Connecticut Provider News

August 2021 Connecticut Provider News

Federal Employee Plan (FEP):

Medicare:

Strategic Provider System to be implemented in August 2021

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

In July, Anthem advised of the delay in the implementation of our new data management system called Strategic Provider System (SPS), which was first announced in June 2021. We are pleased to advise that SPS will now be implemented in August, and will replace our legacy internal provider data management system for Connecticut providers. This investment in advanced technology will significantly improve provider data accuracy and transparency, enhancing the overall provider experience. New system features strengthen our ability to match submitted claims for more accurate pricing and processing.

System upgrades special notice

We will be implementing SPS upgrades from August 6 through August 12. Provider demographic updates submitted during this time will be processed after August 12. We appreciate your patience as we upgrade our systems.

Next steps: New Provider Data Maintenance coming soon

Beginning in September 2021, the second phase of our improvement will be integration with Availity's Provider Data Management (PDM) functionality, which will roll out in phases. Through this tool, providers can view, maintain, update, and attest provider demographic information is accurate for Anthem (and other health plans) in one easy-to-use portal. This service will replace our *Provider Maintenance Form* in the coming months. The PDM service also features a simplified *quick verification* process, which enables providers to complete the required verifications online – eliminating the need to fax or email or use separate online forms.

Get ready for the change today

If your organization is not already registered on Availity portal, we strongly encourage you to get started right away. Your organization's designated administrator can go to the Availity portal to register and to find other helpful information about using Availity. Availity is Anthem's secure provider portal platform where providers can enjoy the convenience of digital transactions including prior authorization submission, claims submission and benefit and eligibility look-up.

Starting with claims submitted after August 12, Anthem will deny claims submitted without a billing national provider identifier (NPI). Submitting claims with complete and correct data is critical to help ensure we are able to process your claims efficiently and accurately. Please submit your full address including your line 2 address (suite #, unit etc.) when applicable. All data fields on claims are used when building your claim record. Review your billing practices carefully to ensure provider tax identification number (TIN), billing national provider identifier (NPI), taxonomy code, and servicing/rendering provider information (if applicable) are submitted in the appropriate fields**.**

1268-0821-PN-CT

URL: https://providernews.anthem.com/connecticut/article/strategic-provider-system-to-be-implemented-in-august-2021

Register now for our August CME webinars

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

Join us throughout the year in a new Continuing Medical Education (CME) webinar series as we share practices and success stories to overcoming barriers in achieving clinical quality goals, attaining better patient outcomes and improving STARs ratings.

Program objectives:

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

Attendees will receive one CME credit upon completion of a program evaluation at the conclusion of each webinar.

Article Attachments

Registration for our August webinars is now available.

Motivating Patients to Adhere to Cervical Cancer Prevention and Screening Recommendations

Date: Tuesday, August 3, 2021
Time: 12:00 p.m. ET
Presented by the American Cancer Society (ACS), this webinar will focus on the pandemic's impact on cancer screenings and implications of delayed cervical cancer screenings and will provide tools and tactics to engage and motivate your patients to adhere to ACS prevention and screening recommendations.

10 Best Practices for Improving Pharmacy Quality Measures

Date: Thursday, August 12, 2021
Time: 1:00 p.m. and 3:00 p.m. ET *(two sessions offered)*
This webinar will explain the role of pharmacy quality measures on overall outcomes and offer practical approaches to improving pharmacy quality measures.

6 Ways to Improve Risk Adjustment Documentation Accuracy

Date: Tuesday, August 17, 2021
Time: 12:00 p.m. and 3:00 p.m. ET *(two sessions offered)*
This webinar will offer best practices to documentation and explain how documentation and coding can enhance patient outcomes.

Register here for these upcoming clinical quality webinars!

1275-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/register-now-for-our-august-cme-webinars-2

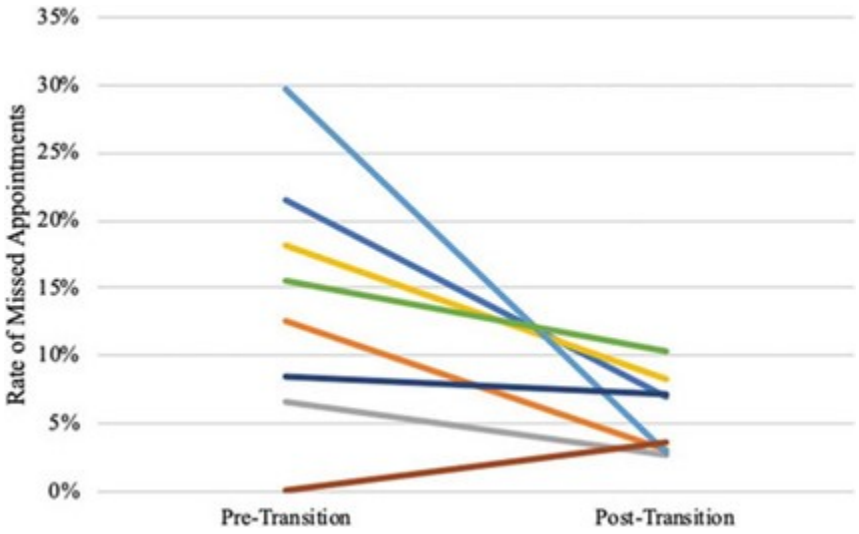
Telehealth visits can impact after-hospitalization follow-up care for mental illness

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

Significant reductions in missed appointments

Telehealth visits are having a significant impact on missed appointments according to a study published in Counselling Psychology Quarterly. Prior to transitioning to telehealth, clinicians in the study "Psychotherapy at a public hospital in the time of COVID-19: telehealth and implications for practice,[1]" experienced a 14.25% missed appointment rate. After transitioning to telehealth, the missed appointment rate fell to 5.63%.

Rate of missed appointments before and after transitioning to telehealth
The graph below illustrates the changes in the average rate of missed appointments (cancellations and no-show) for each of the eight clinicians in the study between the periods before and after the transition to telehealth.



https://www.tandfonline.com/doi/full/10.1080/09515070.2020.1777390

"While there are a number of limitations to consider regarding this data, [which is further discussed in the study], the statistically significant reduction in missed appointments pre-and-post [digital] transition is striking," cited in the study report.

Telehealth and telephone visits with members after a behavioral health (BH) inpatient stay meet HEDIS® criteria for the measure: Follow-up after Hospitalization for Mental Illness (FUH). With transportation being one of the barriers to after hospitalization follow-up, telehealth visits could be an ideal solution.[2]

The FUH HEDIS measure evaluates:

Article Attachments

- Members (6 years and older) who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner.

Two areas of importance for this HEDIS measure are:

1. The percentage of behavioral health inpatient discharges for which the member received follow-up within 7 days after discharge.
2. The percentage of behavioral health inpatient discharges for which the member received follow-up within 30 days after discharge.

These two consecutive follow-up appointments are paramount to positive outcomes as well as meeting this HEDIS measure. Telehealth visits can greatly increase the likelihood of keeping follow-up appointments leading to reduced numbers of rehospitalization and more favorable outcomes for these patients. To learn more about the FUH HEDIS measure, visit the NCQA website.

1 Counselling Psychology Quarterly. Psychotherapy at a public hospital in the time of COVID-19: telehealth and implications for practice
https://www.tandfonline.com/doi/full/10.1080/09515070.2020.1777390
2 Traveling towards disease: transportation barriers to health care access.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/#:~:text=Transportation%20barriers%20are%20often%20cited,and%20thus%20poorer%20health%20outcomes

1264-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/telehealth-visits-can-impact-after-hospitalization-follow-up-care-for-mental-illness-1

Some requests to AIM require documentation to support prior authorization

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

Providers currently submit prior authorization requests to AIM Specialty Health® (AIM) for outpatient diagnostic imaging services. These prior authorizations are often reviewed based on provider attestation as to certain requirements. As part of our ongoing quality improvement efforts, certain review requests may require documentation to substantiate the attestations that supports the clinical appropriateness of the request. This documentation can be uploaded during the intake process.

When requested, providers must submit such documentation from the patient's medical record. If medical necessity is not supported through documents submitted, the request may be denied as not medically necessary. Documentation is limited to what has been asserted via the prior authorization review attestations. If the request would be denied as not medically necessary, providers can participate in a prior authorization discussion with an AIM physician reviewer.

1269-0821-PN-CT

URL: https://providernews.anthem.com/connecticut/article/some-physician-requests-to-aim-require-submission-of-documentation-to-support-attestations-for-prior-authorization

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Clearing up coding confusion for retinal eye exams (DRE)

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

3072F: new language about two-year compliance

The Comprehensive Diabetes Care HEDIS® Measure Retinal Eye Exam (DRE) valuates the percent of adult members ages 18 to 75, with diabetes (type 1 and type 2), who had a retinal eye exam during the measurement year.

Changes to 3072F

The definition for the code 3072F (negative for retinopathy) has been redefined to: *Low risk for retinopathy (no evidence of retinopathy in the prior year).* This can be particularly confusing because it would not be used at the time of the exam. It would be used the following year, along with the exam coding for the current year, to indicate that retinopathy was not present the previous year.

A simpler coding solution

Using these three codes count toward the DRE measurement if they are billed in the current measurement year, ***or*** the prior year. This means you can submit the appropriate code at the time of the exam, and it covers both years:

- 2023F - Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)
- 2025F7 - standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (DM)
- 2033F - Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)

For more about diabetic retinopathy, visit CMS.gov or use this link to read more.

Meeting the measurement for all diabetes care

These exams are also important in evaluating the overall health of diabetic patients, as well as meeting the Comprehensive Diabetes Care HEDIS measure:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Retinal eye exam performed
- Blood pressure control (<140/90 mm Hg)

Record your efforts in the member's medical records for the HbA1c tests and results, retinal eye exam, blood pressure, urine creatinine test and the estimated glomerular filtration rate test. Meeting the mark and closing gaps in care is key to good health outcomes.

1265-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/clearing-up-coding-confusion-for-retinal-eye-exams-dre-1

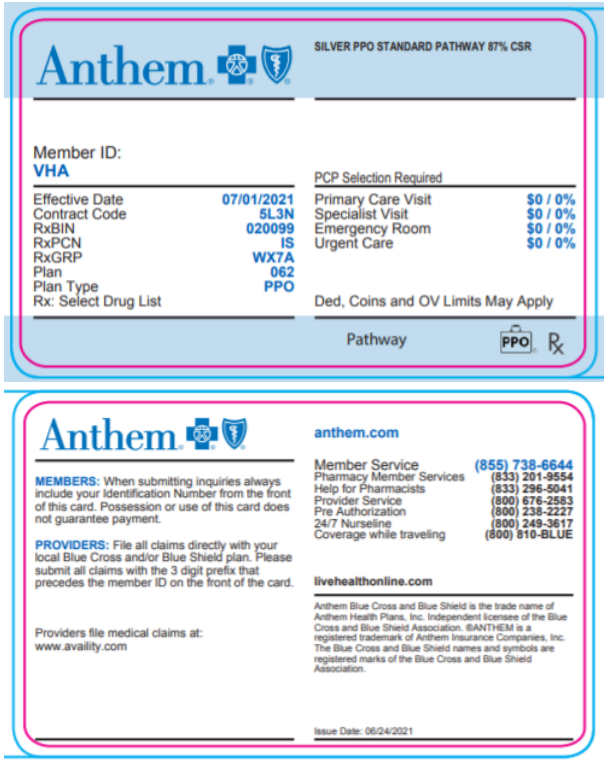
Reminder: Covered Connecticut Program began July 1, 2021

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

In June, we announced the new Covered Connecticut Program which became effective on July 1, 2021. The Program was created by the State of Connecticut to provide healthcare coverage for certain Connecticut residents who meet specific eligibility requirements. Covered Connecticut members pay $0 cost shares for their healthcare coverage.

In this new program, the State of Connecticut pays the member portion of the monthly premium payment directly to Anthem, and also pays for the cost sharing amounts (deductibles, co-pays, co-insurance and maximum out-of-pocket costs) – *members have no cost sharing for services received.*

Below is a sample member ID card for Covered Connecticut members. Note that these members are enrolled in Anthem's Silver PPO Standard Pathway 87% CSR Plan using the Pathway provider network. Additional individuals will continue to be added to this Program going forward as eligibility requirements are met.



Due to the importance and urgency to create the Covered Connecticut Program to provide these individuals with health coverage effective July 1, we were not able to complete certain system updates necessary to allow for digital verification of member eligibility and coverage. Although we normally recommend verifying member eligibility and coverage via Availity.com, *for Covered Connecticut members, please instead contact us via the Provider Service number located on the member ID card at 1-800-676-2583. At this time, Availity.com will not have updated information regarding the $0 cost sharing benefit.* Should you collect any cost sharing from a Covered Connecticut member in error, those monies will need to be returned to the member. We will notify you in a future update when Availity.com has been updated to provide the applicable benefit and eligibility for Covered Connecticut members.

Article Attachments

1278-0821-PN-CT

URL: https://providernews.anthem.com/connecticut/article/reminder-covered-connecticut-program-began-july-1-2021

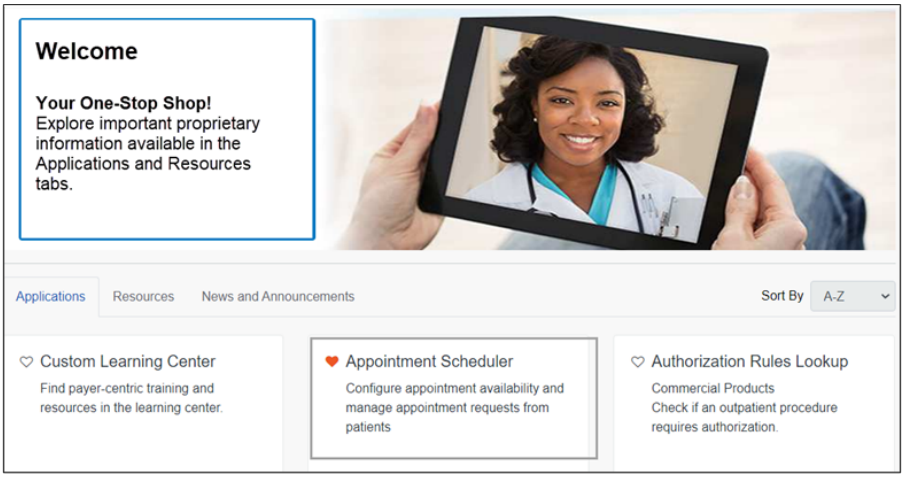
New! Schedule appointments online through Availity

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

We're making it even easier for you to schedule online appointments through the Appointment Scheduler App on Availity. The Appointment Scheduler App gives you secure access to new appointment requests. You'll also receive digital access to the member's ID number, contact information and any special health information.

Appointment Scheduler App features include:

- Manage appointment requests
- Configure appointment availability
- Notifications for new visit requests on your Availity dashboard
- Members are automatically notified by text or email when appointments are confirmed



Article Attachments

Administrators, administrator assistants and users with the role of ‘office staff’ will have access to the Appointment Scheduler App.

To access Appointment Scheduler, log onto Availity.com and select Anthem from Payer Spaces. The Appointment Scheduler App will be located in your Applications menu. To learn more about the new App, go to the Custom Learning Center in Availity and keyword search Appointment Scheduler.

1266-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/new-schedule-appointments-online-through-availity

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Reimbursement policy update: Claims requiring additional documentation (facility)

Published: Aug 1, 2021 - **Policy Updates** / Reimbursement Policies

In our May issue of *Provider News*, we announced a threshold increase for the itemized bill requirement for outpatient facility claims. This requirement will remain; however, effective August 1, 2021, we will remove the threshold amount from the policy language for outpatient facility claims and inpatient stay claims.

For more information about this policy, visit the Reimbursement Policies page at anthem.com.

1260-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/reimbursement-policy-update-claims-requiring-additional-documentation-facility-29

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

Published: Aug 1, 2021 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after November 1, 2021, we will update the Related Coding section to indicate no modifier override for the neurostimulator device when billed with the surgical code for the implantation of the neurostimulator device.

The following code pairs have been added to the Related Coding Section:

- L8680 when reported with 63655
- L8679 when reported with 63650
- L8679 when reported with 63655
- L8687 when reported with 63650
- L8687 when reported with 63655

For more information about this policy, visit the Reimbursement Policies page at anthem.com.

1261-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/reimbursement-policy-update-distinct-procedural-service-modifiers-59-and-xe-xp-xs-xu

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Reimbursement policy update: Virtual Visits - professional and facility

Published: Aug 1, 2021 - **Policy Updates** / Reimbursement Policies

Beginning with dates of service on or after November 1, 2021, Anthem's current Telehealth policy will be renamed Virtual Visits. We allow reimbursement for professional and facility Virtual Visits when interactive services occur between the member and the provider, when they are not in the same location, unless provider, state, or federal contracts and/or mandates indicate otherwise. Reimbursement is allowed for professional and facility Virtual Visits rendered at the distant site via live audio visual services and for Remote Patient Monitoring. In addition, facility Virtual Visits will be allowed for the originating site fee. The Related Coding section details the modifiers allowed for reimbursement.

For more information about this policy, visit the Reimbursement Policies page at anthem.com.

1267-0821-PN-CT

URL: https://providernews.anthem.com/connecticut/article/reimbursement-policy-update-virtual-visits-professional-and-facility

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Transition to AIM Specialty Health Imaging of the Heart Clinical Appropriateness Guideline for computed tomography to detect coronary artery calcification

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

Effective November 1, 2021, Anthem will transition the clinical criteria for medical necessity review of computed tomography to detect coronary artery calcification to AIM Imaging of the Heart Clinical Appropriateness Guideline.

As part of this transition of clinical criteria, the following procedures will be subject to prior authorization at AIM:

CPT code	Description
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary artery calcium
S8092	Electron beam CT (also known as ultrafast CT, cine CT)

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

- Access AIM's ***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 AIM via the Availity Web Portal at availity.com
- Call the AIM Contact Center toll-free number at 866-714-1107, Monday – Friday, 8:00 a.m. – 5:00 p.m.

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 here.

1258-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/transition-to-aim-specialty-health-imaging-of-the-heart-clinical-appropriateness-guideline-for-computed-tomography-to-detect-coronary-artery-calcification-1

Updated AIM Musculoskeletal Program effective November 1, 2021 - site of care reviews

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

We are committed to being a valued health care partner in identifying ways to achieve better health outcomes, lower costs and deliver access to a better healthcare experience for consumers.

Effective November 1, 2021, AIM Specialty Health® (AIM), a separate company, will expand the AIM Musculoskeletal Program to perform medical necessity review of the requested site of service for certain spine, joint and interventional pain procedures for Anthem fully insured members, as further outlined below.

AIM will continue to manage the AIM Musculoskeletal Program and level of care review. The AIM Level of Care Guideline for Musculoskeletal Surgery and Procedures is used for the level of care review. Prior authorization will now also be required for the clinical appropriateness of the site in which the procedure is performed (site of care). AIM will use the following Anthem Clinical UM Guideline: CG-SURG-52: Site of Care: Hospital-Based Ambulatory Surgical Procedures and Endoscopic Services. The clinical criteria to be used for these reviews can be found on the Anthem Clinical UM Guidelines page. *Please note, this does not apply to procedures performed on an emergent basis.*

A subset of the AIM Musculoskeletal Program codes will be reviewed for site of care. A complete list of CPT codes requiring prior authorization for the AIM Musculoskeletal site of care program is available on the AIM Musculoskeletal microsite. To determine if the AIM Musculoskeletal Program applies to an Anthem member on or after November 1, 2021, providers can contact the Provider Services number on the back of the member's ID card for benefit information. AIM will also have a file upload from Anthem regarding the members to whom the program applies, and will not provide prior authorization for members to whom the program does not apply. If providers use the Interactive Care Reviewer (ICR) tool on the Availity Portal to request prior authorization for a member for the Musculoskeletal Program, ICR will produce a message referring the provider to AIM. (Note: ICR cannot accept prior authorization requests for services administered by AIM.)

Members included in the new program

All fully insured and administrative services only (ASO) members currently participating in the AIM Musculoskeletal program are included. For self-funded (ASO) groups that currently do not participate in the AIM Musculoskeletal program, the program will be offered to self-funded accounts (ASO) to add to their members' benefit package as of November 1, 2021.

Prior authorization requirements

For surgeries that are scheduled to begin on or after November 1, 2021, all providers must contact AIM to obtain prior authorization. The following plans are excluded: Medicare Advantage, Medicaid, Medicare, Medicare supplement, MA EGR, Federal Employee Program® (FEP®).

For services provided on or after November 1, 2021, ordering and servicing providers may contact AIM for review beginning October 18, 2021. Providers may submit prior authorization requests to AIM in one of several ways:

- Access AIM's ***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 AIM via the Availity Web Portal at availity.com.
- Call the AIM Contact Center toll-free number at 866-714-1107, Monday- Friday, 8:00 a.m. – 5:00 p.m.

Initiating a request on AIM's ***Provider****Portal*$_{SM}$ for physical, speech or occupational therapy, and entering all the requested clinical questions will allow you to receive an immediate determination. If the request is approved, you will receive the Order ID, the number of visits and valid time frame. The AIM Musculoskeletal Program microsite on the AIM provider portal helps you learn more and access helpful information and tools such as order entry checklists.

AIM Musculoskeletal training webinars
We invite you to take advantage of a free informational webinar that will introduce you to the program and the robust capabilities of the AIM ***Provider****Portal*$_{SM.}$ Go to the AIM Musculoskeletal microsite to register for an upcoming webinar. If you have previously registered for other services managed by AIM, there is no need to register again.

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

1263-0821-PN-CT

URL: https://providernews.anthem.com/connecticut/article/updated-aim-musculoskeletal-program-effective-november-1-2021-site-of-care-reviews

Specialty dose rounding program for certain oncology medications

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

Providers treating members covered by Anthem plans will be asked in selective circumstances to voluntarily reduce the requested dose to the nearest whole vial for over 40 oncology medications (see list below). Reviews for these oncology drugs will continue to be administered by AIM Specialty Health® (AIM).

As part of the online prior authorization process, providers will be asked about the dosage of the medication being requested in pop-up questions:

- Whether or not the recommended dose reduction is acceptable
- If the patient is considered unable to have his or her dose reduced, then a second question will appear asking for the provider's clinical reasoning.

For prior authorization requests made outside of the online AIM Provider Portal (i.e. via phone or fax) the same questions will be asked by the registered nurse or medical director reviewing the request. **Since this program is voluntary, the decision made regarding dose reduction will not affect the final decision on the prior authorization.**

The dose reduction questions will appear only if the originally requested dose is within 10 percent of the nearest whole vial. This threshold is based on the current medical literature and recommendations from the Hematology and Oncology Pharmacists Association (HOPA) it is appropriate to consider dose rounding within 10 percent. View the HOPA recommendations here.

The voluntary dose reduction program only applies to the specific oncology drugs listed below. Providers can view prior authorization requirements for Anthem members on the Medical Policy & Clinical UM Guidelines page at anthem.com.

Drug Name	HCPCS Code	Drug Name	HCPCS Code
Abraxane (paclitaxel protein-bound)	J9264	Kadcyla (ado-trastuzumab emtansine)	J9354
Actimmune (interferon gamma-1B)	J9216	Kanjinti (trastuzumab-anns)	Q5117
Adcetris (brentuximab vedotin)	J9042	Keytruda (pembrolizumab)	J9271
Alimta (pemetrexed)	J9305	Kyprolis (carfilzomib)	J9047
Asparlas (calaspargase pegol-mknl)	J9118	Lumoxiti (moxetumomab pasudotox-tdfk)	J9313
Avastin (bevacizumab)	J9035	Mvasi (bevacizumab-awwb)	Q5107
Bendeka (bendamustine)	J9034	Mylotarg (gemtuzumab ozogamicin)	J9203
Besponsa (inotuzumab ozogamicin)	J9229	Neupogen (filgrastim)	J1442
Blincyto (blinatumomab)	J9039	Ogivri (trastuzumab-dkst)	Q5114
Cyramza (ramucirumab)	J9308	Oncaspar (pegaspargase)	J9266
Darzalex (daratumumab)	J9145	Ontruzant (trastuzumab-dttb)	Q5112
Doxorubicin liposomal	Q2050	Opdivo (nivolumab)	J9299
Elzonris (tagraxofusp-erzs)	J9269	Padcev (enfortumab vedotin-ejfv)	J9177
Empliciti (elotuzumab)	J9176	Polivy (polatuzumab vedotin-piiq)	J9309
Enhertu (fam-trastuzumab deruxtecan-nxki)	J9358	Riabni (rituximab-arrx)	Q5123
Erbitux (cetuximab)	J9055	Rituxan (rituximab)	J9312
Erwinase (asparginase)	J9019	Ruxience (rituximab-pvvr)	Q5119
Ethyol (amifostine)	J0207	Sarclisa (isatuximab-irfc)	J9227
Granix (tbo-filgrastim)	J1447	Sylvant (siltuximab)	J2860
Halaven (eribulin mesylate)	J9179	Trazimera (trastuzumab-qyyp)	Q5116
Herceptin (trastuzumab)	J9355	Treanda (bendamustine)	J9033
Herzuma (trastuzumab-pkrb)	Q5113	Truxima (rituximab-abbs)	Q5115
Imfinzi (durvalumab)	J9173	Vectibix (panitumumab)	J9303
Istodax (romidepsin)	J9315	Yervoy (ipilimumab)	J9228
Ixempra (ixabepilone)	J9207	Zaltrap (ziv-aflibercept)	J9400
Jevtana (cabazitaxel)	J9043	Zirabev (bevacizumab-bvzr)	Q5118

Note: In some plans “dose reduction to nearest whole vial” or another term “waste reduction” may be the term used in benefit plans, provider contracts or other materials instead of or in addition to “dose reduction to nearest whole vial” and in some plans, these terms may be used interchangeably. For simplicity, we will hereafter use “dose reduction (to nearest whole vial).”

Providers should continue to verify eligibility and benefits for all members prior to rendering services.

If you have questions, please call the Provider Service phone number on the back of the member’s ID card.

1245-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/specialty-dose-rounding-program-for-certain-oncology-medications-1

Specialty dose rounding program for certain non-oncology medications effective August 1, 2021

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

We are committed to being a valued healthcare partner in identifying ways to achieve better health outcomes, lower costs and deliver access to a better healthcare experience for consumers.

Effective with dates of service on or after August 1, 2021, providers treating members covered by Anthem Commercial plans may be asked to consider voluntarily reducing the requested dose to avoid vial wastage for select non-oncology specialty medications. The dose reduction suggestion will only be made if the originally requested dose is within 10% of the nearest whole vial.

Since this program is voluntary, the decision to participate will not affect the final decision on the prior authorization.

Reviews for these specialty drugs will continue to be administered by IngenioRx®.

As part of the prior authorization process, providers may be asked the following questions:

- Whether the suggested dose reduction is clinically acceptable
- Clinical reasoning if the dose reduction is not appropriate

Providers can view prior authorization requirements for Anthem members on the Medical Policy & Clinical UM Guidelines page at anthem.com.

Providers should continue to verify eligibility and benefits for all members prior to rendering services.

If you have questions, please call the Provider Service phone number on the back of the member's ID card.

1273-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/specialty-dose-rounding-program-for-certain-non-oncology-medications-effective-august-1-2021

Immune globulin adjusted body weight dosing program begins August 1, 2021

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

We are committed to being a valued healthcare partner in identifying ways to achieve better health outcomes, lower costs and deliver access to a better healthcare experience for consumers.

Effective with dates of service on or after August 1, 2021, providers treating members covered by Anthem commercial plans may be asked to consider voluntarily using adjusted body weight (AdjBW) dosing compared to actual body weight (ABW) dosing for immune globulin medications. The dose change using AdjBW will only be made if the member's actual body weight is more than 20% of the ideal body weight (IBW).

Since this program is voluntary, the decision to participate will not affect the final decision on the prior authorization.

Reviews for the immune globulin medications will continue to be administered by IngenioRx® as these will specifically target specialty non-oncology indications.

As part of the prior authorization process, providers may be asked the following questions:

- Whether the suggested use of AdjBW and change in dose is clinically acceptable
- Clinical reasoning if the dose change (using AdjBW) is not appropriate

Providers can view prior authorization requirements for Anthem members on the Medical Policy & Clinical UM Guidelines page at anthem.com.

Providers should continue to verify eligibility and benefits for all members prior to rendering services.

If you have questions, please call the Provider Service phone number on the back of the member's ID card.

1274-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/immune-globulin-adjusted-body-weight-dosing-program-begins-august-1-2021

Reminder: New requirement to obtain certain specialty drugs from CVS Specialty Pharmacy

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

In June 2021, we mailed a communication to acute care facilities to announce that beginning September 15, 2021, Anthem in Connecticut has designated CVS Specialty as an exclusive provider of certain specialty medications administered in the outpatient hospital setting. This applies to Anthem commercial members and claims priced by Anthem for commercial BlueCard Program members. This does not apply to Medicare Advantage, Medicaid, Medicare Supplement, or the Federal Employee Program®. Please contact your Anthem Contract Manager if you have any questions.

Under this policy, facilities will be required to procure the select specialty pharmacy medications administered in the hospital outpatient setting through CVS Specialty Pharmacy. **For dates of service on or after September 15, 2021**, the prescribing provider for Anthem commercial members should continue to contact AIM Specialty Health or IngenioRx for prior authorization. During the authorization process, the prescribing provider will be notified of the requirement to utilize CVS Specialty as the dispensing provider for the specialty pharmacy medication when administered in the outpatient hospital setting. The failure to do so will result in claim denials and the member cannot be billed for these specialty medications. Hospitals may continue to submit a claim for administration of the specialty pharmacy medications in the outpatient hospital setting, which will be reimbursed at the current contracted rates.

The list of specialty pharmacy medications subject to the above will be posted at anthem.com for reference and is subject to change. All specialty pharmacy prior authorization requirements will still apply and are the responsibility of the prescribing provider.

This will have no impact on how members obtain non-specialty pharmacy medications at retail pharmacies or by mail-order.

To access the current Designated Medical Specialty Pharmacy Drug List, visit anthem.com, select *Providers*, select the state Connecticut (top right of page), select *Forms and Guides* (under the *Provider Resources* column). Scroll down and select *Pharmacy* in the Category drop down.

If you have questions, or would like to discuss the terms for providing certain specialty medications, please contact your Anthem Contract Manager. Thank you for your continued participation in the Anthem networks and the services you provide to our members.

1253-0821-PN-CT

URL: https://providernews.anthem.com/connecticut/article/reminder-new-requirement-to-obtain-certain-specialty-drugs-from-cvs-specialty-pharmacy

Anthem to update formulary lists for commercial health plan pharmacy benefit

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Effective with dates of service on and after October 1, 2021, and in accordance with the IngenioRx Pharmacy and Therapeutics (P&T) process, Anthem will update our drug lists that support commercial health plans.

Updates include changes to drug tiers and the removal of medications from the formulary.

Please note, this update does not apply to the Select Drug List and does not impact Medicaid and Medicare plans.

To help ensure a smooth member transition and minimize costs, providers should review these changes and consider prescribing a drug on formulary or on a lower tier, if appropriate.

View a summary of changes in the attached PDF.

Article Attachments

10.1.21_Formulary_Change summary.pdf
application/pdf - 58.24 KB

1270-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/anthem-to-update-formulary-lists-for-commercial-health-plan-pharmacy-benefit-15

Specialty pharmacy updates effective November 1, 2021

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Prior authorization updates

Effective for dates of service on and after November 1, 2021, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our prior authorization review process.

Please note, 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.

Visit our website to access the clinical criteria information.

Prior authorization clinical review of non-oncology use of specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team. Review of specialty pharmacy drugs for oncology use will be managed by AIM Specialty Health® (AIM).

Clinical Criteria	HCPCS or CPT Code(s)	Drug
**ING-CC-0196	J3490, J9999, J3590	Zynlonta
**ING-CC-0197	J3490, J3590, J9999	Jemperli
*ING-CC-0199	J3490, J3590, C9399	Empaveli

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

Quantity limit updates
Effective for dates of service on and after November 1, 2021, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our quantity limit review process.

Please note, 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.

Visit our website to access the clinical criteria information.

Prior authorization clinical review of non-oncology use of specialty pharmacy drugs will be managed by Anthem's medical specialty drug review team.

Clinical Criteria	HCPCS or CPT Code(s)	Drug
*ING-CC-0199	J3490. J3590, C9399	Empaveli

***** Non-oncology use is managed by Anthem's medical specialty drug review team.

1271-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/specialty-pharmacy-updates-effective-november-1-2021

Pharmacy information available on anthem.com

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For more information on copayment/coinsurance requirements and their applicable drug classes, drug lists and changes, prior authorization criteria, procedures for generic substitution, therapeutic interchange, step therapy or other management methods subject to prescribing decisions and other requirements, restrictions or limitations that apply to certain drugs, visit anthem.com/pharmacyinformation. The commercial and marketplace drug lists are reviewed and updates are posted to the website quarterly (the first of the month for January, April, July and October).

- To locate the commercial drug list, select 'Click here to access your drug list'.
- To locate the Marketplace Select Formulary and pharmacy information, scroll down to 'Select Drug Lists', then select the applicable state's drug list link.

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

1250-0921-PN-NE

URL: https://providernews.anthem.com/connecticut/article/pharmacy-information-available-on-anthemcom-103

Change in email submission of service requests for Federal Employee Program® members

Published: Aug 1, 2021 - **State & Federal** / Federal Employee Plan (FEP)

Effective **November 1, 2021,** in order to help ensure our member's security, the Blue Cross and Blue Shield Federal Employee Program (FEP®) will be decommissioning the Utilization Management (UM) email address for processing eReviews, FEPE-Reviews@anthem.com.

About the ICR portal
ICR is Anthem's innovative UM portal that allows providers, in addition to phone or fax, to submit prior authorization requests and to provide clinical documentation (including imaging) to support initial and continued stay reviews. This enables prior authorization requests and clinical information to be transmitted directly to UM staff.

Key features of ICR

- No cost electronic UM solution
- Instant access from any location at any time
- Create a UM preauthorization case and instantly submit it for review
- Attach clinical documents for review – no faxing required
- Check status of any case regardless of the method used to originally submit request
- Complete record of submissions and dispositions – all in one place
- Bi-directional communication

To submit prior authorization service requests electronically, register for use of Interactive Care Reviewer (ICR) **prior to November 1, 2021** on the Availity portal.

For more information on Anthem ICR, including training resources:
https://www.anthem.com/provider/prior-authorization/interactive-care-reviewer/

Register for ICR via the Availity portal: https://www.availity.com/provider-portal-registration

Need help registering? View this video: How to Access Availity and Register

As a reminder, in addition to using ICR on the Availity portal, you can submit authorizations, to FEP UM by phone or fax:

- FEP UM precertification toll free: 800-860-2156
- FEP UM precertification fax: 800-732-8318
- FEP UM Advance Benefit determination fax: 877-606-3807

1247-0821-PN-NE

URL: https://providernews.anthem.com/connecticut/article/change-in-email-submission-of-service-requests-for-federal-employee-program-members-7

Preventing claim denials: Shingles vaccine

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

Shingles vaccinations are a Medicare Part D benefit whether administered in your office or in the pharmacy

We want you to have the information you need when filing claims for our Medicare Advantage members so your payments are received quickly and effortlessly. The shingles vaccine and the administration of the vaccine is commonly billed in error under the member's Medicare Part B medical benefit. The shingles vaccination is a Medicare Part D pharmacy benefit, which requires the member to pay in advance of reimbursement. The member then submits the prescription drug claim form to their Medicare Part D plan for reimbursement.

You can also refer the member to the pharmacy for the vaccine. The claim is usually filed for the member by the pharmacy provider using a clearinghouse platform that enables Medicare Part D claims transactions. Or, if you have access to clearinghouse platforms that enable you to file pharmacy transactions, that is another option for administering the vaccination in your office and for further serving the member.

The Centers for Medicare & Medicaid Services (CMS) has a helpful resource, MLN Fact Sheet: Medicare Part D Vaccines, that offers an all-inclusive look into patient access, vaccine administration, and reimbursement. Use this link to download a copy.

For more information about filing claims, visit this link.

ABSCARE-0988-21

URL: https://providernews.anthem.com/connecticut/article/preventing-claim-denials-shingles-vaccine

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Keep up with Medicare news

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

Please continue to check Important Medicare Advantage Updates at anthem.com/medicareprovider for the latest Medicare Advantage information, including:

- Prior authorization requirement changes effective October 1, 2021 – UM AROW 1907
- Infliximab Step Therapy - Effective 7/15/2021

URL: https://providernews.anthem.com/connecticut/article/keep-up-with-medicare-news-216
