BLUE REVIEW℠

A Provider Publication

MAY 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.

Update: New BCBSTX Lab Policies and Laboratory Management Program with Avalon Postponed

The May 1 launch of our new lab policies and laboratory management program with Avalon Healthcare Solutions has been postponed. Please watch our News and Updates page for future updates about this program.

BEHAVIORAL HEALTH

Follow-Up Care for Substance Abuse Disorders

Alcohol-related deaths in the U.S. increased more than 25 percent during the first year of the COVID-19 pandemic, according to a recent report in the Journal of the American Medical Association. At the same time, more than 40 million people ages 12 and older in the U.S. needed treatment for substance abuse disorder, but only about 2.6 million received it, according to the latest survey by the Substance Abuse and Mental Health Services Administration. We encourage providers to talk with our members about the signs of substance abuse disorder and urge them to seek help, if appropriate.

Closing Care Gaps

As part of monitoring and improving quality of care, we track **two measures related to substance abuse**:

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

- Follow-up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Both are Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA).

What IET Measures
IET applies to members ages 13 and older with a new episode of alcohol or other drug abuse or dependence. The measure captures two stages of adequate and timely follow-up treatment:

- **Initiation of treatment,** one treatment within 14 days of the diagnosis
- **Engagement of treatment,** at least two additional treatment sessions within 34 days of the initiation appointment

Treatment may occur in an inpatient, residential, outpatient or telehealth setting or as medication-assisted treatment (MAT).

What FUA Measures
FUA applies to members ages 13 and older with a principal diagnosis of alcohol or other drug abuse or dependence during an emergency department (ED) visit. The measure captures rates for follow-up visits for alcohol or other drug abuse or dependence after an ED visit:

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

If the first follow-up visit is within seven days after discharge, both rates are counted for this measure.

Tips to Consider:

- Discuss with members the importance of timely follow-up visits.
- Use the same diagnosis for substance use at each follow-up.
- Coordinate care between behavioral health and primary care physicians. Share progress notes and include the diagnosis for substance use.
- Reach out to members who cancel appointments and help them reschedule as soon as possible.
- For FUA, ED providers can help members schedule an in-person or telehealth follow-up visit within seven days. Send ED discharge paperwork to the appropriate outpatient provider within 24 hours of discharge.

CLAIMS & ELIGIBILITY

Coding for Breast Augmentation and Removal for Gender Affirming Surgery

The American Medical Association (AMA) recently updated their guidance for the correct Current Procedural Terminology (CPT®) codes to use when filing claims for breast removal and breast augmentation as part of gender reassignment surgeries. Blue Cross and Blue Shield of Texas (BCBSTX) has updated its system to align with AMA and American Academy of Professional Coders (AAPC) billing guidance, as summarized below.

What's new: For gender affirming breast reduction and/or removal for transgender male and non-binary members, the AMA and AAPC guidance is to use CPT code 19318 for breast reduction/reduction mammaplasty. Claims should not be coded with 19303 for complete mastectomy +19350 for nipple/areola reconstruction.

Background: The AMA recommends the use of CPT code 19303 for the treatment or prevention of breast cancer. It recommends CPT code 19318 for reduction mammaplasty when breast tissue is removed for breast-size reduction and not for treatment or prevention of breast cancer.

The AAPC does not recommend the use of CPT code 19350 for nipple reconstruction in transmasculine gender reassignment. AAPC advises that CPT code 19318

may be used to reflect reshaping of the nipple for cosmetic purposes.

BCBSTX Resources

Refer to BCBSTX Medical Policy Gender Assignment Surgery and Gender Reassignment Surgery with Related Services SUR717.001 for more information.

CPT Category II Codes Can Help Close Care Gaps

Using the proper Current Procedural Terminology (CPT) Category II codes when filing claims can help streamline your administrative processes and ensure gaps in care are closed.

Read More

Advisory on Telemedicine/Telehealth Services – Place of Service (POS) Codes

What's changing: Blue Cross and Blue Shield of Texas (BCBSTX) has updated its telemedicine/telehealth commercial reimbursement guidelines due to recent updates by the Centers for Medicare & Medicaid Services (CMS).

CMS recently made updates to the telehealth POS codes:

- Adding POS 10 "Telehealth Provided in Patient's Home"
- Updating POS 02 from "Telehealth or Telemedicine" to "Telehealth Provided Other than in Patient's Home"

However, for BCBSTX claims, providers will need to continue using POS 02 with telehealth claims even when telehealth is provided in a patient's home. Claims using POS 10 may be rejected.

BCBSTX will notify you when POS 10 should be used for telehealth claims as appropriate.

The above POS code changes are intended to differentiate telehealth in the home as opposed to outside the patient's home. The POS 02 code changes do not impact the services covered.

This notification applies to our commercial member claims. For Medicare Advantage member claims, providers should follow CMS guidelines including using POS 10 and POS 02 appropriately.

More information: Continue to visit the News and Updates page on the provider website and the Blue Review newsletter for further updates regarding telemedicine/telehealth.

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 member (for Blue Advantage Plus point-of-service benefit plan) to an out-of-network provider for non-emergency services (when such services are 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 our provider website.

Also, 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.

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.

CLINICAL RESOURCES

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:

- CPCP006 Preventive Services Policy – Effective 04/01/2022
- CPCP034 Unbundling Policy – Professional Providers – Effective 04/11/2022
- CPCP021 Laboratory Panel Billing – Effective 04/14/2022
- CPCP023 Modifier Reference Policy – Effective 07/15/22

HEALTH & WELLNESS

Supporting Care During and After Pregnancy

For pregnant and postpartum women, care visits can set the stage for their and their infants' long-term well-being, according to the American College of Obstetricians and Gynecologists. We encourage you to discuss timely care with our members during and after pregnancy. Resources that may help include our Preventive Care Guidelines and Perinatal Wellness Guidelines.

Closing Care Gaps

Prenatal and Postpartum Care (PPC) is a quality measure developed by 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.

PPC measures the percentage of live-birth deliveries on or between Oct. 8 of the year before the measurement year and Oct. 7 of the measurement year. It captures:

- **Timeliness of prenatal care,** or the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with Blue Cross and Blue Shield of Texas
- **Postpartum care,** or the percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery

Tips to Consider to Close Care Gaps:

- Discuss with members that it's important to attend all visits.
- Schedule initial prenatal visits in the first 12 weeks of pregnancy with an OB/GYN, primary care physician (PCP) or another prenatal practitioner.
- Be aware that post-operative visits after a Cesarean section within a couple of days of discharge or during an inpatient stay don't count as a postpartum visit. A postpartum visit must take place on or between seven and 84 days after delivery. It should be scheduled during the Cesarean section post-op visit.
- Data for this measure is collected from claims and chart review, with services being performed by an OB/GYN, midwife, family practitioner or other PCP:
    - **When documenting a prenatal visit**, include diagnosis of pregnancy, last menstrual period or estimated date of delivery, prenatal risk assessment, complete obstetrical history, fetal heart tone and screening tests. Telehealth visits can be considered in meeting this requirement.
    - **When documenting a postpartum visit**, notate postpartum care, check or six-week check. Document the pelvic exam and evaluation of weight, blood pressure, breasts, and abdomen.

MEDICARE ADVANTAGE PLANS

Update to Prior Authorization Codes for Medicare Advantage Members, Effective July 1, 2022

We are changing the prior authorization requirements for Blue Cross Medicare Advantage[SM] members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA) effective July 1, 2022.

What's Changing:

- Addition of one Outpatient Sleep code to be reviewed by eviCore® healthcare (eviCore)
- Addition of two Outpatient Specialty Drug codes to be reviewed by eviCore

- Addition of Outpatient Specialty Drug, **Susvimo**, reported with codes **J3590 or C9399** to be reviewed by eviCore
- Addition of Outpatient Specialty Drugs, **Cortophin and Vyvgart** reported with codes **J3490, J3590, or C9399** to be reviewed by eviCore

Refer to the Utilization Management section of our provider website for access to the **Prior Authorization Lists.** 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.

Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM Annual Health Assessment (AHA) Incentive FAQs – 2022

Review FAQs regarding this year's AHA incentive, such as who is eligible and how the incentive works.
Read More

PHARMACY

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

Based on the availability of new prescription medications and Prime's National Pharmacy and Therapeutics Committee's review of changes in the pharmaceuticals market, some additions (new to coverage) and/or coverage tier changes (drugs moved to a lower out-of-pocket payment level) will be made to our drug lists. Your patients may ask you about therapeutic or lower cost alternatives if their medication is affected by one of these changes.
Read More

STANDARDS & REQUIREMENTS

Patient Appointment Access Standards

Providers are required to follow these Blue Cross and Blue Shield of Texas Patient Access Standards:

ACCESS MEASURE	PATIENT ACCESS STANDARD
Initial New Patient Visit	Within 30 days of request
Preventive Care by Primary Care Provider (Annual physical)	Within 30 days of request
Routine Primary Care	Within 5 days of request
Urgent Care	Within 24 hours of request
Emergency Care • During Office Hours • After Office Hours	Immediate
After Hours Care • Urgent Care • Alternative Care	24 Hours per day, 7 days a week
In Office Wait Time	Within 30 minutes of appointment time
High Impact***** or High-Volume Specialists****** • Urgent Care • Routine Care	• Within 5 days of request • Within 21 days of request

***High Impact Specialists**: Practitioner types who treat conditions with high mortality or morbidity rates where treatment requires significant resources comprised of, but not limited to, the following:

- Neurology
- Oncology

****High Volume Specialists**: Practitioner types as determined by annual high-volume report are comprised of, but not limited to, the following:

- Obstetrics/Gynecology
- Cardiovascular Disease
- Orthopedic Surgery
- Psychiatry
- Psychology

- Licensed Professional Counselors (LPC)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Medical Social Workers- Advanced Clinical Practice (LMSW-ACP)

More Information: Refer to the Quality Improvement sections of our Provider Manuals.

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.

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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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