August 2023

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Unspecified Diagnosis Code **of Site and Laterality**

ICD-10-CM laterality codes are developed to precisely define laterality (e.g., left, right or bilateral). ICD-10-CM guidelines for laterality coding provide that some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left or right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right sides. If the side is not identified in the medical record, assign the code for the unspecified side.

Impact to providers
Code claims to the highest level of specificity in accordance with ICD 10-CM coding guidelines for site and laterality when specified laterality codes exist and to submit the appropriate laterality code in accordance with the condition. Professional claims submitted on a CMS-1500 form or facility claims submitted on CMS-1450 with a date of service on or after September 1, 2023, that do not reflect the highest level of specificity when the code exists will be denied.

Example:
- Reported diagnosis: H60.339 (swimmer's ear, unspecified ear)
- Billed CPT code or modifier: CPT 69000-RT (drainage external ear, abscess or hematoma: simple [right side])
- Determination: It is not appropriate to report unspecified diagnosis codes when a more specific code (e.g., H60.331 swimmer's ear, right ear) is available; therefore, the claim line will be denied.

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

Healthy Blue will continue to enhance its editing system to automate edits and simplify remittance messaging supported by correct coding guidelines. The enhanced editing automation will promote faster claim processing and reduce follow-up audits and/or record requests for claims not consistent with correct coding guidelines.

If you have questions about this communication or need assistance, contact the Customer Care Center.

Help Your Patients **Stay Covered**

Medicaid renewal is in full effect. Tell your patients they may need to renew their Medicaid or CHIP health care benefits.

You can help ease patients' concerns by sharing the correct information. Let them know what a patient will need to do to keep his or her health coverage.

Our step-by-step video tutorial walks you through how to find patients' information and what they should do if they're coming up for renewal.

See it at bcove.video/41U1m2F.

Together, we can help your patients stay covered.

New Specialty Pharmacy **Medical Step Therapy Requirements**

Effective for dates of service on and after July 1, 2023, the following specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process. Step therapy review will apply upon prior authorization initiation or renewal in addition to the current medical necessity review of all drugs noted in this document.

Clinical Criteria CC-0002 currently has a step therapy preferring Neulasta®, Neulasta OnPro® and the biosimilar Udenyca®. This update is to notify providers that the new biosimilars Fylnetra® and Stimufend® and the new long-acting colony-stimulating factor Rolvedon™ will be added to existing step therapy as nonpreferred agents.

The list of clinical criteria is publicly available on our provider website. Visit the Clinical Criteria webpage to search for specific clinical criteria.

Clinical criteria	Status	Drug(s)	HCPCS codes
CC-0002	Nonpreferred	Fulphila®	Q5108
CC-0002	Nonpreferred	Fylnetra®	Q5130
CC-0002	Nonpreferred	Nyvepria™	Q5122
CC-0002	Nonpreferred	Rolvedon	J1449
CC-0002	Nonpreferred	Stimufend®	Q5127
CC-0002	Nonpreferred	Ziextenzo®	Q5120
CC-0002	Preferred	Neulasta	J2506
CC-0002	Preferred	Neulasta OnPro	J2506
CC-0002	Preferred	Udenyca	Q5111

Healthy Blue Provider **Office Manual**

Healthy Blue offers resources to its providers to ensure they have all the information they need for seamless processes. One of the most important resources is the provider manual. It contains information on covered services, National Committee for Quality Assurance standards and much more.

We made the manual to be informative and help you navigate participation with Healthy Blue. Unless otherwise noted in the provider contract, the information in the manual is not binding upon Healthy Blue and is subject to change. For this reason, please do not print the provider manual. Instead, visit www.HealthyBlueSC.com to see the most up-to-date information. The latest updates were made in May 2023.

If you have questions, please call the Customer Care Center at 866-757-8286.

Updates to Carelon Medical Benefits Management Inc. — **Advanced Imaging**

Effective for dates of service on and after Sept. 10, 2023, updates will apply to these services as they relate to the Carelon Medical Benefits Management Advanced Imaging Clinical Appropriateness Guidelines:

- Imaging of the extremities
- Imaging of the spine
- Vascular imaging

As part of the Carelon Medical Benefits Management Guidelines annual review process, these updates focus on advancing efforts to drive clinically appropriate, safe and affordable health care services. Carelon Medical Benefits Management Inc. is an independent company providing utilization management services on behalf of BlueChoice HealthPlan.

Medical Policies and Clinical Utilization **Management Guidelines Updates**

These medical policies, clinical utilization management (UM) guidelines and third-party criteria were developed and/or revised to support clinical coding edits. Note, several policies and guidelines were revised to provide clarification only and are not included. Existing prior authorization requirements have not changed. **Please share this notice with other providers in your practice and office staff.** To view a guideline, visit www.HealthyBlueSC.com and select **Providers**.

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

- **MED.00145 — Digital Therapy Devices for Treatment of Amblyopia**
  - Digital therapy devices for treatment of amblyopia are considered investigational and not medically necessary.
- **CG-LAB-26 — Outpatient Alpha-Fetoprotein Testing**
  - This outlines the criteria for determining medical necessity or no medical necessity for outpatient alpha-fetoprotein testing.
- **CG-LAB-27 — Human Chorionic Gonadotropin Testing**
  - This outlines the criteria for determining medical necessity or no medical necessity for laboratory testing of human chorionic gonadotropin (hCG).
- **CG-LAB-28 — Prostate Specific Antigen Testing**
  - This outlines the criteria for determining medical necessity or no medical necessity for prostate specific antigen (PSA) testing.
- **CG-SURG-18 — Septoplasty**
  - The update reformatted the hierarchy in the Clinical Indications section.
  - The update revised the criteria for medical necessity related to conservative management.
  - The update revised "chronic recurrent sinusitis" to "chronic or recurrent acute sinusitis."
  - The update revised Not Medically Necessary statement to remove bulleted list below statement.

Carelon Medical Benefits Management Inc. updates

Effective for dates of service on and after Sept. 10, 2023, the following updates will apply to the Carelon Medical Benefits Management, Inc. Clinical Appropriateness Guidelines for medical necessity review for Healthy Blue:

- **Musculoskeletal guidelines:**
  - Spine surgery
  - Sacroiliac joint fusion
- **Sleep disorder management guideline**

Effective for dates of service on and after Aug. 1, 2023, MRI of the Breast — RAD.00036 is transitioning to Carelon Medical Benefits Management Inc. criteria in two guidelines. Carelon Medical Benefits Management Inc. is an independent company providing utilization management services on behalf of BlueChoice®:

- Imaging of the chest
- Oncologic imaging

Medical policies On Feb. 16, 2023, the Medical Policy and Technology Assessment Committee (MPTAC) approved the following medical policies applicable to Healthy Blue. These guidelines take effect Aug. 6, 2023.

Publish date	Medical policy no.	Medical policy title	New or revised
2/23/2023	GENE.00049	Circulating Tumor DNA Panel Testing (Liquid Biopsy)	Revised
4/12/2023	*MED.00145	Digital Therapy Devices for Treatment of Amblyopia	New
3/29/2023	SURG.00011	Allogeneic, Xenographic, Synthetic, Bioengineered and Composite Products for Wound Healing and Soft Tissue Grafting	Revised
4/12/2023	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (Without Extraocular Reservoir)	Revised

Clinical UM guidelines On Feb. 16, 2023, the MPTAC approved the following clinical UM guidelines applicable to Healthy Blue. These guidelines were adopted by the medical operations committee for Medicaid members on March 23, 2023. These guidelines take effect Aug. 6, 2023.

Publish date	Clinical UM guideline number	Clinical UM guideline title	New or revised
4/12/2023	*CG-LAB-26	Outpatient Alpha-Fetoprotein Testing	New
4/12/2023	*CG-LAB-27	Human Chorionic Gonadotropin Testing	New
4/12/2023	*CG-LAB-28	Prostate Specific Antigen Testing	New
2/23/2023	CG-SURG-106	Venous Angioplasty With or Without Stent Placement or Venous Stenting Alone	Revised
2/23/2023	CG-SURG-115	Mechanical Embolectomy for Treatment of Stroke	Revised
4/12/2023	CG-SURG-117	Balloon Dilation of the Eustachian Tubes	New
4/12/2023	*CG-SURG-18	Septoplasty	Revised
4/12/2023	CG-SURG-46	Myringotomy and Tympanostomy Tube Insertion	Revised
4/12/2023	SURG.00103	Intraocular Anterior Segment Aqueous Drainage Devices (Without Extraocular Reservoir)	Revised

Reimbursement Policy — **Robotic Assisted Surgery (Policy G-10004)**

Beginning with dates of service on or after Nov. 1, 2023, the Robotic Assisted Surgery reimbursement policy for Healthy Blue will expand to include CPT® codes for computer-assisted surgical systems. This policy does not allow separate reimbursement for technology-assisted services detailed in the Related Coding section. These services are considered integral to the primary surgical procedure, are included in the primary surgical procedure, and are not separately reimbursed.

The Related Coding section of the policy has been updated to include the following computer-assisted surgical musculoskeletal navigation procedures:

- **0054T:** Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (list separately in addition to code for primary procedure)
- **0055T:** Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (list separately in addition to code for primary procedure)

The policy has been renamed to Technology-Assisted Surgical Procedures, which defines both robot-assisted and computer-assisted techniques. For additional information, please review the Technology-Assisted Surgical Procedures reimbursement policy at www.HealthyBlueSC.com.

Clinical **Criteria Updates**

On May 20, 2022; Aug. 19, 2022; Sept. 12, 2022; Sept. 15, 2022; Nov. 18, 2022; Dec. 12, 2022; and Feb. 24, 2023, the Pharmacy and Therapeutic (P&T) Committee approved clinical criteria applicable to the medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

Visit the Clinical Criteria webpage to search for specific policies. If you have questions or need more information, use this email.

Please see the following explanation or definition for each category of clinical criteria:

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

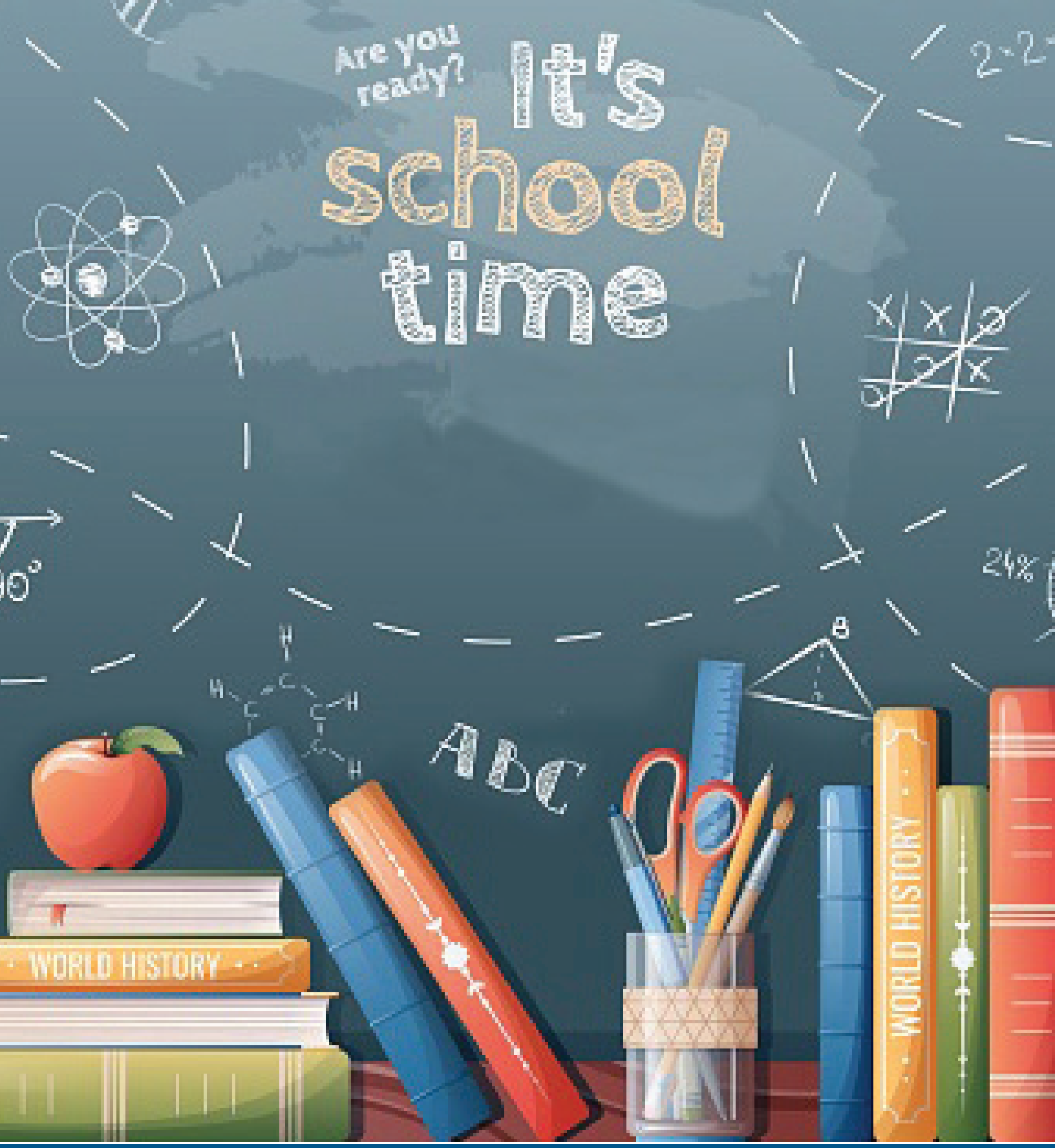
Please note:

- The following listed clinical criteria apply only to the medical drug benefits in the member's medical policy. This does not apply to pharmacy services.
- This notice is meant to inform the provider of new or revised criteria that have been adopted by Healthy Blue only. It does not include details regarding any authorization requirements. Authorization rules are sent in a separate notice.

Effective Date: July 17, 2023

Document number	Clinical criteria title	New or revised
*CC-0232	Lunsumio (mosunetuzumab-axgb)	New
*CC-0230	Adstiladrin (nadofaragene firadenovec-vncg)	New
*CC-0233	Rebyota (fecal microbiota, live — jslm)	New
*CC-0234	Syfovre (pegcetacoplan)	New
*CC-0231	Lamzede (velmanase alfa-tycv)	New
CC-0007	Synagis (palivizumab)	Revised
CC-0066	Monoclonal Antibodies to Interleukin-6	Revised
CC-0210	Enjaymo (sutimlimab-jome)	Revised
*CC-0128	Tecentriq (atezolizumab)	Revised
*CC-0116	Bendamustine agents	Revised
CC-0127	Darzalex (daratumumab) and Darzalex Faspro (daratumumab and hyaluronidase-fihj)	Revised
CC-0161	Sarclisa (isatuximab-irfc)	Revised
*CC-0086	Spravato (esketamine) Nasal Spray	Revised
*CC-0158	Enhertu (fam-trastuzumab deruxtecan-nxki)	Revised
CC-0125	Opdivo (nivolumab)	Revised
*CC-0119	Yervoy (ipilimumab)	Revised
CC-0099	Abraxane (paclitaxel, protein bound)	Revised
*CC-0093	Docetaxel (Taxotere)	Revised

Document number	Clinical criteria title	New or revised
CC-0094	Pemetrexed Agents (Alimta, Pemfexy)	Revised
CC-0130	Imfinzi (durvalumab)	Revised
CC-0118	Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin)	Revised
CC-0123	Cyramza (ramucirumab)	Revised
CC-0131	Besponsa (inotuzumab ozogamicin)	Revised
CC-0121	Gazyva (obinutuzumab)	Revised
*CC-0096	Asparagine Specific Enzymes	Revised
*CC-0120	Kyprolis (carfilzomib)	Revised
CC-0117	Empliciti (elotuzumab)	Revised
CC-0126	Blincyto (blinatumomab)	Revised
CC-0132	Mylotarg (gemtuzumab ozogamicin)	Revised
CC-0097	Vidaza (azacitidine)	Revised
CC-0129	Bavencio (avelumab)	Revised
CC-0090	Ixempra (ixabepilone)	Revised
*CC-0110	Perjeta (pertuzumab)	Revised
*CC-0115	Kadcyla (ado-trastuzumab)	Revised
CC-0124	Keytruda (pembrolizumab)	Revised
*CC-0062	Tumor Necrosis Factor Antagonists	Revised
CC-0165	Trodelvy (sacituzumab govitecan)	Revised
*CC-0160	Vyepti (eptinezumab)	Revised
*CC-0034	Hereditary Angioedema Agents	Revised
*CC-0020	Tysabri (natalizumab)	Revised
*CC-0174	Kesimpta (ofatumumab)	Revised
*CC-0011	Ocrevus (ocrelizumab)	Revised
*CC-0072	Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised
*CC-0001	Erythropoiesis Stimulating Agents	Revised
*CC-0166	Trastuzumab Agents	Revised
*CC-0075	Rituximab agents for Nononcologic Indications	Revised
*CC-0167	Rituximab Agents for Oncologic Indications	Revised
*CC-0209	Leqvio (inclisiran)	Revised
*CC-0182	Iron Agents	Revised
*CC-0107	Bevacizumab for Nonophthalmologic Indications	Revised
*CC-0002	Colony Stimulating Factor Agents	Revised



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