BLUE REVIEW℠

A Provider Publication

APRIL 2022

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 on our News and Updates page.

BEHAVIORAL HEALTH

2021 Behavioral Health Quality Improvement Program Evaluation Executive Summary

Review an analysis and evaluation of the effectiveness and key accomplishments of our Behavioral Health Quality Improvement program.
Read More

Supporting Mental Health

More than half of Americans will be diagnosed with a mental illness or disorder at some point in their lives, according to the Centers for Disease Control and Prevention. We encourage providers to talk with our members about mental health and getting help if needed.
A depression screening tool can help with this conversation.

To help assess and improve our members' care, we track these Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA):

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

What AMM Measures

AMM captures the percentage of members ages 18 and older with major depression who are newly treated with antidepressant medication and remain on it. As defined by NCQA, providers who prescribe antidepressants should support members in reaching these two phases:

- Effective acute treatment phase: Adults who remained on antidepressant medication for at least 84 days (12 weeks)
- Effective continuation treatment phase: Adults who remained on antidepressant medication for at least 180 days (six months)

Each phase starts when the prescription is first filled. **To help close gaps in care related to AMM, consider these tips:**

- Document the date of service, diagnosis of major depression and clear evidence that antidepressant medication was prescribed.
- Help our members understand that most antidepressants take four to six weeks to work. How long treatment lasts depends on the episode severity and number of recurrences.
- Assess members within 30 days from when the prescription is first filled for any side effects and their response to treatment.

What FUH and FUM Measure

As defined by NCQA, FUH applies to members ages 6 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)

FUM focuses on follow-up visits for mental illness after an ED visit for members ages 6 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)

To help close gaps in care, EDs and hospitals can help 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. Professional providers may want to consider:

- Encouraging members to bring their discharge paperwork to their first appointment.
- Using the same diagnosis for mental illness at each follow-up visit. A non-mental illness diagnosis code will not fulfill this measure.
- Coordinating care between behavioral health and primary care providers.

Free Behavioral Health Webinars and Continuing Education Credit

Join us for free one-hour webinars in April and May 2022. Each webinar provides one continuing medical education (CME) credit or continuing education unit (CEU). Registration is required.

Diabetes and Behavioral Health
We will offer the webinar twice:

- **Monday, April 18, 2022, at 8 a.m. CT** (register here)
- **Wednesday, April 20, 2022, at 9 a.m. CT** (register here)

The webinar will provide a high-level overview of the relationship between diabetes and several behavioral health conditions. This introductory training focuses on addressing behavioral health conditions in the primary care setting, with treatment options across various care settings.

Substance Abuse: Coordinating Care and Improving Follow-Up
We will offer the webinar twice:

- **Monday, May 16, 2022, at 8 a.m. CT** (register here)
- **Wednesday, May 18, 2022, at 9 a.m. CT** (register here)

The webinar will provide a high-level overview of substance abuse and strategies for coordinating care and improving follow-up. This introductory training focuses on addressing substance abuse in the primary care setting, with treatment options across various care settings.

Differential Diagnoses of Depression

- A recording of our March 2022 webinar, Differential Diagnoses of Depression: Assessment and Treatment, is available online. Sign in (registration required) to view the free webinar and earn CME/CEU credit.

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 event has been approved for a total of 1 CEU.

Physicians, nurses, physician assistants, physical and occupational therapists, and psychologists can use AOA Cat 1-4 credit toward licensure. Social workers and mental health counselors (LPC, LCPC, LPCC) can use the Social Work CEU credit toward licensure.

CLAIMS & ELIGIBILITY

Change Coming to FEP Out-of-State Claims Processing

Claims for out-of-area Federal Employee Program® (FEP) members should be filed with the local (Host) Plan where services are rendered.

Currently, some out-of-area FEP claims that are mistakenly submitted to the member's Home Plan are manually forwarded to the appropriate local Plan where services were rendered.

- If Blue Cross and Blue Shield of Texas (BCBSTX) is the Home Plan, we've manually forwarded the claims to the appropriate Host Plan where services were rendered.
- Similarly, if you treated an out-of-area FEP member and submitted your claim to the member's Home Plan rather than BCBSTX, the member's Home Plan may have manually forwarded the misdirected claim back to us.

What's changing: Effective June 15, 2022, BCBSTX will no longer forward misdirected claims we receive for FEP members to the Host Plan for processing. Instead, we'll deny these claims and instruct providers to resubmit the claims to the appropriate local Plan where the service was rendered.

Other Blue Cross and Blue Shield Plans are making this change, too. If you treat out-of-area FEP members of Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Oklahoma, Blue Cross and Blue Shield of New Mexico or Blue Cross and Blue Shield of Montana, be sure to submit your claims to BCBSTX.

ClaimsXten™ Quarterly Update Effective June 13, 2022

Blue Cross and Blue Shield of Texas (BCBSTX) will implement its second quarter code updates for the ClaimsXten auditing tool on or after June 13, 2022.

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 of 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/Provider Tools section of our provider website for more information on C3 and ClaimsXten. It includes a user guide, rule descriptions and other details.

Retinal Eye Exams and CPT II Coding

We appreciate the care and services you provide to our Blue Cross and Blue Shield of Texas (BCBSTX) members. Many primary care providers (PCPs) refer diabetic patients 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. There is a specific Current Procedural Terminology CPT II code that indicates the documented communication of the eye exam findings to the PCP managing the diabetes care. This is a good example of evidence of continuity and coordination of care between providers.

Why it matters: Using the proper CPT® Category II codes when filing claims can help streamline your administrative processes and ensure gaps in care are closed.

CPT II codes are tracked for certain performance measures. We use these measures to monitor and improve the quality of care our members receive. CPT II codes are more specific than CPT I codes and can help:

- Provide more accurate medical data
- Identify and close gaps in care more accurately and quickly
- Track member screenings to help you monitor care and avoid sending unnecessary reminders

Diabetic Retinal Exam	CPT/CPT II
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care Members ages 18-75 diagnosed with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed, had documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the dilated macular or fundus exam at least once within 12 months	5010F Code description: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
Diabetic Eye Exam without Evidence of Retinopathy in Prior Year	3072F
Diabetic Eye Exam without Evidence of Retinopathy	2023F, 2025F, 2033F
Diabetic Eye Exam with Evidence of Retinopathy	2022F, 2024F, 2026F
Automated Eye Exam	92229
Diabetic Eye Exam	67028, 67030, 67031, 67036, 67039, 67040, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202, 92225, 92226, 92227, 92228, 92230, 92235, 92240, 92250, 92260, 99203, 99204, 99205, 99213, 99214, 99215, 99242, 99243, 99244, 99245

Hospitals and Routine Services and Supplies

Routine services and supplies are generally 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 and 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
    - Admitted to a given treatment area or units are not separately billable
    - Receiving the same service are not separately billable

CLINICAL RESOURCES

Medical Necessity Review of Observation Services

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

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 policies have been recently added or updated:

- CPCP013 Increased Procedural Services (Modifier 22) – Effective 3/7/2022
- CPCP030 Point-of-Care Ultrasound Examination Policy – Effective 3/7/2022
- CPCP031 Trauma Activation – Effective 3/7/2022
- TXCPCP03 Surgical and Non-Surgical Services – Effective 3/10/2022
- CPCP014 Global Surgical Services – Professional Providers – Effective 6/13/2022

HEALTH & WELLNESS

Closing Gaps in Colon Care

Screening is the most effective way to reduce the risk of colorectal cancer, according to

the Centers for Disease Control and Prevention (CDC). The CDC and the U.S. Preventive Services Task Force (USPSTF) recommend that everyone 45 to 75 years old get a screening. We encourage you to discuss screening and colon health with our members. We've created resources that may help.

Recommended Screening

USPSTF recommends screening with any of the following tests for adults ages 45 to 75:

- Annual guaiac fecal occult blood test (gFOBT)
- Annual fecal immunochemical testing (FIT)
- DNA-FIT every one to three years
- Flexible sigmoidoscopy every five years
- Flexible sigmoidoscopy every 10 years with annual FIT
- Computed tomography (CT) colonography every five years
- Colonoscopy every 10 years

Providers may want to discuss earlier screening with members with a family history of colorectal disease or other risk factors. See our preventive care guidelines for more information about screening.

Closing Care Gaps

Colorectal Cancer Screening is a quality measure developed the National Committee for Quality Assurance (NCQA) that tracks appropriate screenings. We track data from quality measures to help assess and improve our members' care. To help close gaps in care, consider these tips:

- In our members' records, document the date a colorectal cancer screening is performed or include the pathology report indicating the type and date of screening.
- Encourage members to stay up-to-date on screening.
- Reach out to members who cancel screenings and help them reschedule.

Checking Eligibility and Benefits

For most of our members, preventive colorectal cancer screening is covered at no cost share. Note that family history or additional risk factors may impact the member's cost share. Check member eligibility and benefits using Availity® Essentials or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include members' coverage status and other important information, such as applicable co-pays, coinsurance and deductibles.

Some screenings involve a member's pharmacy benefits in addition to their medical benefits, such as the prep kit for colonoscopies. For details about pharmacy benefit coverage, call the number on the member's ID card. A member's pharmacy benefit may be managed by a company other than Blue Cross and Blue Shield of Texas (BCBSTX).

MEDICARE ADVANTAGE PLANS

Update to Prior Authorization Codes for Medicare Members Effective 04/01/2022

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare 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.

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.

Changes include:

- **April 1, 2022** – Replacement of Medical Oncology code J2505 with code J2506 reviewed by eviCore Healthcare

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.

NETWORK PARTICIPATION

Verify and Update Your Information Online via Availity® Provider Data Management

The Availity Provider Data Management (PDM) tool offers professional providers a quick and easy way to update, validate, and attest to the accuracy of their information on file with Blue Cross and Blue Shield of Texas (BCBSTX). This multi-payer tool in Availity Essentials also allows you to make updates once and have that information sent to all participating payers.

PDM offers two workflows:

1. Directory Verification – Must verify and/or update your business' directory information every 90 days as part of the federal Consolidated Appropriations Act (CAA)

of 2021. Receive quarterly notifications within Availity when it's time to verify directory information.

2. Core PDM – Update information about your business and provider directories, as well as key staff directories.

Below is some helpful guidance on PDM updates for BCBSTX.

Accepted	Not Accepted
• Doing Business As (DBA) name • Business website URL • Provider's personal information • Service locations address change • Service location contact information • Languages spoken • Hours of operation • Payment address change and contact information	These updates should be made by completing the appropriate form on the Verify and Update Your Information page of our website: • National Provider Identifier (NPI) number or Tax ID number change • Business closure • New provider or new service location • Inactivate a provider or delete a service location • Organization's business name change

Facility, laboratory, dental, and ancillary* providers should request demographic and other changes by completing the appropriate form on the Verify and Update Your Information page of our website.

PDM is accessible to existing Availity Administrators and users assigned the Provider Data Management role. If you are not an Availity registered user and would like to use this tool, sign up today at Availity or contact Availity Client Services at **1-800-282-4548.**

For more information, refer to the instructive Provider Data Management (PDM) User Guide located on the Provider Tools page of our website.

* Ancillary includes Ambulance, Home Health Care, Home Infusion, Hospice, Durable Medical Equipment, Dialysis, and Skilled Nursing Facilities.

PHARMACY

Pharmacy Benefits

As a participating practitioner, you are given a list of drugs that are reviewed and updated throughout the year. For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for a drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines.

For more information regarding our Pharmacy programs, visit the Pharmacy Program section on our provider website. For Federal Employee Program® (FEP®) members, information can be found at fepblue.org/pharmacy. We encourage you to check the website regularly and watch for updates in this newsletter.

You can find the following information on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits or quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step therapy protocols

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Contact Us

View our quick directory of contacts for BCBSTX.

Verify and Update Your Information

Verify your directory information every 90 days. Use the Provider Data Management feature on Availity® or our Demographic Change Form. You can also use this form to submit email addresses for you and your staff to receive the *Blue Review* each month.

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.

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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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