BLUE REVIEW℠
A Provider Publication

DECEMBER 2021

NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

Check for continuing updates to our COVID-19 Preparedness, COVID-19 Provider Information for ERS Participants and COVID-19 Related News pages.

Fighting Fraud, Waste and/or Abuse

Every year analysts and investigators for Blue Cross and Blue Shield of Texas (BCBSTX) review claims data, industry trends and investigative results to identify potential areas of fraud, waste and/or abuse.

When billing issues are identified in this review, providers will receive letters explaining the concerns. The most recent letters focused on instances of potential billing abuse around COVID-19 testing and vaccinations. Future letters may identify upcoding, unbundling or other billing issues.

The letters will remind you to comply with BCBSTX's policies and requirements.

For more information, please refer to the Provider Standards and Requirements on our website for additional information on policies.

If you encounter potential fraud, waste and/or abuse, please file a report online or call our Fraud Hotline at **1-800-543-0867.** All online reports and calls are confidential, and you may remain anonymous. For more information, visit our Fraud and Abuse page.

Provider Directory Information Verification

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

The Consolidated Appropriations Act (CAA) requires provider directory information to be verified **every 90 days**. Providers and insurers have roles in fulfilling this requirement to maintain an accurate directory.

What this means for you: Starting Jan. 1, 2022, you must:

- Verify your directory information every 90 days
- Update your information when it changes, including if you come in or go out of a network

You can submit your changes via the Demographic Change Form or, if you are adding additional networks, use the Provider Onboarding Form. Also, watch for information coming soon in our News and Updates or Blue Review newsletter regarding the **Provider Data Management** tool that will provide easy access to update your information via Availity®. We won't accept changes by email, phone, or fax. Updates will be reflected in our Provider Finder®.

Under CAA, **we are required to remove providers from our directory** whose data we are unable to verify within 90 days. If you don't verify your details every 90 days, we will reach out to you by **email** and ask that you **quickly respond** by following the unique link in the email. It will take you to a secure landing page where you can update your information.

If you leave a network, please update your directory information immediately. If you are incorrectly identified as an in-network provider, it may limit member cost-sharing to in-network levels.

More on the CAA and Transparency in Coverage Final Rule.

BEHAVIORAL HEALTH

The Magellan Connection: Partnering with PCPs

Magellan Healthcare® is contracted to perform **behavioral health** managed care functions supporting members and participants for the following Blue Cross and Blue Shield of Texas HMO networks; Blue Advantage HMO ℠, Blue Cross Medicare Advantage HMO ℠, Blue Cross Medicare Advantage Dual Care (HMO SNP) ℠ and MyBlue Health ℠. Magellan offers access to a variety of resources and services that can assist you in enhancing medical and behavioral outcomes for your patients.

Website resources

- Access Magellan's Practitioner Toolkit for behavioral health resources. This online resource is:
  - Designed to give medical practitioners the information and screening tools needed to assist in making behavioral health referrals.
  - A tool that allows the PCP and the behavioral health professional to improve the safety and efficacy of services collaboratively while focusing on better outcomes for members. Offering numerous platforms and tools for standardizing and streamlining effective collaborative relationship such as:
    - Clinical Practice Guidelines
    - HEDIS Quality Measure Information Specific to Behavioral Health
    - Diagnostic Screening Tools
    - Community Resources

Magellan's Webinar Series: Improve patient outcomes with these quality

measures

Care coordination is an integral component of the relationship between behavioral health providers and a primary care provider. It is especially important for members with chronic conditions who are receiving care from various settings. When behavioral health care is coordinated and integrated, our Blue Cross and Blue Shield of Texas members will benefit.

Magellan Healthcare® (Magellan) has a series of webinars to assist primary care providers, using National Committee for Quality Assurance (NCQA) preferred practices and performance measures for coordination across all settings of care. These webinars provide recommendations and guidance on crucial Healthcare Effectiveness Data and Information Set (HEDIS) Measures such as:

- Strategies for care transition
- Improvements and recommendations specific to mental health populations, and those with mental illness who could subsequently develop an acute medical disease such as diabetes.

The Magellan Healthcare HEDIS Webinar series include:

- Follow-Up After Hospitalization for Mental Illness (FUH)
- Antidepressant Medication Management (AMM)
- Follow-up Care for Children Prescribed ADHD Medication (ADD)
- Initiation and engagement of Alcohol & Other Drug Dependence Treatment (IET)

For more information, access Magellan Provider Focus resources and/or contact Magellan's Provider Services directly at 1- (800) 788-4005.

CLAIMS & ELIGIBILITY

New Information on Member ID Cards

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

The Consolidated Appropriations Act requires that member ID cards include **deductible information** and **out-of-pocket maximums**. We will provide all members with updated **electronic ID cards** that include this information.

How to access ID cards:

- You can view, download, and print most members' electronic cards by completing an eligibility and benefits inquiry through Availity®.
- Members can access their card several ways:
    - Through the BCBSTX app
    - By printing a copy of their updated electronic ID card, including deductible and out-of-pocket information from Blue Access for Members℠ (BAM)
    - By requesting a physical card from customer service

We will mail new cards that include deductible and out-of-pocket information to current members whose benefit plan changes in 2022. We'll also send cards with updated information to new members whose plans go into effect in 2022.

More on the CAA and Transparency in Coverage Final Rule.

Single Sign-On Access to AIM Specialty Health® via Availity®

Checking patient eligibility and benefits is an imperative first step to confirm coverage and prior authorization requirements before rendering services. The Availity Eligibility and Benefits Inquiry allows you to quickly confirm prior authorization requirements, along with contact information for the utilization management vendor, if applicable.

If the requested service(s) require prior authorization through AIM Specialty Health, providers can now utilize the new single sign-on access to AIM from the Availity portal.

How to Access AIM from the Availity Portal* :

- Select Patient Registration from the navigation menu and choose *Authorizations & Referrals.*
- On the Authorization page, select the *AIM (BCBSTX)* link in the Additional Authorizations and Referrals section.
- Select your provider organization and provider type (provider or facility), then click *Submit.*
- Users will be redirected to the AIM portal to start and submit the prior authorization request.

**The above information applies only to prior authorization requests handled by AIM. The process of submitting prior authorization requests to Blue Cross and Blue Shield of Texas (BCBSTX) or through other vendors has not changed.*

Refer to the Eligibility and Benefits User Guide for assistance with determining prior authorization requirements in the Availity portal.

View Withdrawn Claim Descriptions via the Availity Claim Status Tool

There may be instances when you receive a "claim withdrawn" notification by mail. But you can also use the Availity Claim Status Tool to determine why a claim was withdrawn. Claim status responses include original, duplicate, adjusted, replacement and withdrawn claims. Refer to the **Custom Status Description** field on the Results page to determine why a claim was withdrawn. After addressing the reason, the claim may be resubmitted electronically for processing. For assistance with verifying claim status online, refer to the Claim Status User Guide *Note: This information is not applicable to Medicare Advantage or Texas Medicaid claims.*

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:

- CPCP017 Wasted/Discarded Drugs and Biologicals Policy – Effective 11/8/2021
- CPCP020 Drug Testing Clinical Payment and Coding Policy – Retired 12/31/2021
- CPCP037 Lab Management Program – Effective date changed to 01/01/2022
- CPCP036 Paravertebral Facet Injection Procedure Coding and Billing Policy – Effective 02/24/2021

Claim Editing Enhancements Coming Jan. 10, 2022

Effective Jan. 10, 2022, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance our claims editing and review process with Cotiviti, Inc. for some of our commercial members to help ensure accurate coding of services and that services are properly reimbursed.

What this means for you: The enhancements will require you to continue to follow generally accepted claim payment policies. With your help, the enhanced claims review process will help our members get the right care at the right time and in the right setting.

BCBSTX will continue to follow claim payment policies that are global in scope, simple to understand and come from recognized sources, including the Centers for Medicare and Medicaid Services (CMS). Using these guidelines will help ensure a more accurate review of all claims.

Note: Inaccurately coded claims will result in denied or delayed payment.

What's changing: Components of the editing and review enhancements include:

Coding for services within the global surgical period - The global surgery package payment policies include all necessary services normally provided by the surgeon before, during and after a surgical procedure, and applies only to primary surgeons and co-surgeons. The global surgery package applies only to surgical procedures that have post-operative periods of 0, 10 and 90 days, as defined by CMS.

More Details from CMS:

The global surgery package includes:

- Review of preoperative evaluation and management visits after the decision is made to operate, where the visits occur one day prior to major surgery and on the same day a major or minor surgical procedure is performed.
- When a physician sees a patient within the global follow-up period of a surgical procedure that has a 10-, or a 90-day post-operative period, the physician should report the appropriate modifier(s), relevant to the circumstance, for the procedure performed.

- The physician should report the appropriate modifier for any surgical procedure performed within the follow-up period of the original surgical procedure, if applicable. The appropriate, applicable modifiers are as follows:
  - **58** - Staged or Related Procedure or Service by the Same Physician during the Postoperative Period
  - **78** - Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
  - **79** - Unrelated Procedure or Service by the Same Physician during the Postoperative Period

More Information: Visit our provider web site for Clinical Payment and Coding Policies with more information on the global surgery package payment policies.

Cotiviti, INC. is an independent company that provides medical claims administration for BCBSTX. References to other third-party sources or organizations are not a representation, warranty or endorsement of such organization. Any questions regarding those organizations should be addressed to them directly.

CLINICAL RESOURCES

Annual HEDIS®/Quality Rating System Reports

We have a Quality Improvement Program to monitor and improve the care and service our members receive. Please review some key measures, interventions and accomplishments of the program. Read More

---

Health Benefits of Collaborating with Eye Care Professionals

We appreciate the care and services you provide to our Federal Employee Program® (FEP®) members. This article pertains to care/services provided to our FEP members and to encourage continuity and coordination of care.

Many primary care providers (PCPs) refer our diabetic FEP members to eye care specialists for annual eye examinations. PCPs need to know details about the care their patients receive and to receive communications from their patients' eye care specialists. We want to encourage eye care specialists to share results routinely and promptly with PCPs.

Below is a screening recommendation summary from the American Diabetes Association (ADA)[1] and additional information to assist you when you are providing annual eye exams to our diabetic FEP members. Members may be hesitant or even have difficulty getting or adhering to their annual exam, especially given the barriers associated with COVID-19. However, diabetic annual eye exams remain an American Diabetes Association (ADA) recommended element in the treatment of patients with diabetes.

Screening:	• Comprehensive evaluation by an eye care specialist should not be substituted by retinal photography. However, for screening purposes retinal photography with remote reading by a retinal specialist is acceptable where eye care professionals are not readily available.
Routine Exams:	• Every two years in the absence of retinopathy • Annually in the presence of retinopathy • At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression
Initial Exam:	• Within five years of diagnosis for adults who have Type 1 diabetes • At the time of diagnosis for adults with Type 2 diabetes
Pregnancy:	• Educate women who are planning to be or are pregnant and who also have diabetes about the risk of diabetic retinopathy developing or progressing • Perform an eye exam prior to or at the time of diagnosis of pregnancy, during every trimester, and one year after delivery in the presence of pre-existing Type 1 or Type 2 diabetes

To help improve patient outcomes, please consider the following:

- Incorporate ADA recommendations into practice
- Gather patient historical information
- Educate your patients
- Ensure diabetic eye exam results are made available to the members' Primary Care Provider (PCP)
- Remind your diabetic patients to contact the number on their member ID card if they have any questions about their health care coverage details.

We thank our primary care providers and eye care specialist for collaborating and supporting the ongoing health and wellness of our FEP members. Working together, we can help support improved continuity of care and health outcomes for people with diabetes.

[1]Diabetic Retinopathy: A Position Statement by the American Diabetes Association, Sharon D. Solomon, Emily Chew, Elia J. Duh, Lucia Sobrin, Jennifer K. Sun, Brian L.VanderBeek, Charles C. Wykoff, Thomas W. Gardner, Diabetes Care, Mar 2017, 40 (3) 412-418; DOI: 10.2337/dc16-2641. Additional information on diabetic retinopathy can be found on the ADA site.

Hospital Discharge Summaries Empower Members and Inform Providers

It is important for primary care providers (PCPs) to know details about the care their patients receive during inpatient hospital stays. The hospital discharge summary is the key source for this information. The Blue Cross

Blue Shield of Texas (BCBSTX) 2021 PCP and specialist satisfaction survey results showed improvements in receiving the hospital discharge summary but there are still some providers not receiving them. It is important to communicate timely and ensure continuity of care for our Federal Employee Program® (FEP®) members to transition home or to the next level of treatment. The discharge summary is not only used to improve coordination and quality of care, but ultimately to reduce the number of preventable readmissions. Additional guidance for discharge planning was published in 2019 by the Centers for Medicaid and Medicare Services (CMS).

As a reminder, use of Electronic Health Records (EHRs), including wider acceptance of member portals when available, ensures smooth flow of information from the hospital when discharging FEP members to the next level of care. Supporting the member's transition includes providing culturally appropriate member instructions, medication reconciliation and educating caregivers.

Studies have shown that providing timely, structured discharge summaries to PCPs helps reduce readmission rates, improves patient satisfaction, and supports continuity of care. One study found that, at discharge, approximately 40 percent of patients typically have test results pending and 10 percent of those results require action. PCPs and patients may be unaware of these results.[1,3]

One study found that one in five patients discharged from the hospital to their homes experienced an adverse event (defined as an injury resulting from medical management rather than from the underlying disease) within three weeks of discharge. This study found 66 percent of these were drug-related adverse events.[2,3]

As a reminder, please include the following information in every discharge summary:

- Course of treatment
- Diagnostic test results Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes/medication reconciliation

FEP Case Management staff are available to work with members, providers and collaborate with medical teams while inpatient and post discharge to facilitate discharge planning instruction. BCBSTX and FEP applaud PCPs who have adopted the best practice of utilizing written discharge summaries along with medication reconciliation from their inpatient admission.

[1]Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143(2):121–8.

[2]Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–7.

[3]Snow, V., MD. (2009). Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. Journal of Hospital Medicine, 4(6), 364-370. doi:10.1002

Encourage Early and Timely Intervention for Pre-and Post-Partum Care

Communication between Federal Employee Program® (FEP®) members and their health care professionals during the patient's pre-pregnancy, pregnancy, and postpartum medical journey is important. Establishing regular appointments and immediately notifying the patient at time of discharge facilitates the completion of the discharge summary, which ensures continuity of care and informs the member of next steps. This is an ongoing process, not a one-time follow-up encounter.

Post-partum visits are recommended to be scheduled before discharge from the hospital. Coordination of care is best achieved when providers help members anticipate and follow through with transitions of care between settings. When providing care, please document the following information in the patient's chart to help ensure effective coordination and continuity of care:

- Prenatal Visit in First Trimester
  - Prenatal risk assessment including:
    - Diagnosis of pregnancy
    - Complete medical and obstetrical history
    - Physical exam as referenced in the American College of Obstetrics and Gynecology (ACOG) Form[1]
  - Prenatal lab reports
  - Ultrasound
  - Estimated date of delivery (EDD)
  - Documentation of prenatal risk and education/counseling
- Post Postpartum
  - Provider staff calling member within one week after delivery to schedule postpartum follow-up visit
  - Documentation of a postpartum visit on or between 7 to 84 days after delivery
  - Postpartum office visit progress notation documenting comprehensive postpartum exam (may include an evaluation of weight, blood pressure, breast exam, abdominal exam, and pelvic exam)

Thank you for your help in supporting continuity of care and improving quality outcomes for our FEP and other Blue Cross Blue Shield of Texas (BCBSTX) members.

[1] American College of Obstetrics and Gynecology form

Continuity of Care Changes

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

Most of our group and fully insured plans currently include a period for continuity of care at in-network reimbursement rates when a provider leaves our networks. The new legislation also requires continuity of care for affected members when:

- A provider's network status changes
- A group health plan changes health insurance issuer, resulting in the member no longer having access to a participating provider in our network

What this means for you

If you leave our network, we will notify members and allow them to request continuity of care for the following conditions or care:

- Treatment of a serious and complex condition
- Institutional or inpatient care
- Schedule a nonelective surgery
- Pregnancy or course of treatment for pregnancy
- Terminal illness

Members can choose to continue services with the same in-network coverage for either 90 days after the notice or until the date they're no longer a continuing care patient, whichever is earlier.

State laws, which may require a longer continuity of care period for certain conditions, will continue to apply.

You (or your facility) must accept payment from us plus member cost share as payment in full during the continuity of care period.

More on the CAA and Transparency in Coverage Final Rule.

EDUCATION & REFERENCE

Surprise Billing Provisions of No Surprises Act

Requirement of the Consolidated Appropriations Act (plan years on or after Jan. 1, 2022)

The No Surprises Act (NSA) is part of the Consolidated Appropriations Act (CAA). Under NSA, most out-of-network providers will no longer be allowed to balance bill patients for:

- Emergency services
- Out-of-network care during a visit to an in-network facility
- Out-of-network air ambulance services if patients' benefit plan covers in-network air ambulance services

For items and services subject to NSA requirements, member cost-share will be calculated based on the lesser of a new **qualified payment amount** or the provider's billed charge. The qualified payment amount is a new median contract rate calculation set forth by the NSA and related interim rules.

Generally, if an out-of-network provider isn't satisfied with a payment on items or services subject to NSA, they can first initiate a negotiation with the plan and, failing that, pursue binding **independent dispute resolution (IDR).** Through this process, the parties submit their respective offers and other required information, and the

IDR entity selects one of the parties' offers as the outcome, which determines whether any additional amount will be paid to the provider.

The NSA and related interim rules state that some of its provisions, such as member cost-share requirements, claim payment deadlines, and availability of the federal IDR process, do not apply if a state law provides a method for determining the total amount payable to the provider for that item or service.

CAA expands the current definition of emergency services. Emergency services continue to be defined by the prudent layperson standard. If a plan covers services in an emergency department or independent freestanding emergency room, the following services will be included as emergency services under NSA:

- Screening and ancillary services necessary to evaluate the emergency condition (participating and non-participating)
- Services to stabilize the patient (participating and non-participating)
- Post-stabilization outpatient observation or an inpatient or outpatient stay, if the plan would cover the services (non-participating only)

More on the CAA and Transparency in Coverage Final Rule.

HEALTH & WELLNESS

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in the News and Updates section of our website and on our Wellness Can't Wait web page.

MEDICARE ADVANTAGE PLANS

2022 Blue Cross Medicare Advantage Expansion Service Areas

Effective January 1, 2022, Blue Cross Blue Shield of Texas (BCBSTX) announces that Blue Cross Medicare Advantage HMO, and PPO networks are expanding its service areas across Texas. The expansion builds on strong networks already in place in Texas and is part of our commitment to providing members with access to affordable health care.

Blue Cross Medicare Advantage (HMO)℠ Expansion Areas: Brazoria, Ellis, Johnson, Parker, Rockwall, and Waller counties.

Plan highlights include:

- $0 premiums
- $0 PCP visits
- Over-the-counter quarterly mail order benefit
- Cost-free SilverSneakers® gym membership

- Cost-free transportation for travel to/from doctors' visits
- Some supplemental vision, dental and hearing benefits

Remember to view the Blue Cross Medicare Advantage HMO SNP provider training here.

Blue Cross Medicare Advantage (PPO)℠ Expansion Areas:

Archer, Austin, Bee, Bell, Blanco, Bosque, Brazoria, Brooks, Burleson, Clay, Coryell, Dimmit, Duval, Ellis, Erath, Falls, Freestone, Goliad ,Grimes, Hamilton, Henderson, Hopkins, Houston, Jack, Jim Hogg, Jim Wells, Karnes, Kenedy, La Salle, Limestone, Madison, Mason, McCulloch, McLennan, Mills, Nueces, Orange, Palo Pinto, Parker, Polk, Rains, Refugio, San Jacinto, San Patricio, San Saba, Shackelford, Somervell, Throckmorton, Trinity, Tyler, Van Zandt, Walker, Waller, Washington, Webb, and Zavala counties.

Plan highlights include:

- Cost-free SilverSneakers® gym membership
- Some plans offer supplemental vision and dental
- Dallas Choice Premier PPO plan offers a supplemental hearing aid allowance
- New Flexible Medicare Advantage PPO Plan

Have questions?

Call 1-972-766-7100, Email Texas Medicare Advantage Network or reference the Medicare Advantage Provider Quick Reference Guide.

†SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

HMO Special Needs Plan provided by Blue Cross and Blue Shield of Texas, which refers to GHS Insurance Company (GHS), an Independent Licensee of the Blue Cross and Blue Shield Association. GHS is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in GHS' plan depends on contract renewal.

NETWORK PARTICIPATION

MyBlue Health℠ Network Expansion

Blue Cross and Blue Shield of Texas (BCBSTX) is expanding the **MyBlue Health℠** network, effective **January 1, 2022** for Bexar, Travis and Williamson Counties. MyBlue Health members in these areas will access care through providers contracted in the **MyBlue Health** network. Note these additional counties have no impact on the current MyBlue Health network benefits applicable to Dallas and Harris counties.

MyBlue Health members must choose a Primary Care Physician (PCP). Members can choose a family practitioner, internist, pediatrician, physician assistant (PA) or advanced practice registered nurse (APN) and/or obstetrician/gynecologist as their PCP.

In Bexar, Travis and Williamson counties, some MyBlue Health members may choose a MyBlue Health Select PCP within the following practice groups which may result in a lower copayment for scheduled PCP office visits as indicated in their schedule of copayments and benefit limits.

- CentroMed
- CommUnityCare
- Lone Star Circle of Care

Members covered by MyBlue Health can be identified through their ***BCBSTX ID card:***

- **MyBlue Health** is displayed on the ID card.
- MyBlue Health members have a unique network ID: **BFT**.
- The 3-character prefix is on the ID card: **T2G**

Patient eligibility and benefits should be checked prior to every scheduled appointment through the Availity Provider Portal® or your preferred web vendor. Eligibility and benefit quotes include participant confirmation, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. Its strongly recommended providers **ask to see the participant's** ID card for current information and **photo ID** at every visit to guard against medical identity theft. When services may not be covered, participants should be notified they may be billed directly.

If you have any questions, please contact your Network Management Representative:

- Bexar County **1-361-878-1623** or email
  Provider Relations South Texas
- Travis County **1- 800-336-5696/1- 512-349-4847** or email
  Provider Relations Austin
- Williamson County **1- 800-336-5696/1- 512-349-4847** or email
  Provider Relations Austin
- All others, contact your local Network Management office location

Additional information regarding **MyBlue Health** will be available in future Blue Review newsletters and on our provider website.

PRIOR AUTHORIZATION

Revision to Prior Authorization Codes for Commercial Members

On Sept. 29, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) announced changes to the commercial member prior authorization procedure code lists effective Jan. 1, 2022.

Additional Code Removals

We have updated the lists of procedure codes, for some commercial members, to reflect removing some additional codes from requiring prior authorization through BCBSTX or AIM Specialty Health® (AIM) due to updates from Utilization Management or the American Medical Association (AMA).

The revisions effective Jan. 1, 2022 include the removal of some codes in the following categories:

- Reviewed by BCBSTX

    - Spinal Cord Stimulation codes
    - Multiple Stimulation codes
- Reviewed by AIM
    - Cardiology codes
    - Radiation Oncology codes
    - Advanced Imaging codes
    - Medical Oncology codes

More Information:

The **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans** page under the Utilization Management section of our provider website include the revised lists. Refer to AIM's website for available training sessions.

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.

Cardiology (Echo) Reminder:

The updates posted Sept. 29, 2021 include the addition of several cardiology (echo) codes to be reviewed by AIM as of Jan. 1, 2022. Be sure to review the list if your practice provides or refers for these services.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without 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.

Coordinated Home Care & Home Infusion Therapy Prior Authorizations Reminders

To identify if a service requires prior authorization for our members, always check eligibility and benefits through Availity® or our preferred vendor for services requiring prior authorization including those below:

Reminders:

- As a provider rendering Coordinated Home Care (CHC) and Home Infusion Therapy (HIT), you can submit **initial** prior authorizations for both **CHC and HIT** requests via Availity. Always submit the correct service type to avoid delays.
- **Referrals or prior authorizations** for therapy services should be submitted separately.
- You will get a real-time Availity or clinical review response per the prior authorization guidelines for **initial** requests by fax or phone directly to the provider.

What should you do?

- Provide all pertinent information related to your patient services.
- Specifically submit:
  - Referrals should only include **consultation CPT codes.** Note: referrals are for HMO plans only.
  - Prior authorizations with **correct codes** for CHC, HIT or therapy services
- Call **1-800-441-9188** for **concurrent/extensions** requesting additional units or days. ever submit concurrent/extensions via Availity to avoid delays. You will receive your responses for additional units or days for current/extensions from **Blue Cross and Blue Shield of Texas** via fax or a phone call directly to the provider per concurrent/extension guidelines.

If you have questions, please call the number on back of the member's ID card or **1-800-441-9188**.

STANDARDS & REQUIREMENTS

Machine-Readable Files

Requirement of the Transparency in Coverage Final Rule

Health insurers are required to publicly display certain health care price information via machine-readable files on their websites beginning in 2022. These machine-readable files will include negotiated rates with in-network providers, allowed amounts for out-of-network providers, and may include prescription-drug pricing. The Departments of Health and Human Services (HHS), Labor, and Treasury have issued guidance indicating they will delay their enforcement of the machine-readable file requirements until July 1, 2022.

What this means for you

- These files will include your federal Taxpayer Identification Number (TIN), in addition to your National Provider Identifier (NPI).

- If you are using your Social Security number as your TIN, we encourage you to register for a new TIN and update us through Availity® or submit a Demographic Change Form.

More on the CAA and Transparency in Coverage Final Rule.

Contact Us

View our quick directory of contacts for BCBSTX.

Update Your Information

Do you need to update your location, phone number or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local BCBSTX Network Management Representative to have up to 10 of your office email addresses added.

Checking eligibility, benefit information and/or if a service has been prior authorized 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 services were rendered. If you

Material presented 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. The fact that a service or treatment is described is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for select health care services on behalf of BCBSTX.

CPT copyright 2020 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third-party vendor that is solely responsible for its products and services.

ConVergence Point is a trademark of Verscend Technologies, Inc., an independent third-party vendor that is solely responsible for its products and services.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third party vendors such as Availity or Medecision. If you have any questions about the products or services offered by such vendors, you should contact the vendor(s) directly.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent

Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's certificate of coverage which may vary from the limits set forth above. The listing of any particular drug or classification of drugs is not a guarantee of benefits.

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.

Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

bcbstx.com/provider

© Copyright 2021 Health Care Service Corporation. All Rights Reserved.