Virginia Provider News

November 2021 Anthem Provider News - Virginia

Medicaid:

Medicare:

Include referring provider name and NPI on home infusion therapy and ambulatory infusion suite professional claims

Published: Nov 1, 2021 - **Administrative**

In an ongoing effort to promote accurate claims processing and payment, Anthem Blue Cross and Blue Shield (Anthem) prefers that the referring physician name and national provider identifier (NPI) be included on professional home infusion therapy services claims in field 17 and 17a on CMS-1500 claim forms.

Providers should report the referring physician information in accordance with the Anthem guidelines in the *EDI Companion Guide* for electronically submitted claims.

If you have questions regarding this process, please contact your local Network Manager at **anthem.com/provider/contact-us**.

1381-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/include-referring-provider-name-and-npi-on-home-infusion-therapy-and-ambulatory-infusion-suite-professional-claims-6

Change in coverage for continuous glucose monitors for some fully insured groups

Published: Nov 1, 2021 - **Administrative**

Effective **January 1, 2022**, continuous glucose monitors (CGMs) will no longer be covered under the medical benefit as durable medical equipment for certain Anthem fully insured groups. For these members, CGMs will only be covered under their pharmacy benefit. This applies for both new prescriptions and refills.

We will notify affected members via mail. Members who need to transfer CGMs from their medical benefit to their pharmacy benefit will need a new prescription from their provider.

Note that some Anthem groups will retain their medical DME coverage for CGMs, and these members will have the option of using either the medical or pharmacy benefit. Generally, members receive their CGMs faster when obtained using their pharmacy benefit, so we encourage the use of the pharmacy benefit.

If you have questions, please contact Provider Services.

1411-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/change-in-coverage-for-continuous-glucose-monitors-for-some-fully-insured-groups-7

Time to prepare for HEDIS® medical record review

Published: Nov 1, 2021 - **Administrative**

Each year, Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. perform a review of a sample of our members' medical records as part of the HEDIS quality study. HEDIS is part of a nationally recognized quality improvement initiative and is used by the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and several states to monitor the performance of managed care organizations.

For 2021, Anthem will begin requesting medical records in January 2022. No special authorization is needed for you to share member medical record information with us, since quality assessment and improvement activities are a routine part of healthcare operations.

HEDIS review is time sensitive, so please submit the requested medical records within the timeframe indicated in the initial HEDIS request document.

Ways to submit your records:

- **Remote Electronic Medical Record (EMR) Access Service – *New!***

  As we published in the September edition of *Provider News*, we now offer the Remote EMR Access Service to providers to submit member medical record information to Anthem. If you are interested in more information, please contact us at Centralized_EMR_Team@anthem.com.
- **Upload to our secure portal**

  Medical records can be uploaded to Anthem's secure portal using the instructions in the request document.
- **Fax**

  Medical records can be faxed to Anthem using the instructions in the request document.

- **Mail**

  Medical records can be mailed to Anthem using the instructions in the request document.

We appreciate the quality of care you provide to our members. Your assistance is crucial to ensuring our data is statistically valid, auditable and accurately reflects quality performance.

1382-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/time-to-prepare-for-hedis-medical-record-review-10

Reducing the burden of medical record review and improving health outcomes with HEDIS® Electronic Clinical Data Systems reporting

Published: Nov 1, 2021 - **Administrative**

The HEDIS® Electronic Clinical Data Systems (ECDS) reporting methodology encourages the exchange of the information needed to provide high-quality healthcare services. The ECDS Reporting Standard provides a method to collect and report structured electronic clinical data for HEDIS quality measurement and improvement.

Benefits to providers:

- Reduced burden of medical record review for quality reporting
- Improved health outcomes and care quality due to greater insights for more specific patient-centered care

ECDS reporting is part of the National Committee for Quality Assurance (NCQA's) larger strategy to enable a digital quality system and is aligned with the industry's move to digital measures.

Learn more about NCQA's digital quality system and what is means to you and your practice.

ECDS Measures

The first publicly reported measure using the HEDIS Electronic Clinical Data System reporting standard is the **Prenatal Immunization Status (PRS)** measure. In 2022, NCQA will include the PRS measure in Health Plan Ratings for Medicaid and Commercial plans for measurement year 2021.

For HEDIS Measurement Year 2022, the following measures can be reported using ECDS:

Childhood Immunization Status **CIS-E***
Immunizations for Adolescents **IMA-E***
Breast Cancer Screening **BCS-E**
Colorectal Cancer Screening **COL-E**
Follow-Up Care for Children Prescribed ADHD Medication **ADD-E**
Metabolic Monitoring for Children and Adolescents on Antipsychotics **APM-E***
Depression Screening and Follow-Up for Adolescents and Adults **DSF-E**
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults **DMS-E**
Depression Remission or Response for Adolescents and Adults **DRR-E**
Unhealthy Alcohol Use Screening and Follow-Up **ASF-E**
Adult Immunization Status **AIS-E**
Prenatal Immunization Status **PRS-E** (Accreditation measure for 2021)
Prenatal Depression Screening and Follow-Up **PND-E**
Postpartum Depression Screening and Follow-Up **PDS-E**

*Indicates that this is the first year that the measure can be reported using ECDS

Of note, NCQA added the ECDS reporting method to three existing HEDIS measures:

Breast Cancer Screening,
Colorectal Cancer Screening and
Follow-up Care for Children Prescribed ADHD Medication.

Initially, the ECDS method will be optional which provides health plans an opportunity to report using the ECDS method while transitioning to ECDS only in the future.

Other sources:

HealthITgov: https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange

1392-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/reducing-the-burden-of-medical-record-review-and-improving-health-outcomes-with-electronic-clinical-data-systems-reporting

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Be Antibiotics Aware: Protect your patients

Published: Nov 1, 2021 - **Administrative**

Each year, the Centers for Disease Control and Prevention (CDC) encourages healthcare professionals, patients, and families to learn more about antibiotics by promoting U.S. Antibiotic Awareness Week (USAAW). Highlighting the importance of improving antibiotic prescribing and use, USAAW brings these lifesaving drugs to the forefront.

With a focus on helping to fight antibiotic resistance, USAAW asks you to *Be Antibiotic Aware*[1] and share this information with your patients:

1. **Antibiotics can save lives**. When a patient needs antibiotics, the benefits outweigh the risks of side effects or antibiotic resistance.
2. **Antibiotics aren't always the answe** Everyone can help improve antibiotic prescribing and use.
3. **Antibiotics do not work on viruses,** such as those that cause colds, flu, bronchitis, or runny noses.
4. **Antibiotics are only needed for treating infections caused by bacteria,** but even some bacterial infections get better without antibiotics, including many sinus infections and

some ear infections.

5. **Antibiotics will not make patient's feel better if the illness is a virus**. Respiratory viruses usually go away in a week or two without treatment.
6. **If antibiotics are needed, they should be taken exactly as prescribed.** Provide information about potential side effects, including those that could result in treatment.
7. **Antibiotics are critical tools** for treating life-threatening conditions.

Article Attachments

Each year in the United States, more than 2.8 million infections occur from antibiotic-resistant bacteria. More than 35,000 people die as a result.

Measure up: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

This HEDIS® measure looks at the percentage of members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event. Visit the NCQA website for exceptions.

Description	CPT®/HCPCS/ICD-10
Acute Bronchitis	*ICD-10:* J20.3, J20.4, J20.5, J20.6, J20.7, J20.8 J121.0, J21.1, J21.8, J21.9
Online assessments	*CPT:* 98970, 98971, 98972, 99422, 99423, 994 G0071, G2010, G2012, G2061, G2062, G2063
Telephone visits	*CPT:* 98966, 98967, 98968, 99441, 99442, 994

To learn more about antibiotic prescribing and use, visit www.cdc.gov/antibioticuse.

[1]CDC www.cdc.gov/antibiotic-use

1406-1121-PN-VA

Surprisingly easy ways to help patients quit smoking cigarettes

Published: Nov 1, 2021 - **Administrative**

More than 42 million Americans reach for cigarettes regularly, but almost 70 percent of them say they want to quit. Perhaps, the traditional ways to quit smoking, such as “going cold turkey” or wearing a nicotine patch haven’t worked for them in the past. Thankfully, there are plenty of new ways to kick the smoking habit. Here are five approaches to share with patients who are trying to quit.

1. **Download a quit smoking app**

There are plenty of downloadable quit smoking apps ready to coach patients along the way. Many former smokers recommend the LIVESTRONG MyQuit Coach, a free app available on iTunes.

1. **Start a Quit Reward Fund**

According to a study from The New England Journal of Medicine, putting money on the line can help smokers quit. Researchers found 15.7% of people successfully quit for at least six months when they were offered an $800 reward. Patients can set aside their own money as a deposit that they get back when they successfully quit.

1. **Ask Human Resources about resources**
Many employers offer smoking cessation programs, which offer cash rewards, savings on insurance or other perks for not taking a puff. According to the American Lung Association, up to 57% of their smoking cessation program participants reported quitting smoking by the end of the program. Freedom From Smoking®, offered by American Lung Association is an often recommended program.

1. **Quit smoking with meditation**
For many smokers, the act of lighting up is automatic. But a Yale University study found meditating and practicing mindfulness can cancel that relationship and slash cravings. Recommend a mobile app like Stop Smoking – Mindfulness Meditation App to Cessation Smoking Support.

1. **Consider medication**
Over-the-counter nicotine patches are designed to lessen withdrawal symptoms and have been a go-to for decades. But if those haven't worked prescription medications can reduce cravings or make smoking less enjoyable.

Measure Up! Medical Assistance with Smoking and Tobacco Use Cessation (MSC) HEDIS® measure looks at members 18 and older to assess different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising smokers and tobacco users to quit
- Discussing cessation medications
- Discussing cessation strategies

Measure adherence is determined by member response through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey.

Sources:

Article Attachments

https://quitsmokingcommunity.org/the-6-best-quit-smoking-apps/

https://itunes.apple.com/us/app/livestrong-myquit-coach-dare/id383122255?mt=8&ign-mpt=uo%3D4

http://www.nejm.org/doi/full/10.1056/NEJMoa1414293#t=articleDiscussion

http://elischolar.library.yale.edu/cgi/viewcontent.cgi?article=1712&context=ymtdl

https://itunes.apple.com/us/app/stop-smoking-mindfulness-meditation/id621443244?mt=8

http://www.health.harvard.edu/blog/whats-best-way-quit-smoking-201607089935

http://www.lung.org/support-and-community/corporate-wellness/help-employees-stop-smoking.html?referrer=https://www.google.com/

1407-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/surprisingly-easy-ways-to-help-patients-quit-smoking-cigarettes-6

Join Anthem in talking about racism and its impact on health and earn continuing education credits

Published: Nov 1, 2021 - **Administrative**

Healthcare and mental healthcare professionals have a vital role in improving health and wellbeing in our communities by identifying and treating racial trauma and injustice experienced by the individuals we serve. At Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc., we are committed to addressing racism in our society through open discussions about trauma, injustice, and inequality. These conversations are critical to improving the wellbeing of all Americans and the communities in which we live and serve.

We can impact the injustice of racism together.

Anthem has partnered with Motivo*, the first HIPAA-compliant digital platform that connects mental health therapists and clinical supervisors, to engage providers and associates in conversations on racial injustice, trauma, and inequality. Together, we are continuing to evolve the conversation and digging deeper on a quarterly basis to keep the dialogue going.

Our racial equity forums focus on:

- Exploring how racism impacts health outcomes.
- Discussing how to identify racism in your practice and how to be an ally to your patients.
- Recognizing implicit bias (we all have it) and how it affects the care provided to your patients.
- Understanding the impact of prolonged exposure to racism on people of .
- Providing you with actionable resources to recognize and reduce racism that may exist in your practice.

Since October 2020, Anthem has sponsored four virtual forums:

1. Racial Trauma in America
2. The Road to Allyship: Playing Your Part in Racial Equity
3. In Pursuit of Racial Equity: Deconstructing Bias Forum
4. Exploring the Impact of Racial Trauma on the Health & Wellbeing of Children

Please plan to join the next forum:

Equity, COVID, and Holidays: Coping with grief

December 8, 2021
4 to 5:30 p.m. ET

REGISTER today!

Continuing education credits are available for those who sign up and participate.

The first step in doing your part to addressing racism is to recognize it exists.

These conversations may feel uncomfortable at first, and that's OK. This is how we will make progress together in creating a more just and equitable society.

*Motivo is an independent company providing a virtual forum on behalf of Anthem.

1403-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/join-anthem-in-talking-about-racism-and-its-impact-on-health-and-earn-continuing-education-credits-5

Continuing medical education credits available in 2021 for a variety of clinical quality webinars: Register now

Published: Nov 1, 2021 - **Administrative**

We recently offered a series of continuing medical education (CME) webinars on a variety of topics. If you missed any of them, you can still register for the recorded webinars and earn CME credits. The webinars offer best practices to overcoming barriers in achieving clinical quality goals, and attaining better patient outcomes. We also expect to offer more live CME webinars in the coming weeks.

- Learn strategies to help you and your care team improve your performance across a range of clinical areas.
- Apply the knowledge you gain from the webinars to improve your organization's clinical quality.

Attendees will receive one CME credit upon answering required questions at the conclusion of each webinar.

Register **for our upcoming live and on-demand clinical quality webinars.**

Article Attachments

1391-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/continuing-medical-education-credits-available-in-2021-for-a-variety-of-clinical-quality-webinars-register-now

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EnrollSafe is available: Our new electronic funds transfer enrollment portal for Anthem providers

Published: Nov 1, 2021 - **Administrative** / Digital Tools

EnrollSafe is now available as the electronic funds transfer (EFT) enrollment portal for providers participating with Anthem Blue Cross and Blue Shield and our affiliate HealthKeepers, Inc. Effective **November 1, 2021**, CAQH Enrollhub is no longer offering EFT enrollment to new users.

CAQH Enrollhub is the only CAQH tool being decommissioned. All other CAQH tools are not impacted.

Benefits of EFT

Electronic funds transfer makes the payment process more convenient and easier to reconcile your direct deposits. EFT is also much faster. You'll receive your payments up to seven days sooner than through the paper check method.

EnrollSafe: Secure and available 24-hours a day

Beginning November 1, 2021, if you need to change an EFT enrollment previously submitted through CAQH, or enroll a new bank account for EFT, visit the EnrollSafe portal at https://enrollsafe.payeehub.org and select "Register." Once you have completed registration, you'll be directed through the EnrollSafe secure portal to the enrollment page. There, you'll provide the required information to receive direct payment deposits. **There is no fee to register for EFT via EnrollSafe.**

Already enrolled in EFT through CAQH Enrollhub?

Please note if you're already enrolled in EFT through CAQH Enrollhub, **no action is needed.** Your EFT enrollment information is not changing as a result of the new enrollment hub.

If you ever have changes to make to your bank account, use EnrollSafe going forward to update your EFT bank account information.

Electronic remittance advice (ERA) makes reconciling your EFT payments easy and paper-free

Now that you are enrolled in EFT, using the digital ERA is the very best way to reconcile your deposits – securely and efficiently. You'll be issued a trace number with your EFT deposit that matches up with your ERA on Availity.

You can retrieve your ERAs directly from Availity. Simply log onto Availity and select **Claims and Payments** > **Send and Receive EDI Files** > **Received Files** folder. When using a clearinghouse or billing service, they will supply the 835 ERA for you. You also have the option to view or download a copy of the **Remittance Advice** under **Payer Spaces** > **Remittance Inquiry tool**.

Need further help? EFT and ERA registration and contact information

Type of transaction	How to register, update, or cancel	For registration related questions	To resolve issues after registration
EFT only	Use EnrollSafe	EnrollSafe help desk at **877-882-0384** Available Monday through Friday 9 a.m. to 8 p.m. ET, except public and/or bank holidays. Email: Support@payeehub.org	EnrollSafe help desk at **877-882-0384** Available Monday through Friday 9 a.m. to 8 p.m. ET, except public and/or bank holidays. Email: Support@payeehub.org
ERA (835) only	Use Availity	Availity Support at **800-282-4548**	Availity Support at **800-282-4548** *NOTE: Providers should allow up to 10 business days for ERA enrollment processing.*

1399-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/enrollsafe-is-available-our-new-electronic-funds-transfer-enrollment-portal-for-anthem-providers-5

Against medical advice discharge physician tracking tool

Published: Nov 1, 2021 - **Administrative** / Digital Tools

Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. are pleased to announce a new provider tool to assist physicians in tracking patients who are discharged from the hospital against medical advice (AMA).

This new tool, available through Anthem's online Availity provider portal, will allow physicians to sign up for admission discharge transfer (ADT) alerts as well as other useful alerts. Once the report is accessed, the discharge type field is where an against medical advice (AMA) event will be identified. This will allow the primary care physician to reach out to the patient and schedule any follow-up care as soon as possible.

Anthem encourages the use of this new tool as well as the other reports available. If you are interested in learning more and or obtaining additional information, please contact your assigned Provider Experience representative or visit us at **anthem.com/provider/contact-us** to view additional contact options.

1374-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/against-medical-advice-discharge-physician-tracking-tool

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Clarification to reimbursement policy updates: Modifier Rules and Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation - Professional

Published: Nov 1, 2021 - **Guideline Updates** / Reimbursement Policies

In the contract amendment dated October 1, 2021, Anthem Blue Cross and Blue Shield in Virginia and our affiliate HealthKeepers, Inc. included updates to the following Commercial reimbursement policies:

- Modifier Rules – Professional

- Guidelines for Reporting Timed Units for Physical Medicine and Rehabilitation – Professional

For clarification, these modifier updates align with the codes the Centers for Medicare & Medicaid Services (CMS) has designated as "always therapy" services, and require GN, GO or GP modifiers for physical therapy, occupational therapy, or speech-language pathology services when billed on a professional claim.

1401-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/clarification-to-reimbursement-policy-updates-modifier-rules-and-guidelines-for-reporting-timed-units-for-physical-medicine-and-rehabilitation-professional-12

Update regarding annual wellness visits for health plans compliant with the Affordable Care Act

Published: Nov 1, 2021 - **Products & Programs**

Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc. cover annual wellness visits and well-woman visits at 100% with no member cost-sharing when provided by in-network providers for members who have plans that comply with the Affordable Care Act (ACA). Beginning January 1, 2022, Anthem will encourage some ACA-compliant individual and small group plan members to schedule annual wellness visits or well-woman visits with their physician within the first 90 days of the plan renewal.

Some providers currently require patients to schedule wellness visits or well-woman visits at least one year past their most recent visit. This practice helps ensure a patient does not exceed more than one wellness visit per calendar year. Beginning January 1, 2022, providers can perform the annual wellness visit or well-woman visit for these members, even if it has been less than one year since the last wellness visit. The claim for the wellness visit or well-woman visit will be processed as a preventive care service covered at 100% as long as it's billed accordingly.

Please note, this benefit may not apply to all health plans. Providers should continue to verify eligibility and benefits for all members prior to providing services or receiving member copayments, deductibles, or coinsurance.

1380-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/update-regarding-annual-wellness-visits-for-health-plans-compliant-with-the-affordable-care-act

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Blue High Performance Network name changing for 2022

Published: Nov 1, 2021 - **Products & Programs**

Blue High Performance Network plans offer access to providers with a record of delivering high-quality, efficient care. BlueHPN® networks first went live January 1, 2021, in more than 50 cities across the country, including the Richmond and Washington, D.C-Arlington-Alexandria metro areas. Since then, our national customer base has grown, and again this fall, major employers will offer plans with access to our high performance network for the 2022 benefit year.

Member ID cards and other plan material will feature one small change for 2022: BlueHPN is now a single word rather than two.

Anthem Blue Cross and Blue Shield offers Virginia national employers BlueHPN plans, and offers large and small group employers in Virginia plans with access to the HPN, referred to as the Blue Connection network.

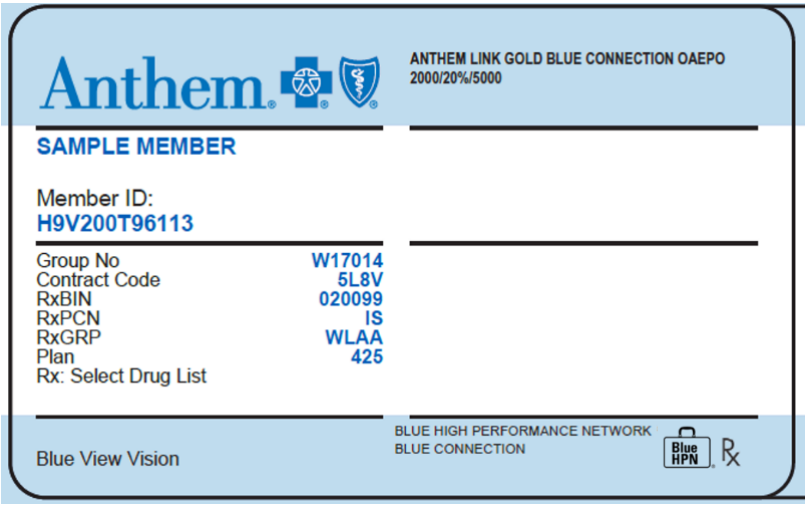
Updated BlueHPN participation will be displayed in provider profiles in our Find Care provider directory January 1, 2021.

As has been the case this year, in 2022 you may see patients accessing this network through either a national employer plan, BlueHPN, or large or small group employer Exclusive Provider Organization (EPO) plans and health savings account (HSA) plans with EPO network. Under EPO plans, out-of-network benefits are limited to emergency or urgent care. Members may be required to select a primary care provider (PCP), but PCP referrals are not required for specialty care.

Article Attachments

Large group BlueHPN health plans sold in Virginia will have a plan prefix of “H8V” and small group plans prefixes will include “H9V” and “H5V.” Keep in mind that other prefixes may be part of HPN plan member IDs. The new “Blue High Performance Network” logo and “BlueHPN” indicator in the suitcase icon are the most reliable indicators that a member is enrolled in a HPN plan.

Below is a sample ID card for a Virginia member enrolled in a large group BlueHPN plan. Please note the new “Blue High Performance Network” logo and “BlueHPN” indicator in the suitcase icon.



The above SAMPLE Virginia ID card is for illustration purposes only.

1387-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/blue-high-performance-network-name-changing-for-2022-8

Specialty pharmacy updates are available (effective for dates of service on and after February 1, 2022)

Published: Nov 1, 2021 - **Products & Programs** / Pharmacy

Specialty pharmacy updates for Anthem Blue Cross and Blue Shield are listed below. These updates are effective for dates of service on and after February 1, 2022.

Prior authorization clinical review of *non-oncology* use of specialty pharmacy drugs is managed by Anthem Blue Cross and Blue Shield's medical specialty drug review team. Review of specialty pharmacy drugs for *oncology* use is managed by AIM Specialty Health® (AIM), a separate company.

For Anthem along with our affiliate HealthKeepers, Inc., prior authorization clinical review of these specialty pharmacy drugs will be managed by Anthem. Drugs used for the treatment of Oncology will still require pre-service clinical review by AIM Specialty Health.

This applies to members with Preferred Provider Organization (PPO), HealthKeepers (HMO), POS AdvantageOne, and Act Wise (CDH plans).

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

The Health Plan requires that claims for injection services performed in the office setting must include the applicable HCPCS J-code, Q-code, or S-code, with the corresponding NDC, for the injected substance. This requirement is consistent with CMS guidelines. A covered drug will not be eligible for reimbursement when the NDC is not reported on the same claim.

Prior authorization updates

Effective for dates of service on and after February 1, 2022, 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	HCPCS or CPT Code(s)	Drug
ING-CC-0096**	J3590	Rylaze
ING-CC-0167**	Q5119	Ruxience
ING-CC-0167**	Q5115	Truxima
ING-CC-0202	J3490 J3590	Saphnelo
ING-CC-0203	J3490 J3590	Ryplazim

***** Non-oncology use is managed by the medical specialty drug review team.
** Oncology use is managed by AIM.

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 February 1, 2022, 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.

Clinical Criteria	Status	HCPCS or CPT Code(s)	Drug
ING-CC-0075*	Preferred	J9312	Rituxan
		Q5123	Riabni
	Non-preferred	Q5119	Ruxience
		Q5115	Truxima
ING-CC-0167**	Preferred (no prior authorization or step therapy required)	J9312	Rituxan
		Q5123	Riabni
	Non-preferred	Q5119	Ruxience
		Q5115	Truxima

***** Non-oncology use is managed by the medical specialty drug review team.
** Oncology use is managed by AIM.

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

Quantity limit updates

Effective for dates of service on and after February 1, 2022, 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	HCPCS or CPT Code(s)	Drug
ING-CC-0081	J0584	Crysvita
ING-CC-0202	J3490 J3590	Saphnelo

***** Non-oncology use is managed by the medical specialty drug review team.
** Oncology use is managed by AIM.

1389-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/specialty-pharmacy-updates-are-available-effective-for-dates-of-service-on-and-after-february-1-2022

Anthem clinical criteria updates for specialty pharmacy are available

Published: Nov 1, 2021 - **Products & Programs** / Pharmacy

Effective for dates of service on and after February 1, 2022, the following current clinical criteria were revised and might result in services that were previously covered but may now be found to be not medically necessary.

For Anthem Blue Cross and Blue Shield and affiliate HealthKeepers, Inc., prior authorization of these specialty pharmacy drugs will be managed by Anthem. Drugs used for the treatment of Oncology will still require prior authorization by AIM Specialty Health® (AIM), a separate company. This applies to members with Preferred Provider Organization (PPO), Anthem HealthKeepers (HMO), POS AdvantageOne, and Act Wise (CDH plans).

Access the **clinical criteria document information**.

ING-CC-0001	Erythropoiesis Stimulating Agents
ING-CC-0027	Denosumab Agents
ING-CC-0029	Dupixent (dupilumab)
ING-CC-0038	Human Parathyroid Hormone Agents
ING-CC-0104	Levoleucovorin Agents
ING-CC-0156	Reblozyl (luspatercept)
ING-CC-0182	Iron Agents

1376-1121-PN-VA

URL: https://providernews.anthem.com/virginia/article/anthem-clinical-criteria-updates-for-specialty-pharmacy-are-available-19

Important update on Botox® for Anthem members

Published: Nov 1, 2021 - **Products & Programs** / Pharmacy

Effective **January 1, 2022,** CVS Specialty Pharmacy and IngenioRx Specialty Pharmacy will no longer dispense the brand name drug Botox®. However, Botox will still be available to Anthem members through other vendors.

Please note:

- This is not a change in member benefits. This is a change in the Botox vendor only.

- If the member is not using IngenioRx Specialty Pharmacy or CVS Specialty Pharmacy to obtain Botox, no action is needed.

- This change will not affect any other specialty pharmacy coverage.

Medical specialty pharmacy benefits

Our members who currently obtain Botox through CVS Specialty Pharmacy using their **medical specialty pharmacy benefits** must move this prescription by January 1, 2022. Here are the options:

- Providers can purchase Botox for their patients, then supply it to Anthem members. Providers would then bill Anthem for the drug and administration of the drug. This will require a new prior authorization to notify Anthem of this change.

- If the Anthem member's pharmacy benefit manager is IngenioRx, providers can transition the Botox prescription to receive the drug from any in-network pharmacy using their pharmacy benefits. Transferring the coverage will require a new prescription and new prior authorization.

For questions regarding a member's **medical specialty pharmacy benefits**, call Provider Services using the information on the back of the member's ID card.

Pharmacy benefits manager benefits

Effective January 1, 2022, members who currently obtain Botox through IngenioRx Specialty Pharmacy using their **pharmacy benefits** must move this prescription from IngenioRx Specialty Pharmacy to another in-network specialty pharmacy that dispenses Botox. If there are refills still available on the current prescription, members can transfer it to the new pharmacy. If not, members will need a new prescription.

For questions regarding a member's **pharmacy benefits**, call Pharmacy Member Services using the information on the back of the member's ID card.

1383-1121-PN-VA

Electronic data interchange process

Published: Nov 1, 2021 - **State & Federal** / Medicaid

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Availity* serves as our electronic data interchange (EDI) partner for all electronic data and transactions. The Availity EDI processing generates response files for each submitted electronic file and delivers them to the submitter's Availity mailbox. It is important to review these responses to understand where your claims are in the process.

Electronic file submitter:

- If your organization uses a clearinghouse or vendor, they have an Availity mailbox to submit clients' files. Availity delivers the responses for claims to the same mailbox, and the clearinghouse or vendor is responsible for returning the results to their clients and resubmitting any files rejected for formatting, interchange, or transaction set errors. The submitter in this scenario is the clearinghouse or vendor.

- If your organization uses a practice management software, an Availity mailbox is set up during initial registration for your electronic file submissions. The submitter is your organization and is responsible for analyzing the responses to verify there are not any file errors or claim rejections that require correction and resubmission within timely filing guidelines.

Availity electronic file process:

1. **Submit electronic file to Availity** — Availity validates for file format and returns file acknowledgments to the submitter's Availity mailbox. If there are any edits at this point,

the entire electronic file will not advance and will require resubmission within timely filing guidelines.

1. **Health Insurance Portability and Accountability Act (HIPAA) and payer specific edits** — The electronic file moves to the next phase, which is HIPAA and business editing. Examples include:

- Valid subscriber ID for the date of service
- Billing and coding validation

If an error occurs at this point, the individual claims with the errors must be corrected, resubmitted as an original claim and do not advance. The claims that do not have an edit will then route to the adjudication systems for second-level edit validation.

1. **Anthem HealthKeepers payer receives electronic file from Availity** — For the Medicaid line of business, there is a second level of editing.

Edits for this second level return the *Delayed Payer Report (DPR)*. Only claims that pass will advance for adjudication and will be displayed using Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice, and paper *Explanation of Payment*. If there are edits, the claim requires resubmission within timely filing guidelines.

Electronic responses

File acknowledgment — Indicates whether we receive an electronic file in the correct format and acceptance by Availity.

- **Action required** — If any errors occur at this stage, the submitter will need to correct and resubmit the entire electronic file to Availity.

Immediate Batch Response (IBR) — This report acknowledges accepted claims and identifies claim edits due to *HIPAA* and business edits. The report also includes claim counts and charges for the electronic file. Availity creates this file prior to routing accepted claims to the adjudication systems.

- **Action required for claims with edits**: Rejected claims require resubmission within timely filing guidelines and will not advance to the adjudication system that would display Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice, and paper *Explanation of Payment*. Not applicable to denied claims.

Delayed Payer Report (DPR) — This report is currently only returned for the Medicaid line of business and contains second-level editing from the adjudication system after Availity has routed claims that passed on the IBR report.

- **Action required for claims with edits**: Rejected claims would need to be resubmitted and will not display on Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice and paper *Explanation of Payment*.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**, or Availity Client Services with any questions at **800-AVAILITY (282-4548)**.

* Availity, LLC is an independent company providing administrative support services on behalf of HealthKeepers, Inc.

AVA-NU-0395-21

URL: https://providernews.anthem.com/virginia/article/electronic-data-interchange-process-14

Clinical Criteria updates

Published: Nov 1, 2021 - **State & Federal** / Medicaid

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

Summary: On August 21, 2020, November 20, 2020, and June 24, 2021, the Pharmacy and Therapeutics (P&T) Committee approved the following *Clinical Criteria* applicable to the medical drug benefit for HealthKeepers, Inc. 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.

Effective date	Document number	*Clinical Criteria* title	New or revised
November 1, 2021	*ING-CC-0201	Rybrevant (amivantamab-vmjm)	New
November 1, 2021	*ING-CC-0042	Monoclonal Antibodies to Interleukin-17	Revised
November 1, 2021	*ING-CC-0050	Monoclonal Antibodies to Interleukin-23	Revised
November 1, 2021	ING-CC-0125	Opdivo (nivolumab)	Revised
November 1, 2021	ING-CC-0124	Keytruda (pembrolizumab)	Revised
November 1, 2021	*ING-CC-0102	GnRH Analogs for Oncologic Indications	Revised
November 1, 2021	ING-CC-0076	Nulojix (belatacept)	Revised
November 1, 2021	*ING-CC-0077	Palynziq (pegvaliase-pqpz)	Revised
November 1, 2021	ING-CC-0067	Prostacyclin Infusion and Inhalation Therapy	Revised
November 1, 2021	ING-CC-0194	Cabenuva (cabotegravir extended-release; rilpivirine extended-release) Injection	Revised
November 1, 2021	*ING-CC-0174	Kesimpta (ofatumumab)	Revised
November 1, 2021	*ING-CC-0182	Agents for Iron Deficiency Anemia	Revised

AVA-NU-0425-21

URL: https://providernews.anthem.com/virginia/article/clinical-criteria-updates-31

Unspecified diagnosis reminder

Published: Nov 1, 2021 - **State & Federal** / Medicaid

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

This is a reminder to all providers that we require laterality-specific coding when applicable. Therefore, claims processed on or after October 1, 2021, will be denied when ICD-10-CM laterality coding guidelines are not followed.

In accordance with the International Classification of Disease, 10th Revision, clinical modification
(ICD-10-CM) correct coding guidelines, in which state Medicaid programs follow, we will begin to edit diagnosis in *Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue* for appropriate laterality billing.

ICD-10-CM diagnosis coding falls under *Health Insurance Portability and Accountability Act (HIPAA)* correct code sets and they are designed to specifically define laterality (for example left, right, unspecified, or exists bilaterally, etc.). Providers are required to submit the defined code in accordance with the condition. The ICD-10-CM guidelines for Coding and Reporting state (for Laterality coding), “Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.”

The ICD-10-CM diagnosis code should correspond to the medical record, CPT® and HCPCS code(s), and/or modifiers billed.

If you have any questions about this communication, call Anthem HealthKeepers Plus, Medallion Provider Services at **800-901-0020** or Anthem CCC Plus Provider Services at **855-323-4687**.

AVA-NU-0427-21

URL: https://providernews.anthem.com/virginia/article/unspecified-diagnosis-reminder-4

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4 things you can do to encourage cancer screenings for your women patients

Published: Nov 1, 2021 - **State & Federal** / Medicaid

Please note, this communication applies to Anthem HealthKeepers Plus, Medallion and Anthem HealthKeepers Plus, Commonwealth Coordinated Care Plus (Anthem CCC Plus) offered by HealthKeepers, Inc.

The American Cancer Society estimates there will be approximately 1,898,160 cancer cases diagnosed in 2021. That's the equivalent of 5,200 new cases every day.[1] The good news is, patients say they are more likely to get screened when you recommend it. What else can you do to influence cancer screenings?[2]

1. Understand the power of the physician recommendation:	Your recommendation is the most influential factor in whether a person decides to get screened. Patients are 90% more likely to get a screening when they reported a physician recommendation. "My doctor did not recommend it," is the primary reason for screening avoidance.
2. Measure the screening rates in your practice; it may not be as high as you think:	Set goals to get screening rates up. Follow the HEDIS® guidelines included in this article to help accurately track your care gap closures.
3. More screening doesn't have to mean more work for you:	Reach out to us about available member data — We may be able to help identify those members who are due for screenings. Develop a reminder system, which has been demonstrated to be effective, to remind you and staff that patients have screenings due.
4. Help members access benefit information about screenings to eliminate the cost barrier:	Log on to Availity.com* and use the *Patient Registration* tab to run an Eligibility and Benefits Inquiry. Members can access their benefit information by logging on to **mss.anthem.com/va** and selecting the *Benefits* tab, or by using **Anthem Medicaid mobile app**.

Members earn rewards for screenings through the Healthy Rewards Program

Through Healthy Rewards, members receive incentives for completing certain screenings. They can redeem their reward dollars for retail gift cards — just another way we can work together for better health outcomes.

Screening	Reward	Timing
Breast Cancer Screening (BCS)	$50	Every two years
Cervical Cancer Screening (CCS)	$50	Every three years
Chlamydia Screening in Women (CHL)	$25	Annually

Measure up: Cancer screening for women HEDIS measure specifications
Organized and continuous screenings along with removal of precancerous lesions can lead to a 60% decrease in cervical cancer.[3]

Cervical Cancer Screening (CCS) is measured by the percentage of women 21 to 64 years of age who were screened for cervical cancer using one of the following criteria:

- Women 21 to 64 years of age who had cervical cytology performed within the last three years
- Women 30 to 64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years
- Women 30 to 64 years of age who had cervical cytology/hrHPV co-testing within the last five years

Description and code
Cervical cytology lab test **CPT®:** 88141-88143, 88147, 88148, 88150, 88152-88153, 88164-88167, 88174, 88175 **HCPCS:** G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091 **LOINC:** 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5
hrHPV lab test **CPT:** 87620-87622, 87624-87625 **HCPCS:** G0476 **LOINC:** 21440-3, 30167-1, 38372-9, 59263-4, 59264-2, 59420-0, 69002-4, 71431-1, 75694-0, 77379-6, 77399-4, 77400-0, 82354-2, 82456-5, 82675-0
Absence of cervix diagnosis **ICD-10-CM:** Q51.5, Z90.710, Z90.712
Hysterectomy with no residual cervix **CPT:** 51925, 56308, 57530, 57531, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58575, 58951, 58953, 58954, 58956, 59135 **ICD-10-PCS:** 0UTC0ZZ, 0UTC4ZZ, 0UTC7ZZ, 0UTC8ZZ

More women in the United States are surviving and thriving after breast cancer than ever before. In fact, in the last 30 years, the breast cancer death rate has dropped an **astounding 40%**. The decreases are believed to be the result of finding breast cancer earlier through screening, increased awareness, and better treatments.[4]

Breast Cancer Screening (BCS): The percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer. Compliant members have one or more mammograms any time on or between October 1, two years prior to the measurement year and December 31 of the measurement year.

Description	CPT/HCPCS
Mammography	**CPT:** 77061-77063, 77065-77067 **LOINC:** 24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46350-5, 46351-3, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0

Sexual health is an essential element of overall health and well-being. Many patients want to discuss their sexual health with you, but most of them want you to bring it up. The National Coalition for Sexual Health has published a guide to help physicians feel comfortable about the conversation. Get a copy of the ***Sexual Health and Your Patients: A Provider's Guide*** by clicking on the title or through this website: **http://www.ctcfp.org**.

Chlamydia Screening in Women (CHL) is measured by the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Description	CPT
Chlamydia tests	**CPT:** 87110, 87270, 87320, 87490, 87491, 87492, 87810 **LOINC:** 14463-4, 14464-2, 14467-5, 14474-1, 14513-6, 16600-9, 21190-4, 21191-2, 21613-5, 23838-6, 31775-0, 31777-6, 36902-5, 36903-3, 42931-6, 43304-5, 43404-3, 43405-0, 43406-8, 44806-8, 44807-6, 45068-4, 45069-2, 45075-9, 45076-7, 45084-1, 45091-6, 45095-7, 45098-1, 45100-5, 47211-8, 47212-6, 49096-1, 4993-2, 50387-0, 53925-4, 53926-2, 557-9, 560-3, 6349-5, 6354-5, 6355-2, 6356-0, 6357-8, 80360-1, 80361-9, 80362-7, 91860-7

[1] CA: A Cancer Journal for Clinicians. Cancer Statistics, 2021 https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21654
[2] http://thecanceryoucanprevent.org/wp-content/uploads/14893-80_2018-PROVIDER-PHYS-4-PAGER-11-10.pdf
[3]National Library of Medicine. https://pubmed.ncbi.nlm.nih.gov/9253676/
[4]Research to Help Women Prevent Breast Cancer or Live their best life with it. American Cancer Society. https://www.cancer.org/latest-news/research-to-help-women-prevent-breast-cancer-or-live-their-best-life-with-it.html

* Availity, LLC is an independent company providing administrative support services on behalf of HealthKeepers, Inc.

AVAPEC-3139-21

URL: https://providernews.anthem.com/virginia/article/4-things-you-can-do-to-encourage-cancer-screenings-for-your-women-patients-3

Keep up with Medicaid news: November 2021

Published: Nov 1, 2021 - **State & Federal** / Medicaid

Please continue to check our website https://providers.anthem.com/virginia-provider/home for the latest Medicaid information for members enrolled in HealthKeepers, Inc.'s Anthem HealthKeepers Plus and the Commonwealth Coordinated Care Plus (Anthem CCC Plus) benefit plans. Here are the topics we're addressing in this edition:

- FAQ: New AIM Specialty Health contact center phone number
- Behavioral therapy assessments
- Change to DME incontinence benefit limits
- Prior authorization updates for specialty pharmacy

URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicaid-news-november-2021-5

Medicare Advantage telehealth rural health center and federally qualified health center claims

Published: Nov 1, 2021 - **State & Federal** / Medicare

Anthem Blue Cross and Blue Shield (Anthem) has identified telehealth Medicare Advantage claims for rural health centers (RHC) and federally qualified health centers (FQHC) that have been billed incorrectly during the public health emergency (PHE). The claims that are billed incorrectly are for RHCs and FQHCs for which Anthem has contracted as professional groups (as opposed to facilities).

During the PHE, professional groups should be billing for telehealth services with the applicable professional telehealth service code or the evaluation and management code that represents the service rendered with modifier 95. However, professional groups are billing for telehealth services using only G2025. The only providers who should be billing G2025 are those contracted as a facility to bill, like Original Medicare.

Enhancements will be made to configuration that will begin denying claim lines for G2025 when billed on a professional claim form.

If you have any questions about this communication or any other item, please contact the Provider Services number on the back of your patient's member ID card.

ABSCARE-1125-21

URL: https://providernews.anthem.com/virginia/article/medicare-advantage-telehealth-rural-health-center-and-federally-qualified-health-center-claims

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Electronic data interchange process

Published: Nov 1, 2021 - **State & Federal** / Medicare

Availity* serves as our electronic data interchange (EDI) partner for all electronic data and transactions. The Availity EDI processing generates response files for each submitted electronic file and delivers them to the submitter's Availity mailbox. It is important to review these responses to understand where your claims are in the process.

Electronic file submitter:

- If your organization uses a clearinghouse or vendor, they have an Availity mailbox to submit clients' files. Availity delivers the responses for claims to the same mailbox, and the clearinghouse or vendor is responsible for returning the results to their clients and resubmitting any files rejected for formatting, interchange, or transaction set errors. The submitter in this scenario is the clearinghouse or vendor.

- If your organization uses a practice management software, an Availity mailbox is set up during initial registration for your electronic file submissions. The submitter is your organization and is responsible for analyzing the responses to verify there are not any file errors or claim rejections that require correction and resubmission within timely filing guidelines.

Availity electronic file process:

1. **Submit electronic file to Availity** — Availity validates for file format and returns file acknowledgments to the submitter's Availity mailbox. If there are any edits at this point, the entire electronic file will not advance and will require resubmission within timely filing guidelines.

1. **Health Insurance Portability and Accountability Act (HIPAA) and payer specific edits** — The electronic file moves to the next phase, which is *HIPAA* and business editing. Examples include:

- Valid subscriber ID for the date of service
- Billing and coding validation

If an error occurs at this point, the individual claims with the errors must be corrected, resubmitted as an original claim and do not advance. The claims that do not have an edit will then route to the adjudication systems for second-level edit validation.

1. **Anthem Blue Cross and Blue Shield payer receives electronic file from Availity** — For the Medicare line of business, there is a second level of editing.

Edits for this second level return the *Delayed Payer Report (DPR)*. Only claims that pass will advance for adjudication and will be displayed using Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice, and paper *Explanation of Payment*. If there are edits, the claim requires resubmission within timely filing guidelines.

Electronic responses

File acknowledgment — Indicates whether we receive an electronic file in the correct format and acceptance by Availity.

- **Action required** — If any errors occur at this stage, the submitter will need to correct and resubmit the entire electronic file to Availity.

Immediate Batch Response (IBR) — This report acknowledges accepted claims and identifies claim edits due to *HIPAA* and business edits. The report also includes claim counts and charges for the electronic file. Availity creates this file prior to routing accepted claims to the adjudication systems.

- **Action required for claims with edits**: Rejected claims require resubmission within timely filing guidelines and will not advance to the adjudication system that would display Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice, and paper *Explanation of Payment*. Not applicable to denied claims.

Delayed Payer Report (DPR) — This report is currently only returned for the Medicare line of business and contains second-level editing from the adjudication system after Availity has routed claims that passed on the IBR report.

- **Action required for claims with edits**: Rejected claims would need to be resubmitted and will not display on Availity claim status, electronic claim status transactions, Availity remittance inquiry, 835 electronic remittance advice and paper *Explanation of Payment*.

Need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Experience representative or call the Provider Services on the back of patient's member ID card, or Availity Client Services with any questions at **800-AVAILITY (282-4548)**.

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

ABSCRNU-0237-21

URL: https://providernews.anthem.com/virginia/article/electronic-data-interchange-process-15

Clinical Criteria updates

Published: Nov 1, 2021 - **State & Federal** / Medicare

Summary: On August 21, 2020, November 20, 2020, and June 24, 2021, the Pharmacy and Therapeutics (P&T) Committee approved the following *Clinical Criteria* applicable to the medical drug benefit for Anthem Blue Cross and Blue Shield (Anthem). These policies were developed, revised, or reviewed to support clinical coding edits.

Visit ***Clinical Criteria*** to search for specific policies. If you have questions or need 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

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.

Effective date	Document number	*Clinical Criteria* title	New or revised
November 1, 2021	*ING-CC-0201	Rybrevant (amivantamab-vmjm)	New
November 1, 2021	*ING-CC-0042	Monoclonal Antibodies to Interleukin-17	Revised
November 1, 2021	*ING-CC-0050	Monoclonal Antibodies to Interleukin-23	Revised
November 1, 2021	ING-CC-0125	Opdivo (nivolumab)	Revised
November 1, 2021	ING-CC-0124	Keytruda (pembrolizumab)	Revised
November 1, 2021	*ING-CC-0102	GnRH Analogs for Oncologic Indications	Revised
November 1, 2021	ING-CC-0076	Nulojix (belatacept)	Revised
November 1, 2021	*ING-CC-0077	Palynziq (pegvaliase-pqpz)	Revised
November 1, 2021	ING-CC-0067	Prostacyclin Infusion and Inhalation Therapy	Revised
November 1, 2021	ING-CC-0194	Cabenuva (cabotegravir extended-release; rilpivirine extended-release) Injection	Revised

ABSCRNU-0261-21

URL: https://providernews.anthem.com/virginia/article/clinical-criteria-updates-32

Anthem Blue Cross and Blue Shield offering Advance Medical Directives program for 2022

Published: Nov 1, 2021 - **State & Federal** / Medicare

In 2022, Anthem Blue Cross and Blue Shield (Anthem) will be providing members with a new tool to develop an advance medical directive for many of its DSNP Medicare Advantage plans. Anthem has partnered with MyDirectives,* a leader in the industry for electronic advance directives. Information on the service will be provided to members via their *Annual Notice of Change* (*ANOC*), *Evidence of Coverage* (*EOC*), and *Benefit Summaries*.

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

MyDirectives has an easy-to-use guide that takes members through a series of questions around their care preferences, establishing of healthcare agents (medical powers of attorney), sharing of information, and more. If they already have a written advance directive, the software allows members to upload copies of their current directive, making it easier to store and share when necessary.

Physicians and hospitals can access a member's advance directive via healthcare exchanges such as eHealth Exchange, Carequality, and CommonWell Health Alliance.

The benefit and associated links will be live as of the new plan year. We encourage you to speak to your members about the value of an establishing an advance directive and support members as they go through the process.

* MyDirectives is an independent company providing electronic advance directives services on behalf of Anthem Blue Cross and Blue Shield.

ABSCRNU-0269-21

URL: https://providernews.anthem.com/virginia/article/anthem-blue-cross-and-blue-shield-offering-advance-medical-directives-program-for-2022-3

Updates to AIM Specialty Health Cardiology Clinical Appropriateness Guidelines

Published: Nov 1, 2021 - **State & Federal** / Medicare

Effective for dates of service on and after March 13, 2022, the following updates will apply to the AIM Specialty Health®* *Diagnostic Coronary Angiography and Percutaneous Coronary*

Intervention Clinical Appropriateness Guidelines. As part of the AIM guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable healthcare services.

Diagnostic coronary angiography:

- Removed indications for asymptomatic patients (in alignment with the ischemia trial)
- Facilitated coronary angiography with a view to intervention in non-culprit vessels following ST-segment elevation myocardial infarction (STEMI), in alignment with the complete trial
- For patients undergoing preoperative evaluation for transcatheter aortic valve replacement (TAVR) or other valve surgery, aligned criteria with the updated American College of Cardiology (ACC)/American Heart Association (AHA) guideline for the management of patients with valvular heart disease

Percutaneous coronary intervention:

- Revised criteria such that, for some cohorts, only those patients with persistent unacceptable symptoms and moderate or severe stress test abnormalities can proceed to revascularization (in alignment with the ischemia trial)
- For non-left main percutaneous coronary intervention (PCI), expanded use to non-culprit vessels in patients following STEMI, and restricted use to those with moderate or severe stress test abnormalities who have failed medical therapy
- Left main PCI limited to situations where coronary artery bypass grafting (CABG) is contraindicated or refused (in alignment with noble and excel trials)
- Clarified requirements for patients who have undergone CABG: at least 70% luminal narrowing qualifies as stenosis, symptomatic ventricular tachycardia is considered an ischemic symptom, and instant wave-free ratio fractional flow reserve (iFR) is considered in noninvasive testing
- Removed requirement to calculate syntax score for patients scheduled to undergo renal transplantation
- For patients scheduled for percutaneous valvular procedures (e.g., TAVR/TAVI or mitral valve repair), added clarification that PCI should only be attempted for complex triple vessel disease when CABG is not an option

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

- AIM ***Provider****Portal*$_{SM}$ — **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.
- Availity Portal* — **avaiility.com**
- AIM Contact Center toll-free number — **800-714-0040**, Monday through Friday, 7 a.m. to 7 p.m. CT

Need assistance?

For questions related to guidelines, please contact AIM via email at aim.guidelines@aimspecialtyhealth.com. Additionally, you may access and download a copy of the current and upcoming guidelines **online**.

* AIM Specialty Health is an independent company providing some utilization review services on behalf of Anthem Blue Cross and Blue Shield.

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

ABSCRNU-0272-21

URL: https://providernews.anthem.com/virginia/article/updates-to-aim-specialty-health-cardiology-clinical-appropriateness-guidelines-6

New York City Medicare Advantage announcement

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The City of New York has awarded their group retiree business to the Retiree Health Alliance, an alliance between Empire BlueCross BlueShield (Empire) and EmblemHealth. Effective January 1, 2022, approximately 240,000 Medicare-eligible City of New York retirees across the United States will transition to Retiree Health Alliance's NYC Medicare Advantage Plus plan.

The NYC Medicare Advantage Plus plan is a Medicare Advantage PPO plan that allows retirees to receive services from both in-network and out-of-network providers. Out-of-network providers must be eligible to receive Medicare payments to provide care to NYC retirees. Under this new plan, City of New York retirees will have no difference in cost share for both in-network and out-of-network services. NYC Medicare Advantage Plus offers the same hospital and medical benefits covered by original Medicare as well as additional benefits original Medicare does not provide, such as an annual routine physical exam, hearing, health and fitness tracker, LiveHealth Online,* and SilverSneakers.*

Retirees enrolled in **NYC Medicare Advantage Plus** will have access to BlueCross BlueShield Medicare Advantage PPO Network Sharing effective January 1, 2022. Recently, you may have received calls from City of New York retirees inquiring if you are participating or if you accept **NYC Medicare Advantage Plus**. Retirees may also refer to the new plan as Medicare Advantage Plus or the Alliance.

Currently, City of New York retiree claims are processed by Medicare as primary and then by Empire for facility services or EmblemHealth for professional services as supplemental coverage under the General Health Insurance/Empire Senior Care plan.

Beginning January 1, 2022, under the NYC Medicare Advantage Plus plan, providers will change billing processes as follows:

- Providers should submit all claims (facility, professional, and ancillary) to your local Blue plan:
    - For independent clinical laboratories, providers should file to the BCBS Plan where the referring provider is located.
    - For durable/home equipment and supplies (D/HME), providers should file to the BCBS Plan where the equipment was shipped to or purchased from in a retail store.
- Providers should not transmit any claims to original Medicare.
- Claims can be submitted electronically or by paper submission (*UB-04*or *CMS-1500* form) to your local Blue plan.

For additional information, review the NYC Medicare Advantage FAQ at **https://www.anthem.com/da/inline/pdf/abscare-1134-21.pdf**.

* Availity, LLC is an independent company providing administrative support services on behalf of Empire BlueCross BlueShield.
LiveHealth Online is an independent company providing online doctor visits on behalf of Empire BlueCross BlueShield.
SilverSneakers is an independent company providing fitness management on behalf of Empire BlueCross BlueShield.

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Keep up with Medicare news: November 2021

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

- Anthem Blue Cross and Blue Shield expands specialty pharmacy precertification list

URL: https://providernews.anthem.com/virginia/article/keep-up-with-medicare-news-november-2021-5
