MAY 2021

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.

Provider Satisfaction Survey 2021

Building a strong network of providers and working with you to serve our members is important to us. To support this effort, we survey a random sample of providers each year. The **Provider Satisfaction Survey** measures your satisfaction with Blue Cross and Blue Shield of Texas (BCBSTX) and identifies areas where we can improve.

How it works:

SPH Analytics (SPH) will administer this year's survey between **May and August**. If selected to participate, **SPH will contact you** via **email, mail and phone**.

- SPH will send out **email survey invitations** to selected providers with email addresses. These invitations will be followed by a **printed survey**.
- The survey will also be available online at the web address provided on the mailed survey.
- If no response from email or mail, SPH will reach out by phone.
- The physician, nurse, office manager or other qualifying staff may complete the survey.

We look forward to your feedback.

SPH Analytics is an independent third-party vendor that is solely responsible for its products and services.

Access to Resources to Support Quality Care

Now's the time to encourage our members to catch up on their health. Their wellness can't wait – even during the COVID-19 pandemic. To support quality care, we are providing information to providers and members to encourage discussions on health topics.

On our Wellness Can't Wait: Delivering Quality Care page you'll find:

- Quality toolkits and tip sheets
- Member outreach and educational collateral
- Other resources, like Indices, to help you identify gaps in care as reflected in claims and other regularly updated data.

Bookmark our Wellness Can't Wait: Delivering Quality Care page and check back for updates.

Professional Provider Fee Schedule via Availity®

Fee schedules are a key component of your contractual relationship with Blue Cross and Blue Shield of Texas (BCBSTX). To ensure you have this information quickly, coming soon BCBSTX will be implementing a new online Fee Schedule viewer tool via the Availity Provider Portal for some participating professional providers. Once it's available professional providers may use this Availity tool to electronically request up to 20 procedure codes and immediately receive the currently contracted price allowance for the patient services submitted.

How to Use the Availity Fee Schedule Listing Tool:

Note: Availity Administrators must assign the "Provider Fee Schedule" role for users to gain access to this tool.

- Log in to Availity
- Select Claims & Payments from the navigation menu
- Select Fee Schedule Listing
- Select BCBSTX as the payer
- Select your organization and Tax ID number
- Enter the Billing National Provider Identifier (NPI) and Rendering NPI (if applicable)
- Select the Network, Place of Service, and Provider
- Enter the procedure code(s) and modifier(s)

You must be registered with Availity to use the new Fee Schedule tool. You can sign up today at Availity, at no charge. For registration assistance, call Availity Client Services at 800-282-4548. If you do not have online access, you may continue to submit your requests using the Professional Fee Schedule Request form located on our provider website.

Training

BCBSTX is hosting complimentary webinars for you to learn how to use the new Availity Fee Schedule Listing tool. To register for a webinar, click on your preferred session date below.

June 1, 2021 – 10:00 a.m. to 10:30 a.m.

June 2, 2021 – 1:00 p.m. to 1:30 p.m.

June 3, 2021 – 10:00 a.m. to 10:30 a.m.

June 4, 2021 – 1:00 p.m. to 1:30 p.m.

For More Information

Watch the News and Updates page for information on when the tool will be available. Also, we will have an instructional **Fee Schedule Tool User Guide** that will be added to the Provider Tools section of our website. If you have further questions, please contact our Provider Education Consultants.

Medicare Advantage and Texas Medicaid

Links to these fee schedules are available by selecting the Claims & Payments menu, Fee Schedule Listing, and then choose the appropriate Additional Fee Schedules for Medicare and/or Medicaid. They can also be found via the Resources tab in the BCBSTX-branded Payer Spaces section in the Availity portal.

Reminder: PEAQ Program

What is PEAQ

The PEAQ Program evaluates physician performance in a transparent and multidimensional way. A goal of PEAQ is to work with the physician community to maximize physician efficiency, appropriateness, and quality of care.

The guiding principles of the program include metrics, transparency, collaboration, continuous improvement, insights, and member focus to achieve more optimal outcomes and effective delivery. Providers can review the current methodology on our PEAQ Program page.

PEAQ Program Reports

Results of the PEAQ evaluation will show how a physician was scored and where their scores rank in comparison to peers within the same region and working specialty. These reports will be available soon and providers can access them via Availity® by using the Reporting On-Demand tool located in the Blue Cross and Blue Shield of Texas-branded Payer Spaces section. If you are not currently registered with Availity get ready now by signing up at Availity, **at no charge**. If you need registration assistance, contact Avility Client Services at **1-800-282-4548**.

Watch News and Updates and the Blue Review for more detailed information on accessing your PEAQ reports in the near future.

BEHAVIORAL HEALTH

New Applied Behavior Analysis (ABA) Service Request Forms

As of March 2021, we've updated our ABA service request forms to streamline data required for review. **To request services:**

- Download the appropriate new form from the Behavioral Health/Mental Health section on our Forms page. Please note for participants with the Employees Retirement System of Texas (ERS) or Teacher Retirement System of Texas (TRS), select the forms specific for ERS and TRS.

  The following forms have been updated.

  - **Initial Assessment Request**
  - **Clinical Service Request** for initial and concurrent treatment requests
- Be sure to include the contact information and signature of the **rendering Qualified Healthcare Provider (QHP)** who is providing treatment.
- Fax the completed form to **1-877-361-7646 at least two weeks before the requested start date**. If we don't receive the form within 30 days of the start date, you will need to submit claims through your normal process.

Questions? Call us at **1-800-528-7264**.

Find other forms under Education and Reference.

Major Depressive Disorder

Depression is the most common mental disorder. It carries a high cost in terms of relationship problems, family suffering and lost work productivity, according to the American Psychiatry Association. Accurately and completely documenting and coding Major Depressive Disorder (MDD) can help our members access needed resources. Below is information from the ICD-10-CM Official Guidelines for Coding and Reporting.

Sample ICD-10-CM Codes for Single MDD Episode	
F32.0	Single episode, mild
F32.1	Single episode, moderate
F32.2	Single episode, severe without psychotic features
F32.3	Single episode, severe with psychotic feature
F32.4	Single episode, in partial remission
F32.5	Single episode, in full remission
F32.8x	Other depressive disorders
F32.9	Single episode, unspecified
Sample ICD-10-CM Codes for Recurrent MDD Episodes	
F33.0	Recurrent, mild

F33.1	Recurrent, moderate
F33.2	Recurrent, severe without psychotic features
F33.3	Recurrent, severe with psychotic symptoms
F33.4x	Recurrent, in remission
F33.8	Other recurrent depressive disorders
F33.9	Recurrent, unspecified

Coding for MDD

When coding and documenting for MDD, it's critical to capture the episode and severity with the most accurate diagnosis codes.

Documentation should include:

- Episode: single or recurrent
- Severity: mild, moderate, severe without psychotic features or severe with psychotic features
- Clinical status of the current episode: in partial or full remission

The fourth and fifth characters in the ICD-10-CM codes capture the severity and clinical status of the episode.

F32.9 MDD, single episode, unspecified, is equivalent to Depression Not Otherwise Specified (NOS), Depressive Disorder NOS and Major Depression NOS. This code should rarely be used and only when nothing else, such as the severity or episode, is known about the disorder.

Best Practices

- Include patient demographics, such as name, date of birth and date of service in all progress notes.
- Document legibly, clearly and concisely.
- Ensure a credentialed provider signs and dates all documents.
- Document each diagnosis as having been monitored, evaluated, assessed and/or treated on the date of service.
- Note complications with an appropriate treatment plan.
- Take advantage of the Annual Health Assessment (AHA) or other yearly preventative exam as an opportunity to capture conditions impacting member care.

For more details, see:

- ICD-10-CM Official Guidelines for Coding and Reporting, Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01-F99)

CLAIMS & ELIGIBILITY

CERiS to Review Complex Claims

One of our post-payment **reviewers of complex claims is changing**. CERiS will continue to conduct post-payment reviews of complex claims from providers and facilities on behalf of Blue Cross and Blue Shield of Texas (BCBSTX). However, beginning July 2021, **EquiClaim, a Change Healthcare Solution, will no longer provide these reviews** and you will no longer be contacted by them if your claim was incorrectly paid.

CERiS will continue to review claims for:

- Compliance with the provider agreement
- Compliance with clinical payment and coding policies
- Accuracy of payment

If a claim is determined to be reimbursed incorrectly, CERiS will tell you how to repay the funds or appeal the decision. We may recoup payment for any claim that doesn't meet our policies. For more information, refer to our Provider Manuals.

Questions? Contact your BCBSTX Network Representative.

CorVel Healthcare Corporation, dba CERiS and EquiClaim, a Change Healthcare Solution, are independent companies that have contracted with BCBSTX to provide medical claim audits for members with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus point-of- service benefit plan) member to an out-of-network provider for non-emergency services – if such services are also available through an in- network provider – the referring participating network provider must complete the appropriate Out-of- Network Care – Enrollee Notification forms for Regulated Business (used when "TDI is on the member's ID Card) or Non-Regulated Business (No "TDI on member's ID card). Locate them under Forms on the provider website.

The referring network physician must provide a copy of the completed form to the enrollee and retain a copy in the enrollee's medical record files.

It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the financial impact of an out-of-network referral to a health care provider that does not participate in their BCBSTX provider network. They have out-of-network benefits and may choose to use out-of- network providers, however they will be responsible for an increased cost-share under their out-of-network benefits.

Multiple Procedure Payment Reduction Claims Review

Blue Cross and Blue Shield of Texas (BCBSTX) will be conducting post pay claim reviews of certain diagnostic cardiovascular and ophthalmology services to ensure reimbursement adheres to BCBSTX reimbursement policy for Multiple Procedure Payment Reduction (MPPR) of the Technical Component (TC) of Certain Diagnostic Cardiovascular and Ophthalmology Procedures effective June 1, 2021.

What this means to you: If you submit claims with multiple diagnostic cardiovascular or ophthalmology services performed for the **same member**, on the **same day**, you may have been paid 100% for the technical component of **each** service. This is most common when services are submitted on separate claims for the same day and same member. If this occurred, services may be overpaid and a refund for an overpayment may be requested. This could also **impact the member's cost-share**.

To avoid overpayment, please submit services for same member on the same day on a single claim.

MPPR policy applies to the following plans:

- Blue Advantage HMO℠ and Blue Advantage Plus℠ HMO
- Blue Choice PPO℠
- Blue Essentials℠ and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- PAR Plan

View the MPPR policy here or go to the BCBSTX website under **Standards and Requirements, General Reimbursement Information, Reimbursement Schedules and Related information**. The information is secure and requires a password to access. Contact your BCBSTX Network Management Representative, you need the password or have additional questions.

Please be advised that the reimbursement information being disclosed within this notice contains confidential information proprietary to BCBSTX. The use and disclosure of this information is restricted under Texas Insurance Code Section 1301.136(b), Texas Insurance Code Section 843.321(b) and the terms of your BCBSTX agreements.

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:

- Preventive Services Policy – Effective 4/1/2021
- Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective 05/15/2021 – Updated 03/26/2021 for code C9771
- Medical Record Documentation Guideline – Effective 07/12/2021
- Psychological and Neuropsychological Testing – Effective 07/12/2021
- Surgical and Non-Surgical Services Guide – Effective 07/12/2021
- Modifier Reference Guideline – Effective 07/15/2021

CLINICAL RESOURCES

Speaking Out About the 'Silent Killer'

High blood pressure, or hypertension, is known as a "silent killer" because it usually has no warning signs. Nearly half of adults in the U.S. have hypertension, according to the Centers for Disease Control and Prevention (CDC), and only about 1 in 4 of them have the condition under control. Encourage our members to talk with you about their blood pressure and heart health.

Why Is Blood Pressure Control Important?

Controlling high blood pressure can prevent heart disease and stroke, which are among the leading causes of death in the U.S. According to the American Heart Association, blood pressure control can also reduce the risk of kidney disease, vision loss, peripheral artery disease and sexual dysfunction.

Closing Care Gaps

Controlling high blood pressure is recognized as a quality measure by the National Committee for Quality Assurance (NCQA). The NCQA recommends controlling both the systolic blood pressure (SBP) and diastolic blood pressure (DBP) in adults as follows:

- SBP < 140 mmHg
- DBP < 90 mmHg

View our clinical practice guidelines on hypertension.

Best Practices

Best practices include talking with members about:

- Taking medications as prescribed
- Smoking cessation
- Increased physical activity
- Maintaining a healthy weight
- Limiting alcohol intake

- Eating a low-sodium diet
- Returning for follow-up visits. Reach out to members who cancel or miss appointments and assist them with rescheduling as soon as possible.

Best practices also include using the proper codes when filing claims. Proper coding can help identify gaps in care, provide accurate data and streamline your administrative processes.

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.

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.

MEDICARE ADVANTAGE PLANS

Blue Cross Medicare Advantage (PPO)SM Network Sharing

All Blue Cross and Blue Shield Medicare AdvantageSM (BCBS MA PPO) plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO plan if the member sees a contracted BCBS MA PPO provider. Access detailed information on BCBS MA PPO network sharing. If you have any questions regarding the BCBS MA PPO program or products, contact Blue Cross Medicare Advantage (PPO) Customer Service at 1-877-774-8592.

Preventive Services Reminder: Zero Copay for Blue Cross Medicare AdvantageSM

Are your patients up to date on preventive services benefits? BCBSTX would like to remind you that there are no copays for preventive services for Blue Cross Medicare Advantage (PPO)SM or Blue Cross Medicare Advantage (HMO)SM. Blue Cross Medicare Advantage covers a full range of preventive services to help keep patients healthy, help find problems early and determine when treatment is most effective. You should let members know which of these services is right for them.

Access the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network Medicare Preventive Services for detailed information on Medicare Preventive Services for detailed information on Medicare

Preventive Services.

Additionally, you should check eligibility and benefits electronically through Availity®, or your preferred web vendor.

Annual Health Assessment Coding*

Code**	Service	Description
G0402	**Initial Preventive Physical Examination**	Code is limited to new beneficiary during the first 12 months of Medicare enrollment.
G0438	**Initial Annual Wellness Visit (AWV)**	The initial AWV, G0438, is performed on patients who have been enrolled with Medicare for more than one year, including new or established patients.
G0439	**Subsequent AWV**	The subsequent AWV occurs one year after a patient's initial visit.

**Codes for Annual Health Assessments are subject to change by Medicare Advantage Organization (MAO), without prior notice to Medical Group, for codes to be consistent with Medicare coding requirements for Annual Health Assessments.*

***Any updates, deletions and/or additions to coding shall be updated according to nationally recognized coding guidelines.*

Update to Prior Authorization Codes for Medicare and Medicaid Members

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare and Medicaid members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

For Medicare: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website. The revised lists can be found on the Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ page.

For Medicaid: Refer to **Prior Authorization Lists and Reports** on the **Utilization Management** section of our Medicaid provider website.

Changes include:

- **July 1, 2021** - Removal of Advanced Imaging codes previously reviewed by eviCore
- **July 1, 2021** - Removal of Genetic Testing codes previously reviewed by eviCore
- **July 1, 2021** - Adding Genetic Testing codes to be reviewed by eviCore
- **July 1, 2021** - Adding Specialty Drug codes to be reviewed by eviCore

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.

Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Annual Health Assessment Incentive

Due to COVID-19, many Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) members haven't completed their annual health assessment (AHA). It's important to encourage these members to set up an in-person or telehealth AHA. For every eligible AHA you complete for Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO) members, you'll receive an incentive payment of $100, in addition to your contracted rate.

PRIOR AUTHORIZATION

Update to 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, for some commercial members, to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA).

More Information: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website, Revised lists can be found on the **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans.** Changes include:

Effective April 16, 2021

- Removed review by AIM for **E1399* - Sleep Medicine Durable Medical Equipment** review by AIM

*Code E1399 may require prior authorization by BCBSTX medical management dependent on the description of the unlisted DME.

Effective July 1, 2021

- Added review by BCBSTX Medical Management for **E0764 - Functional Neuromuscular Stimulator**
- Removed review by AIM for:
  - **76975** from **Advanced Imaging**
  - **G9840** and **G9841** from **Molecular Genetic Testing**
  - **62324** and **64640** from **Pain Management**

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.

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.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com.

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).

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.

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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.

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

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