BLUE REVIEW℠

A Provider Publication

FEBUARY 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 pages.

New Look Ahead for Provider Website

Coming soon, our provider website will have a new streamlined design. We're making changes to enhance your online experience and help you easily find the information you need. Information will be in the sections you're used to seeing, such as Claims and Eligibility and Education and Reference. Please watch for future updates.

Verify Your Directory Details

Due to a new federal law, your directory information must be verified every 90 days. It's easy and quick to get it done for all health plans in Provider Data Management via Availity Essentials, or if you prefer, you can use our Demographic Change Form. If we don't receive your timely verification, look for friendly reminders with a checkmark symbol by email or postcard that'll remind you it's time to verify or update.

Annual Medical Record Data Collection for Quality Reporting begins Feb. 1

Blue Cross and Blue Shield of Texas (BCBSTX) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS) and by the U.S. Department of Health and Human Services (HHS) for the Quality Rating System (QRS). HEDIS is the most widely used and nationally accepted

effectiveness of care measurement available. Additionally, HHS requires reporting of QRS measures for accredited Qualified Health Plans. These activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule and patient authorization for release of information is not required. Texas state law (Chapter 108 of the Texas Health and Safety Code) requires Health Maintenance Organizations in Texas to report HEDIS data, by service area to the Department of State Health Services (DSHS) on an annual basis.

To meet these requirements, BCBSTX will be collecting medical records using Change Healthcare (CHC), an independent contracted third-party vendor, as well as BCBSTX staff. If you receive a request for medical records, we encourage you to reply within 3 to 5 business days. Cooperation with the collection of HEDIS and QRS data or any quality improvement activities are required under the providers' contractual obligation at no cost to BCBSTX or as stated within the provider's individual contract.

A representative from Change Healthcare or BCBSTX staff may be contacting you anytime between Feb. and May 2022 to set up appointments for onsite visits or to set up an expected delivery date via fax, provider portal and when necessary the U.S. Mail. As part of the request, you will receive a letter for the HEDIS and QRS data request, a medical record request list with members' names and other identifying demographics and the medical record information needed for identified measures. If you have any questions, contact the representative listed on the letter requesting the medical record information.

Federal Employee Program Annual Medical Record Data Collection for HEDIS Quality Reporting

Blue Cross and Blue Shield Federal Employee Program (FEP) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is the most widely used and nationally accepted effectiveness of care measurement available and used for Federal Employees Health Benefits Program (FEHBP).

To meet this annual quality reporting requirement, BCBS FEP will be collecting medical records using internal resources and leveraging an independently contracted third-party vendor Episource. The

FEP Quality Reporting for HEDIS Measurement Year (MY) 2021 medical retrieval process will begin in February and run through April 2022.

If you receive a request for medical records, we encourage you to reply within 5 business days. BCBS FEP or the vendor referenced above may be contacting your office or facility in February 2022 to identify a key contact person and to ascertain which data collection method your office or facility prefers (fax, secure email, sFTP (secure file transfer protocol) or onsite). Appointments for onsite visits will be scheduled with your staff, if applicable. You will then receive a letter outlining the information that is being requested, and the medical record request list with members' names and the identified measures that will be reviewed.

Patient authorization for release of medical record data is not required. These reporting activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) of 1996 and its **implementing regulations (45 C.F.R. Parts 160 and164), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as incorporated in the American Recovery and Reinvestment Act (ARRA) of 2009, and its implementing regulations, each as issued and amended**.

ClaimsXten™ Quarterly Update Effective April 11, 2022

Blue Cross and Blue Shield of Texas (BCBSTX) will implement its first quarter code updates for the ClaimsXten auditing tool on or after April 11, 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 which includes a user guide and other details. In addition, review our ClaimsXten Rule Descriptions on the Coding, Billing and Bundling Information page.

CLAIMS & ELIGIBILITY

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:

- CPCP027 Inpatient Readmissions – Effective 1/1/2022
- CPCP006 Preventive Services – Effective 1/1/2022
- CPCP016 Chiropractic Care Services – Effective 1/14/2022
- CPCP002 Inpatient/Outpatient Unbundling - Facility – Effective 1/14/2022
- CPCP004 Neonatal Intensive Care Unit (NICU) Level of Care Authorization and Reimbursement – Effective 1/14/2022
- CPCP017 Wasted/Discarded Drugs and Biologicals – Effective 1/14/2022
- CPCP018 Outpatient Facility and Hospital Claims: Revenue Codes Requiring CPT, HCPCS and/or NDC Codes – Effective 3/22/2022
- CPCP022 Pneumatic Compression Devices – Outpatient Use – Effective 04/12/2022
- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – Effective 04/15/2022

Claim Editing Enhancements Coming April 1, 2022

Effective **April 1, 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 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.

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

About the guidelines: BCBSTX will continue to follow claim payment policies that are global in scope, simple to understand and come from recognized sources, including:

- ICD-10 coding guidelines
- The Healthcare Common Procedure Coding System (HCPCS)
- Current Procedural Terminology (CPT®) codes as documented by the American Medical Association (AMA)
- Correct Coding Initiatives (CCI)
- Post-Operative Period Guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS)

Using these guidelines will help ensure a more accurate review of all claims.

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

- **Anatomical Modifiers** – CMS-defined anatomical modifiers validate the area or part of the body on which a procedure is performed. Procedure codes that do not specify right or left require an anatomical modifier. This includes procedures on fingers, toes, eyelids and coronary arteries which have specific CMS-defined modifiers.
- **Diagnosis Code Guidelines** - Use of correct ICD-10 codes will be verified. Use of ICD-10 clinical modification (CM) diagnosis coding guidelines, including reporting of inappropriate code pairs, as well as correct coding of secondary, manifestation, sequelae, chemotherapy administration, external causes and factors influencing health

status diagnoses. These guidelines are contained in the ICD-10-CM Diagnosis Codes Manual.

Reminder: these new enhancements follow a previous announcement for an edit that will go live Jan. 10, 2022. See the previous announcement.

More Information: View the Cotiviti, Inc Edit Descriptions for additional guidance. To edit or correct a denied claim, refer to the Claim Forms, Submissions, Responses and Adjustments section under Claims Filing Tips on our provider website. Watch News and Updates for future updates.

CLINICAL RESOURCES

Cervical and Breast Cancer Screenings

Regular screenings for cervical cancer and breast cancer play an important role in women's health. The new year is an opportunity to remind our members to schedule their screenings, since early detection is easier to treat.

Recommended Screenings

The U.S. Preventive Services Task Force recommends:

- Screening all women for cervical cancer starting at age 21
- Screening women ages 50 to 74 for breast cancer every two years—you may want to discuss the risks and benefits of starting screening mammograms before age 50.

See our preventive care guidelines for more information.

Closing Gaps in Care

Cervical Cancer Screening and Breast Cancer Screening are Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). We track data from HEDIS measures to help assess and improve the quality of our members' care.

For Cervical Cancer Screening National Committee for Quality Assurance (NCQA), NCQA measures the following:

- Women ages 21 to 64 who had cervical cytology performed within the last 3 years

- Women ages 30 to 64 who had either:
    - cervical high-risk human papillomavirus (hrHPV) testing within the last 5 years or
    - cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

Breast Cancer Screening assesses the percentage of women ages 50 to 74 who had at least one mammogram in the past two years.

See our quality improvement tip sheets for more information.

Tips to Consider:

- Talk with our members about risk reduction and prevention. We've created resources on cervical cancer and breast cancer screenings that may help.
- Document screenings in the medical record. Indicate the specific date and result.
- Document medical and surgical history in the medical record, including dates.
- Use correct diagnosis and procedure codes. Submit claims and encounter data in a timely manner.

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

Blue Cross Medicare Advantage℠ Prior Authorization Code Update Effective April 1, 2022

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

Changes effective **April 1, 2022** include:

- Addition of Lab codes to be reviewed by eviCore healthcare (eviCore)
- Addition of Specialty Drug codes to be reviewed by eviCore

- Addition of Medical Oncology codes to be reviewed by BCBSTX

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)SM and Blue Cross Medicare Advantage (HMO)SM page.

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.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan. 1, 2022 – Part 2

Review important benefit reminders, drug list changes, drug list updates and Utilization Management Program changes.

PRIOR AUTHORIZATION

Prior Authorization Code Update Effective 4/1/22 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).

Changes effective April 1, 2022, include the following codes reviewed by AIM Specialty Health® (AIM):

- Addition of Musculoskeletal codes
- Addition of Molecular Genetic Lab Testing codes
- Removal of one Musculoskeletal code
- Removal of Radiation Therapy/Radiation Oncology
- Addition of Advanced Imaging/Radiology

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**.

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.

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.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSTX. Change Healthcare is solely responsible for the software and all the contents. BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors such as Change Healthcare. If you have any questions about the products or services provided by such vendors, you should contact the vendor(s) directly.

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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.

Change Healthcare is an independent third-party vendor that is solely responsible for the products or services they offer. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendors. If you have any questions regarding the services they offer, you should contact the vendor directly.

Episource LLC is an independent third-party vendor that is solely responsible for the products or services they offer. BCBS FEP makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendor. If you have any questions regarding the services they offer, you should contact the vendor directly.

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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