BLUE REVIEW℠
A Provider Publication

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NOTICES & ANNOUNCEMENTS

MyBlue Health℠ Network Expansion

Blue Cross and Blue Shield of Texas (BCBSTX) is expanding the MyBlue Health network, effective Jan. 1, 2023, for Cameron and Hidalgo (The Valley Service Area), Collin, Denton, and Tarrant (Dallas Service Area), and El Paso counties.

MyBlue Health members in these areas will access care through providers contracted in the MyBlue Health network. Note these additional counties have no impact on the current MyBlue Health network benefits applicable to Dallas and Harris counties effective as of Jan. 1, 2020, and Bexar, Travis, and Williamson counties as of Jan. 1, 2022.

MyBlue Health members must choose a Primary Care Physician (PCP). Members can choose a family practitioner, internist, pediatrician, physician assistant (PA) or advanced practice registered nurse (APN), and/or obstetrician/gynecologist as their PCP.

In Cameron and Hidalgo (The Valley Service Area), Collin, Denton, and Tarrant (Dallas Service Area), and El Paso counties, some MyBlue Health members may choose a MyBlue Health Select PCP* within the following practice groups which may result in a lower copayment for scheduled PCP office visits as indicated in their schedule of copayments and benefit limit:

Cameron County	Su Clinica Familiar and BHS Physicians Network
Hidalgo County	South Texas Health System Clinic and BHS Physicians Network
Collin, Denton, & Tarrant	VMD Primary Providers North Texas
El Paso County	BHS Physicians Network, Centro De Salud Familiar La Fe Inc, and Project Vida Health Center

*Depending on the plan, some MyBlue Health members may choose a MyBlue Health Select PCP based on their benefits.

Members covered by MyBlue Health can be identified through their BCBSTX ID card:

- **MyBlue Health** is displayed on the ID card.
- MyBlue Health members have a unique network ID: **BFT**
- The 3-character prefix is on the ID card: **T2G**

Patient eligibility and benefits should be checked prior to every scheduled appointment through the Availity Essentials Provider Portal® or your preferred web vendor. Eligibility and benefit quotes include participant confirmation, coverage status and other important information, such as applicable copayment, coinsurance, and deductible amounts. It's strongly recommended that providers ask to see the participant's ID card for current information and photo ID at every visit to guard against medical identity theft. When services may not be covered, participants should be notified they may be billed directly.

If you have any questions, please contact your Network Management Representative. Additional information regarding MyBlue Health will be available in future Blue Review and on our provider website.

UT CARE™ Medicare PPO

As a reminder, on Jan. 1, 2023, approximately 30,000 retirees from the University of Texas System (UTS) will become members of UT CARE Medicare PPO (UT CARE). UT CARE is our open access Medicare Advantage PPO plan for UTS retirees. Read more.

BEHAVIORAL HEALTH

Diabetes and Depression

Diabetics are at risk of developing several psychological conditions. Approximately 40% of people living with diabetes struggle with their mental wellbeing (Kalra, 2018). The demands of diabetes often lead to depression, and studies show there is a bidirectional relationship between diabetes and depression.

Depressive disorders are common mental disorders, and they occur two to three times more often in people with diabetes mellitus but only 25% to 50% get diagnosed and treated (CDC, 2018). Depression and diabetes represent the 4th and 8th causes of disability separately, and disability occurs up to two to three times higher in people with diabetes and depression (ADA, 2019). There are numerous considerations for people living with diabetes, such as medication management, managing multiple comorbidities, and monitoring their blood glucose. This balancing act and continually changing environment can negatively affect their emotional wellbeing. As diabetes self-management can be complicated, a multifaceted approach must optimize treatment and offset the adverse risks. The timely diagnosis and treatment of depression may improve members' quality of life and increase their social participation. People who adhere to their antidepressants have better diabetes outcomes and quality of life than those with poor adherence (Science Daily, 2021).

How You Can Help

Help empower your patients to manage their own care. Some things to consider:

- Patients with diabetes may feel more comfortable discussing depression and other psychological pressures with a primary care provider instead of a mental health specialist.
- Medication reviews and counseling on medication changes should be a part of every encounter.
- Identify patients with psychological and emotional needs, ask them about their emotional wellbeing, and use a validated screening tool.
- Discuss treatment options and plan next steps together.
- If you refer to a psychiatrist, psychologist, or other community mental health provider let the patient know you will coordinate care and remain active in their depression treatment.
- You can also provide the patient with structured depression education and set goals during your appointments.

Source:

C. (2018, August 06). Diabetes and Mental Health. Retrieved September 22, 202, page last reviewed September 30 2022, https://www.cdc.gov/diabetes/managing/mental-health.html

Kalra, S., Jena, B., & Yeravdekar, R. (2018). Emotional and Psychological Needs of People with Diabetes. Retrieved September 29, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6166557/

Riddle, M., M.D. (2019, January). Diabetes Care. Retrieved from https://care.diabetesjournals.org/content/diacare/suppl/2018/12/17/42.Supplement_1.DC1/DC_42_S1_2019_UPDATED.pdf

The Endocrine Society. "Antidepressants may improve outcomes in people with diabetes and depression." ScienceDaily. ScienceDaily, 14 July 2021. <www.sciencedaily.com/releases/2021/07/210714131927.htm>.

Provider Depression Disorder Prescribing

Screening and Treatment

The National Institute of Health (NIH) estimated 21 million American adults, or 8.4% of the adult population, have had at least one depressive episode (NIH, 2022). Depression may adversely affect treatment and create barriers to management of other chronic medical conditions. Patient outcomes can improve when patients are assessed for symptoms, screened for depression, and receive treatment. Screening should utilize evidence-based screening tools to ensure accurate diagnosis, efficient treatment, and appropriate follow-up.

After a positive depression screening, providers should discuss screening results with patients and provide an individualized, evidence-based treatment plan. The plan should include a follow-up assessment and support for medication adherence and referral to a behavioral health provider when needed. Depression is remarkably responsive to antidepressant therapy, but only if the patient receives appropriate treatment in a timely manner. Proper treatment of depression has been proven to effectively reduce symptoms, decrease the risk of relapse, emergency department visits, and hospitalization rates (Simon, M.D., 2019).

Treating Depression with Telemedicine

Telehealth has been used in clinical settings for over 60 years and telehealth visits for mental health increased by 556 percent between March 11 and April 22, 2020, primarily due to the COVID-19 pandemic (SAMHSA, 2021). Antidepressant therapy treatments delivered through telehealth have been shown to improve health outcomes, recovery, crisis support, and Medication-Assisted Treatment (MAT) across diverse behavioral health and primary care settings because it makes services more accessible and convenient. Leveraging telemedicine for mental health may allow an otherwise reluctant member to receive desperately needed care, reduce health disparities, and resolve treatment gaps.

Reference

https://www.nimh.nih.gov/health/statistics/major-depression

- An estimated 21.0 million adults in the United States had at least one major depressive episode. This number represented 8.4% of all U.S. adults.

Simon, M.D., 2019

SAMHSA, 2021

CLINICAL RESOURCES

Kidney Health Evaluation for Patients with Diabetes

We collect clinical data from our providers to measure and improve the quality of care our members receive. Kidney Health Evaluation for Patients with Diabetes (KED) is one aspect of care we measure in our quality programs. KED tracks members ages 18 to 85 with diabetes (type 1 or type 2) who received an annual kidney health evaluation. An evaluation is defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year. The uACR is identified by the member having both a quantitative urine albumin test and a urine creatinine test with service dates four or less days apart.

Tips to Consider

- Identify care gaps and schedule lab tests before office visits to review results and adjust treatment plans if needed.
- Discuss the importance that regular kidney health evaluations (KED) include both blood and urine tests with members.
- Lab orders should include eGFR **AND** uACR; easy for lab tech to have member provide a urine specimen.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.
- Submit claims and encounter data in a timely manner.

Resources

- Kidney Health Evaluation for Patients with Diabetes
- Preventative Care Guidelines

- Clinical Practice Guidelines

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 were added or updated:

- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services Update – Effective 1/1/2023

EDUCATION & REFERENCE

Continuity of Care is Driven by Prompt Communication Upon Hospital Discharge

Discharge summaries are critical to primary care providers (PCPs) as a key source of reference about the most up to date care their patients receive following their inpatient hospital stays. The hospital discharge summary is the key source for this information to support the continuity of care for all members. Blue Cross Blue Shield of Texas (BCBSTX) Provider satisfaction survey results from PCPs and Specialists are audited annually to note the receipt of timely hospital discharge summaries and those providers who are not receiving them. It is important to communicate timely and ensure continuity of care for our members, their family, and the transition home or the next level of treatment. The discharge summary is not only used to improve coordination and quality of care, but ultimately to reduce the number of preventable readmissions.

We want to remind you about some important information to help you when discharging Federal Employee Program® (FEP®) members after inpatient hospital stays. Use of Electronic Health Records (EHRs), including wider acceptance of member portals, when available, ensures smooth flow of information from hospital to the member's next level of care. Supporting the member's transition includes providing culturally appropriate member instructions, medication reconciliation and educating caregivers.

Studies have shown that providing timely, structured discharge summaries to PCPs helps reduce readmission rates, improves patient satisfaction, and provides an updated medication summary upon discharge, which all support continuity of care. One study found that, at discharge, approximately 40 percent of patients typically have test results pending and 10 percent of those results require action. PCPs and patients may be unaware of these results.[1,3] This demonstrates the need for timely discharge summaries after hospitalization for both members and providers.
A prospective cohort study found that one in five patients discharged from the hospital to their homes experienced an adverse event (defined as an injury resulting from medical management

rather than from the underlying disease) within three weeks of discharge. This study found 66 percent of these were drug-related adverse events.[2,3]

As a reminder, please include the following information in every discharge summary:

- Course of treatment
- Diagnostic test results Follow-up plans
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes and most commonly known side effects

Communication between the inpatient medical team and the PCP helps ensure continuity and a smooth transition of the FEP patient to the next level of care. FEP Case Management staff also are available to work with members and providers and collaborate with the medical team while inpatient and post discharge to facilitate and reinforce discharge planning instruction. BCBSTX and FEP applaud PCPs who have adopted the best practice of utilizing written discharge summaries along with medication reconciliation from their inpatient admission.

[1]Roy CL, Poon EG, Karson AS, et al. Patient safety concerns arising from test results that return after hospital discharge. Ann Intern Med. 2005;143(2):121–8.

[2]Forster AJ, Murff HJ, Peterson JF, et al. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–7.

[3]Snow, V., MD. (2009). Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine. Journal of Hospital Medicine, 4(6), 364-370. doi:10.1002

Keeping an Eye on Improved Provider Collaboration

We appreciate the care and services you provide to our Federal Employee Program® (FEP®) members. This article pertains to care/services provided to our FEP members and to encourage communication and coordination of care between primary care providers (PCPs) and eye care specialists.

Many PCPs refer our members with diabetes to eye care specialists for annual eye examinations. PCPs benefit from receiving communication from their patients' eye care specialists. We want to encourage eye care specialists who do not routinely or promptly share results to consider doing so. For your reference, the following is a summary of the American Diabetes Association's (ADA) screening recommendations for patients with diabetes.[1]Diabetic annual eye exams remain an American Diabetes Association (ADA) recommended element in the treatment of patients with diabetes. Members may be hesitant or have difficulty getting or adhering to their annual exam, so reminders from their PCPs and eye care specialists can be beneficial to improve compliance.

Screening:	• Comprehensive evaluation by an eye care specialist should not be substituted by retinal photography.

	Exception: For screening purposes, retinal photography with remote reading by a retinal specialist is acceptable where eye care professionals are not readily available.
Routine Exams:	• Annually or every two years in the absence of retinopathy • Annually in the presence of retinopathy • At more frequent intervals in the presence of progressive retinopathy and/or deterioration of vision due to disease progression
Initial Exam:	• Within five years of diagnosis for adults who have Type 1 diabetes • At the time of diagnosis for adults with Type 2 diabetes
Pregnancy:	• For women who are planning to be or are pregnant and who also have diabetes, educate about the risk of diabetic retinopathy developing or progressing • Perform an eye exam prior to or at the time of diagnosis of pregnancy, or in the first trimester in patients with preexisting type 1 or type 2 diabetes, and then patients should be monitored every trimester and for 1year post-partum as indicated by the degree of retinopathy

To help improve patient outcomes, please consider the following:

- Incorporate ADA recommendations into practice
- Gather patient historical information
- Educate your patients
- Ensure diabetic eye exam results are made available to the members' PCP
- Remind your diabetic patients to contact the number on their member ID card if they have any questions about their health care coverage details.

We thank our primary care providers and eye care specialist for collaborating and supporting the ongoing health and wellness of our FEP members. Working together, we can help support improved continuity of care and health outcomes by ensuring prompt communication for annual eye exam for all FEP members with diabetes.

[1]American Diabetes Association Professional Practice Committee; 12. Retinopathy, Neuropathy, and Foot Care: Standards of Medical Care in Diabetes—2022. Diabetes Care 1 January 2022; 45 (Supplement_1): S185–S194. https://doi.org/10.2337/dc22-S012

HEALTH & WELLNESS

To support quality care, we provide information to providers and members to encourage discussions on health topics. Watch for more on health care quality in our website's News and Updates section and on our Wellness Can't Wait web page.

Diabetes Screening for People Using Antipsychotic Medications

People with serious mental illness who use antipsychotic medications are at increased risk of diabetes, according to the National Committee for Quality Assurance (NCQA). **Regular screening for diabetes is important** for detecting, monitoring and the treatment of the disease.

The NCQA quality measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) tracks the number of people 18 to 64 years old who had an **annual diabetes screening**. We track SSD and other Healthcare Effectiveness Data and Information Set (HEDIS®) measures to help assess and improve our members' care.

Tips to Help Close Gaps in Care

- Order an annual diabetes screening test, such as a **glucose or HgbA1c test**, for our members with schizophrenia or bipolar disorder who are using antipsychotic medications.
- Build care gap alerts for screening tests in your electronic medical records. Reach out to our members who cancel appointments and help them reschedule as soon as possible.
- Encourage shared decision-making by educating members and caregivers about:
    - Increased risk of diabetes with antipsychotics
    - Importance of screening for diabetes
    - Diabetes symptoms

We've created resources for members about diabetes that may help.

- **Coordinate care** between behavioral health and primary care physicians (PCPs) by requesting test results, communicating about test results, or scheduling an appointment for testing.
- For members who don't have regular contact with their PCP, behavioral health practitioners may order diabetes screening tests and communicate the results to the PCP.

Importance of Early and Timely Intervention for Pre- and Post-Partum Care to Help Improve Health Outcomes

The following article provides information about the importance of communication between health care professionals and their patients and care documentation during a patient's pre-pregnancy, pregnancy, and postpartum medical journey. Federal Employee Program ® (FEP®) members should be encouraged to establish early appointments for prenatal care. Providers should be notified immediately at time of discharge to facilitate the timely scheduling of post-partum exams. This ensures continuity of care and to inform the member of next steps. This is an ongoing process, not a one-time follow-up encounter.

Post-partum visits are recommended to be scheduled before discharge from the hospital. Written and/or electronic instruction is beneficial to the health of the member and the child. Coordination of

care is best achieved when providers help members anticipate and follow through with transitions of care and between settings. When providing care, please document the following information in the patient's chart to help ensure effective coordination and continuity of care[1]:

Prenatal Visit in First Trimester

- Prenatal risk assessment, including the diagnosis of pregnancy, complete medical and obstetrical history, and physical exam as referenced in the American College of Obstetrics and Gynecology (ACOG) Form
- Prenatal lab reports Ultrasound, estimated date of delivery (EDD)
- Documentation of prenatal risk and education/counseling

Post Postpartum

- Documentation of a postpartum visit on or between 7 to 84 days after delivery. Postpartum office visit progress notation that documents comprehensive postpartum exam which may include an evaluation of weight, blood pressure, breast exam, abdominal exam, and pelvic exam.
- Best practice supports provider staff calling member within one week after delivery to schedule postpartum follow-up visit.

Thank you for your help supporting continuity of care and improved quality outcomes for our members.

[1]Prenatal and postpartum care (PPC). NCQA. Retrieved September 6, 2022

MEDICARE ADVANTAGE PLANS

Chiropractor Medicare Physician Fee Schedule Increase for Medicare Advantage PPO℠

Effective Jan. 1, 2023, we will implement an increase in the maximum allowable fee schedule for some procedure codes. Read More.

Update Prior Authorization Codes for Medicare AdvantageSM, Effective January 1, 2023

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare Advantage members to reflect new, replaced or removed codes due to updates from Utilization Management prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) changes from the Centers for Medicaid & Medicare Services.

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 effective Jan. 1, 2023, include:

- Addition of Sleep drug codes to be reviewed by eviCore
- Addition of a Radiation Oncology code to be reviewed by eviCore
- Addition of Specialty Drug codes to be reviewed by eviCore
- Addition of prior authorization codes to be reviewed by BCBSTX
- Removal of prior authorization codes previously reviewed by BCBSTX

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 Oct. 1, 2022 – Part 2

Review important pharmacy benefit reminders, drug list updates and Utilization Management program changes. Read More.

PRIOR AUTHORIZATION

Prior Authorization Exemption Status via Availity® Essentials

On Sept. 12, 2022, Blue Cross and Blue Shield of Texas (BCBSTX) shared information regarding our implementation of Texas House Bill 3459 for Prior Authorization (PA) Exemption(s).

As a reminder, providers who have met the criteria to be reviewed for a Prior Authorization (PA) Exemption(s) for particular services will be able to quickly check online via Availity for their exemption status on or before to Oct. 1, 2022. This includes services that received PA exemptions managed by* BCBSTX Medical Management, Kelsey-Seybold, AIM Specialty Health® or Magellan.

* Prior authorization exemption status for prior authorizations managed by a Pharmacy Benefit Manager (PBM) may be conveyed by the PBM.

Checking Exemption Status Via Availity
You can access the **Prior Authorization Exemption Status Viewer** application in our BCBSTX-branded Availity Payer Spaces to determine the services you may have qualified for an PA exemption as follows:

1. Log into Availity Essentials
2. Select **Payer Spaces** from the navigation menu and choose **BCBSTX**
3. Select **Prior Authorization Exemption Status Viewer** from the Applications tab
4. Enter the required data elements and select Submit

The response will provide a link to the PA exemption status letter for your provider
Watch our provider website for the **Prior Authorization Exemption Status User Guide.** If you not currently registered for Aviality you can do so at no charge on Availity Essentials or by contacting Availity Client Services at **1-800-282-4548** to get access.

If you have notified BCBSTX your preference of receiving your notice by email or mail, you will also receive it by the method requested. If you are not currently registered for Availity, you will receive a mailed copy. All providers still have the option of also viewing it in Availity.

More Information
Please check our Prior Authorization Exemption page.

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 coverageapplicable on the date services were rendered.

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, limitationsand 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 independentcompany that provides utilization review for select health care services on behalf of BCBSTX.CPT copyright 2021 American Medical Association (AMA). All rights reserved. CPT is a registeredtrademark of the AMA.

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.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Primeto 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 orservices they offer.

BCBSTX makes no endorsement, representations or warranties regarding any products or services provided by third party vendors

HEDIS is a registered trademark of NCQA.

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 certificateof 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.

Members should refer to their certificate of coverage for more details, including benefits, limitationsand exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

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