives creation tool.

What is MyDirectives?

MyDirectives is a digital tool that can be used to easily create, maintain, and share information on advance directives. It has an easy-to-use guide that takes members through a series of questions about their care preferences, the establishment of healthcare agents (medical powers of attorney), the sharing of information, and more.

Your role as a provider

To support the successful delivery of person-centered care, providers should speak to their patients about the value of establishing an advance directive during the annual wellness

visit. The CMS recently revised its **advance care planning (ACP) fact sheet**, which includes important documentation and time requirements for this service.

How members access and use MyDirectives

To get started with the Advance Directives program, members can visit the Anthem member website and select the **Benefits** tab to access the link for the Advance Directives program. Selecting this link will take the member to the MyDirectives app, where they can create a free account or link an existing account:

- If they already have a written advance directive, MyDirectives allows members to upload copies of their current directives, making it easier to store and share when necessary.
- Members can create a contact list of individuals who can have access to their advance directives, including physicians. A member's advance directive can also be retrieved through national data exchanges such as eHealth Exchange, Carequality, and CommonWell Health Alliance.

MyDirectives customer support:

- MyDirectives offers online customer support, which is the preferred contact method. Members can also call **888-884-3324** or email support@mydirectives.com.

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

MULTI-BCBS-CR-068079-24

MOBCBS-CRCM-067873-24

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/seamless-advance-care-mydirectives-digital-tool-for-d-snp-me-21907**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Policy Updates | Medicare Advantage | September 3, 2024

Clinical Criteria updates

Effective October 4, 2024

Summary: On June 10, 2024, the Pharmacy and Therapeutic (P&T) Committee approved the following *Clinical Criteria* applicable to the medical drug benefit for Anthem. These policies were developed, revised, or reviewed to support clinical coding edits.

Visit ***Clinical Criteria*** to search for specific policies. For questions or additional information, use this **email**.

Please see the explanation/definition for each category of *Clinical Criteria* below:

- New: newly published criteria
- Revised: addition or removal of medical necessity requirements, new document number
- Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive

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

Please note:

- The *Clinical Criteria* listed below applies only to the medical drug benefits contained within the member's medical policy. This does not apply to pharmacy services.
- This notice is meant to inform the provider of new or revised criteria that has been adopted by Anthem only. It does not include details regarding any authorization requirements. Authorization rules are communicated via a separate notice.

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
October 4, 2024	*CC-0263	Imdelltra (tarlatamab-dlle)	New
October 4, 2024	*CC-0264	Anktiva (nogapendekin alfa inbekicept-pmln)	New
October 4, 2024	*CC-0265	Kisunla (donanemab)	New
October 4, 2024	*CC-0166	Trastuzumab Agents	Revised
October 4, 2024	CC-0187	Breyanzi (lisocabtagene maraleucel)	Revised
October 4, 2024	CC-0118	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin)	Revised
October 4, 2024	CC-0094	Pemetrexed (Alimta, Pemfexy, Pemrydi)	Revised
October 4, 2024	CC-0032	Botulinum Toxin	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
October 4, 2024	*CC-0041	Complement C5 Inhibitors	Revised

MULTI-BCBS-CR-063982-24-CPN63395

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-21704**

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MOBCBS-CRCM-067873-24

Medical Policy & Clinical Guidelines | Medicare Advantage | September 10, 2024

Medical Policies and *Clinical Utilization Management Guidelines* update

Effective October 10, 2024

The *Medical Policies*, *Clinical Utilization Management (UM) Guidelines*, and *Third-Party Criteria* below were developed and/or revised during Quarter Two, 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 **https://anthem.com/provider/policies/clinical-guidelines**.

Notes/updates

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

- MED.00055 - Wearable Cardioverter Defibrillators:
  - Reformatted language from the to a wearable cardioverter defibrillator and moved punctuation
  - Added Not Medically Necessary statement when individual has an automated external defibrillator
- RAD.00069 - Absolute Quantitation of Myocardial Blood Flow Measurement:

    - The use of absolute quantitation of myocardial blood flow testing is considered Investigational & Not Medically Necessary for all indications
- 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 Medically Necessary and Not Medically Necessary section and added new Medically Necessary criterion addressing non-healing or persistent corneal epithelial defects
    - Removed VersaWrap from Investigational & Not Medically Necessary statement
    - Removed Phasix Mesh from Investigational & Not Medically Necessary statement
    - Added Phasix Mesh and Phasix ST Mesh to Medically Necessary and Not Medically Necessary statements
- CG-DME-54 - Mechanical Insufflation-Exsufflation Devices:
    - Outlines the Medically Necessary and Not Medically Necessary criteria for use of mechanical insufflation-exsufflation devices

Medical Policies

On May 9, 2024, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following *Medical Policies* applicable to Anthem. These *Medical Policies* take effect October 10, 2024.

Publish Date	*Medical Policy* Number	*Medical Policy* Title	New or Revised
6/28/2024	ANC.00009	Cosmetic and Reconstructive Services of the Trunk, Groin, and Extremities	Revised
6/28/2024	*MED.00055	Wearable Cardioverter Defibrillators	Revised

Publish Date	*Medical Policy* Number	*Medical Policy* Title	New or Revised
6/28/2024	*RAD.00069	Absolute Quantitation of Myocardial Blood Flow Measurement	New
6/28/2024	*SURG.00011	Allogeneic, Xenographic, Synthetic, Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
6/28/2024	SURG.00121	Transcatheter Heart Valve Procedures	Revised

Clinical UM Guidelines

On May 9, 2024, the MPTAC approved the following *Clinical UM Guidelines* applicable to Anthem. These guidelines were adopted by the medical operations committee for Medicare Advantage members on June 27, 2024. These guidelines take effect October 10, 2024.

Publish Date	*Clinical UM Guideline* Number	*Clinical UM Guideline* Title	New or Revised
6/28/2024	*CG-DME-54	Mechanical Insufflation-Exsufflation Devices	New
6/28/2024	CG-DME-55	Automated External Defibrillators for Home Use	New

Publish Date	*Clinical UM Guideline* Number	*Clinical UM Guideline* Title	New or Revised
6/28/2024	CG-MED-68	Therapeutic Apheresis	Revised
6/28/2024	CG-MED-97	Biofeedback and Neurofeedback	New

MULTI-BCBS-CR-066602-24-CPN65660

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Visit **https://providernews.anthem.com/missouri/articles/medical-policies-and-clinical-utilization-management-guideli-21801**

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MOBCBS-CRCM-067873-24

Prior Authorization | Medicare Advantage | September 23, 2024

Prior authorization requirement changes

Effective January 1, 2025

Effective January 1, 2025, 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
0141U	Infectious disease (bacteria and fungi), gram-positive organism identification and drug resistance element detection, DNA (20 gram-positive bacterial targets, 4 resistance genes, 1 pan gram-negative bacterial target, 1 pan Candida target), blood culture, amplified probe technique, each target reported as detected or not detected ePlex® BCID Gram-Positive Panel, GenMark Diagnostics, Inc, GenMark Diagnostics, Inc
0142U	Infectious disease (bacteria and fungi), gram-negative bacterial identification and drug resistance element detection, DNA (21 gram-negative bacterial targets, 6 resistance genes, 1 pan gram-positive bacterial target, 1 pan Candida target), amplified probe technique, each target reported as detected or not detected ePlex® BCID Gram-Negative Panel, GenMark Diagnostics, Inc, GenMark Diagnostics, Inc

MOBCBS-CRCM-067873-24

0321U	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens, identification of 20 bacterial and fungal organisms and identification of 16 associated antibiotic-resistance genes, multiplex amplified probe technique Bridge Urinary Tract Infection Detection and Resistance Test, Bridge Diagnostics
0369U	Infectious agent detection by nucleic acid (DNA and RNA), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique
0370U	GI assay (Gastrointestinal Pathogen with ABR), Lab Genomics LLC, Thermo Fisher Scientific
0373U	Infectious agent detection by nucleic acid (DNA and RNA), respiratory tract infection, 17 bacteria, 8 fungus, 13 virus, and 16 antibiotic-resistance genes, multiplex amplified probe technique, upper or lower respiratory specimen
0445U	β-amyloid (Abeta42) and phospho tau (181P) (pTau181), electrochemiluminescent immunoassay (ECLIA), cerebral spinal fluid, ratio reported as positive or negative for amyloid pathology
0524T	Elecsys® PhosphoTau (181P) CSF (pTau181) and βAmyloid (1-42) CSF II (Abeta 42) Ratio, Roche Diagnostics Operations, Inc (US owner/operator)
21086	Impression & Custom Preparation; Auricular Prosthesis

36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
64568	Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator
A2026	Restrata MiniMatrix, 5 mg
A4438	Adhesive clip applied to the skin to secure external electrical nerve stimulator controller, each
C1734	Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable)
C9796	Repair of enterocutaneous fistula small intestine or colon (excluding anorectal fistula) with plug (e.g., porcine small intestine submucosa [SIS])

C9797	Vascular embolization or occlusion procedure with use of a pressure-generating catheter (e.g., one-way valve, intermittently occluding), inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector
L8045	Auricular Prosthesis
Q4305	American Amnion AC Tri-Layer, per sq cm
Q4306	American Amnion AC, per sq cm
Q4307	American Amnion, per sq cm
Q4308	Sanopellis, per sq cm
Q4309	VIA Matrix, per sq cm
S9002	Intravaginal motion sensor system, provides biofeedback for pelvic floor muscle rehabilitation device

Not all PA requirements are listed here. Detailed PA requirements are available to providers on **https://anthem.com/provider/medicare-advantage** on the Resources tab or for contracted providers by accessing **Availity.com**.

MULTI-BCBS-CR-066981-24-CPN66375

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MOBCBS-CRCM-067873-24

Prior Authorization | Medicare Advantage | September 6, 2024

Changes to special supplemental benefits for the chronically ill eligibility requirements

Effective January 1, 2025, Anthem will change its process for approving members for special supplemental benefits for the chronically ill (SSBCI), such as groceries, utilities, chronic meals (for more than 90 days), and nonemergency transportation to non-health-related destinations.

Per CMS guidelines, to be eligible for SSBCI benefits, a member must have a qualifying chronic condition and meet **all** the criteria below:

1. Has one or more comorbid and medically complex chronic conditions that are life threatening or significantly limit the overall health or function of the enrollee
2. Has a high risk of hospitalization or other adverse health outcomes
3. Requires intensive care coordination

To ensure that members, care providers, and other clinical teams have a clear understanding of eligibility requirements, Anthem has established a set of *Clinical Guidelines* that we believe equate to the above criteria. In short, a member would be deemed eligible for an SSBCI benefit if they:

- Have a valid chronic condition as listed in their *Evidence of Coverage (EOC)*
- And **any** of the following are true:
    - Had one or more inpatient admissions (inclusive of behavioral health) related to the chronic condition in the last 12 months
    - Had one or more urgent care or emergency room visits related to the chronic condition in the last 12 months

- Had two or more outpatient visits related to the chronic condition (including primary care or specialty care visits) in the last 12 months
- Are a patient who requires home health visits related to the chronic condition
- Are a patient who has an impairment in daily living activities related to the chronic condition (bathing, dressing, toileting, transferring, and eating) or cognitive impairments
- Are a patient with one or more chronic conditions and a need for one or more pieces of durable medical equipment (DME) in the outpatient setting, including but not limited to: group 3 power/manual wheelchair, noninvasive ventilation (NIV), wound vacuums, bipap machines, mechanical in-exsufflation devices, or group 2 or group 3 mattresses
- Are successfully enrolled in a chronic special needs plan (CSNP)

In the past, Anthem and many other plans used a member's chronic condition as the principal cause for eligibility. As a result of the revised guidance, Anthem will need to ensure that all new members as well as those previously approved meet the criteria above.

Use of care provider confirmations to support eligibility

When insufficient evidence is available for Anthem to render an organizational determination on a member's eligibility, Anthem will request a medical review by its participating care providers that a member meets the clinical guidelines listed above.

The request will generally be faxed to care providers as an *SSBCI Provider Confirmation Form,* preprinted with member information and including instructions and reference materials such as a summary of eligible conditions and applicable *Clinical Guidelines.* Since these requests impact a member's access to benefits, we are requesting that they be treated like any other organizational determination request, preferably returned within three to five days of receipt.

The process for both new and existing members will begin in October 2024 and will impact members' benefits for the 2025 plan year.

Additional notes for care providers delegated for utilization management by Anthem

For care providers delegated by Anthem for utilization management, this process is being retained by Anthem as it applies to supplemental benefits, which generally are not included in such delegation. Consequently, we ask that these care providers please follow the guidance provided above and work directly with Anthem to establish member eligibility for SSBCI benefits.

For answers to other questions, contact your Provider Services representative.

MULTI-BCBS-CR-067399-24-CPN67224

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/changes-to-special-supplemental-benefits-for-the-chronically-21820**

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MOBCBS-CRCM-067873-24

Reimbursement Policies | Commercial | October 1, 2024

Reimbursement policy update: Modifiers 59 and XE, XP, XS, and XU: Distinct Procedural Service — Professional

Beginning with dates of service on or after January 1, 2025, Anthem will update the *Modifiers 59 and XE, XP, XS, and XU: Distinct Procedural Service — Professional* reimbursement policy Related Coding section to add the following:

- J1202 will deny when reported with G0138.

In addition, the policy title was renamed from *Distinct Procedural Service: Modifiers 59 and XE, XP, XS, and XU*.

For specific policy details, visit the **reimbursement policy page**.

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

MULTI-BCBS-CM-067539-24

To view this article online:

MOBCBS-CRCM-067873-24

Visit **https://providernews.anthem.com/missouri/articles/reimbursement-policy-update-modifiers-59-and-xe-xp-xs-and-xu-22177**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Reimbursement Policies | Medicare Advantage | October 1, 2024

Clarification to reimbursement policy update: Nurse Practitioner and Physician Assistant Services

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

In the **August 2024 edition** of the *Provider News*, we announced an update to the *Nurse Practitioner and Physician Assistant Services* policy. To clarify, we are aligning the reimbursement policy with Centers for Medicare & Medicaid Services (CMS) guidelines to indicate which services will be eligible for a payment reduction according to the *Nurse Practitioner and Physician Assistant Services* reimbursement structure.

The following services are subject to the *Nurse Practitioner and Physician Assistant Services* reimbursement payment reduction and will be removed from the physicians' services exclusion section:

- Preventive Services
- Radiology Services

The following services are not subject to the NP PA reimbursement payment reduction and will be included in the physicians' services exclusion section:

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

For specific policy details visit the **reimbursement policy page**.

MULTI-BCBS-CR-066719-24-CPN66373

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/clarification-to-reimbursement-policy-update-nurse-practitio-21952**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Products & Programs | Commercial | October 1, 2024

Introduction of the Specialty High Performing Provider designation program for commercial networks

In a **previous newsletter**, Anthem informed you that we were implementing a new High Performing Provider (HPP) designation to care providers meeting certain cost and quality metrics as part of our expansion of consumer tools and programs. In that communication, we indicated that the designation will initially focus on certain types of professional providers we categorize as primary care providers (PCPs), but it may be broadened to include other care provider types in the future.

Effective on or about December 1, 2024, Anthem will use a new HPP methodology (cost and quality metrics) to designate certain specialists as High Performing Providers.

The methodology we notified you about in the **newsletter article** (where a link to the methodology was included) will continue to be used for the designation of PCPs. That methodology has been revised to apply to specialists.

As with PCP HPP, Anthem may highlight specialist HPPs in various ways, including, but not limited to:

- Special opportunities to participate in product offerings.
- When members contact Anthem with requests for referral options.
- Placing a designation in the Care and Cost Finder. This would be in addition to Anthem's existing tool in Care and Cost Finder called *Personalized Match*, which provides Anthem members with the option to search for in-network care providers through a specialized sorting tool that considers certain cost and quality metrics as well.

- Personalized Match search results sorting similar to how the HPP methodology for non-Exchange PCPs impacts Personalized Match rankings. You may review a copy of the Personalized Match methodology for Exchange PCPs posted on Availity Essentials — our secure web-based provider tool — using the following navigation: Go to Availity > Payer Spaces > Health Plan > Provider Online Reporting > Programs > Personalized Match Methodology.pdf.

As shown in the specialty HPP methodology, the specialty methodology for determining a specialty HPP closely mirrors the methodology for determining an HPP PCP.

To view the specialty HPP designation methodology which includes a listing of specialties included, please click **here**. For more information on the specialty HPP designation, or to find out if your practice will receive the specialty HPP designation, please contact Provider Services or your local provider relationship management representative.

Look for further updates on the specialty HPP designation in this newsletter. To sign up for this newsletter, go to **https://providernews.anthem.com**, select the appropriate state, and then select **Subscribe to Email** in the top right corner.

MULTI-BCBS-CM-065488-24-CPN65370

ATTACHMENTS (available on web): **High Performing Provider (HPP) 1.0 Methodology Summary Specialty Care Providers Commercial (pdf - 1.94mb)**

To view this article online:

MOBCBS-CRCM-067873-24

Visit **https://providernews.anthem.com/missouri/articles/introduction-of-the-specialty-high-performing-provider-desig-22106**

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MOBCBS-CRCM-067873-24

Products & Programs | Commercial | October 1, 2024

Introduction of the HPP designation program for individual member (Exchange) commercial networks

Anthem informed you in a **previous newsletter** that we were implementing a new High Performing Provider (HPP) designation to care providers meeting certain cost and quality metrics as part of our expansion of consumer tools and programs. We informed you that initially the designation will focus on certain types of professional providers we categorize as primary care providers (PCPs), but it may be broadened to include other care provider types in the future.

Beginning October 31, 2024, Anthem will be using a new HPP methodology (cost and quality metrics) to designate HPPs for PCPs participating in our individual member (Exchange) plan networks that service our *Affordable Care Act* plans (IND HPPs). The new IND HPP methodology will be tailored for our Exchange plans.

The methodology we notified you about in the **newsletter article** (where a link to the methodology was included) will continue to be used for our non-Exchange commercial health plan networks.

As with the non-Exchange HPP designation, Anthem may highlight Exchange HPPs in various ways, including, but not limited to:

- Offering special opportunities to participate in product offerings.
- When members contact Anthem with requests for referral options.
- Placing a designation in the Care and Cost Finder. This would be in addition to Anthem's existing tool in Care and Cost Finder, called *Personalized Match*, which provides Anthem members with the option to search for in-network care providers

through a specialized sorting tool that considers certain cost and quality metrics as well.

- Personalized Match search results sorting, similar to how the HPP methodology for non-Exchange PCPs impacts Personalized Match rankings. You may review a copy of the Personalized Match methodology for Exchange PCPs posted on Availity – our secure web-based provider tool – using the following navigation: Go to Availity > Payer Spaces > Health Plan > Provider Online Reporting > Programs > Personalized Match Methodology.pdf.
- A factor in auto assignment PCP methodology for health benefit plans that require a member to pick a PCP and the member fails to do so.

The IND HPP methodology for determining an IND HPP is similar to the methodology for determining an HPP PCP in general (which services the health plan's large and small group commercial populations); however, certain metrics may solely apply to the individual member population. The IND HPP designation is solely for PCPs seeing an individual member population and is not for specialists.

You can view the IND HPP designation methodology **here**. For more information on the individual HPP designation, or to know if your practice will receive the individual HPP designation, please contact Provider Services or your local provider relationship management representative.

Look for further updates on the IND HPP designation in this newsletter. To sign up for this newsletter, go to **https://providernews.anthem.com**, select the appropriate state, and then select **Subscribe to Email** in the top right corner.

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MULTI-BCBS-CM-062857-24-CPN60903

ATTACHMENTS (available on web): **Individual Member (Exchange) High Performing Provider designation (pdf - 1.01mb)**

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/introduction-of-the-hpp-designation-program-for-individual-m-21557**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Pharmacy | Commercial | October 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.

MOBCBS-CRCM-067873-24

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-068346-24

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/pharmacy-information-available-on-our-provider-website-21829**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Pharmacy | Commercial | September 16, 2024

Specialty pharmacy updates — October 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.

Note: Currently, your patients may be receiving these medications without prior authorization. As of the effective date below, you may be required to request a 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 the claim processing of drugs billed with a Not Otherwise Classified (NOC) code.

Prior authorization updates

Effective for dates of service on or after January 1, 2025, 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 **https://tinyurl.com/4dv6rxe4** to view the complete information for these prior authorization updates.

Clinical Criteria	Drug	HCPCS or CPT® code(s)
CC-0265	Kisunla (donanemab)	J0175

CC-0041	Piasky (crovalimab-akkz)	J3590

Step therapy updates

Effective for dates of service on or after January 1, 2025, 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.

The current Orencia step therapy preferred product list under the medical benefit is being modified to include only those that are considered medical benefit drugs.

Access our *Clinical Criteria* at **https://tinyurl.com/4dv6rxe4** to view the complete information for these step therapy updates.

Clinical Criteria	Status	Drug	HCPCS or CPT code(s)
CC-0078	Non-Preferred	Orencia	J0129
CC-0078	Preferred	Avsola	Q5121
CC-0078	Preferred	Remicade	J1745
CC-0078	Preferred	Unbranded Infliximab	J1745
CC-0078	Preferred	Simponi Aria	J1602

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 January 1, 2025, 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 **https://tinyurl.com/4dv6rxe4** to view the complete information for these quantity limit updates.

Clinical Criteria	Drug	HCPCS or CPT code(s)
CC-0265	Kisunla (donanemab)	J0175
CC-0041	Piasky (crovalimab-akkz)	J3590

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

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MULTI-BCBS-CM-067804-24-CPN67634

To view this article online:

MOBCBS-CRCM-067873-24

Visit **https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-october-2024-21913**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Pharmacy | Medicare Advantage | October 1, 2024

Medicare Part D overhaul: What's new in 2025 for your prescription drug costs?

At a glance:

- Significant Medicare Part D updates in 2025 include a $2,000 out-of-pocket cap and elimination of the coverage gap.
- Enhanced benefits will remove cost-sharing in catastrophic coverage and expand low-income subsidies to 150% of the federal poverty level (FPL).
- The Medicare Prescription Payment Plan (M3P) will allow members to spread out prescription costs over the year for added financial flexibility.

What's changing in 2025?

Changes in deductible and out-of-pocket thresholds

In 2024, the standard deductible was $545 with the initial coverage limit at $5,030, and the catastrophic coverage threshold was $8,000. By 2025, the deductible will increase to $590, and members will enter the catastrophic phase when their out-of-pocket expenditure reaches $2,000. Members might see higher upfront costs due to the increased deductible, but reaching catastrophic coverage will be significantly easier, offering greater financial protections much sooner.

Elimination of the coverage gap (donut hole)

The elimination of the coverage gap will simplify the benefit structure. Previously, beneficiaries paid 25% of the cost of both brand-name and generic drugs in the coverage gap. The full elimination of this gap will remove the phase where members faced higher out-of-pocket costs, reducing financial uncertainty and streamlining the benefits process.

Introduction of a $2,000 out-of-pocket cap

In 2025, after reaching the $2,000 out-of-pocket cap, members will no longer have to pay added costs for their medications for the remainder of the year. This offers financial protection and predictability in managing healthcare expenses, helping those with high prescription drug costs.

Elimination of cost-sharing in catastrophic coverage

While in 2024, members had to pay 5% of drug costs after reaching the out-of-pocket threshold; this requirement will lift entirely in the next year. This ensures complete coverage once members reach the catastrophic phase, removing the financial burden for members with extremely high drug costs.

Enhanced low-income subsidy (LIS) benefits

We are also introducing enhanced LIS benefits, extending full benefits to individuals with incomes up to 150% of the FPL from the previous 135% FPL threshold. This change means more members will qualify for full LIS benefits, reducing their premiums, deductibles, and copayments, which improves access to necessary medications for low-income beneficiaries.

Introduction of the Medicare Prescription Payment Plan (M3P)

M3P allows members to manage their out-of-pocket Medicare Part D drug costs by spreading the total sum of their filled prescription costs across the calendar year. This option is voluntary, free to enroll, and members can choose to participate at any point during the year. Instead of paying at the pharmacy, members will receive a bill from their health or drug plan to pay for their prescription drugs each month, offering greater financial flexibility and predictability.

Action plan and resources

To ensure a smooth transition, we've laid out a comprehensive educational and communication strategy:

- **Information campaign:** As of July 2024, we began an extensive marketing and educational campaign, including public relations efforts, direct member communications, and care provider briefings.
- **Training and support:** We are providing training materials, talking points, and FAQs to our support teams, ensuring they are well-prepared to assist you.

Key dates:

- October 15, 2024: Enrollment in M3P begins
- January 1, 2025: All other M3P requirements become effective

Next steps:

- Care providers should stay up to date and make use of the resources we provide to better assist patients. Staying updated on any changes in the formulary and benefit structures will ensure that you can provide the highest quality care possible.
- Members should keep an eye out for detailed communications about their enhanced Medicare Part D coverage. Members can contact our support team for personalized assistance.

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

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

As we move into 2025, our goal is to provide you with the knowledge and resources needed to maximize the new Medicare Part D benefits. Thank you for trusting us to help manage your healthcare needs.

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MULTI-BCBS-CR-067660-24-CPN65205

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/medicare-part-d-overhaul-whats-new-in-2025-for-your-prescrip-22037**

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MOBCBS-CRCM-067873-24

Quality Management | Commercial / Medicare Advantage | October 1, 2024

Prevent flu and COVID-19: drive the change through vaccination

- Encourage patients to get flu and COVID-19 vaccines for overall health safety.
- Use resources from **LetsVaccinate.org**, the CDC, and the American Lung Association to raise vaccination rates.
- Research validates that vaccinations prevent severe COVID-19 outcomes and significantly lower the risk of intensive care unit (ICU) admission and death from flu.

You care about your patients and want to keep them healthy. That's why it's important that you and your care team remind your patients to stay up to date with their flu and COVID-19 vaccines. Physician recommendation is the greatest motivator for people to vaccinate themselves and their family members. Customized patient outreach can influence your patients' decisions to get recommended vaccines.

The tools below were developed by clinical experts to support you and your care team in educating your patients on the health benefits of vaccines:

- **Let's Vaccinate** provides ready-to-use resources and strategies to help your care team increase vaccination rates.
- **CDC's vaccine information** for healthcare professionals offers evidence-based immunization strategies and best practices critical to implementing a successful vaccination program.
- **Fend Off Flu** is the American Lung Association's campaign to increase flu knowledge and vaccination rates.

Research shows:

- In a 2021 study among adults hospitalized with flu, vaccinated patients had a 26% lower risk of ICU admission and a 31% lower risk of death from flu compared with those who were unvaccinated.*
- COVID-19 vaccinations remain the safest strategy for avoiding hospitalizations, long-term health outcomes, and death from COVID-19.*

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

* **cdc.gov/covid/vaccines/benefits.html?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html**.

MULTI-BCBS-CRCM-065074-24-CPN64664

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/prevent-flu-and-covid-19-drive-the-change-through-vaccinatio-22068**

Or scan this QR code with your phone

MOBCBS-CRCM-067873-24

Quality Management | Commercial / Medicare Advantage | October 1, 2024

HEDIS medical record submission made easier with our Remote EMR Access service

Instead of submitting medical records for the HEDIS® hybrid project, use our Remote EMR Access service. We offer providers the ability to grant access to your electronic medical record (EMR) system directly to pull the required documentation to aid your office in reaching compliance. Granting our team remote access to your EMR helps reduce the time and costs associated with medical record retrieval while improving efficiency and allowing your office to focus on patient care.

We have a centralized EMR team experienced with multiple EMR systems and extensively trained annually on *HIPAA*, EMR systems, and HEDIS measure updates. We complete medical record retrieval based on minimum necessary guidelines:

- We only access medical records of members pulled into the HEDIS sample using specific demographic data.
- We only retrieve the medical records that have claims evidence related to the HEDIS measures.
- We only access the least amount of information needed for a use, disclosure, or a request.
- We only save to file and do not physically print any PHI.

Getting started with Remote EMR Access is just one email away. Email Centralized_EMR_Team@anthem.com today.

Frequently asked questions

Q. How do you retrieve our medical records?

A. We access your EMR using a secure website and retrieve only the necessary

documentation by printing to an electronic file we store internally on our secure network drives.

Q. Is this process secure?

A. Yes, we only use secure internal resources to access your EMR systems. All retrieved records are stored on our secure network drives.

Q. Why does the health plan need full access to the entire medical record?

A. There are several reasons we need to look at the entire medical record of a member:

- HEDIS measures can include up to a six-year lookback of member's information.
- Medical record data for HEDIS compliance may come from several different areas of the EMR system, including labs, radiology, surgeries, inpatient stays, outpatient visits, and case management.
- Compliant data may be documented or housed in a non-standard format, such as an in-office lab slip scanned into miscellaneous documents.

Q. What information do I need to submit to use your Remote EMR Access service?

A. Email Centralized_EMR_Team@anthem.com with the following information:

- Practice/facility demographic information (for example, address, national provider ID, or taxpayer identification numbers)
- EMR system information (for example, type of EMR system, required access forms, or access type)
- List of current providers/locations or a website for accessing this list

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MOBCBS-CRCM-067873-24

MULTI-BCBS-CRCM-065361-24-CPN64123

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/hedis-medical-record-submission-made-easier-with-our-remote-21809**

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MOBCBS-CRCM-067873-24