BLUE REVIEW℠
A Provider Publication

OCTOBER 2022

NOTICES & ANNOUNCEMENTS

UT CARE™ Medicare PPO

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

Earn Continuing Education Credit through Webinar on Suicide Prevention

Join us for a one-hour webinar, **Suicide Prevention with the Military Community**, on **Thursday, Nov. 3, 2022**, at **9 a.m.** CT. It is free to providers.

Those who attend will earn one continuing medical education credit (CME) or continuing education unit (CEU). **Register here to attend.**

Psychologist R. Blake Chaffee, PhD, and psychiatrist and internist Brooke Parish, MD, will lead the webinar. They will provide a high-level overview of suicide within the military community. They'll discuss behavioral health conditions impacting veterans and strategies for intervention and treatment.

This introductory training will focus on:

- Clinical considerations when working with veterans
- Screening for behavioral health conditions
- Strategies for addressing suicide ideation with veterans
- Suicide prevention resources

Other Continuing Education Credits

Recordings of our previous 2022 webinars are available online. Sign in (registration required) to view the following free webinars and earn CME/CEU credit:

- Differential Diagnoses of Depression: Assessment and Treatment
- Diabetes and Behavioral Health
- Substance Abuse: Coordinating Care and Improving Follow-Up

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

New 'Message This Payer' Option via Availity® Essentials

We are launching a new digital *Message This Payer* option for you to resolve your claim inquiries online! Starting Oct. 3, 2022, providers can use this convenient electronic method to send secure messages to Blue Cross and Blue Shield of Texas (BCBSTX) for claim management questions.

How to Access Message This Payer:

- Log in to Availity Essentials
- Select Claims & Payments from the navigation menu
- Perform a Claim Status transaction using the *Member* or *Claim number* rch options
- Click *Message this Payer* at the top of the claim status results

Note: *Availity Administrator must assign the "Messaging App" role for users to gain access to this tool.*

Using this option will allow you the opportunity to…

- Initiate a message to BCBSTX from the Claim Status tool
- Receive a response within two business days from a BCBSTX associate
- Monitor message status via a dashboard view
- View and print conversations

For More Information

Refer to the instructional **Message This Payer User Guide** found in the Provider Tools section of our website. If you need further assistance, you can email our Provider Education Consultants.

Don't have an Availity Essentials account?

You can register today by going to Availity or contact Availity Client Services at 800-282-4548.

This information is not applicable to Medicare Advantage or Texas Medicaid claims.

Submitting Unlisted or Miscellaneous Codes: Billing Guidelines and Reminders

When billing with unlisted or miscellaneous codes on claims submitted to Blue Cross and Blue Shield of Texas (BCBSTX), you can avoid additional documentation requests for unlisted or miscellaneous codes by describing the specific drug, service, supply or procedure provided. This will help avoid processing delays or denials, and unnecessary requests for medical records and/or supporting documentation.

What are unlisted or miscellaneous codes?

These are codes labeled as Non-Specified, Not Listed, Not Elsewhere Specified (NEC), Not Otherwise Classified (NOC), Not Otherwise Specified (NOS), Unclassified, Unlisted, or Unspecified.

Pre-Service Review

Some unlisted or miscellaneous codes could require prior authorization to determine coverage and benefits. Be sure to check eligibility and benefits via Availity® Essentials or your preferred electronic vendor to confirm prior authorization requirements and vendors, if applicable. 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.

If you submit a prior authorization or predetermination request that includes an **unlisted** or **miscellaneous code**, be sure to **include a detailed description** of the service. along with any documentation to support your request. This step helps avoid the need for post-service medical necessity review.

Refer to our Utilization Management section for more information, such as how to submit electronic requests for prior authorization and predetermination.

Claim Filing

Claims submitted with an unlisted or miscellaneous code without a description are typically denied for lack of supporting documentation. Get your claims processed faster by submitting a pre-service request as noted above and/or including a description of the specific drug, service, supply or procedure on your claim.

When using unlisted or miscellaneous codes on claims for all BCBSTX members:

- Use the most specific unlisted code that's available if a code doesn't exist that accurately describes the drug, service, supply or procedure.
- Describe the service and include documentation when submitting claims with codes that are identified as "unlisted" or "miscellaneous."

More Information: Learn more about filing claims in the Claims and Eligibility section of our provider website. Also, refer to the current Unlisted/Not Otherwise Classified (NOC) Coding Policy on the Clinical Payment and Coding Policy page.

ClaimsXten™ Quarterly Update Effective Dec. 5, 2022

Blue Cross and Blue Shield of Texas (BCBSTX) will implement its fourth quarter code update for the ClaimsXten auditing tool on or after Dec. 5, 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

Antidepressant Medical Management

Major Depression is one of the most common mental illnesses effecting more than 20 million American adults each year. [1] Approximately, 60% of those treated for depression are cared for by Primary Care Physicians (PCPs) who prescribe almost 80% of their patients' antidepressants. [2] Many patients who are prescribed antidepressants do not take their medication as prescribed. Commonly referred to as non-adherence, this can be caused by many factors such as patient beliefs, illness characteristics, social context, access, and service issues. Barriers to adherence can include stigma, lack of understanding how the drug works, inadequate knowledge of the drug, fear of side effects or dependence, cost, and access. [3]

Despite the demand placed on PCPs to treat depression, some practitioners may need resources to help them educate patients on the importance of medication adherence. A checklist can be a valuable tool to help practitioners improve adherence with thorough patient education,

opportunities for shared decision-making, and emphasizing the importance of follow-up appointments. [4]

Checklist to improve patient education and shared decision-making:
1. Confirm the diagnosis and explain to the patient that it is a biological and treatable disorder. Include examples of symptomology the patient reported.

2. Discuss any recommendation for pharmacological treatment based on the severity of symptoms, previous depressive episodes, current situation etc. Discuss patient expectations for medication.

3. Include the patient in the selection of an antidepressant and explain why one may be more effective than another based on age, gender, previous experiences, medical and psychiatric comorbidities.

4. Once a medication is chosen, explain to the patient:
- How the medication works, its advantages, and how to use it safely
- It may take three to four weeks for the medication to have a noticeable impact on mood
- How long treatment will last
- Potential side effects, how long they usually last, and when to reach out with concerns
- Dosage, scheduling and compliance recommendations
- Lifestyle changes that need to be made such as avoiding caffeine and alcohol or increasing physical activity.

Additional Resources:
- Behavioral Health Clinical Practice Guidelines 2021-2022
- Antidepressant Medication Management HEDIS Tip Sheet
- Link to Provider Educational Webinar Information
- Check out our AMM Provider Packet for printable member fliers on Medication Adherence, Using Medications Safely, and Talking with Your Pharmacist
- American Medical Association

Addressing Disparities in Breast Cancer for Black Women

Breast cancer is one of the most common cancers among women in the U.S. About 1 in 8 women will be diagnosed with breast cancer at some point in their life. According to the American Cancer Society, **breast cancer disproportionately affects Black women**. They are more likely to:
- Have breast cancer diagnosed at a younger age and an advanced stage.
- Die from breast cancer than any other racial and ethnic group. While white women get breast cancer at a slightly higher rate, Black women have a 40% higher mortality rate than white women.
- Have triple negative breast cancers, which are aggressive cancers with a poor prognosis.

Non-medical drivers of health, such as education levels and poverty, are also linked to different breast cancer outcomes. Mortality rates are higher among women with less education, according to the Kaiser Family Foundation, and low socioeconomic status is linked to inconsistent access to care. See our Health Equity and Social Determinants of Health page for more information on health equity.

How You Can Help

The U.S. Preventive Services Task Force recommends that women ages 50 to 74 be screened for breast cancer every two years.

- Talk with our members about the importance of regular screening for women and the unique risks and barriers faced by Black women. We've created information for members that may help. You may want to discuss with members the risks and benefits of starting screening mammograms before age 50. See our preventive care guidelines on breast cancer screening.
- Partner with mammogram facilities to ensure members with referrals complete their mammogram.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Follow up with members if they miss their appointment and help them reschedule.

Ensure that screenings and results are documented in the member's electronic medical record. This helps us monitor and improve our members' care by tracking their progress on Breast Cancer Screening. This quality measure from the National Committee for Quality Assurance **tracks women ages 50 to 74 who had at least one mammogram in the past two years.** As we learn about gaps in care, we can reach out to members who haven't had their screening and help address barriers to screening.

For members who need language assistance, let them know we offer help and information in their language at no cost. To speak to an interpreter, members may call the customer service number on their member ID card.

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:

- CPCP006 Preventive Services Policy – Effective 09/01/2022
- CPCP035 Unlisted/Not Otherwise Classified (NOC) Coding Policy – Effective 9/20/2022
- CPCP029 Medical Record Documentation – Effective 12/26/2022

Utilization Management Decisions

We are dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management (UM) determinations are made by licensed clinical personnel based on the:

- benefits policy (coverage) of a member's health plan,
- evidence-based medical policies and medical necessity criteria, and the
- medical necessity of care and service.

All UM decisions are based on appropriateness of care and service and existence of coverage. We prohibit decisions based on financial incentives, nor do we specifically reward practitioners or clinicians for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

The criteria used for UM determinations are available upon request by calling the customer service or health advocate number on the back of the member's ID card.

EDUCATION & REFERENCE

Educational Webinar Sessions

We've added additional trainings to our Educational Webinar Sessions webpage. Complimentary training opportunities include:

- AIM ProviderPortal℠ Training for Prior Authorizations
- Authorizations & Referrals via Availity Essentials
- Availity Essentials Orientation – Save Time and Go Online
- Behavioral Health – Free CME/CEU Webinars

Read More

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.

Health Equity and Social Determinants of Health: New Resources for Providers

Health inequities persist even among those who get their health care coverage through work, according to this recent study. To help close these gaps in care, we are expanding our efforts to address health equity and social determinants of health.

We have a new Health Equity and Social Determinants of Health webpage dedicated to improving access to care for all our members including what it is, how we're helping address it and what you can do to help.

One example of our efforts is through the Caring Foundation of Texas (CFT) Care Van® Program. Blue Cross and Blue Shield of Texas (BCBSTX) is the lead sponsor of the Care Van program. We support a fleet of vans that bring public health services to children in schools, community events and other locations. Services include immunizations, dental sealants, vision and hearing screenings and health literacy. Services are provided at no cost to under and uninsured populations. Learn more here.

More information: Check out our new Health Equity and Social Determinants of Health (SDoH) web page on the provider website to learn more about our programs for members in need.

Well onTarget Resources Reminder For Your Patients

Well onTarget offers a digital well-being experience, health coaching, and a fitness program to some Blue Cross Blue Shield of Texas members. While you care for your patients, it empowers them to reach their wellness goals and share their **Healthcare Provider Reports** with you as they utilize the following resources:

- The Well onTarget Member Wellness Portal
- Offers an engaging online member experience promoting success through a range of interactive, educational features, supporting members in their quest for learning, while promoting personal accountability.

Key Features:

- **Health Assessment (HA):** Provides a series of member questions allowing them to learn more personal tips for healthier lifestyles and options to share their personal wellness report with you.
- **Self-Management Programs:** Access to a broad range of educational content from (articles to podcasts). These programs let members work at their own pace to reach their health goals. Topics available include nutrition, fitness, losing weight, quitting smoking, managing stress and many more. Members are able to track their progress as they make their way through each lesson.
- **Wellness Challenges:** Members are able to join challenges to help them meet their wellness goals. Tools & trackers are also available to help keep them on course.

- **Fitness & Nutrition Tracking:** Device integration is available to support tracking of wellness goals.
- **Health Coaching:** Professionally certified coaches counsels members via phone contact or secure messaging (based on member preference) on nutrition, physical activity, stress management, tobacco cessation, improving blood pressure, improving cholesterol, weight loss, and weight maintenance.
- **Blue Points Program:** Allows members to earn reward points for participating in various wellness activities. Members can redeem points in an online shopping mall.

The Well on Target Fitness Program

- Allows members access to a nationwide network of up to 12,400 fitness locations, with a choice of gym networks to fit the member's budget and preferences.
- Digital Fitness Option for members allows them to:
    - Stay active from the comfort of their home
    - Access thousands of digital fitness videos and live classes including cardio, bootcamp, barre, yoga, and more through the online member platform.

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.

Prior Authorization Changes for Inpatient Services Effective Oct. 1, 2022

Blue Cross and Blue Shield of Texas (BCBSTX) is **removing** some inpatient services from requiring prior authorization, effective Oct. 1, 2022, for fully insured plans (TDI on ID card) and certain commercial groups. This does not impact the Employees Retirement System of Texas (ERS) or Teacher Retirement System of Texas (TRS) at this time.

What's Changing: Effective Oct. 1, 2022, the following inpatient services will **no longer require** a prior authorization:

- Elective Acute (Medical, Hospice, Maternity, Surgical, Transplant)
- Elective Post-Acute (LTAC, Rehab, SNF)
- All Behavioral Health Elective Inpatient (Rehab and Residential Treatment Center)

All of our systems will be updated to reflect these changes on or before Oct. 1, 2022. Instead of a required prior authorization, providers will have the option of submitting a **Recommended Clinical Review.** Recommended Clinical Reviews are reviews for medical necessity before services are provided. These reviews are optional and inform the provider of situations where a service will be denied based upon medical necessity. You can find a list of services for which Recommended Clinical Review is available on the Recommended Clinical Review page.

- Unlike a required prior authorization, there is no penalty if a provider does not elect to use Recommended Clinical Review but the service will be subject to retrospective review.
- BCBSTX will review Recommended Clinical Review requests to determine if the planned service meets approved medical policy, American Society of Addiction Medicine (ASAM) or MCG Guidelines criteria before services are provided for medical and behavioral health services.
- Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis.

- Providers will be notified of an adverse determination and have the opportunity to appeal if the Recommended Clinical Review determines the proposed service does not meet medical necessity.

Recommended Clinical Reviews are not required prior authorizations. As a result, a provider is not eligible for an exemption with respect to these services and Recommended Clinical Reviews are not considered when a provider's required prior authorization exemption approval rating is calculated. Review the BCBSTX Prior Authorization Exemption page for more information.

Be sure to check eligibility and benefits via Availity® Essentials or your preferred electronic vendor prior to rendering services. This process will also notify you, if the service requires prior authorization or is eligible for Recommended Clinical Review for your member. A Recommended Clinical Review can be submitted utilizing Availity Authorizations and Referrals or by calling the number on the member's ID card.

More Information
Visit the Utilization Management page on our provider website for more information on our revised **Prior Authorization Lists** reflecting the removal of services that no longer require a prior authorization and what services are eligible for Recommended Clinical Review.

Watch News and Updates for more information.

This does not apply to BCBSTX Medicare and Medicaid Government Programs.

Removal of Outpatient Services Requiring Prior Authorization Effective Sept. 18, 2022

Blue Cross and Blue Shield of Texas (BCBSTX) is removing some outpatient services from requiring prior authorization, effective Sept. 18, 2022, for fully insured plans (TDI on ID card) and certain Administrative Services Only (ASO)[1] groups.

The below outpatient services will no longer require prior authorization:

- Durable Medical Equipment (DME)
- Physical Therapy, Occupational Therapy and Speech Therapy (PT/OT/ST) – Except Coordinated Home Care (home health) services continue to require PA.
- Chiropractic Services
- Dental/Accident Injury

Refer to the provider website for a list of outpatient procedure codes in the above outpatient categories where a predetermination of benefits can be submitted to determine coverage and whether BCBSTX considers it medically necessary using the current predetermination process.
Be sure to check eligibility and benefits via Availity® Essentials or your preferred electronic vendor prior to rendering services. This process will also notify you if the service requires prior authorization or is eligible for Recommended Clinical Review for your member.

More Information
Visit the Utilization Management page on our provider website for more information on our revised **Prior Authorization Lists** reflecting the removal of services that no longer require a prior authorization.

Watch News and Updates for more information.

[1] *Refer to the website for current list*

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).

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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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