Indiana Provider News

March 2023 Anthem Provider News - Indiana

Medicaid:

Medicare:

Reminder - Updated Carelon Musculoskeletal Program effective April 1, 2023: monitored anesthesia care reviews

Published: Mar 1, 2023 - **Administrative**

We communicated in the June 2022 edition of the *Provider News* that Carelon Medical Benefits Management, Inc.* (then, AIM Specialty Health®), would expand the Musculoskeletal Program for Anthem Blue Cross and Blue Shield (Anthem) fully insured members and select members who are covered under self-insured (ASO) benefit plans with services medically managed by Carelon beginning October 1, 2022. However, the initial program implementation was delayed. The confirmed new implementation date is April 1, 2023.

Unless otherwise stated in the provider's agreement, for services on or after April 1, 2023, prior authorization will be required for the clinical appropriateness of monitored anesthesia or conscious sedation (MAC) when requested in conjunction with interventional pain codes. Carelon will use the following Anthem *Clinical UM Guideline:* CG-MED-78: *Anesthesia Services for Interventional Pain Management Procedures*. The *Clinical Criteria* to be used for these reviews can be found on the Anthem provider website *Clinical UM Guidelines* page. Clinical site of care review may also apply if these procedures are requested in a hospital outpatient department and could safely be done in an ambulatory surgery center. If you have a member in a current course of treatment for pain management where services were approved without reviewing the MAC, identify the member for us at the next request. **Please note, this does not apply to procedures performed on an emergent basis.**

The anesthesiologist may determine that a member requires monitored anesthesia on the day of service. A retrospective review may be requested, or a post service claim may be submitted with a clinical record including the pre-anesthesia assessment, the patient's medical history documenting that patient meets criteria for MAC, and a detailed description of the procedure performed for Carelon to determine coverage for the service as medically necessary.

At this time, the codes that will be reviewed are 01991, 01992, 01937, 01938, 01939, and 01940. A complete list of CPT® codes requiring prior authorization for the *Carelon Monitored Anesthesia Care for Interventional Pain* program is available on the Carelon Musculoskeletal microsite. To determine if prior authorization is needed for a member on or after April 1, 2023, contact the Provider Services phone number on the back of the member's ID card for benefit information. Providers using the Interactive Care Reviewer (ICR) tool on the Availity Essentials* platform to pre-certify an outpatient musculoskeletal service will receive a message referring the provider to Carelon. (**Note: ICR cannot accept prior authorization requests for services administered by Carelon.**)

Members included in the new program

Members of the following products are excluded: Medicare Advantage, Medicaid, Medicare, Medicare supplement, MA GRS, Federal Employee Program® (FEP®).

Pre-service review requirements

For services provided on or after April 1, 2023, ordering and servicing providers may begin contacting Carelon as early as March 20, 2023, for review. Providers may submit prior authorization requests to Carelon in one of the following ways:

- Access Carelon's ProviderPortal$_{SM}$ directly at **www.providerportal.com**. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization. Initiating a request on Carelon's ProviderPortal$_{SM}$ and entering responses to all the requested clinical questions will allow you to receive an immediate determination.
- Access Carelon via Availity Essentials* at **www.availity.com** in **Payer Spaces** under the *Resources* tab.
- Call the Carelon Contact Center's toll-free number at **877-291-0360**, Monday through Friday, 8 a.m. to 5 p.m. ET.

Training webinars

Carelon will be offering two Monitored Anesthesia Care training sessions that providers are invited to attend:

- Thursday March 30, 2023 – 12 p.m. ET

  Register **here**.

- Thursday April 6, 2023 – 12 p.m. ET

  Register **here**.

We value your participation in our network and look forward to working with you to help improve the health of our members.

* CarelonRx, Inc. is a separate company providing utilization review services on behalf of the health plan. Availity, LLC is an independent company providing administrative support services on behalf of the health plan.

MULTI-BCBS-CM-017598-23

AIM Specialty Health will transition to Carelon Medical Benefits Management Inc.

Published: Mar 1, 2023 - **Administrative**

This communication applies to the Commercial, Medicaid, and Medicare Advantage programs from Anthem Blue Cross and Blue Shield in Indiana.

In March 2023, AIM Specialty Health®* will transition to Carelon Medical Benefits Management Inc. **This transition is a name change only, and there will be no process changes.** The new name will not impact the way AIM works with health plans and providers. In March, any operational assets that mention AIM Specialty Health (such as determination letters) will adopt the new Carelon Medical Benefits Management Inc. name.

Provider brand transition FAQ

Provider experience focus area	
1. Will the **AIM *ProviderPortal*$_{SM}$** URL or platform name be changed?	1. No, the website address will not be impacted; all providers will continue to have access to **www.providerportal.com**. The AIM logo will be replaced with a Carelon logo. No changes are being made to the case submission process.
2. Will there be any changes to the ***AIM Clinical Guidelines*** URL or content?	2. Yes, the clinical guidelines site will be automatically redirected to a new Carelon URL, and the branding will be updated to reflect Carelon.
3. Are any phone number changes planned as part of this transition?	3. No, inbound phone numbers are not being changed. References to AIM within recorded scripting will be replaced with Carelon Medical Benefits Management Inc.
4. Will there be any changes for providers who connect with AIM via other means such as **Availity Essentials***?	4. No, access changes are not needed or planned; however, all references to the AIM company name will eventually be updated to Carelon Medical Benefits Management Inc.
5. Will AIM references on health plan websites and member materials such as ID cards be changed?	5. Not right away. Providers may continue to see the AIM company name on health plan websites and member ID cards for some time, but it's expected that these will be changed through scheduled content update cycles.
Corporate website	
1. Will the **AIM corporate website** URL be changed?	1. The corporate website will be moved to **www.carelon.com**. All links to the ***Provider****Portal* and clinical guideline pages will remain active and will be redirected.
Provider microsites	

1. Will the AIM provider microsite URLs change?	1. The provider microsite URLs you use today to access information from AIM will be automatically redirected to new Carelon URLs, and the branding will be updated to reflect Carelon branding.

* Availity, LLC is an independent company providing administrative support services on behalf of the health plan. AIM Specialty Health is an independent company providing some utilization review services on behalf of the health plan.

INBCBS-CDCRCM-015622-22

URL: https://providernews.anthem.com/indiana/article/aim-specialty-health-will-transition-to-carelon-medical-benefits-management-inc-15

Statin Therapy Exclusions for Patients With Cardiovascular Disease/Diabetes HEDIS measures

Published: Mar 1, 2023 - **Administrative**

This communication applies to Commercial and Medicare Advantage plans from Anthem Blue Cross and Blue Shield (Anthem).

The Statin Therapy Exclusions for Patients With Cardiovascular Disease (SPC) HEDIS® measures examines the percentage of patients with atherosclerotic cardiovascular disease (SPC) who received and adhered to statin therapy throughout the measurement year. However, statin therapy does not work for everyone, and alternative therapies are necessary to minimize their risk for future complications. If you have patients who cannot tolerate statin therapy, it is important that you document and notify us annually so we can exclude the patients from your list of open care gaps. Refer to NCQA guidelines for a complete listing of exclusion criteria.

How to submit exclusion data:

- Indicate the appropriate ICD-10 code for encounters.
- Use standard data file submission or EMR/EHR access for supplemental data collection.

Exclusions are applied based on diagnosis codes on the date of service provided on the claim or through supplemental data collection. Based on the timing of your data submission and when reports are generated, it may take several weeks for exclusions to be reflected on your reports.

Please note, if exclusions are not coded properly or given to Anthem Blue Cross and Blue Shield in the proper format, the care gap will remain open until the failure reason is corrected. Patients listed on the *open care gap report* are assumed to tolerate statin therapy and will have their care gaps closed after claims for moderate to high intensity statins are adjudicated by Anthem.

Tips for implementing best practices and improving your quality scores:

- Educate your patients on the importance of adhering to their statin therapy regime and on potential side effects. If they start to experience muscle pain or weakness, have them contact you to discuss their options.
- Statin therapy should also be accompanied by lifestyle modifications, such as a healthy diet and exercise. Work with your patients to proactively identify and overcome any barriers that may prevent lifestyle modifications. Discuss creating a realistic, individualized exercise routine based on the patient's ability and interests. Encourage a healthy diet based on the patient's culture and locally available produce, stores, and resources.

If you have any questions or concerns about Anthem Blue Cross and Blue Shield you can contact the phone number on the back of the member's ID card for Provider Services.

MULTI-BCBS-CRCM-015194-22-CPN14452

URL: https://providernews.anthem.com/indiana/article/statin-therapy-exclusions-for-patients-with-cardiovascular-diseasediabetes-hedis-measures-1

Carelon Medical Benefits Management (formerly AIM Specialty Health) Radiology Clinical Appropriateness Guidelines CPT code list update*

Published: Mar 1, 2023 - **Administrative**

**Change* to Prior Authorization Requirements*

This communication applies to Commercial and Medicare Advantage plans from Anthem Blue Cross and Blue Shield.

Effective for dates of service on and after June 1, 2023, the following code updates will apply to the Carelon Medical Benefits Management, Inc. Radiology Clinical Appropriateness Guidelines.

Advanced imaging of the abdomen and pelvis

CPT® code	Description
0648T	Quantitative magnetic resonance for analysis of tissue composition (for example, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation, and report, obtained without diagnostic MRI examination of the same anatomy (for example, organ, gland, tissue, target structure) during the same session.

Oncologic imaging

CPT code	Description
0633T	CT Breast W/3d Rendering Uni without contrast
0634T	CT Breast W/3d Rendering Uni with contrast
0635T	CT Breast W/3d Rendering Uni with or without contrast
0636T	CT Breast W/3d Rendering Bi without contrast
0637T	CT Breast W/3d Rendering Bi with contrast
0638T	CT Breast W/3d Rendering Bi with or without contrast

As a reminder, ordering and servicing providers may submit prior authorization requests to Carelon in one of several ways:

- Access the ***Provider****Portal*$_{SM}$ directly at **providerportal.com.**

- **Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.**

- Access the Availity* website at **availity.com.**

If you have questions related to guidelines, please email MedicalBenefitsManagement.guidelines@carelon.com. Additionally, you may access and download a copy of the current and upcoming guidelines **here**.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield. Carelon Medical Benefits Management, Inc. is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield.

MULTI-BCBS-CRCM-013590-22-CPN12763

URL: https://providernews.anthem.com/indiana/article/carelon-medical-benefits-management-formerly-aim-specialty-health-radiology-clinical-appropriateness-guidelines-cpt-code-list-update-1

New policy for EMR clinical data sharing and ADT notifications*

Published: Mar 1, 2023 - **Administrative**

**Change to Prior Authorization Requirements*

Effective June 1, 2023, Anthem Blue Cross and Blue Shield (Anthem) is implementing a new policy related to submission of certain clinical data that builds upon our 2021 policy regarding sharing of ADT notifications.

When requested by Anthem, providers will be required to submit clinical data (such as discharge summaries, consult notes, and medication lists) and admission, discharge, and transfer (ADT) data to Anthem for certain healthcare operations functions. We collect this data to improve the quality and efficiency of healthcare delivery to our members. Providers are required to submit:

- ADT data to Anthem on a near real-time basis (no later than 24 hours) from the time of admission, discharge, or transfer of a member.
- Clinical data for a member on a daily, weekly, or monthly basis, based on the provider's electronic medical record (EMR) or other electronic data sharing capabilities.

Anthem's permitted uses of the data with respect to clinical data requests include utilization management, case management, identification of gaps in care, conducting clinical quality improvement, risk adjustment, documentation in support of HEDIS® and other regulatory and accrediting reporting requirements, and for any other purpose permitted under *HIPAA*.

Anthem has determined the data requested is the minimum necessary for Anthem to accomplish its intended purposes. The data will be provided in accordance with data layout and format requirements defined by Anthem.

We value you as our partner in providing quality care and appreciate your continued participation in our network.

MULTI-BCBS-CM-017652-23

URL: https://providernews.anthem.com/indiana/article/new-policy-for-clinical-data-sharing-and-adt-notifications-5

You are invited: Advancing Mental Health Equity for Youth & Young Adults

Published: Mar 1, 2023 - **Administrative**

Register today for the Advancing Mental Health Equity for Youth & Young Adults forum hosted by Anthem Blue Cross and Blue Shield (Anthem) and Motivo* for Anthem providers on March 15, 2023.

Anthem is committed to making healthcare simpler and reducing health disparities for youth and young adults. We believe that advancing health equity for young people is critical to not only improving their experience, but also ensuring the mental health system is a safe and trusted resource. Authentic conversations lead to reducing implicit bias and improving the health and wellbeing of all Americans and the communities in which we live and serve.

Wednesday, March 15, 2023
4 to 5:30 p.m. ET

Please register for this event by visiting this **link**.

Please join us to hear from a diverse panel of experienced professionals from Motivo and Anthem as we discuss the intersection of mental health, race, sexual orientation, gender identity, disability, and supporting youth and young adults on their mental health journey.

Each quarterly forum will continue the exploration of ways we can reduce disparities in healthcare, demonstrate cultural humility, address and deconstruct bias, have difficult and productive conversations, learn about valuable resources, and increase diversity equity and inclusion in healthcare.

* Motivo is an independent company providing a virtual forum on behalf of Anthem Blue Cross and Blue Shield.

MULTI-BCBS-CRCM-017473-23-CPN17407

Article Attachments

MULTI-BCBS-CRCM-017473-23-CPN17407 EXPRESS Racial Equity Forum Q1 2023_FINAL.pdf
application/pdf - 482.45 KB

URL: https://providernews.anthem.com/indiana/article/you-are-invited-advancing-mental-health-equity-for-youth-young-adults-1

March is National Colorectal Cancer Awareness Month

Published: Mar 1, 2023 - **Administrative**

In conjunction with National Colorectal Cancer Awareness Month, Anthem Blue Cross and Blue Shield (Anthem) would like to remind healthcare professionals to raise awareness to their patients about colorectal cancer screenings.

Encourage your patients to make time for regular colorectal cancer screenings. It's one of the most valuable ways they can protect their health and peace of mind. Colorectal cancer is the **third most common type of cancer among adults**, but it often doesn't show any symptoms, especially at first.

The good news is that the **survival rate for colorectal cancer is about 90%** when it's caught early, before it's had the chance to spread. Regular screenings are the number one way to detect it, but **many adults who need screenings don't get them**. Making these important tests a priority is about your patients staying healthy and strong for the ones they love.

The **American Cancer Society**[1] recommends that most adults have regular colorectal cancer screenings from age 45 to age 75. Talk to your patients about when and how often they should be tested and what kind of screening is right for them.

You and your Anthem patients have access to high-quality, low-cost colorectal cancer screening fecal immunochemical test (FIT) kits by Labcorp and Quest Diagnostics. If you have specific questions, contact the labs directly:

- Labcorp: FIT test, **888-LABCORP** (**888-522-2677**) or **labcorp.com/cancer/colorectal/providers**
- Quest Diagnostics: InSure ONE™ kit, **866-MY-QUEST** (**866-697-8378**) or **https://clinical.QuestDiagnostics.com/QuestInSureONE**

To find Labcorp, Quest Diagnostics and other participating labs in your patient's plan network, select **Find Care** from the *Provider Resources* menu at https://www.anthem.com.

[1] Colorectal Cancer Guideline | How Often to Have Screening Tests

MULTI-BCBS-CM-018516-23

URL: https://providernews.anthem.com/indiana/article/march-is-national-colorectal-cancer-awareness-month-1

Engagement with your patient counts

Published: Mar 1, 2023 - **Administrative**

This communication applies to the Commercial, Medicaid, and Medicare Advantage programs from Anthem Blue Cross and Blue Shield in Indiana.

Why is this important?
Each year, a random sample of enrolled members receive a *CAHPS* Survey* or a *Qualified Health Plan Enrollee Survey* asking them to evaluate their experiences with healthcare. The surveys ask members to rate their experiences with:

1. Their health plan.
2. Their personal provider.
3. Their specialist.

Several responses are combined and evaluated for the following:

- Getting needed care
- Receiving care quickly
- Communicating with providers
- Sharing in the decision-making process

The responses give us an idea of how your patients and our members perceive us and provide opportunities for us to improve the way we deliver services. Our engagement and interaction with patients and members are critical. Together, we can provide positive experiences for our shared members and patients.

Members receive the survey either by mail or phone between February and May. Some of the
questions they are asked include:

- In the last six[1] months, how often did your personal provider explain things in a way that was easy to understand?
- In the last six[1] months, how often did your personal provider listen carefully to you?
- In the last six[1] months, how often did your personal provider show respect for what you had to say?
- In the last six[1] months, how often did your personal provider spend enough time with you?
- Using any number from zero to 10, where zero is the worst personal provider possible,

and 10 is the best personal provider possible, what number would you use to rate your personal doctor?

- We want to know your rating of the specialist you saw most often in the last six[1] Using any number from zero to 10, where zero is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate the specialist?

Every interaction with a patient is an opportunity to make their healthcare experience positive.

We thank you for striving to provide quality care for our members and for the continued focus on improving our member experience.

Additional information

Continuing medical education (CME) education opportunities: **http://www.mydiversepatients.com.**

[1]The commercial survey asks the same questions, but for the last 12 months vs. 6 months and language on the Medicaid Child Survey is slightly different to reflect asking a parent/guardian about their child's experience.

*CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

INBCBS-CDCRCM-008616-22-CPN6881

URL: https://providernews.anthem.com/indiana/article/engagement-with-your-patient-counts-11

Physical and manipulative therapy for restoration versus maintenance

Published: Mar 1, 2023 - **Administrative**

Physical and manipulative therapy benefits, including chiropractic benefits, are only covered with habilitative or rehabilitation diagnoses and as part of a restoration course of treatment.

Some plans may opt to cover these benefits as part of a maintenance program. However, most plans consider maintenance a noncovered service.

Any questions?
Please contact your assigned Anthem Blue Cross and Blue Shield Provider Relationship Management account manager.

INBCBS-CM-017309-23

URL: https://providernews.anthem.com/indiana/article/physical-and-manipulative-therapy-for-restoration-versus-maintenance

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Important reminder: Preventive care guidance for colonoscopy screening

Published: Mar 1, 2023 - **Administrative**

On January 10, 2022, updated **Preventive Care Guidance** was released by the U.S. Departments of Labor, Health and Human Services (HHS), and the Treasury. This new guidance applies to most *Affordable Care Act*-compliant non-grandfathered health plans like Anthem Blue Cross and Blue Shield (Anthem) when services are provided in network.

This new guidance indicates:
On May 18, 2021, the United States Preventive Services Task Force (USPSTF) updated its ***recommendation for ectal cancer screening****. The USPSTF continues to recommend with an "A" rating screening for ectal cancer in all adults aged 50 to 75 years and extended its recommendation with a "B" rating to adults aged 45 to 49 years. In its "Practice Considerations" section detailing screening strategies, the Final Recommendation Statement provides: "When stool-based tests reveal abnormal results, follow up with colonoscopy is needed for further evaluation…. Positive results on stool-based screening tests require follow-up with colonoscopy for the screening benefits to be achieved." Additionally, the Final Recommendation Statement provides with respect to direct visualization tests: "Abnormal findings identified by flexible sigmoidoscopy or CT colonography screening require follow-up colonoscopy for screening benefits to be achieved."*

For a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test for ectal cancer, in-network providers should code the claim as a screening colonoscopy rather than as a diagnostic colonoscopy.

Providers can contact the Provider Service number on the back of the member ID card to determine if a member's plan includes this benefit.

INBCBS-CM-017389-23

URL: https://providernews.anthem.com/indiana/article/important-reminder-preventive-care-guidance-for-colonoscopy-screening

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Reimbursement policy update: Modifiers 25 and 57 - Professional

Published: Mar 1, 2023 - **Policy Updates** / Reimbursement Policies

Effective March 1, 2023, the *Modifiers 25 and 57: Evaluation and Management with Global Procedures* reimbursement policy will be renamed *Modifiers 25 and 57 - Professional*. Additionally, the *Nonreimbursable* section of the *Modifiers 25 and 57* policy was updated to indicate that CPT® code 99211 is not eligible for reimbursement when billed with modifier 25. This update was previously communicated in the July 2022, edition of the *Provider News* article titled *Reimbursement Policy update:Modifier Rules – Professional:*

- **July 2022 *Provider News* article for Indiana**

For specific policy details, visit the following *Reimbursement Policy* pages at the Anthem Blue Cross and Blue Shield website:

- **Indiana *Reimbursement Policy* page**

MULTI-BCBS-CM-018757-23

URL: https://providernews.anthem.com/indiana/article/reimbursement-policy-update-modifiers-25-and-57-professional-3

Consumer payment option, Pay Doctor Bill, to terminate effective March 31, 2023

Published: Mar 1, 2023 - **Products & Programs**

This communication applies to Commercial and Medicare Advantage plans from Anthem Blue Cross and Blue Shield (Anthem).

The provider payment option, Pay Doctor Bill, offered to consumers via InstaMed,* will be terminated effective March 31, 2023. Anthem contracted with InstaMed to deliver options for consumers to view their claims and pay their out-of-pocket responsibility to doctors from the Sydney Health mobile app or from **https://www.anthem.com/provider**.This is not related to the payment of health insurance premiums.

Even though this option will no longer be available, consumers still have other ways of paying doctors:

- Through a Health Savings Account (HSA) or Flexible Spending Account (FSA) if they have this type of account
- Through their bank's bill pay feature on a mobile app or website
- Directly through doctor's secure payment website or at the doctor's office with a debit or credit card

A month prior to the termination of Pay Doctor Bill from the Sydney Health mobile app and the Anthem website, we will notify consumers within these applications.

* InstaMed is an independent company providing consumers with access to provider payment options on behalf of the health plan.

MULTI-BCBS-CRCM-015142-22-CPN14680

URL: https://providernews.anthem.com/indiana/article/consumer-payment-option-pay-doctor-bill-to-terminate-effective-march-31-2023-2

Specialty pharmacy updates for March 2023*

Published: Mar 1, 2023 - **Products & Programs** / Pharmacy

**Change to Prior Authorization Requirements*

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

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

Including the national drug code on your claim may help expedite claim processing for drugs billed with a *not otherwise classified* code.

Prior authorization updates
Effective for dates of service on and after June 1, 2023, 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-0227	Briumvi (ublituximab)	J3490, J3590
CC-0228	Leqembi (lecanemab)	J3490, J3590
CC-0229	Sunlenca (lenacapavir)	J3490, C9399

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

Step therapy updates
Effective for dates of service on and after January 17, 2023, 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-0227	Non-preferred	Briumvi (ublituximab)	J3490, J3590

Quantity limit updates

Effective for dates of service on and after June 1, 2023, 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-0227	Briumvi (ublituximab)	J3490, J3590
CC-0229	Sunlenca (lenacapavir)	J3490, C9399

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

MULTI-BCBS-CM-019364-23-CPN18451

URL: https://providernews.anthem.com/indiana/article/specialty-pharmacy-updates-for-march-2023-3

Pharmacy information available on our provider website

Published: Mar 1, 2023 - **Products & Programs** / Pharmacy

Visit the **Drug Lists** page on our provider website at **https://www.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 **www.fepblue.org** > Pharmacy Benefits.

MULTI-BCBS-CM-018448-23

URL: https://providernews.anthem.com/indiana/article/pharmacy-information-available-on-our-provider-website-1

Keep up with Medicaid News - March 2023

Published: Mar 1, 2023 - **State & Federal** / Medicaid

Please continue to check Provider Communications & Updates on the provider webpage for the latest information, including:

- *Medical Policies* and *Clinical Utilization Management Guidelines* Update
- Prior authorization updates for medications billed under the medical benefit (Yusimry)

URL: https://providernews.anthem.com/indiana/article/keep-up-with-medicaid-news-march-2023-1

Complex Case Management program

Published: Mar 1, 2023 - **State & Federal** / Medicaid

Managing healthcare can be an especially daunting task for some patients. It can be difficult to know how to obtain essential resources for treatment, or who to contact with questions and concerns.

Anthem Blue Cross and Blue Shield is available to offer assistance through our Complex Case Management program. Our care managers are part of an interdisciplinary team of clinicians and other resource professionals working to support members, families, PMPs, and caregivers. Our Complex Case Management process uses the experience and expertise of our Case Coordination team to educate and empower our members by increasing self-management skills. It can also help members understand their condition and learn about care choices to ensure they have access to quality, efficient healthcare.

Members or caregivers can refer themselves or family members by calling the Member Services number located on the back of their ID card. They will be transferred to a care manager based on their immediate need. Physicians can refer their patients by contacting us telephonically or through electronic means. We can help with transitions across levels of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

You can contact us by phone at:

- Hoosier Healthwise: **866-408-6132**
- Healthy Indiana Plan: **844-533-1995**
- Hoosier Care Connect: **844-284-1798**

Our Complex Case Management business hours are Monday through Friday from 8 a.m. to 5 p.m. ET.

The Complex Case Management team provides the following services:

- Assists members in establishing a medical, dental, or behavioral health home, and educates them on the value of prevention and wellness.
- Provides education to members with a new diagnosis and supports them in acquiring prescribed medical equipment to support their treatment plan.
- Assists members with smoking cessation/reduction through education and connection to local resources to achieve healthier living.
- Provides support, education, and resources to high-risk OB populations to support the

reduction of infant mortality, prematurity, and low birth weight.

- Assesses for desire and readiness to connect our non-English speaking population to English as a second language classes and other support resources to enhance their cultural experience in Indiana.

Complex Case Management is a member-centric program, which promotes autonomy, healthy living, ease of utilizing their benefits, and much more.

INBCBS-CD-003826-22-CPN3339

URL: https://providernews.anthem.com/indiana/article/complex-case-management-program-27

Important information about utilization management

Published: Mar 1, 2023 - **State & Federal** / Medicaid

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. We do not 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 underutilization. Our medical policies are available on our provider website at **https://www.anthem.com/provider/policies/clinical-guidelines/search**.

You can request a free copy of our UM criteria from our Medical Management department. Providers can discuss a UM denial decision with a physician reviewer by calling us toll-free at the numbers listed below. You can access UM criteria online at the web address listed above.

We are staffed with clinical professionals who coordinate our members' care and are available 24/7 to accept precertification requests. Secured voicemail is available during off-business hours. A clinical professional will return your call within the next business day. Our staff will identify themselves by name, title, and organization name when initiating or returning calls regarding UM issues.

You can submit precertification requests by:

- Submitting online at:
    - Availity Essentials:* **availity.com**
- Calling our Provider Helpline at:
    - Hoosier Healthwise: **866-408-6132**
    - Healthy Indiana Plan: **844-533-1995**
    - Hoosier Care Connect: **844-284-1798**
- Faxing us at:
    - Inpatient medical fax: **866-406-2803**
    - Outpatient medical fax: **866-406-2803**
    - Pharmacy fax (retail): **844-864-7860**
        - Medical injectable: **888-209-7838**

- Behavioral health inpatient fax: **844-452-8074**
- Behavioral health outpatient fax: **844-456-2698**

Have questions about utilization decisions or the UM process?
Call us at the Provider Helpline listed above, Monday through Friday, from 8 a.m. to 8 p.m.

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

INBCBS-CD-003871-22-CPN3786

URL: https://providernews.anthem.com/indiana/article/important-information-about-utilization-management-84

Keep up with Medicare News - March 2023

Published: Mar 1, 2023 - **State & Federal** / Medicare

Please continue to read news and updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

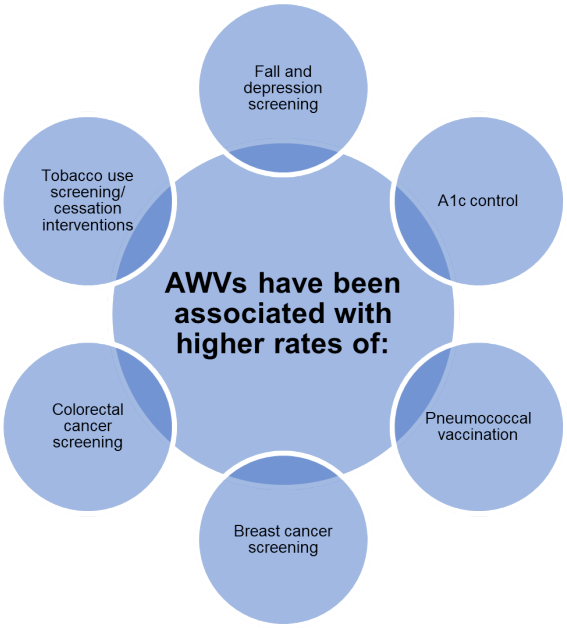
- Update: Carelon Medical Benefits Management, Inc. Cardiology Clinical Appropriateness Guidelines CPT Code List for Indiana
- Carelon Medical Benefits Management, Inc. Genetic Testing Clinical Appropriateness Guidelines CPT code list update
- What date to select for inpatient admissions for claims
- *Clinical Criteria* updates
- New specialty pharmacy medical step therapy requirements (Neulasta, Neulasta OnPro, Udenyca)
- Updates to Carelon Medical Benefits Management, Inc. *Cardiac Clinical Appropriateness Guidelines*

URL: https://providernews.anthem.com/indiana/article/keep-up-with-medicare-news-march-2023-3

Annual planned visits

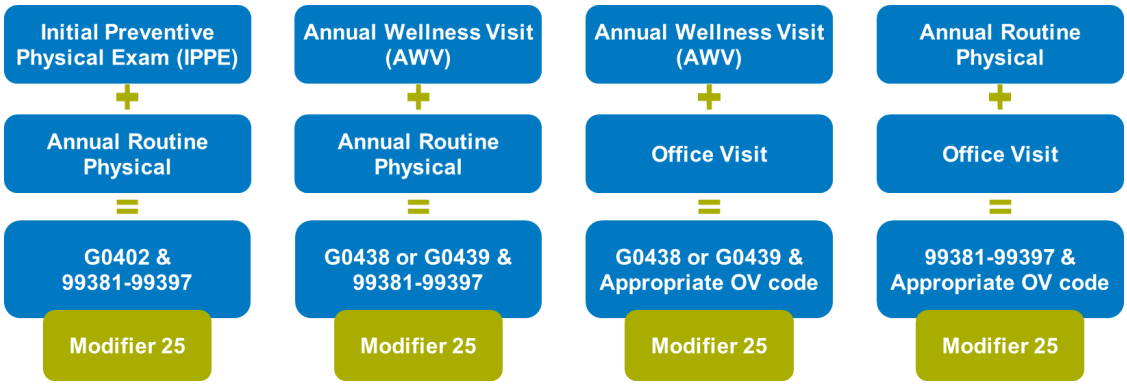
Published: Mar 1, 2023 - **State & Federal** / Medicare

An annual planned visit (APV) can be a significant driver of positive health outcomes and engagement with a patient's provider. There are three main types of important, but often underutilized, APVs: initial preventive physical exam (IPPE), annual wellness visit (AWV), and annual routine physical (ARP). By engaging your patient early in the year to schedule these visits, there is opportunity to increase your APVs in 2023, and, in turn, improve the health of your patients and increase your success in the value-based programs (VBPs) you may participate in.

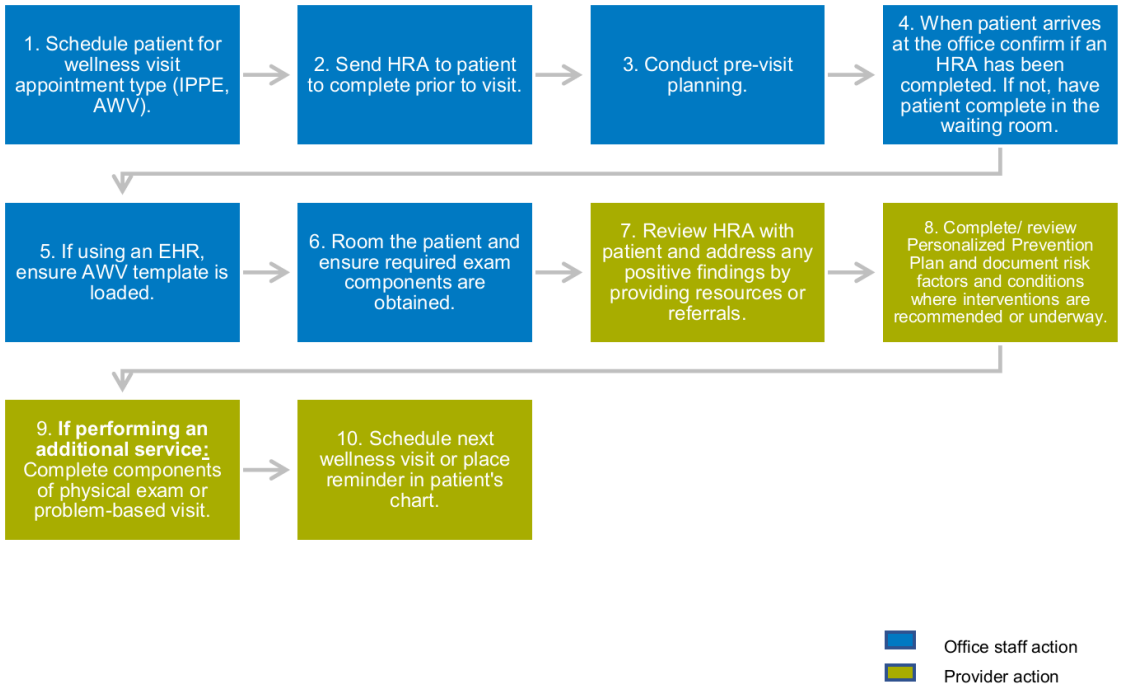


The AWV is an important opportunity to address up to 20 Medicare Advantage Stars measures that encompass both clinical quality and patient experience. The development of a personalized prevention plan is a required component of the AWV and can be a useful tool in leading these conversations with patients.

(**AMJC**).



While the AWV may seem to have many requirements, several components of this visit can be performed by care team members other than the provider. See the sample workflow below that highlights steps that office staff can complete.



It is essential for providers to complete an APV for each of their assigned Medicare members. These visits help keep patients healthy and can increase practice revenue. For more tools and resources, please visit **https://www.anthem.com/provider/medicare-advantage/** or reach out to your provider representative.

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Controlling High Blood Pressure and Submitting Compliant Readings

Published: Mar 1, 2023 - **State & Federal** / Medicare

The Controlling High Blood Pressure (CBP) HEDIS® measure can be challenging as it not only requires proof of a blood pressure (BP) reading, but also that the patient's blood pressure is adequately controlled. CBP care gaps can open and close throughout the year depending on if the patient's most recent BP reading is greater than 140/90 mmHG. As we start a new year, it's important that we have record of your patients' blood pressure readings and that you continue to monitor patients with elevated readings.

Tips when scheduling members to close CBP care gaps:

- When scheduling appointments, have staff ask patients to avoid caffeine and nicotine for at least an hour before their scheduled appointment time.
- If possible, update your scheduling app and/or your reminder text message campaigns to include reminders about abstaining from caffeine and nicotine prior to appointment time as well as a reminder to arrive early to avoid a sense of rushing.

Tips for lower BP readings during the appointment:

- Ask the patient if they tend to get nervous at appointments and have higher readings as a result. If they do, take their blood pressure at both the start and end of the appointment and document the lower reading.
- Readings can also vary arm to arm. If slightly elevated in one arm, try the other and document the lower reading.

Getting credit for adequately controlled blood pressure readings:

- Submit readings via Category II CPT® codes on claims.

Description	Code
Diastolic BP	**CAT II:** 3078F-3080F **LOINC:** 8462-4
Diastolic 80 to 89	**CAT II:** 3079F
Diastolic greater than/equal to 90	**CAT II:** 3080F
Diastolic less than 80	**CAT II:** 3078F
Systolic BP	**CAT II:** 3074F, 3075F, 3077F **LOINC:** 8480-6
Systolic greater than/equal to 140	**CAT II:** 3077F
Systolic less than 140	**CAT II:** 3074F, 3075F

- Ensure readings are carefully and appropriately documented within your electronic medical record system.
- If you have questions on how to submit readings, speak to your care or practice consultant.
- Also, be sure to adequately code patients who meet the exclusion criteria:
  - Exclusions:
    - Palliative care
    - Enrolled in hospice
    - Frailty and/or advanced illness
    - Living in long-term care
  - Optional exclusions:
    - Dialysis (ESRD), kidney transplant, nephrectomy
    - Female members with a diagnosis of pregnancy
    - Non-acute inpatient admissions

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URL: https://providernews.anthem.com/indiana/article/controlling-high-blood-pressure-at-the-end-of-the-year-13

Informational Update Modifier Usage

Published: Mar 1, 2023 - **State & Federal** / Medicare

(Policy G-06006)

The Modifier Usage policy is aligning with Medicare modifier requirements by adding the following to our Related Coding section:

- Modifier CO — Outpatient occupational therapy assistant services
- Modifier CQ — Outpatient physical therapy assistant services

Additionally, Modifier FB (Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples) was expanded to facility providers.

For additional information, please review the Modifier Usage reimbursement policy at **https://www.anthem.com/medicareprovider**.

MULTI-BCBS-CR-015034-22-CPN10025

URL: https://providernews.anthem.com/indiana/article/informational-update-modifier-usage-1

Shared savings and transition care management after inpatient discharges

Published: Mar 1, 2023 - **State & Federal** / Medicare

Anthem Blue Cross and Blue Shield is actively seeking to promote CMS's transition care management (TCM) program for its Medicare members.

The goal is to ensure comprehensive physician follow-up and management of patients within seven and/or 14 days of discharge from hospital, skilled nursing facility (SNF), inpatient rehabilitation hospital (IRF), or long-term acute care hospitals (LTAC). And thus, to minimize clinical relapses, that often result in acute hospital readmissions, within 30-days of discharge.

CPT® codes for these visits are:

- 99496 (post-discharge comprehensive follow-up within seven days): pays between $250 to $350, depending on region, and;
- 99495 (post-discharge follow-up within 14 days): pays between $190 to $260, depending on region.

The primary intent for these visits is close post-discharge patient follow up with comprehensive physician/provider management of ongoing chronic comorbidities. So, visits should include:

- Review of the discharge information
- Medication reconciliation
- Treatment of acute exacerbations and/or fluctuations in the physician office as appropriate
- Active management of and attention to chronic renal, lung, cardiac, skeletal, social, caregiver, etc. conditions, and providers should:
    - Review the need for pending diagnostics, and/or follow up of said diagnostics.
    - Interact with other healthcare professionals who may assume care of any system-specific problems.
    - Educate the patient, family, and caregiver.
    - Establish referrals, arrange needed community resources, address/assist/advise the member/family with relevant caregiver needs.
    - Help schedule required community providers and services follow-up.
    - Comprehensively and holistically manage common chronic/acute medical conditions seen after hospital discharge, such as (but not limited to): Heart failure, COPD, DM,

polypharmacy/medication reconciliation, and even custodial/social needs impacting/resulting in admission(s).

CMS encourages TCM for Medicare members. CMS has detailed fact sheets explaining the program, and billing, see resources below:

- **https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf**
- **https://edit.cms.gov/files/document/billing-faqs-transitional-care-management-2016.pdf**

Appendix

CPT 99496 coding requirements:

1. Attestation that the initial communication between patient/practitioner began within two business days of discharge:
    1. Geared to patients with conditions requiring medium or high-level decision-making
    2. Direct contact: telephone/electronic
2. Face-to-face visit within **seven days** of DC. Cannot be virtual
3. Clinician-patient visit can be done by physician, PA, or nurse practitioner, or other practitioners as authorized by state law
4. Includes DC from hospitals, SNFs, IRFs, and LTACs
5. Includes time spent coordinating patient services for specific medical care or psychosocial needs and guiding them through activities of daily living

CPT 99495 coding requirements:

1. Attestation that the initial communication between patient/practitioner began within two business days of DC:
    1. Geared to patients with conditions requiring at least moderate complexity decision-making

Direct contact: telephone/electronic

2. Face-to-face visit within **14 days** of discharge. Cannot be virtual

3. Clinician-patient visit can be done by physician, PA, or nurse practitioner, or other practitioners as authorized by state law

4. Includes DC from hospitals, SNFs, IRFs, and LTACs

5. Includes time spent coordinating patient services for specific medical care or psychosocial needs and guiding them through activities of daily living

MULTI-BCBS-CR-018709-23-CPN18422

URL: https://providernews.anthem.com/indiana/article/shared-savings-and-transition-care-management-after-inpatient-discharges-1
