BLUE REVIEW℠

A Provider Publication

MARCH 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.

It's Here! New Look for the BCBSTX Provider Website

Our provider website has a new streamlined design and should enhance your online experience of easily finding the information you need. Information is still in the sections you're used to seeing, such as:

- Network Participation
- Claims and Eligibility
- Education and Reference
- Clinical Resources
- Pharmacy
- Standards and Requirements

All Providers Will Now Display in Provider Finder®

In October, we told you about the Consolidated Appropriations Act (CAA) of 2021 and its requirements for provider directory information. One requirement is that **all our contracted providers must be listed** in our **Provider Finder**, including those who chose not to be displayed in the past.

What This Means for You

If you previously chose not to be listed in Provider Finder, your directory information will be displayed starting in February. Directory information includes name, location and hours, contact information, specialties, languages spoken, credentials, affiliations and whether you are accepting new patients. The address you've provided to us will be displayed.

To verify or update your information, you may use the Availity® **Provider Data Management** feature (preferred) or our Demographic Change Form. Facilities may only use the Demographic Change Form to verify and update information. **Under CAA, your provider directory information must be verified every 90 days**.

We won't accept changes by email, phone or fax to enable us to meet the two-day update requirement defined by CAA. Any demographic updates requested through these channels will be rejected and closed.

Learn more on our Verify and Update Your Information webpage.

New Laboratory Management Program & Related Clinical Payment and Coding Policies to Begin on May 1, 2022

You may have seen the communication that we delayed the launch of our new **Laboratory Benefit Management Program** with Avalon Health Solutions (Avalon). We delayed this launch because we required additional time to make improvements to the program.

Effective May 1, 2022, Blue Cross and Blue Shield of Texas (BCBSTX) will implement its new program with Avalon for claims for certain outpatient laboratory services provided to many of our **commercial** members. This implementation includes the posting of new **Clinical Payment and Coding Policies**. See below for key points to help you prepare.

The new program will:

- Help ensure our members have access to the right care at the right time and in the right setting
- Better prepare you to submit claims that support and reflect high quality, affordable care delivery to our members

Clinical Payment and Coding Policy Updates

Review the new and revised Clinical Payment and Coding Policies listed under **Lab Benefit**

Management Program posted to our provider website effective on **May 1, 2022**, related to certain laboratory services, tests and procedures.

Affected Claims

Our new program may include the following outpatient laboratory claims:

- Dates-of-service on **May 1, 2022**
- Performed in an outpatient setting (typically office, hospital outpatient or independent laboratory)

Note: Laboratory services provided in an emergency room, hospital observation or hospital inpatient settings are **excluded** from this program. Member coverage terms still apply.

Provider Resources
Beginning on **May 1, 2022**, you can get **free** access **24/7** to Avalon's **Trial Claim Advice Tool** by registering on Availity® Essentials. It will allow you to input laboratory procedure and diagnosis codes to see, before submitting a claim, the potential outcome of your claim.

- The Trial Claim Advice Tool does not guarantee approval, coverage, or reimbursement for health care services
- Potential claim outcomes provided by Avalon's Trial Claim Advice Tool consider information entered into the tool for the date of service entered, historical claims finalized through the prior business day and may link to applicable policies and/or guidelines

Provider Training
Attend free webinars on how to use the **Avalon Trial Claim Advice Tool** and learn more about the Laboratory Management Program. To register, select your preferred date and time from the list below:

- April 5, 2022, from 1 pm to 2 pm CDT
- April 12, 2022, from 1 pm to 2 pm CDT

For More Information: Watch News and Updates for future announcements.

CLAIMS & ELIGIBILITY

Technical and Professional Components
Modifiers 26 and TC: Modifier 26 denotes professional services for lab and radiological services. Modifier TC denotes a technical component for lab and radiological services. These modifiers should only be used in conjunction with the appropriate lab and radiological procedures. Note: When a health care provider performs both the technical and professional services for a lab or radiological procedure, he/she must submit the total service, not each individual service.

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:

- Evaluation and Management (E/M) Coding – Professional Provider Services – Effective 05/01/2022
- Laboratory Benefit Management Program (effective 05/01/2022) – Refer to the link for all Clinical Payment and Coding Policies related to this lab program

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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

Supporting Healthy Hearts

Heart disease and stroke are among the leading causes of death in the U.S., according to the Centers for Disease Control and Prevention (CDC). We encourage you to talk with our members about reducing and managing risks. We've created resources that may help, including information on high blood pressure and cholesterol.

Recommended Screenings

- The U.S. Preventive Services Task Force (USPSTF) recommends blood pressure checks for adults age 18 and older at every visit.
- The USPSTF recommends cholesterol screenings for adults ages 40 to 75. In addition, the American Heart Association recommends cholesterol screenings for adults ages 20 to 39 who have risk for coronary heart disease.

Closing Gaps in Care

We track data from quality measures to help assess and improve the quality of our members' care. Controlling High Blood Pressure and Statin Therapy for Patients with Cardiovascular Disease are Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA).

For **Controlling High Blood Pressure**, we measure the percentage of members ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled. NCQA defines controlling blood pressure as:

- Systolic blood pressure < 140 mmHg
- Diastolic blood pressure < 90 mmHg

Statin Therapy for Patients with Cardiovascular Disease tracks the percentage of male members ages 21 to 75 and female members ages 40 to 75 who:

- Have atherosclerotic cardiovascular disease, and
- Were dispensed at least one high- or moderate-intensity statin medication and remained on the medication for at least 80% of the treatment period

For more information, see our preventive care and clinical practice guidelines, and quality improvement tip sheets.

Tips to Consider:

- Talk with our members about taking medications as prescribed, smoking cessation, increasing physical activity, and eating a low-sodium diet.
- Encourage members to return for follow-up visits. Reach out to those who cancel or miss appointments and help them reschedule as soon as possible.
- Build care gap alerts in your electronic medical records as reminders.

Imaging Studies for Low Back Pain

Low back pain (LBP) is common, affecting about 75 percent of Americans at some time in their lives. The preferred conservative treatment for uncomplicated LBP is prescription-strength analgesics and physical therapy, according to the American Association of Neurological Surgeons.

Evidence doesn't support imaging for LBP within the first 28 days of diagnosis, according to the National Committee for Quality Assurance (NCQA). When not indicated, imaging may expose members unnecessarily to radiation and additional treatment. LBP improves for most people within two weeks of onset.

Supporting Quality Care

The Healthcare Effectiveness Data and Information Set (HEDIS®) from NCQA measures the appropriate use of diagnostic imaging studies, including X-rays, for LBP. We track data from HEDIS measures to help assess and improve our members' care.

The LBP measure captures **members ages 18 to 75 with a principal diagnosis of LBP who did not have an imaging study** (plain X-ray, MRI, or CT scan) within 28 days of the LBP diagnosis in the following care settings:

- Office visits, outpatient evaluations, telemedicine/telehealth visits, emergency department visits, and observation level of care

- Physical therapy and/or osteopathic and/or chiropractic manipulative treatment

A higher score indicates better performance.

Exclusions for Other Medical Concerns
Imaging within 28 days of diagnosis may be necessary if a member has other medical conditions, such as:

- Cancer
- Recent trauma
- IV drug use
- Neurologic impairment
- Human immunodeficiency virus (HIV)
- Spinal infection
- Major organ transplant
- Prolonged use of corticosteroids

Document the condition and appropriate code, when applicable, to exclude a member with LBP from the HEDIS measure. See HEDIS Measures and Technical Resources for more details.

EDUCATION & REFERENCE

Differential Diagnoses of Depression

Join us for a free one-hour webinar, **Differential Diagnoses of Depression: Assessment and Treatment**. We will offer the webinar twice:

- **Monday, March 7, 2022, at 8 a.m.** Central time
- **Wednesday, March 9, 2022, at 9 a.m.** Central time

Those who attend one of the sessions will earn one continuing medical education (CME) credit or continuing education unit (CEU).

The webinar will provide a high-level overview of depression and differential diagnoses, as well as assessment and treatment. This introductory training focuses on addressing depression in the primary care setting, with treatment options across various care settings.

How to Attend
Registration is required.

Future CME/CEU Offerings
Upcoming free webinars include:

- Diabetes and Mental Health, April 18 and April 20, 2022
- Substance Abuse: Coordinating Care and Improving Follow-up, May 16 and May 18, 2022

Watch News and Updates and our Provider Training page for information on training.

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.

MEDICARE ADVANTAGE PLANS

Closing Gaps in Care for Group Medicare Advantage Members

Through the Blue Cross and Blue Shield (BCBS) National Coordination of Care program, we can work with you to help close gaps in care for Blue Cross Group Medicare Advantage (PPO)℠ (Group MA PPO) members. These include Blue Cross and Blue Shield of Texas (BCBSTX) members with Group MA PPO coverage, as well as Group MA PPO members enrolled in other BCBS plans who are living in Texas.

What This Means for Medicare Providers
If we need medical records for Group MA PPO members, you will receive requests only from BCBSTX or our vendor, Change Healthcare. You won't receive requests from multiple BCBS plans or their vendors. 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® Essentials 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.

New Medicare Advantage Flex (PPO) Plan

The new Blue Cross Medicare Advantage Flex (PPO)℠ Plan allows BCBSTX members to visit any provider in the U.S. who accepts Medicare. Read through questions and answers about the plan and how it may affect your payments.

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2022 – Part 1

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

PRIOR AUTHORIZATION

Update to Prior Authorization Codes for Commercial Members

What's New: Due to updates from Blue Cross and Blue Shield of Texas (BCBSTX) Utilization Management or the American Medical Association (AMA), we are updating are prior authorization lists for some commercial members. These updates reflect new, replaced or removed codes.

Changes include:

- **Effective March 1, 2022 -** Replacement of Medical Oncology code J2505 with code J2506 reviewed by AIM Specialty Health® (AIM)

- **Effective April 1, 2022, removal of:**
    - Orthopedic Musculoskeletal codes previously reviewed by BCBSTX
    - Wound Care code previously reviewed by BCBSTX
    - Musculoskeletal Joint and Spine codes previously reviewed by AIM
    - Musculoskeletal Pain codes previously reviewed by AIM

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® Essentials 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.

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

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the member and their health care provider.

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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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