December 2024 Provider Newsletter

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MOBCBS-CRCM-072819-24

To view this publication online:

Visit **https://providernews.anthem.com/missouri/publications/december-2024-provider-newsletter-3508**

Or scan this QR code with your phone

Administrative | Commercial | December 1, 2024

Important information about utilization management

Our utilization management (UM) decisions are based on the appropriateness of care and service needed, as well as the member's coverage according to their health plan. We do not reward providers or other individuals for issuing denials of coverage, service, or care. Nor do we make decisions about hiring, promoting, or terminating these individuals based on the idea or thought that they will deny benefits. In addition, we do not offer financial incentives for UM decision makers to encourage decisions resulting in under-utilization. Anthem medical policies are available at **Anthem.com**.

You can also request a free copy of our UM criteria from our medical management department, and each treating provider directly involved in the member's care may discuss a UM denial decision with a physician reviewer by calling us at the toll-free number listed on the UM denial letter, if they haven't already done so, and before all applicable appeals are completed. UM criteria are also available on the web. Go to **Anthem.com** and select For Providers > Provider Resources > Policies, Guidelines and Manuals > Select your state > View *Medical Policies* & *Clinical UM Guidelines*.

We work with providers to answer questions about the utilization management process and the authorization of care. Here's how the process works:

- Call us toll-free from 8:30 a.m. to 5 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program (FEP) hours are 8 a.m. to 7 p.m. ET.
- If you call after normal business hours, you can leave a private message with your contact information. Our staff will return your call on the next business day. Calls received after midnight will be returned the same business day.

- Our associates will contact you about your UM inquiries during business hours, unless otherwise agreed upon.

The following phone lines are for physicians and their staff. Members should call the customer service number on their health plan ID card.

To discuss UM process and authorizations	To discuss peer-to-peer UM denials with physicians	To request UM criteria	TDD/TTY	Business hours
800-992-5498 **866-398-1922** Transplant: **888-574-7215** National Transplant: **844-644-8101** **866-536-7612** Behavioral Health: **866-302-1015** Autism: Call customer service number on the back of the member's ID card. FEP: **800-860-2156**	**888-870-9342** National: **800-821-1453** **866-776-4793** Behavioral Health: **866-302-1015** Adaptive Behavioral Treatment: Call customer service number on back of member's ID card FEP: **800-860-**	**800-992-5498** **866-398-1922** Behavioral Health: **866-302-1015** FEP: **800-860-2156**	711 or TTY/ASCII: **800-735-2966** Voice: **866-735-2460**	Call us toll-free from 8:30 a.m. to 5 p.m. Monday through Friday (except on holidays). More hours may be available in your area. Federal Employee Program hours are 8 a.m. to 7 p.m. ET.

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For language assistance, members can call the customer service phone number on the back of their ID card and a representative will be able to assist them.

Our utilization management associates identify themselves to all callers by first name, title, and company name when making or returning calls. They can inform you about specific utilization management requirements and operational review procedures and discuss utilization management decisions with you.

MOBCBS-CM-072612-24

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/important-information-about-utilization-management-23069**

Or scan this QR code with your phone

Administrative | Commercial | December 1, 2024

Case Management program

Managing any illness can be challenging. Knowing who to contact, what test results mean, and how to access needed resources is important but can be overwhelming.

We are available to help with our case management program. Our case managers are part of an interdisciplinary team of clinicians and professionals who support members, families, primary care physicians, behavioral health practitioners, and caregivers. The case management process utilizes the experience and expertise of the care coordination team, whose goal is to educate and empower our members to increase their self-management skills, understand their illness, and learn about care choices to access quality, efficient healthcare.

Members or caregivers can refer themselves or family members for physical health services by calling the number below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals. This voluntary program is private and offered at no cost to our members. They can opt out anytime if they change their mind about participating in the program.

For behavioral health or substance use disorder services, members can contact their health plan to verify benefits and access at **Anthem.com** or if they are Federal Employee Program (FEP) members, **https://www.fepblue.org/** to search for and access behavioral health providers. To ensure privacy, having the member or member's family contact our department directly is best.

How do you contact us?

The member can contact customer service for assistance for commercial and exchange members.

For FEP members, physical and behavioral health practitioners can refer to our behavioral health case management by calling **800-711-2225, option 3,** with member consent.

We are committed to helping patients more easily access the care they need.

MOBCBS-CM-072591-24-CPN70347

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/case-management-program-23165**

Or scan this QR code with your phone

Administrative | Commercial | December 1, 2024

PCP after-hours access requirements

We are dedicated to ensuring compliance with NCQA accessibility standards by providing members with phone access to their PCPs beyond regular business hours. The annual after-hours access study assesses adequate phone messaging for our members with perceived emergencies or urgent situations after office hours. Most of our plans measured still fall short of the after-hours access expectations that patients have phone access to their practitioners 24 hours a day, 7 days a week, 365 days a year.

The current after-hours messaging requirement is: When a patient calls after hours, a live person directs them to the practitioner or the on-call practitioner, **or a recording or live person directs the patient to an urgent care center, 911, or the ER.**

If a patient reaches a practitioner's voicemail, compliant messaging is imperative to assist the patient in gaining access to appropriate care.

We continue to work towards identifying simplified ways to access care.

MULTI-BCBS-CM-072073-24-CPN70346

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/pcp-afterhours-access-requirements-23150**

Or scan this QR code with your phone

Administrative | Commercial | December 1, 2024

Coordination of care

Coordination of care among providers is vital to good treatment planning and ensures appropriate diagnosis, treatment, and referral. We want to take this opportunity to stress the importance of communicating with your patients' other healthcare practitioners, including PCPs/PMPs, medical specialists, and behavioral health practitioners.

Coordination of care is essential for patients who use general medical services extensively and those referred to a behavioral health specialist by another healthcare practitioner. We urge all our practitioners to obtain the appropriate permission from these patients to coordinate care between behavioral health and other healthcare practitioners when treatment begins.

We expect all healthcare practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit the necessary information; if you furnish a referral, report appropriate information to the referring practitioner.
6. Document evidence of clinical feedback (for example, a consultation report) that includes, but is not limited to:
    - Diagnosis
    - Treatment plan
    - Referrals
    - Psychopharmacological medication (as applicable)

To facilitate coordination of care, we have several tools available at **https://www.Anthem.com/provider/forms/** for behavioral health and other medical practitioners, including:

- *Coordination of Care Form*
- *Coordination of Care Letter Template — Behavioral Health*
- *Coordination of Care Letter Template — Medical*
- Resources for provider collaboration and integrated care, including *Practice Guidelines,* assessment tools, suicide awareness, and multicultural education and guidance

The following behavioral health forms, brochures, and screening tools for substance use disorder and attention-deficit/hyperactivity disorder (ADHD) are also available at **https://www.Anthem.com/provider/forms/**:

- Alcohol use assessment brochure
- Antidepressant medication management
- Edinburgh Postnatal Depression Scale
- Opioid use assessment brochure
- Substance Brief Intervention/Referral Tool (SBIRT)
- Vanderbilt ADHD Diagnostic Parent Rating Scale

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/coordination-of-care-23132**

Or scan this QR code with your phone

Administrative | Commercial | December 1, 2024

Clinical practice and preventive health guidelines available online

As part of our commitment to provide you with the latest clinical information and educational materials, we have adopted nationally recognized medical, behavioral health, and preventive health guidelines, which are available to care providers on our website. The guidelines, which are used for our quality programs, are based on reasonable, medical evidence and are reviewed for content accuracy, current primary sources, the newest technological advances, and recent medical research.

All guidelines are reviewed annually and updated as needed. The current guidelines are available on our website at **Anthem.com** under *For Providers*. Select **Policies, Guidelines & Manuals** under *Provider Resources*. Select your state, then scroll down and select ***Clinical Practice Guidelines*** or ***Preventive Health Guidelines***.

MULTI-BCBS-CM-072074-24-CPN70345

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/clinical-practice-and-preventive-health-guidelines-available-23087**

Or scan this QR code with your phone

Administrative | Medicare Advantage | November 18, 2024

Missouri 2025 Medicare Advantage plan changes

Annual benefit changes for Medicare Advantage plan members under Anthem Blue Cross and Blue Shield will be effective January 1, 2025.

Refer to **attachment** to view full details.

MOBCBS-CR-069482-24-CPN69435

ATTACHMENTS (available on web): **Missouri 2025 Medicare Advantage plan changes (pdf - 0.16mb)**

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/missouri-2025-medicare-advantage-plan-changes-23044**

Or scan this QR code with your phone

Administrative | Medicare Advantage | November 15, 2024

Skilled nursing facility — vaccine serum compensation

Skilled nursing facilities (SNF) compensated based on the prospective payment system for outpatient Medicare Advantage claims may see a change in vaccine serum reimbursement. Beginning March 1, 2025, Part B-covered vaccines will be reimbursed based on the CMS-published vaccine serum rates.

We are committed to helping patients more easily access the care they need.

MULTI-BCBS-CR-070574-24

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/skilled-nursing-facility-vaccine-serum-compensation-23001**

Or scan this QR code with your phone

Administrative | Commercial | December 1, 2024

Members' Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their providers, and their healthcare benefit plans. One of the first steps is for patients and providers to understand their rights and responsibilities. Therefore, in line with our commitment to involve the health plan, participating practitioners, and members in our system, Anthem has adopted a *Members' Rights and Responsibilities* statement.

The statement can be found on our website on the FAQ page. To access it, go to **Anthem.com** and select **For Providers**. From there, select **Policies, Guidelines & Manuals** under *Provider Resources*. Select your state and scroll down to **Member Rights and Responsibilities** under *More Resources*. Select the **Read about member rights** link. Then, under *Laws and Rights that Protect You*, select the question that says **What are my rights as a member?**

Practitioners may access the Federal Employee Plan (FEP) member portal at **fepblue.org/memberrights** to view the *FEP Member Rights and Responsibilities* statement.

MULTI-BCBS-CM-072072-24-CPN70344

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/members-rights-and-responsibilities-22927**

Or scan this QR code with your phone

Digital Solutions | Medicare Advantage | November 18, 2024

Expansion of Carelon Medical Benefits Management, Inc. programs

This is a reminder that effective March 1, 2025, Carelon Medical Benefits Management, Inc. will expand the cardiovascular program to perform medical necessity reviews for an additional procedure for Anthem members. Carelon Medical Benefits Management works to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments — helping to promote care that is appropriate, safe, and affordable.

The expansion will require clinical appropriateness review for additional procedures related to the Carelon Medical Benefits Management cardiovascular program.

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

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

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

Prior authorization review requirements

Carelon Medical Benefits Management will begin accepting PA requests February 24, 2025, for dates of service on or after March 1, 2025. For procedures scheduled to begin on or after March 1, 2025, care providers must contact Carelon Medical Benefits Management to obtain PA for the nonemergency modalities below. Refer to the *Clinical Guidelines* on the microsite resource pages for complete code lists.

Program	Services	*Medical Policies* or *Clinical Guidelines*
Cardiovascular	Vascular-carotidsinus device	SURG.00124

To determine if PA is needed for a member on or after March 1, 2025, call Provider Services using the phone number on the back of the member's ID card. Care providers using the interactive care reviewer (ICR) tool on at **https://Availity.com** for PA requests on an outpatient procedure will receive a message referring the provider to Carelon Medical Benefits Management (Note: ICR cannot accept PA requests for services administered by Carelon Medical Benefits Management).

How to place a review request

Care providers may place a PA request online to Carelon Medical Benefits Management by way of **providerportal.com**, which is available 24/7 and which processes requests in real time using *Clinical Criteria*.

For more information

For resources to help your practice get started with the cardiovascular programs, visit:

- **Cardiovascular Solution (careloninsights.com)**

Our website helps you access information and tools, such as order entry checklists, *Clinical Guidelines,* and answers to frequently asked questions.

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

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

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

MULTI-BCBS-CR-073060-24-CPN72846

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program-23022**

Or scan this QR code with your phone

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

Roster Automation updates: roster download functionality

At a glance:

- **Care providers can request and download a full roster for an organization and TIN.**
- **To request a roster, care providers must go to Payer Spaces in Availity Essentials as detailed below. This functionality is not on the *Upload Roster File* screen, which is where care providers upload rosters for processing.**
- **After downloading the roster, care providers can use it to easily edit demographic information.**

My Roster: request and download a copy of your current roster

Care providers can now download a copy of their full roster in Availity Essentials. This enhancement allows care providers to view and verify the demographic information we maintain and currently have loaded in our system.

To request a roster, go to **Availity.com** > Payer Spaces > Select Payer Tile > Provider Enrollment and Network Management > Request Current Roster.

Care providers will be prompted to select the organization name and TIN they would like included in the roster. Multiple TINs can be included in one request.

Download requested roster

The roster available for download from **Payer Spaces** in Availity Essentials will contain a few more columns than the standard template. The additional columns have drop-down

menus that enable care providers to indicate what data needs to be updated and how (for example, updates or terminations).*

Care providers can edit the downloaded roster and upload the updated version via Availity's *Upload Roster File* screen to easily make changes to their data. Because the download is correctly formatted, it should enable automatic processing.

* Care providers should continue to use the Provider Enrollment application in Availity Essentials to submit requests to add new practitioners under existing groups that require credentialing.

As a reminder, care providers are responsible for the accuracy of the data they submit as well as submitting updates timely. If updates are not submitted timely and result in claim denials or rejections, those denials will stand.

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.

MULTI-BCBS-CRCM-070809-24-CPN70176

MOBCBS-CRCM-072819-24

To view this article online:

Visit https://providernews.anthem.com/missouri/articles/roster-automation-updates-roster-download-functionality-22809

Or scan this QR code with your phone

Behavioral Health | Commercial / Medicare Advantage | December 1, 2024

Comprehensive, holistic care for obstructive sleep apnea

Our Sleep Apnea Program offers clinical and behavioral health support.

Creating the best health outcomes for your patients — our consumers — takes our combined efforts. That's why we're dedicated to partnering with care providers to focus on holistic, integrated care. This includes connecting behavioral and physical health, such as through our Sleep Apnea Program.

Untreated obstructive sleep apnea is related to physical conditions such as high blood pressure and behavioral health conditions such as anxiety and depression.[1,2] Through our Sleep Apnea Program, consumers receive support from our case managers and lifestyle coaches who collaborate with their specialty care providers to help better manage their overall health. The program helps address the multifaceted impact obstructive sleep apnea can have on consumers and their families.

Program eligibility

It's available to over 15,000 of our consumers across all lines of business, ages 60 to 75.[3] Eligibility is determined by diagnosis of both obstructive sleep apnea and a behavioral health condition, alongside at least two of the following:

- Hyperlipidemia
- Hypertension
- Obesity
- Substance use disorder
- Type 1 diabetes
- Type 2 diabetes

No patient referral is required; those who qualify are automatically identified through claims information and enrolled in the program. Be sure to talk with your patients who may be eligible and encourage them to participate.

The Sleep Apnea Program is one example of how we're working to transform healthcare with the goal of lowering costs and improving well-being.

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

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

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1 Bangash A, Wajid F, Poolacherla R, Mim FK, Rutkofsky IH.: *Obstructive Sleep Apnea and Hypertension: A Review of the Relationship and Pathogenic Association. Cureus* (2020): **ncbi,nlm,nih,gov/pmc/articles/PMC7306640/,**
2 Kim J, Ko I, Kim D. *Association of Obstructive Sleep Apnea With the Risk of Affective Disorders. JAMA Otolaryngol Head Neck Surg.* (2019): **jamanetwork,com/journals/jamaotolaryngology/fullarticle/2749521**.
3 Internal data (2024).

MULTI-BCBS-CRCM-070610-24-CPN70190

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/comprehensive-holistic-care-for-obstructive-sleep-apnea-22950**

Or scan this QR code with your phone

Education & Training | Medicare Advantage | November 18, 2024

Notice of change: Part D Rx HCCs

The *Inflation Reduction Act* and its impact on Part D Rx HCC model for 2025

On August 16, 2023, President Biden signed the *Inflation Reduction Act (IRA)* into law. This act brought about crucial reforms in the U.S. healthcare system, specifically impacting Medicare Advantage and Medicare Part D programs.

Starting January 1, 2025, the Part D Rx Hierarchical Condition Categories (HCC) risk adjustment (RA) model will undergo significant updates, reflecting the redesigned Part D benefits mandated by the *IRA*. This Medicare model helps categorize beneficiaries based on their overall health status and expected prescription drug costs. It will use diagnosis and drug utilization data to help predict healthcare costs associated with managing chronic conditions such as hypertension, COPD, and depression.

As part of the Part D Rx HCC model, it is essential for clinicians to thoroughly assess their patients' active chronic conditions for presence or absence during each encounter and at least once each year. By maintaining comprehensive, accurate, and complete documentation during patient visits and coding to the highest level of specificity, providers can significantly enhance:

- Submission of accurate and complete clinical documentation, coding, and data,
- Appropriate resources to support effective management of costs,
- Quality of patient care, and
- Adherence to compliance regulations.

Thank you for your attention to these important updates. As clinicians, your commitment to accurate and complete documentation and compliant coding practices is essential.

Together, we can navigate these changes and support the ongoing delivery of quality patient care.

If you have any RA Part D Rx HCC questions, please contact your Provider Success point of contact to coordinate efforts with the Enterprise Risk Adjustment team. For more detailed Part D model information, please visit the CMS website by clicking this **link**.

MULTI-BCBS-CR-072496-24-CPN72404

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/notice-of-change-part-d-rx-hccs-22984**

Or scan this QR code with your phone

Clinical Criteria updates

Effective December 2, 2024

Summary: On August 16, 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 members of 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
December 2, 2024	*CC-0266	Rytelo (imetelstat)	New
December 2, 2024	CC-0156	Reblozyl (luspatercept)	Revised
December 2, 2024	CC-0244	Columvi (glofitamab-gxbm)	Revised
December 2, 2024	CC-0124	Keytruda (pembrolizumab)	Revised
December 2, 2024	CC-0104	Levoleucovorin Agents	Revised
December 2, 2024	CC-0182	Iron Agents	Revised
December 2, 2024	CC-0197	Jemperli (dostarlimab-gxly)	Revised
December 2, 2024	CC-0247	Beyfortus (nirsevimab)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
December 2, 2024	*CC-0007	Synagis (palivizumab)	Revised
December 2, 2024	*CC-0082	Onpattro (patisiran)	Revised
December 2, 2024	*CC-0217	Amvuttra (vulrisiran)	Revised
December 2, 2024	*CC-0084	Tegsedi (inotersen)	Revised
December 2, 2024	*CC-0010	Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors	Revised
December 2, 2024	CC-0209	Leqvio (inclisiran)	Revised
December 2, 2024	*CC-0193	Evkeeza (evinacumab)	Revised
December 2, 2024	*CC-0027	Denosumab	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
December 2, 2024	CC-0019	Zoledronic Acid	Revised
December 2, 2024	CC-0208	Adbry (tralokinumab)	Revised
December 2, 2024	*CC-0029	Dupixent (dupilumab)	Revised
December 2, 2024	*CC-0246	Rystiggo (rozanolixizumab-noli)	Revised
December 2, 2024	*CC-0207	Vyvgart (efgartigimod alfa-fcab) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-gvfc)	Revised
December 2, 2024	*CC-0028	Benlysta (belimumab)	Revised
December 2, 2024	*CC-0194	Cabenuva (cabotegravir extended-release; rilpivirine extended -release) injection	Revised
December 2, 2024	*CC-0002	Colony Stimulating Factor Agents	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
December 2, 2024	CC-0127	Darzalex (daratumumab) and Darzalex Faspro (daratumumab and hyaluronidase-fihj)	Revised
December 2, 2024	CC-0121	Gazyva (obinutuzumab)	Revised
December 2, 2024	CC-0242	Epkinly (epcoritamab-bysp)	Revised
December 2, 2024	CC-0130	Imfinzi (durvalumab)	Revised
December 2, 2024	CC-0158	Enhertu (fam-trastuzumab deruxtecan-nxki)	Revised
December 2, 2024	CC-0050	Monoclonal Antibodies to Interleukin-23	Revised
December 2, 2024	CC-0066	Monoclonal Antibodies to Interleukin-6	Revised
December 2, 2024	CC-0071	Entyvio (vedolizumab)	Revised

Effective date	*Clinical Criteria* number	*Clinical Criteria* title	New or revised
December 2, 2024	*CC-0048	Spinraza (nusinersen)	Revised
December 2, 2024	*CC-0003	Immunoglobulins	Revised
December 2, 2024	*CC-0058	Sandostatin and Sandostatin LAR (Octreotide) / Octreotide Agents	Revised

MULTI-BCBS-CR-069101-24-CPN68761

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/clinical-criteria-updates-22790**

Or scan this QR code with your phone

New reimbursement policy: Trauma Activation — Facility

Beginning with dates of service on or after March 1, 2025, Anthem will implement a new reimbursement policy titled Trauma Activation — *Facility*.

Under this policy, trauma activation services billed on a *UB-04* claim form will be considered for reimbursement when the following criteria are met:

- Revenue code 068X (trauma activation) and CPT® code 99291 (critical care) must be billed on the same claim. The claim will not be considered for reimbursement if submitted without CPT code 99291 billed on the same claim.
- At least 30 minutes of critical care services must be rendered by the trauma activation team.

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

MULTI-BCBS-CM-072871-24

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/new-reimbursement-policy-trauma-activation-facility-23116**

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Products & Programs | Commercial | November 21, 2024

Expansion of Carelon Medical Benefits Management, Inc. programs

At a glance:

- **Carelon Medical Benefits Management will expand programs to include cardiovascular, musculoskeletal, and surgical reviews beginning March 1, 2025.**
- **Additional outpatient UM will include transportation, fertility, and various other therapeutic and monitoring services.**
- **Providers must obtain online pre-service reviews for certain procedures starting February 24, 2025.**

As a reminder, effective March 1, 2025, Carelon Medical Benefits Management will expand multiple programs to perform medical necessity reviews for additional procedures for our members. Carelon Medical Benefits Management works to improve healthcare quality and manage costs for today's most complex and prevalent tests and treatments, helping promote appropriate, safe, and affordable care.

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

Our *Clinical UM Guidelines* and *Medical Policies* (also known as coverage guidelines in Virginia) for medical necessity review are listed in the table below. Carelon Medical Benefits Management will begin accepting prior authorization requests on February 24, 2025, for dates of service on or after March 1, 2025.

Members included in the new program

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

Pre-service review requirements

For procedures scheduled to begin on or after March 1, 2025, all care providers must contact Carelon Medical Benefits Management to obtain a pre-service review for the services, including, but not limited to, the following non-emergency modalities. Please refer to the *Clinical Guidelines* at Anthem.com > **Providers** > **Provider Resources** > **Policies, Guidelines & Manuals** for complete code lists.

Note: All codes will be reviewed for medical necessity for the requested service and not for site of care.

Program	Services	*Medical Policies* or *Clinical Guidelines*
Additional outpatient UM	• Fertility • Therapeutic Apharesis • Hyperbaric Oxygen Therapy • Physiologic Record of Tremor • Parenteral Nutrition • Imaging Eval. of Skin Lesions • Ambulance Services • Virtual Reality-Assisted Therapy Systems	• CG-MED-68 • MED.00101 • CG-MED-89 • CG-MED-73 • DME.00011 • DME.00048 • MED.00011 • MED.00082 • MED.00092 • MED.00103

Program	Services	*Medical Policies* or *Clinical Guidelines*
	• Quantitative Sensory Test • Automated Nerve Conduction • Bioimpedance Spectroscopy • Autonomic Test • Monitor Intraocular Pressure • Seizure Monitoring • Home Visual Field Monitor • Eye Movement Analysis for Dx of Concussion • Colonic Irrigation • Electrical Stim. Tx. for Pain & Other Conditions • Sensory Stim. for Brain Injury • Automated Evacuation of Meibomian Gland • Selected Sleep Testing	• MED.00105 • MED.00112 • MED.00118 • MED.00130 • MED.00131 • MED.00137 • MED.00141 • MED.00002 • MED.00004 • CG-MED-66 • CG-MED-88 • CG-SURG-35 • LAB.00045 • CG-ANC-04 • CG-ANC-06

Program	Services	*Medical Policies or Clinical Guidelines*
Cardiovascular	• Carotid Sinus Baroreceptor Stim. Devices • Venous angioplasty w/wo stent placement • Vein embolization tx for pelvic congestion syndrome and varicocele • Tx of varicose veins • Artery stent placement w/wo angioplasty • Embolization proc. Dialysis circuit proc.	• CG-SURG-106 • CG-SURG-119 • CG-SURG-28 • CG-SURG-76 • CG-SURG-83 • CG-SURG-93 • RAD.00059 • SURG.00062 • SURG.00124
Musculoskeletal	• Peripheral Nerve Blocks for Tx of Neuropathic PainImplant of Nerve Stim. Devices	• *SURG.00140* • *SURG.00158* • *SURG.00112*
Surgical	• Anesthesia for Dental Svcs. • Skin Related Cosmetic & Reconstructive Services • Balloon Dilation of Eustachian Tubes • Functional Endoscopic Sinus Surgery • Bronchial Thermoplasty • Balloon Sinus Ostial Dilation • Cochlear & Auditory Brainstem Implants	• *SURG.00045* • *SURG.00112* • *SURG.00144* • *SURG.00129* • *ANC.00007* • *CG-MED-41* • *CG-MED-79* • *CG-MED-81* • *CG-SURG-03* • *CG-SURG-08*

Program	Services	*Medical Policies or Clinical Guidelines*
	• Implantable Hearing Aids • Surg. Tx for OSA & Snoring • Drug-Eluting Devices to Maintain Sinus Ostial Patency • Minimally Invasive Tx of Posterior Nasal Nerve for Rhinitis • Temporomandibular Disorders • Septoplasty • Nasal Valve Repair • Bariatric Surgery • MRI Guided US Ablation for Non-Oncologic Indications • Uterine Fibroid Ablation • Sacral Nerve Stim. Tx of Neurogenic Bladder secondary to Spinal Cord Injury • Vagus Nerve Stim. • Ablation for Solid Tumors Outside the Liver • Irreversible Electroporation • Corneal Collagen Cross Linking • Intraocular Telescope • Automated Evacuation of Meibomian Gland • Correct Intraocular Lenses	• *CG-SURG-09* • *CG-SURG-105* • *CG-SURG-117* • *CG-SURG-118* • *CG-SURG-12* • *CG-SURG-120* • *CG-SURG-18* • *CG-SURG-24* • *CG-SURG-61* • *CG-SURG-71* • *CG-SURG-73* • *CG-SURG-79* • *CG-SURG-81* • *CG-SURG-82* • *CG-SURG-83* • *CG-SURG-84* • *CG-SURG-88* • *CG-SURG-95* • *CG-SURG-96* • *CG-SURG-99MCG: ISC: S-660/660-RRG: Hysterectomy, Vaginal* • *MCG: ISC: S-450/450-RRG/5450: Laparotomy for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy* • *MCG: ISC: S-660/660-RRG: Hysterectomy,*

Program	Services	*Medical Policies or Clinical Guidelines*
	• Viscocanalostomy & Canaloplasty • Intraocular Anterior Segment Aqueous Drainage Devices • Extracorporeal Shock Wave Therapy • Implant of Nerve Stim. Devices • Implanted Artificial Iris Devices • Implanted Port Delivery Systems for Ocular Disease • Implantable Infusion Pumps • Tx for Urinary & Fecal Incontinence • Reduction Mammaplasty • Mastectomy for Gynecomastia • Panniculectomy & Abdominoplasty • Regenerative Cell Therapy & Soft Tissue Augmentation • Products for Wound Healing & Soft Tissue Grafting • Surg. & Ablative Tx for Chronic Headaches • Intraoperative Assess. of Surgical Margins During Breast-Conserving Surg. • Mandibular/Maxillary Surg.	*Vaginal* • *MCG: ISC: S-665/665-RRG: Hysterectomy, Laparoscopic* • *MCG: ISC: S-775/775-RRG: Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy* • *MED.00057* • *MED.00103* • *MED.00132* • *SURG.00010* • *SURG.00011* • *SURG.00061* • *SURG.00077* • *SURG.00079* • *SURG.00084* • *SURG.00095* • *SURG.00096* • *SURG.00107* • *SURG.00118* • *SURG.00120* • *SURG.00126* • *SURG.00132* • *SURG.00135* • *SURG.00139* • *SURG.00156*

Program	Services	*Medical Policies* or *Clinical Guidelines*
	• Blepharoplasty, Repair & Brow Lift • Internal Rib Fixation Systems • Prostate Saturation Biopsy • Focal Laser Ablation for Tx of Prostate Cancer • Penile Prosthesis Implantation • Diaphragmatic/Phrenic Nerve Stim. & Pacing Systems • US Ablation for Oncologic Indications • Radiofrequency Ablation of Renal Sympathetic Nerves • Hysterectomy • Laparoscopic Gynecologic Surgery • Myomectomy • Transurethral Destruction, Prostate Tissue • Nerve Block Therapy for Tx of Headache & Neuralgia • Deep Brain, Cortical, and Cerebellar Stim.	• *SURG.00157* • *SURG.00159* • *SURG.00160* • *SURG.00026*

To determine if prior authorization is needed for a member on or after March 1, 2025, contact the Provider Services phone number on the back of the member's ID card for benefit information. Care providers using the Interactive Care Reviewer (ICR) tool on

http://Availity.com/ to pre-certify an outpatient procedure will receive a message referring the provider to Carelon Medical Benefits Management. (**Note:** ICR cannot accept prior authorization requests for services administered by Carelon Medical Benefits Management.)

Care providers should continue to submit pre-service review requests to Carelon Medical Benefits Management using the convenient online service provided on the Carelon Medical Benefits Management provider website. The website is available 24 hours a day, seven days a week, and processes requests in real time using *Clinical Criteria*. Go to **https://www.providerportal.com/** to register.

For more information

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

Cardiovascular Solution | Carelon Insights

Radiology Solution | Carelon Insights

Sleep Solution | Sleep Healthcare | Carelon Insights

Surgical Procedures Solution | Carelon Insights

Radiation Oncology Solution | Carelon Insights

Additional Outpatient Utilization Management

Sign up at **provider training** for provider training for the additional outpatient UM:

- Wednesday, February 5, 2025, at 12 p.m. ET/11 a.m. CT
- Wednesday, February 12, 2025, at 12 p.m. ET/11 a.m. CT
- Friday, February 21, 2025, at 11 a.m. ET/10 a.m. CT
- Wednesday, February 26, 2025, at 12 p.m. ET/11 a.m. CT
- Wednesday, March 5, 2025, at 12 p.m. ET/11 a.m. CT

Our website, **Anthem.com,** provides information and tools such as order entry checklists, *Clinical Guidelines,* and FAQ. You can also contact your provider relationship management representative if you have any questions.

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

MULTI-BCBS-CM-072839-24

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/expansion-of-carelon-medical-benefits-management-inc-program-23151**

Or scan this QR code with your phone

Federal Employee Program (FEP) | Commercial | December 1, 2024

FEP excited to join PSHB program in 2025

What's changing

Effective January 1, 2025, postal employees will break out of the current Blue Cross Blue Shield Service Benefit Plan structure and participate in their own health benefit program: Postal Service Health Benefit Program (PSHB).

Refer to the attachment for more information.

MULTI-BCBS-CM-072405-24

ATTACHMENTS (available on web): **FEP excited to join PSHB program in 2025 (pdf - 0.2mb)**

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/fep-excited-to-join-pshb-program-in-2025-23103**

Or scan this QR code with your phone

Pharmacy | Commercial | December 1, 2024

Pharmacy information available online

Visit the Drug Lists page **here** for more information on:

- 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 *Exchange Select Formulary* and pharmacy information, scroll down to *Select Drug Lists*. This drug list is also reviewed and updated regularly as needed.

FEP Pharmacy updates and other pharmacy-related information may be accessed at **https://www.fepblue.org/** under *Pharmacy*.

If you do not have internet access, please call Provider Services to request a copy of the pharmaceutical information available online.

Through our efforts, we can help our care provider partners deliver high-quality, equitable healthcare.

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To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/pharmacy-information-available-online-23137**

Or scan this QR code with your phone

Pharmacy | Commercial | December 1, 2024

Kroger Specialty Pharmacy acquisition

The parent company of our pharmacy benefit management partner, CarelonRx, Inc., has acquired Kroger Specialty Pharmacy. This follows the recent acquisitions of Paragon Healthcare, Inc. and BioPlus Specialty Pharmacy, all aimed at enhancing support for individuals with chronic and complex conditions.

To ensure a seamless patient experience, most prescriptions for former Kroger Specialty Pharmacy patients are being handled by BioPlus Specialty Pharmacy, a CarelonRx company. This acquisition supports the ability of BioPlus to provide a comprehensive and personalized experience focused on the patient's whole health. If you have new specialty pharmacy prescriptions, please send them to BioPlus Specialty Pharmacy.

If you have any questions, please call your Anthem provider relationship management representative.

MULTI-BCBS-CM-072450-24-CPN72371

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/kroger-specialty-pharmacy-acquisition-23126**

Or scan this QR code with your phone

Pharmacy | Commercial | December 1, 2024

Paragon Healthcare joins our medical specialty pharmacy provider network in 2025

On January 1, 2025, Paragon Healthcare will join our medical specialty pharmacy provider network, for drugs covered under your patients' medical benefit. For more than 20 years, Paragon Healthcare has specialized in providing life-saving and life-giving infusible and injectable drug therapies through their omnichannel model of ambulatory infusion centers, home infusion pharmacies, and other specialty pharmacy services.

What happens next?

You may begin sending new prescriptions or renewals for medical specialty medications to a Paragon Healthcare specialty pharmacy, beginning January 1, 2025. You can reach Paragon Specialty at:

- Phone: **866-906-6560**
- Fax: **833-329-4343**
- NPI: 1114058534

Later in 2025, eligible medical specialty prescriptions with open refills at CVS Specialty Pharmacy will start to be transferred to Paragon Healthcare. You will receive a letter in the mail prior to each wave of migration with more details. Impacted patients will also receive a letter and phone call explaining the transition before it happens.

If you have questions, please call your provider relationship management representative. We are committed to finding solutions that help you offer quality services to your patients.

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MULTI-BCBS-CM-072448-24-CPN72367

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/paragon-healthcare-joins-our-medical-specialty-pharmacy-prov-23124**

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Pharmacy | Commercial | November 18, 2024

Specialty pharmacy updates — December 2024

Specialty pharmacy updates for Anthem are listed below.

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

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.

Prior authorization updates

Effective for dates of service on or after March 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* to view the complete information for these prior authorization updates.

Clinical Criteria	Drug	HCPCS or CPT® code(s)
CC-0267	Ebglyss (lebrikizumab-lbkz)	C9399, J3590

CC-0072	Eylea (aflibercept) biosimilars: Ahzantive (aflibercept-mrbb) Enzeevu (aflibercept-abzv) Opuviz (aflibercept-yszy) Pavblu (aflibercept-ayyh) Yesafili (aflibercept-jbvf)	C9399, J3590
*CC-0268**	Lymphir (denileukin diftitox-cxdl)	C9399, J9999
CC-0269	Nemluvio (nemolizumab-ilto)	C9399, J3590
*CC-0270**	Niktimvo (axatilmab-csfr)	C9399, J3590
CC-0011	Ocrevus Zunovo (ocrelizumab/hyaluronidase-ocsq)	J3590
CC-0271	Tecelra (afamitresgene autoleucel)	C9399, J9999

* Oncology use is managed by Carelon Medical Benefits Management.

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

Step therapy updates

Effective for dates of service on or after March 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.

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

Clinical Criteria	Status	Drug	HCPCS or CPT code(s)
CC-0011	Non-preferred	Ocrevus Zunovo (ocrelizumab/hyaluronidase-ocsq)	J3590

Quantity limit updates

Effective for dates of service on or after March 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* to view the complete information for these quantity limit updates.

Clinical Criteria	Drug	HCPCS or CPT code(s)
CC-0267	Ebglyss (lebrikizumab-lbkz)	C9399, J3590
CC-0072	Eylea (aflibercept) biosimilars: Ahzantive (aflibercept-mrbb) Enzeevu (aflibercept-abzv) Opuviz (aflibercept-yszy) Pavblu (aflibercept-ayyh) Yesafili (aflibercept-jbvf)	C9399, J3590

CC-0269	Nemluvio (nemolizumab-ilto)	C9399, J3590
CC-0011	Ocrevus Zunovo (ocrelizumab/hyaluronidase-ocsq)	J3590

MULTI-BCBS-CM-072458-24-CPN72383

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/specialty-pharmacy-updates-december-2024-23027**

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Pharmacy | Medicare Advantage | November 14, 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

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.

Navigating 2025 formulary changes: leveraging your EMR prescription drug price transparency tool

With Real-Time Prescription Benefit (RTPB), providers can access patient-specific drug benefit information within the e-prescribing process in their electronic health record (EHR).

This functionality allows providers to proactively identify formulary medications, barriers to cost and improve medication adherence.

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 real-time prescription benefit request
4. The PBM delivers cost, formulary, and utilization information for the selected pharmacy back to the prescriber's EHR.
5. Prescriber and patient make a choice together.
6. Help your patients navigate the 2025 formulary changes and save money on their prescriptions with Real-Time Prescription Benefit. Find out if your EHR vendor provides Real-Time Prescription Benefit. There's no charge for the service; however, you will need the latest version of your EHR.

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 **https://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.

MULTI-BCBS-CR-072216-24-CPN72003

To view this article online:

Visit **https://providernews.anthem.com/missouri/articles/medicare-part-d-overhaul-whats-new-in-2025-for-your-prescrip-22947**

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Quality Management | Medicare Advantage | December 1, 2024

Announcing Health Perks — Earn rewards for your healthcare activities

- **Starting in 2025, DSNP members can earn rewards by participating in select healthcare activities.**

Anthem is launching Health Perks, a new incentives program, for select completed healthcare activities starting January 1, 2025.

Dual Special Needs Plan (DSNP) members are eligible for rewards for the following healthcare activities received between January 1, 2025, and December 31, 2025.

Healthcare activity	Reward amount	Eligible claim codes
Annual wellness visit/annual physical	$30	92002, 92004, 92012, 92014, 98966, 98967, 98968, 98970, 98971, 98972, 98980, 98981, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99421, 99422, 99423, 99429, 99441, 99442, 99443, 99457, 99458, 99483, G0071, G0402, G0438, G0439, G0463, G2010, G2012, G2250, G2251, G2252, S0620, S0621, T1015, 0510, 0511, 0513, 0514, 0515, 0516, 0517, 0519, 0520, 0521, 0522, 0523, 0524, 0525, 0526, 0527, 0528, 0529, 0982, 0983, Z00.00, Z00.01, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9, Z76.1, Z76.2
Breast cancer screening	$20	77061, 77062, 77063, 77065, 77066, 77067
Colorectal screening	$30	44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386 45388, 45389, 45390, 45391, 45392, 45393, 45398, G0105, G0121, 45.22, 45.23, 45.25, 45.42, 45.43, 74261, 74262, 74263, 60515-4, 72531-7, 79069-1, 79071-7, 79101-2, 82688-3, 418714002, 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350, G0104, 45.24, 44441009, 841000119107, 396226005, 425634007

Healthcare activity	Reward amount	Eligible claim codes
Fecal occult blood test	$10	82270, 82274, G0328, 14563-1, 14564-9, 14565-6, 2335-8, 27396-1, 29771-3, 58453-2
Bone density screening	$10	76977, 77078, 77080, 77081, 77085, 77086, BP48ZZ1, BP49ZZ1, BP4GZZ1, BP4HZZ1, BP4LZZ1, BP4MZZ1, BP4NZZ1, BP4PZZ1, BQ00ZZ1, BQ01ZZ1, BQ03ZZ1, BQ04ZZ1, BR00ZZ1, BR07ZZ1, BR09ZZ1, BR0GZZ1, 88.98, J0897, J1740, J3489, J0897, J1740, J3110, J3111, J3489
Flu vaccine	$10	88, 135, 140, 141, 144, 150, 153, 155, 158, 166, 168, 171, 185, 186, 197, 205, 90630, 90653, 90654, 90656, 90658, 90661, 90662, 90673, 90674, 90682, 90686, 90688, 90689, 90694, 90756, 111, 149, 90660, 90672

Coverage:

- **For colonoscopy, annual wellness visit, and breast cancer screenings —** No out-of-pocket costs or copayment for the member when completed by an in-network provider:
    - Note: A cost share may apply for additional services or testing performed during the visit as described for each service in this medical chart.
- **For bone density screenings —** Medicare Part B (medical insurance) covers this test once every 24 months (or more often if medically necessary) if one or more of these conditions is met:
    - They are a woman whose doctor determines they are estrogen-deficient and at risk for osteoporosis based on their medical history and other findings.

- Their X-rays show possible osteoporosis, osteopenia, or vertebral fractures.
- They are taking prednisone or steroid-type drugs or are planning to begin this treatment.
- They have been diagnosed with primary hyperparathyroidism.
- They are being monitored to see if their osteoporosis drug therapy is working.

For further information or to verify member eligibility, benefits, or account information, call the phone number on the back of the member's identification card.

MULTI-BCBS-CR-066371-24-CPN66349

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