BLUE REVIEW℠
A Provider Publication

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NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

As the COVID-19 crisis evolves, we're continuing to update 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 FAQs and COVID-19: FAQs for Medicare Providers.

ClaimsXten™ Update to Procedure Codes

Blue Cross and Blue Shield of Texas (BCBSTX) will implement the second and third quarter code updates for the ClaimsXten auditing tool on or after August 24, 2021.

These quarterly code updates aren't considered changes to the software version. Code updates may include additions, deletions and revisions to:

- Current Procedural Terminology (CPT®) codes
- Healthcare Common Procedure Coding System (HCPCS) codes

When applicable, BCBSTX may also post advance notice of significant changes, like implementation of new rules, in the News and Updates section of our Provider website and the Blue Review monthly newsletter.

Use **Clear Claim Connection™ (C3)** to determine how certain coding combinations may be adjudicated when we process your claim. C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software.

Please note that C3 doesn't contain all our claim edits and processes. Its results don't guarantee the final claim decision.

For more information, refer to the Clear Claim Connection page. in the Education and Reference Center/Provider Tools section of our provider website for more information on C3 and ClaimsXten. It includes a user guide, rule descriptions and other details.

BEHAVIORAL HEALTH

Behavioral Health Resources Added to 'Wellness Can't Wait' Web Page

Now's the time to encourage your patients to get caught up on their health screenings, including their mental health. Timely identification and treatment of coexisting medical and behavioral health conditions may lead to better health outcomes. As such, we've added behavioral health and other resources to our Wellness Can't Wait: Delivering Quality Care web page, including:

- Quality improvement tip sheets (including behavioral health)
- Webinar: Depression in a Primary Care Setting (Free CME)
  - June 16 at 8 a.m. CT
- Educational fliers and outreach templates

Supporting Mental Health

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 News and Updates and our Wellness Can't Wait web page.

Mental health conditions are common, affecting people of all ages. The Centers for Disease Control and Prevention (CDC) estimates that half of Americans will be diagnosed with a mental illness or disorder at some point in their lives. The number of Americans seeking help for mental health has increased during the pandemic. We encourage providers to talk with our members about their mental health, including signs of depression and anxiety in adults and children.

Closing Care Gaps

As part of monitoring and helping improving quality of care, we track two measures related to mental health:

- Follow-up after Hospitalization for Mental Illness (FUH)
- Follow-up after Emergency Department (ED) Visit for Mental Illness (FUM)

Both are Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA). Follow-up care for people with mental illness is linked to fewer repeat emergency department (ED) visits and improved physical and mental function, according to NCQA.

- Learn more about identifying gaps in care with our online reporting tool.

About FUH

As defined by NCQA, FUH applies to members ages six and older who had a follow-up visit with a mental health provider after they were hospitalized for the treatment of selected mental illness or intentional self-harm. FUH captures the percentage of discharges for which members had a follow-up visit:

Within 30 days of discharge (31 total days)

Within seven days of discharge (8 total days)

About FUM

FUM focuses on follow-up visits for mental illness after an ED visit for members ages six and older with a diagnosis of mental illness, according to NCQA. FUM captures the percentage of ED visits for which members had a follow-up visit:

- Within 30 days of the ED visit (31 total days)
- Within seven days of the ED visit (eight total days)

For more information, see our HEDIS tip sheets.

Tips to Consider

For EDs and hospitals:

- Help our members schedule an in-person or telehealth follow-up visit with a mental health provider within seven days of discharge. The follow-up visit must be on a different date than the discharge date.
- Educate members about the importance of following up with treatment.
- Focus on member preference for treatment, allowing members to take ownership of the treatment process.

For providers:

- Encourage members to bring their discharge paperwork to their first appointment.
- Educate members about the importance of following up and adhering to treatment recommendations.
- Use the same diagnosis for mental illness at each follow-up visit. A non-mental illness diagnosis code will not fulfill this measure.
- Coordinate care between behavioral health and primary care providers:
  - Share progress notes and updates.
  - Include the diagnosis for mental illness.
  - Reach out to members who cancel appointments and help them reschedule as soon as possible.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material 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.

CLAIMS & ELIGIBILITY

Update to Room Rate Notification Form

Many group and member benefits only provide for a semi-private room. The room rates on file are used to determine a patient's cost-share when the difference between a private room and a semi-private room is the patient's responsibility. Therefore, the information you provide regarding your room rates assists us in adjudicating claims with the correct patient cost-share. We have updated our Room Rate Notification Form. When you need to make updates to your room rates, please submit the revised form to us at

least 30 days before the effective date of the change(s).

Hospitals and Routine Services and Supplies

Generally, routine services and supplies are already included by a provider in charges related to other procedures or services. As such, these items are considered non-billable for separate reimbursement. The following guidelines may assist hospital personnel in identifying items, supplies and services that are not separately billable (this is not an all-inclusive list):

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient or outpatient environments.
- All items and supplies that may be purchased over the counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

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:

- Global Surgical Package – Effective 05/26/2021
- Laboratory Panel Billing – Effective 06/10/2021 (minor format changes from Annual Review)
- Point-of-Care Ultrasound Examination Guideline – Effective 06/10/2021 (minor format changes from Annual Review)
- CPCP023 Modifier Reference Guideline – Effective 07/15//21 (updated to clarify modifiers AS and SA)
- CPCP031 Trauma Activation – Effective 08/26/2021

CLINICAL RESOURCES

Importance of Complete Discharge Summaries

Physicians and other practitioners need to know the details about the care a patient receives during an inpatient hospital stay. Discharge summaries are an invaluable resource that may improve patient outcomes by providing for continuity and coordination of care and a safe transition to other care settings and providers.

Communications via the discharge summary provides a smooth and long-lasting transition of the patient to the next level of care and avoid miscommunication or delays in care that may lead to poor outcomes.

Provider Survey Results: The Blue Cross and Blue Shield of Texas (BCBSTX) Provider Satisfaction Survey includes questions about PCPs' satisfaction with hospital discharge summaries. **In 2020, we saw an increase in overall satisfaction with continuity of care and PCPs reported receiving hospital discharge summary had adequate information about medications compared to 2019.** Of those received, the timeliness remained consistent. The results demonstrate opportunities for improvement, but most importantly making sure the PCP receives a discharge summary.

BCBSTX Provider Satisfaction Survey – Hospital Discharge Summary Feedback

Survey Questions	Goal	2019	2020
Overall satisfaction with continuity of care	90%	75%	79%
When you receive hospital discharge information, does it contain adequate information about medications at discharge?		86%	90%
When you receive hospital discharge information, does it reach your office within a *timely* manner *(within 10 business days)*?		83%	82%
When your patients are admitted to a hospital, are you sent summary information after the discharge?		67%	66%

Improving the Discharge Process: In an effort to improve the exchange of patient information between health care settings and practitioners responsible for follow-up care, CMS has implemented the Interoperability and Patient Access Rule to go into effect in 2021. This electronic event notification is critical in avoiding miscommunication or delays in care while providing patients better access to their medical information and being better informed. More information can be found on the CMS Interoperability and Patient Access Fact Sheet.

We applaud practitioners that have adopted a structured approach to discharge summaries.

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 News and Updates and our Wellness Can't Wait web page.

Free Vaccine Confidence Webinar

Now more than ever, it's vital for health care providers to educate parents on the importance of vaccinating their children.

Register today for your preferred session of our upcoming free webinar for providers: **What is Vaccine Confidence?**.·

Sign up for your preferred session:

- July 21, 2021 at 12 p.m.
- July 21, 2021 at 3 p.m.

In this webinar you'll learn about:

- Possible determinants of and barriers to vaccine confidence, including examples across the lifespan and among specific groups
- Several provider and team approaches to building vaccine confidence, including recommended communication and motivational interviewing techniques

This webinar is hosted by **Dr. Suzanne R. White**, M.D., MBA, FACEP, FACMT, a Regional Medical Director employed by Merck & Co.

More Resources

To support quality care, we are providing information to providers to encourage discussions on health topics. Visit our **Wellness Can't Wait: Delivering Quality Care** page to learn more.

·This webinar is not eligible for a CEU.

Earn CME/CEU Credit at Free Webinar on Opioid Use

Join our board-certified psychiatrists and behavioral health medical directors for a one-hour webinar on opioid use disorder. The webinar is on **Wednesday**, **Aug. 18, 2021**, **at 8 a.m.** central time. It's free to providers. Those who attend will earn one continuing medical education credit (CME) or continuing education unit (CEU).

The webinar will provide a high-level overview of the assessment and treatment of opioid use disorder in a primary care setting. This introductory training focuses on substance abuse in the primary care setting, with treatment options across settings.

How to Attend

Register here.

Future CME/CEU Offering

We will offer a free webinar on comorbid behavioral health and physical health conditions on Oct. 27, 2021.

Watch News and Updates and our Provider Training page for details on these and other trainings.

The New Mexico Osteopathic Medical Association (NMOMA) is accredited by the American Osteopathic Association to provide osteopathic continuing medical education for physicians. NMOMA designates this program for a maximum of 1 AOA Category 1-A credits and will report CME and specialty credits commensurate with the extent of the physician's participation.

Social Work CEUs Approved by NASW-NM. The Licensee must maintain proof of continuing education courses taken for the past four (4) years. The New Mexico Regulations and Licensing Department, Boards and Commissions, Social Work Licensing Board reserves the right to audit a licensee's continuing education records as it deems necessary. This eventhas been approved for a total of 1 CEU.

Physicians (MDs and DOs), nurses, physician assistants and nurse practitioners can use AOA Cat 1-4 credit toward licensure. Psychologists, social workers and mental health counselors (LPC, LCPC, LPCC) can use the Social Work CEU credit toward licensure.

In-Home Test Kits for Colorectal Cancer Screening

Blue Cross and Blue Shield of Texas (BCBSTX) is working with Home Access Health Corporation to provide in-home test kits for certain members who need a colorectal cancer screening. Because of the COVID-19 pandemic, many may have delayed getting appropriate care. Home Access Health is sending Fecal Immunochemical Test (FIT) kits to certain Blue Advantage HMO℠ and Blue Advantage Plus℠ HMO members at no additional charge.

How It Works

The process is quick and easy for members to follow:

- Home Access Health sends the kits to a sample of eligible members who have been identified with a gap in care for colorectal cancer screening. Completing the kit is voluntary.
- The kits don't require fasting, dietary restrictions or preparation. Medications are taken according to members' normal schedule.
- Members complete the test kit at home, provide the name of their primary care provider (PCP) and mail the test for processing to Home Access Health by Dec. 31, 2021. An addressed, postage-paid envelope is included.
- Home Access Health sends results to the member and their PCP in three to four weeks.

How You Can Help

As a trusted provider, you can encourage our members to take advantage of this opportunity to learn more about their health.

- Discuss the importance of colorectal cancer screening and healthy lifestyle choices with our members.
- If our member receives a kit and calls your office with questions, discuss their screening options.
- Document any test results in the member's medical record and discuss the results with our member.

FIT Testing

- The U.S. Multi-Society Task Force on Colorectal Cancer recognizes annual FIT testing and colonoscopy every 10 years as the two cornerstones of screening.
- FIT testing is appropriate screening for individuals with an average risk for colorectal cancer. Average risk means no family history of colorectal cancer, no personal history of inflammatory bowel disease, no previous polyps and no previous colorectal cancer.

Questions? Contact your BCBSTX Provider Network Representative.

Home Access Health Corporation is an independent company that provides health screenings for BCBSTX. Home Access Health Corporation is solely responsible for the products and services it provides.

MEDICARE ADVANTAGE PLANS

Closing Gaps in Care for Group Medicare Advantage (MA) Members

The Blue Cross and Blue Shield (BCBS) **National Coordination of Care** program is again serving **Blue Cross Group Medicare Advantage (PPO)**℠ (Group MA PPO) members. The program paused during the global pandemic. As we told you in December 2019, the program supports continuity of care for all BCBS Group MA PPO members.

What This Means for Medicare Providers

Blue Cross and Blue Shield of Texas (BCBSTX) will work with you to help close gaps in care for BCBSTX and other BCBS Group MA PPO members. If we need medical records, you won't receive requests from multiple BCBS plans or their vendors. You will receive requests only from BCBSTX or our vendor, Change Healthcare. We may request medical records for:

- Risk adjustment gaps related to claims submitted to BCBSTX
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Centers for Medicare & Medicaid Services (CMS) Star Ratings

Important Reminders

- Respond quickly to requests related to risk adjustment, HEDIS and other government-required activities as your contract requires.
- You don't need patient-authorized information releases to fulfill medical records requests and risk adjustment gaps through this program.

- Use the Availity® Provider Portal or your preferred vendor to verify BCBSTX and other BCBS members' eligibility and benefits before every appointment. Eligibility and benefit quotes include:
  - Membership verification
  - Coverage status
  - Prior authorization requirements
  - Provider's network status for the patient's policy
  - Applicable copayment, coinsurance and deductible amounts
- Ask to see the member's ID card and a photo ID to help guard against medical identity theft.
- Notify members that they may be billed directly when services may not be covered.

Questions? Call the Customer Service number on the member's ID card.

CMS Payment Adjustments for Medicare Providers

May 19, 2021, update: The Medicare sequester has been suspended through Dec. 31, 2021. During this time, BCBSTX is suspending the 2% sequestration reduction in Medicare claims payments.

During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) has adjusted certain payments to Medicare providers. Blue Cross and Blue Shield of Texas (BCBSTX) is applying these temporary adjustments to claims reimbursements, as appropriate and where consistent with network contracts, for Medicare Advantage providers.

What has changed?

Diagnosis Related Group (DRG) add-on payment: For discharges of members diagnosed with COVID-19, the weight of the assigned DRG has temporarily increased 20 percent. Providers should use the appropriate diagnosis code and date of discharge to identify members:

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after Jan. 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the emergency period.

Medicare sequestration suspended through Dec. 31, 2021: The Medicare sequester suspension period has been extended through Dec. 31, 2021. It previously was suspended between May 1, 2020, and Dec. 31, 2020, and then extended to March 31, 2021. During this time, BCBSTX is suspending the 2% sequestration reduction in Medicare claims payments. This applies to Medicare providers who service Medicare Advantage members.

Questions? Please call the number on members' ID cards.

Resources: CMS Current Emergencies and News Alerts

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective July 1, 2021 – Part 2

This pharmacy update includes changes/updates to the drug list and the Utilization Management program. It also includes reminders about the Split Fill program and the HDHP/HAS Preventive Drug program. And HIV pre-exposure prophylaxis (PrEP) coverage updates.

PRIOR AUTHORIZATION

Update to AIM Prior Authorization Codes for Commercial Members

What's New: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of procedure codes requiring prior authorization by AIM Specialty Health® (AIM), for some commercial members. These changes reflect new, replaced or removed codes due to updates from Utilization Management (UM) or the American Medical Association (AMA).

More Information: Refer to the Utilization Management section of our provider website for revised lists under the **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans.**

Changes are:

- **May 21, 2021** – Removal of Pain Management codes previously reviewed by AIM (UM change)
- **July 1, 2021** – Adding Genetic Testing codes to be reviewed by AIM (AMA update)

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.

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.

STANDARDS & REQUIREMENTS

PEAQ Program Reports Available on Availity July 15, 2021

Review a list of measured specialties and see an example of the PEAQ reports that will soon be available on Availity.

UTILIZATION MANAGEMENT

Medical Necessity Review of Observation Services

As a reminder, our policy is to provide coverage for observation services when it's determined to be medically necessary (based on the medical criteria and guidelines as outlined in the MCG Care Guidelines). Claims for observation services are subject to a post-service review and we may request medical records to determine medical necessity.

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.

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By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

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

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

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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.

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