BLUE REVIEW℠

A newsletter for physician, professional, facility, ancillary and Medicaid providers

NOVEMBER 2020

NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

As the COVID-19 crisis evolves, we're continuing to make updates on our COVID-19 Preparedness and our COVID-19 Related News pages. Be sure to check these pages frequently for updates including COVID-19: Texas Provider FAQ and COVID-19: FAQs for Medicare Providers.

Blue High Performance Network℠ (Blue HPN)℠ to launch in January 2021

Beginning Jan. 1, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) is launching **Blue HPN,** a new national high-performance network for large Administrative Services Only (ASO) employer groups. Blue HPN will provide additional access to quality and affordable health care nationwide in 55 major markets. **For Blue HPN service areas within Texas**, **see the table below of counties in and near Austin, Dallas-Fort Worth, Houston and San Antonio*.**

Blue HPN value

Provider participation in Blue HPN is based on a range of factors, including:

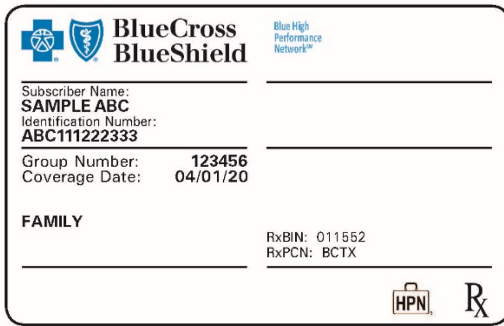
- Performance on national quality indicators, such as measures to close clinical care gaps and impact patients' quality of life
- Performance on local quality indicators, including measures to address local health care challenges and align with community health disparities
- Partnership with BCBSTX to improve affordability, efficiency and health outcomes

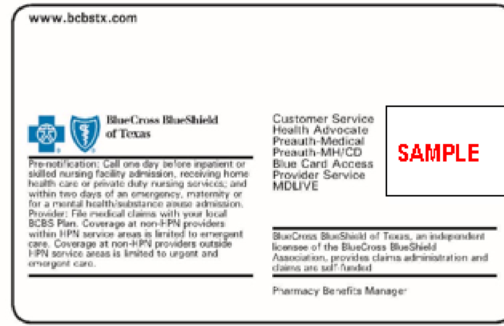
Treating Blue HPN patients

- Blue HPN follows the current processes and requirements of our Blue Choice® PPO network*
- There are no Primary Care Provider (PCP) or referral requirements for in-network specialists
- In Blue HPN service areas, patients have access to **emergent care** with non-Blue HPN providers
- In non-Blue HPN service areas, patients have access to **urgent and emergent** care

Recognizing Blue HPN members

You can identify Blue HPN members by their BCBSTX ID card. Look for the Blue High Performance Network name and the "HPN in the suitcase" logo on the front. This logo indicates that Blue HPN rates apply. To receive additional information on rates, please contact your local Network Management office.





Checking eligibility and benefits

Patient eligibility and benefits should be checked using Availity® Provider Portal or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include patients' coverage status and other important information, such as applicable copays, coinsurance and deductibles. It's strongly recommended that providers **ask to see patients' ID** card and **photo ID** to guard against medical identity theft. If services may not be covered, patients should be notified that they may be billed directly.

Prior Authorization

- You can check the Prior Authorization and Predeterminations page for the list of ASO services and procedure codes that require prior authorization for Blue HPN. Refer to **How to Submit a Prior Authorization or Prenotification** to learn about submission processes.
- For out-of-area members, see our BlueCard® information and the BlueCard authorization process and requirements.

Reminders

Submit claims to BCBSTX as you typically would for Blue Choice PPO. Refer to Claims and Eligibility for more details. Watch News and Updates and our Blue Review newsletter for more details on Blue HPN.

If you have additional questions, need **Blue HPN** rates, would like to apply to join the network or do not have Internet access, please contact your local BCBSTX Network Management Office:

*Network Management Office (city with designated Blue HPN county service areas)	Telephone Number	Fax Number
Austin (Hayes, Travis and Williamson**)**	800-336-5696 / 512-349-4847	512-349-4853
Dallas, Fort Worth (Collin, Dallas, Denton, Ellis, Johnson, Rockwall, Tarrant)	972-766-8900 / 800-749-0966	972-766-2231
Houston, Beaumont (Brazoria, Chambers, Fort Bend, Galveston, Harris, Liberty, Montgomery)	713-663-1149 / 800-637-0171 press 3	713-663-1227
San Antonio, Laredo (Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall)	361-878-1623	361-852-0624
Ancillary–Visit BCBSTX Contact Us for ***phone and fax by specialty***		

As a reminder, it is important to check eligibility and benefits before rendering services. This step will help you determine if benefit prior authorization is required for a member. For additional information, such as definitions and links to helpful resources, refer to the Eligibility and Benefits section on BCBSTX's provider website.

Provider Finder® Gets an Upgrade
View Our Network of Providers for Your Patients' Needs

Do you need help finding a specialist or facility for a consultation or procedure for a Blue Cross and Blue Shield of Texas patient? This October, our **enhanced** online **Provider Finder** will make finding care for our members a lot easier.

What's New?
The new Provider Finder we believe is **visually appealing** and **easy to navigate** with a **streamlined menu** and **filter options**. The filter and sort options include:

- Specialty
- Accepting new patients
- Distance (with map tool)
- Member rating
- Gender of provider
- Quality metrics & awards
- Best match (weighted by quality and accessibility)

Update Your Info
Please help our members find you by visiting the current Provider Finder to **make sure your information is accurate** and up-to-date. If you have any changes, use our Demographic Change Form.

BEHAVIORAL HEALTH

TRS Behavioral Health Prior Authorization Forms
Effective Oct. 16, 2020, providers now need to use new designated prior authorization forms for behavioral health services for Teacher Retirement of Texas (TRS) participants. The new forms contain a bar code for TRS participants that is needed to forward the form to the appropriate area for review. Failure to submit the correct forms could delay processing the forms. Links to the designated forms are located on our provider website's Forms page under Behavioral Health Forms for TRS Participants.

CLAIMS & ELIGIBILITY

Itemized Bills Required for BlueCard® Facility Claims Over $100k
Beginning **Jan. 1, 2021**, we will require facilities to submit an **itemized bill** for inpatient care billed **for $100,000 or more**. This applies to all facility claims for $100,000 or more submitted for BlueCard out-of-area Blue Cross and Blue Shield members. An itemized bill helps ensure an accurate claim payment and reduces the need to submit more information after a claim is paid.

What's Changing
The BlueCard claim amount requiring itemization will be lowered to $100,000 from the current $200,000 threshold.

How to Submit Itemized Bills
You may submit itemized bills electronically using our Claim Inquiry Resolution tool. Include the corresponding **claim number** for quicker review and turnaround time.

More Information
Refer to our **CPCP002 Inpatient/Outpatient Unbundling Policy** on the Clinical Payment and Coding Policy page on our provider website for more information. If you have any questions, please contact your Blue Cross and Blue Shield of Texas (BCBSTX) Provider Network Representative.

Availity® Claim Status Tool Available for All Members

Last year, Blue Cross and Blue Shield of Texas (BCBSTX) launched the **Availity Claim Status tool** for providers to verify detailed claim status online for Medicare Advantage and Texas Medicaid members. Starting **Oct. 19, 2020**, this tool will **include claim status for commercial, Federal Employee Program® (FEP®) and marketplace health plan members**. This improvement will increase your administrative efficiencies by offering you **a single tool to check claim status online for all your BCBSTX patients.**

Claim Status Tool Information

This tool is found in the **Claims & Payment** menu via the Availity Provider Portal and allows providers to search for claims:

- By a member ID or specific claim number. When searching by the member ID, the patient name will now be included in the list of claims returned, based on the search criteria entered;
- In real time;
- With more detailed information than the HIPAA-standard 276/277 claim status transaction.

The following claim status details will be returned:

- Patient and provider data submitted on claims
- In-network and out-of-network patient liability breakdown
- Billing and rendering provider name and NPI
- Check number, check date and payee name
- Other carrier payment amount
- Ineligible reason codes and associated descriptions
- Transaction ID reference numbers

Refer to the **Availity Claim Status User Guide** in the Provider Tools section of our provider website. As a reminder, you must be registered with Availity to use the Claim Status tool. For registration information, visit Availity, or contact Availity Client Services at **1-800-282-4548**.

Going forward, training on the Claim Status tool will be included in the ongoing **Availity 101** sessions. Refer to **Availity** section on the Education Webinar Sessions page.

BCBSTX Claim Research Tool Retirement

The BCBSTX Claim Research Tool (CRT) in Availity will be retired as of Oct. 19, 2020. The detailed claim status information you received within the CRT have been incorporated into the Availity Claim Status tool.

If you have additional questions, contact the Provider Education Consultants.

Submitting Predetermination of Benefits Update

On July 30, 2020, Blue Cross and Blue Shield of Texas (BCBSTX) implemented an electronic predetermination of benefits submission process via Availity's **Attachments tool**. Recently, the Attachments tool was updated to better assist you with submitting your requests online to BCBSTX.

Updates to Online Availity Submission Process

- On-screen messaging has been added in the **Patient Information** section to ensure the patient's first and last names match exactly as they appear on the eligibility and benefit response to prevent the predetermination request from being rejected. Refer to the Availity Eligibility and Benefits User Guide for assistance.
- The **Service From** and **To** date fields have been removed as they are not required for submission.

Make sure you use Availity's Attachments Dashboard to confirm the predetermination of benefits submission was accepted or rejected by BCBSTX. For navigational assistance with this tool, refer to the Electronic Predetermination Request User Guide located in the Provider Tools section of our website.

Reminders

- A predetermination of benefits is a voluntary request for written verification of benefits before rendering services. BCBSTX recommends submitting a predetermination of benefits request if the service may be considered experimental, investigational or unproven, as specified within the BCBSTX Medical Policy.
- Per the Medical Policy, if photos and/or x-rays are required for review, please email to Photo Handling. The body of the email should include the patient's first name and last name, Group number, Subscriber ID and date of birth.
- Urgent requests for a predetermination will be considered when the time periods for making non-urgent care determinations:
    - **a.** could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function,
      or
    - **b.** in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- If you don't have online access, you may continue to fax and/or mail predetermination of benefit requests along with a completed Predetermination Request Form and pertinent medical documentation.

If you need further assistance or customized training, contact our Provider Education Consultants.

The information in this notice does not apply to requests for Medicare Advantage or Texas Medicaid members.

Please note that the fact that a guideline is available for any given treatment or that a service or treatment has been predetermined for benefits, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date the service was rendered.

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is a resource for our payment policies; it is not intended to address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review process. The following have been recently added or updated:

- Chiropractic Services Effective 10/15/2020
- Co-Surgeon/Team Surgeon Modifiers Effective 10/15/2020
- Coordinated Home Care /Private Duty Nursing Policy Guideline Effective 10/15/2020
- Drug Testing Clinical Payment and Coding Policy Effective 12/28/2020
- Evaluation and Management (E/M) Coding – Professional Provider Effective 01/01/2021
- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) (Revision) Effective 12/1/2020
- Preventive Services Policy Effective 10/01/2020
- Pneumatic Compression Devices – Outpatient Use Effective 10/01/2020
- Wasted/Discarded Drugs and Biologicals Guideline Effective 01/10/2021
- Telemedicine and Telehealth Services Effective 01/01/2021

CLINICAL RESOURCES

New HEDIS® 2020-21* Tip Sheets

HEDIS Measures: CBP, CIS3, COL, SPR

We have new tip sheets available to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code appropriately. These measures from the National Committee for Quality Assurance (NCQA) serve as a quality improvement tool to help ensure our members receive appropriate care.

The tip sheets include measurement requirements, medical record best practices and billing codes. Compliance with HEDIS measures reduces the need for you to send medical records later for review.

Controlling High Blood Pressure (CBP) Tip Sheet

This measure assesses adults with hypertension whose blood pressure was adequately controlled:

- 18 to 85 years old
- Systolic blood pressure < 140 mmHg
- Diastolic blood pressure < 90 mmHg

Childhood Immunization Status (CIS 3) Tip Sheet

This measure looks at the percentage of two-year olds who have had the appropriate vaccinations:

- One measles, mumps and rubella (MMR)
- One varicella zoster virus (VAR or VZV)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- Three inactive poliovirus (IPV)
- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Four pneumococcal conjugate (PCV)

Colorectal Cancer Screening (COL) Tip Sheet

This measure evaluates adults who had a recommended colorectal cancer screening:

- 50 to 75 years old
- Appropriate tests:
    - Fecal occult blood test in past year
    - Stool DNA test in past 3 years
    - Flexible sigmoidoscopy in past 5 years
    - Computed Tomography colonography in past 5 years
    - Colonoscopy in past 10 years

Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR) Tip Sheet

This measure assesses adults with chronic obstructive pulmonary disease (COPD) who received spirometry testing to confirm the diagnosis. HEDIS requires spirometry testing to confirm the diagnosis

- 40 years and older
- Newly[1] diagnosed with COPD, emphysema or chronic bronchitis or newly active COPD

* Measurement Year (MY) 2020 and MY 2021

[1] Defined as no diagnosis of COPD, emphysema or chronic bronchitis in previous 2 years

HEDIS® is a registered trademark of the NCQA.

The above material is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment.

Clinical Practice and Preventive Care Guidelines Updated for 2020-2021

Our medical directors and Quality Improvement Committee have updated our **Clinical Practice Guidelines** and **Preventive Care Guidelines** for 2020-2021. The guidelines are built on evidence-based standards of care and nationally recognized medical authorities to **direct our quality and health management programs** and improve member care. They can help **guide your decision-making** as you care for our members.

We **update** our guidelines at least **every two years** or when new significant findings or major advancements in evidence-based care are established. The **guidelines** are on our **website under Clinical Resources**.

Are You Using Shared Decision-Making Aids?

Below is a list of **resources** to help you involve your patients in **shared decision-making.** The evidence-based aids provide information about **treatment options**, **lifestyle changes** and **outcomes**. They don't replace your guidance but can help your conversations with your patients. The list is also on our website.

Why it's important: When patients help make decisions about their health care, it can lead to better outcomes and quality of life.

Mayo Clinic Shared Decision Making National Resource Center

- Cardiovascular Primary Prevention Choice
- Depression Medication Choice
- Diabetes Medication Choice
- Osteoporosis Decision Aid
- Percutaneous Coronary Intervention Choice
- Smoking Cessation Around the Time of Surgery
- Rheumatoid Arthritis (RA) Choice
- Statin Choice Electronic Decision Aid

Cincinnati Children's James M. Anderson Center for Health Systems Excellence

- Attention-Deficit/Hyperactivity Disorder (ADHD) Treatment for the School-Age Child
- Diarrhea Treatment with Lactobacillus GG
- Human Papilloma Virus (HPV) Vaccination
- Hydroxyurea for Sickle Cell Anemia
- Treatment for Children with Autism
- Behavior Concerns in Young Children
- Return of Genetic Test Results from Whole Exome Sequencing
- Juvenile Idiopathic Arthritis Treatment
- Fertility Preservation for Children Newly Diagnosed with Cancer
- Treatment of Obstructive Sleep Apnea
- Weight Loss for Adolescents

Dartmouth-Hitchcock Center for Shared Decision Making

Decision Support Toolkit for Primary Care

The following steps help involve the patient in a primary care setting:

- Step 1: Leadership
- Step 2: Goals and Scope of Project
- Step 3: Assessment
- Step 4: Decision Support Tools
- Step 5: Education and Training
- Step 6: Implementation
- Step 7: Quality Monitoring Tools

Decision Support Toolkit for Specialty Care

- **Breast Cancer**
    - Early Stage Breast Cancer Toolkit
    - Ductal Carcinoma in Situ (DCIS) Toolkit
    - Breast Reconstruction Toolkit

- **Hip and Knee Osteoarthritis** Toolkit

Decision Support as a Clinical Skill Toolkit

- Part 1: The Ottawa Decision Support Tutorial – Online tutorial to develop skills in providing decision support
- Part 2: Workshop for Physicians and Workshop for Non-Physicians

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MEDICARE ADVANTAGE PLANS

New Prior Authorization Lists for Blue Cross Medicare Advantage℠ January 1, 2021

There are important updates to the Prior Authorization Lists for patients enrolled in Medicare Advantage plans offered by Blue Cross and Blue Shield of Texas (BCBSTX) effective ***January 1, 2021.*** These updates are the result of new, replaced or removed codes implemented by the American Medical Association (AMA).

Use Availity® or your preferred vendor to check eligibility and benefits, to determine if you are in–network for your patient and to determine whether any prior authorization or prenotification is required. Availity allows you to determine if prior authorization is required based on the procedure code. Refer to Eligibility and Benefits under the Claims and Eligibility tab on the BCBSTX provider website for more information on Availity.

The updated Blue Cross Medicare Advantage Prior Authorization Lists are posted on the BCBSTX provider website on the Clinical Resources page under Prior Authorizations and Predeterminations. Payment may be denied if you perform procedures without obtaining prior authorization when prior authorization is required. If this happens, you may not bill your patients.

If you need assistance or do not have internet access, please contact your BCBSTX Network Management Representative.

PRIOR AUTHORIZATION INFORMATION

Prior Authorization Expansion to AIM®

What's Changing?

The utilization management vendor that manages certain outpatient prior authorizations for some members in the plans listed below will be AIM Specialty Health® (AIM) effective Jan. 1, 2021:

- Blue Choice PPO℠
- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- Blue Advantage HMO℠
- MyBlue Health℠
- Blue High Performance Network℠ (New plan effective Jan. 1, 2021)

(Note: There are no changes to the vendors for BCBSTX Government Programs (Medicare Advantage and Medicaid plans).

What's Not Changing?

The **care categories and procedure codes** that currently require prior authorization will stay the same* as the previous vendor:

- Advanced imaging**

- Cardiology
- Sleep medicine
- Pain management
- Joint and spine surgery
- Radiation therapy
- Genetic testing

***** *Exception are updates for new, replaced or removed procedure codes that may occur to comply with American Medical Association or Centers for Medicare & Medicaid Services or other industry-standard entities.*
***The AIM Radiology Quality Initiative program (RQI) for Blue Choice PPO members will continue for members that do not require an advanced imaging prior authorization.*

You can find **code lists** for the services that require prior authorization **on our provider website**.

Check which members and services need prior authorization
Use Availity® or your preferred vendor or call the number on the back of the ID card to:

- Check eligibility and benefits
- Determine if you're in-network for your patient
- Find out if the patient and services require prior authorization or a RQI prenotification
- Learn whether prior authorization is required for a procedure code and who to contact

How can you prepare?
Make sure you have an **account** with **AIM**. To **create** an account:

- Access the AIM ProviderPortal, or
- **By Phone** – Call the **AIM Contact Center at 800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a,m. to noon, CT on weekends and holidays.

If you are already registered with AIM, you do not need to register again.

Submit prior authorization requests to AIM. when applicable, for Jan. 1, 2021, in one of the following ways:

- **Online** – Submit requests via the **AIM ProviderPortal** 24/7.
- **By Phone** – Call the **AIM Contact Center** at **1-800-859-5299** Monday through Friday, 6 a.m. to 6 p.m., CT; and 9 a,m. to noon, CT on weekends and holidays.

If benefit prior authorization is required, services performed without benefit prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Look for future news and updates on upcoming training and FAQs that will provide all of the important information you need regarding AIM.

If you have any questions, you may contact your Network Management Representative.

Update to Prior Authorization Services

On Jan. 1, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) will update its list of Current Procedural Terminology (CPT) codes to comply with changes as a result of new, replaced or removed codes implemented bythe American Medical Association (AMA) and BCBSTX Utilization Management updates.

What's New: Effective Jan. 1, 2021 we will update the procedure code list for services that require prior authorization.

More Information: For a revised list of codes effective Jan. 1, 2021, go to our provider website in the prior authorization section. Check the AMA website for more information on CPT code updates.

Check Eligibility and Benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® or your preferred vendor.

CPT copyright 2019 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

STANDARDS & REQUIREMENTS

2020 Annual HEDIS / Quality Rating System Reports

We have a Quality Improvement Program to better serve you. Its purpose is to monitor and improve the care and service our members receive. Review our most recent results.

Read More