BLUE REVIEW℠

A Provider Publication

SEPTEMBER 2022

BEHAVIORAL HEALTH

Videos to Share on Behavioral Health Care

Below are short videos we created for our members about behavioral health care and support. We're making them available to you to show to patients in your waiting rooms, or to share the links in your patient portals or discharge paperwork. Spanish captions are available.

- Reach Out for Help with Drug or Alcohol Problems: Information on treatment and support. Watch it now
- Talk to Your Doctor About Your Mental Health Medications: Ways members can work with their providers to better understand their medications. Watch it now
- Continue Your Care after a Hospital or Emergency Room (ER) Visit: Steps toward wellness after a hospital or ER visit for a mental health or substance use concern. Watch it now
- Don't Let Your Mental Health Care End When You Leave the Hospital: Options for treatment after an ER or inpatient hospital visit for a mental health or substance use concern. Watch it now

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CLAIMS & ELIGIBILITY

Reimbursement Increase

Effective Aug. 1, 2022, Blue Cross and Blue Shield of Texas (BCBSTX) increased the maximum allowable standard fee schedule reimbursement for the following specialties for commercial members in certain networks*.

*Does not apply to Blue Advantage HMO℠, MyBlue Health℠, BCBSTX Medicare Advantage or Medicaid networks administered by Magellan Healthcare®.

Provider Specialties Included:		
Board Certified Assistant Behavior Analyst	Licensed Behavioral Practitioner	Licensed Marriage/Family Therapy
Board Certified Behavior Analyst	Licensed Chemical Dependency Counselor	Licensed Psychological Associate
Board Certified Behavior Analyst- Doctoral	Licenses Clinical Professional Counselor	Social Worker
Licensed Alcohol and Drug Counselor	Licenses Clinical Social Worker	

What's changed? Only eligible services with a Relative Value Unit (RVU) for procedures or services that are identified on the Reimbursement and Schedules and Related Information (Secure Content) area of the General Reimbursement Information page.

Note: To enter the "Secure Content" area of the General Reimbursement Information section of the provider website, requires you to obtain the password from your Network Management Office. This is area is only available to participating providers

More information: To determine if the increase applies to the services you perform, participating providers may use the Fee Schedule Viewer tool via Availity® Essentials and electronically receive the incentive price allowance, as applicable, for up to 20 procedure codes at a time.

Reminders When Using the Claims Inquiry Resolution (CIR) Tool

As an alternative to phone calls or faxing forms, you can use the **Claim Inquiry Resolution (CIR) tool via Availity® Essentials** to submit **claim reconsideration requests online** for certain finalized claims. As a reminder, the CIR tool is in our Blue Cross and Blue Shield of Texas (BCBSTX)-branded Payer Spaces section on Availity.

Here are some tips to help you submit claim inquiries using the CIR tool:

- If your claim was processed within the last 18 months, select "Look Up Claim" on the inquiry screen to populate the Subscriber ID, Group Number, Patient Account, Patient Name and Date of Service on the next screen.

- If your claim processed prior to 18 months, select “Show More Fields” to manually enter this information on the next screen.
- Only include medical records when they are requested or required.

Claim number or document control number required: We will soon be rejecting inquiries that do not include an appropriate claim number, also known as a document control number (DCN) and will ask for a correct claim number. To avoid a rejected inquiry, please ensure your request includes an appropriate claim number/DCN.

CIR limitations: Users can employ this tool for finalized claims that require review relating to reasons outlined in the CIR user guide. The CIR tool **cannot** be used to:

- Obtain eligibility and benefit information
- Check claim status
- Submit formal claim appeals
- Submit predeterminations

More information: Refer to the CIR page on the Provider Tools section of our website for more information and for the instructive CIR User Guide to help you submit claim inquiries online.

Not registered for Availity? Sign up online today, at **no cost** at Availity.

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

Are You Using These Shared Decision-Making Aids?

Shared decision-making is a communications process. It's a way for providers and patients to make informed health care decisions that align with what matters most to patients. Below are resources to help you involve your patients in shared decision-making. These evidence-based aids provide information about treatment options, lifestyle changes and outcomes. They don't replace your guidance but can help your conversations with patients.

Why it's important: When patients help make decisions about their health care, it can lead to improved patient experience, better outcomes, and quality of life.

Mayo Clinic Knowledge and Evaluation Research Unit Care That Fits Tools

- Acute Myocardial Infarction Choice
- Anticoagulation Choice
- Cardiovascular Primary Prevention Choice
- Chest Pain Choice
- Depression Medication Choice
- Diabetes Medication Choice
- Graves' Disease Treatment Choice
- Head CT Choice
- Osteoporosis Choice
- Percutaneous Coronary Intervention Choice
- Rheumatoid Arthritis Choice
- Smoking Cessation Around the Time of Surgery
- Statin Choice

This information is also on our Clinical Practice Guidelines web page.

Avoiding Antibiotics for Acute Bronchitis and Other Viruses

With the start of flu and cold season, we encourage you to talk with our members about taking antibiotics only when needed. **Antibiotics don't work against viruses, which are often the cause of acute bronchitis, colds, and the flu.** They only treat certain bacterial infections.

Why It Matters:

- At least 28% of antibiotics prescribed each year in doctor's offices and emergency departments aren't needed, according to the Centers for Disease Control and Prevention (CDC).
- Antibiotics can cause side effects ranging from minor to severe, including rash, diarrhea, yeast infections, and allergic reactions.
- Antibiotics also give bacteria a chance to become more resistant to them, making future infections harder to treat. More than 35,000 people die each year in the U.S. because of antibiotic-resistant infections.

Closing care gaps: We track Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) to help monitor and improve our members' care. AAB is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). **It measures the appropriate treatment for acute bronchitis/bronchiolitis, meaning antibiotics weren't prescribed**.

Tips to consider: The CDC suggests alternatives to antibiotics for acute bronchitis and other conditions, including:

- Adequate rest and increased fluids
- Using a clean humidifier or cool mist vaporizer
- Inhaling hot shower steam or other sources of hot vapor
- Throat lozenges for adults and children aged 5 years and older
- Over-the-counter medications to treat symptoms

Consider sharing resources with our members, such as these from the CDC. They explain that viruses, not bacteria, cause colds and flu.

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:

EDUCATION & REFERENCE

Webinars on Cross-Cultural Care for Continuing Education Credit

Blue Cross and Blue Shield of Texas (BCBSTX) invites you to sign up for the courses listed below and earn continuing education credit. We're pleased to **offer these webinars at no cost** through Quality Interactions, a separate company that provides cultural awareness training to health care professionals.

How to Attend:

- Enter your email address and create a password on the Quality Interactions website.
- Watch your email for a link to your new account profile. Complete your profile and enter **Learn2022** as your Org ID.

Course Offerings

Select the link for accreditation information and course overviews:

- Recognizing and Responding to Implicit Bias (CME/CEU/CCM/CDE)
- Cross-Cultural Care in Mental Health and Depression (CME/CEU/CCM/LSW)
- Culturally Competent Care for the Medicare Population (CME/CEU/CCM)
- Improving Adherence in Diverse Populations (CME/CEU/CCM/LSW/ACPE)
- Test Your Skills for Clinicians (option A) (CME/CEU/CCM)
- Test Your Skills for Clinicians (option B) (CME/CEU)

Find instructions and get help online. Space is limited, so register soon.

Quality Interactions is a separate company that provides cultural competency training to health care professionals. BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

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.

Help Close Diabetes Disparity Gaps

Diabetes is one of the most common chronic conditions in the U.S. According to the Centers for Disease Control and Prevention (CDC), more than 37 million Americans of all ages have diabetes. An estimated 96 million Americans have prediabetes or are at high risk for type 2 diabetes. **Diabetes has a disproportionate impact on certain populations.**

- Racial and ethnic minorities have a higher risk of diabetes and higher rates of diabetes complications and mortality, according to the American Diabetes Association.
- Adults with less than a high school education and with family income below the federal poverty level have higher rates of diabetes diagnoses, according to the CDC.

For these and other populations affected by diabetes, non-medical drivers of health – or **social determinants of health** –impose barriers to health and wellness, according to the National Institutes of Health. See our Health Equity and Social Determinants of Health page for more details and resources.

How You Can Help

You and your staff may play an important role in supporting our members with diabetes or at risk of developing the disease. To help remove barriers to health equity and close gaps in care, you can:

- Educate our members on the unique risks that affect racial and ethnic minorities and other populations.
- Ask members about their needs related to social determinants of health, such as issues with transportation, food insecurity, or housing. Include ICD-10 Z codes for social determinants of health on claims you submit to us so that we can help address barriers and connect members with available resources.
- Discuss regular tests and screenings with our members. We've created information that may help:

    - Type 1 and Type 2 symptoms
    - Hemoglobin A1c and other tests
    - Annual eye exams to avoid vision loss, or diabetic retinopathy
    - Screenings for kidney disease, or diabetic nephropathy
    - Blood pressure control
- Participate in shared decision-making to identify the best screening and treatment options for each member.
- 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.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Help members schedule appointments and follow up with them if they miss.
- Talk with members and other treating providers to ensure all tests are completed and results are documented in the medical record. To help monitor and improve our members' care, we track quality measures developed by the National Committee for Quality Assurance related to diabetes care, including Kidney Health Evaluation for Patients with Diabetes and Comprehensive Diabetes Care. See our preventive care and clinical practice guidelines on diabetes for more details.

MEDICARE ADVANTAGE PLANS

Closing Gaps in Care for Group Medicare Advantage Members

If we need medical records for Blue Cross Group Medicare Advantage (PPO)℠ members, you will receive requests only from Blue Cross and Blue Shield of Texas (BCBSTX) or our vendor, Change Healthcare. This is part of the Blue Cross and Blue Shield (BCBS) National Coordination of Care program so that you won't receive requests from multiple BCBS plans or their vendors. Please respond quickly to our requests, including requests related to risk adjustment gaps and Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Read more.

Reviewing Inpatient DRG Claims for BlueCard® (Out of Area) Medicare Advantage℠ Members

The Blue Cross and Blue Shield Association requires all host Blue Cross and Blue Shield (BCBS) Plans to review select inpatient, diagnosis-related group (DRG) claims for any out-of-area Blue Cross Medicare Advantage℠ members. Beginning **Oct. 15, 2022**, Blue Cross and

Blue Shield of Texas (BCBSTX) will work with CERiS of CorVel Health Corporation (CERiS) to complete these reviews. The review will check for compliance with ICD-10 procedure coding system guidelines.

Which claims are affected? This review affects inpatient DRG claims for services rendered to any hosted BlueCard member with a Medicare Advantage policy. Hosted BlueCard members are members of any BCBS Plan outside Texas receiving health care services in Texas.

Medical Records Requests
When a claim is selected for review, you may receive a request for medical records from CERiS.

What next: If an error is found in how the claim is coded, you'll receive a letter from Ceris that explains the review and the outcome. If the review determines the diagnosis billed is not supported, BCBSTX will request a refund from the provider.

For more information: If you have questions, please contact your local BCBSTX Provider Network Office. For information about BlueCard, see our website under Claims & Eligibility.

CERiS of CorVel Health Corporation are independent companies that have contracted with BCBSTX to provide medical claim audits for members with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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

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 or the American Medical Association (AMA). A summary of changes is included below.

Changes **effective Oct. 1, 2022**, include additional codes for the following care categories to be reviewed by eviCore healthcare®:

- Specialty Drug codes
- Musculoskeletal Pain codes
- Radiology codes

Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website. The revised lists can be found on the Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM page.

Check eligibility and benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® 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.

NETWORK PARTICIPATION

Verify Your Directory Details Every 90 Days

As a reminder, the Consolidated Appropriations Act (CAA) of 2021 requires that certain directory information be verified every 90 days. It must be verified every 90 days, **even if your data hasn't changed since you last verified it.**

Under the CAA, we're required to remove providers from Provider Finder® whose data we're unable to verify.

What to verify: Verify your name, address, phone, specialty, and digital contact information (website) every 90 days. You also must update your information when it changes, including if you join or leave a network. See our Verify and Update Your Information page on our Provider website.

How Professional Providers Can Verify:

- We recommend you use the **Availity® Essentials Provider Data Management feature** to quickly verify your information with us and other insurers every 90 days. See the Provider Data Management web page and User Guide for more details.
- If you're unable to use Availity, you may use our Demographic Change Form. See our User Guide on how to verify your data using this form.
- If you haven't verified your data, you may receive email or postcard reminders from us. The email has a unique link to verify information.

How facilities and ancillary providers can verify: Facilities and ancillary providers may only use the Demographic Change Form to verify information. See our User Guide for more details.

To update your information: If you need to change your data, you may continue to use the Demographic Change Form. Professional providers may update some data in Availity Provider Data Management. See our Verify and Update Your Information page for details. Updating your data will count as your 90-day verification.

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

Other notices to verify: You may receive other notices to verify your data for the Council for Affordable Quality Healthcare® (CAQH), which collects data as part of our credentialing and recredentialing process. These are separate from the CAA requirements. Entering and attesting to data for CAQH doesn't verify the directory information needed for the CAA.

PHARMACY

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

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

PRIOR AUTHORIZATION

Coming Soon: IVR System to Offer Prior Authorization Requests for FEP Members

Starting **Oct. 15, 2022**, you will be able to use the Blue Cross and Blue Shield of Texas (BCBSTX) interactive voice response (*IVR*) system to complete some prior authorization (PA) requests for Federal Employee Program® (FEP) members.

Through the BCBSTX IVR you will be able to request PA for some:

- Inpatient services
- Outpatient services

You will also be able to:

- Check the status of an existing prior authorization
- Get an extension for an existing prior authorization

Note: use your existing PA request options for the services below. The IVR option **will not accommodate** PA requests for **these services for FEP members:**

- Behavioral health
- Chemical dependency

Remember: Check eligibility and benefits electronically via Availity® Essentials or call the customer service number on the member ID card to find out if PA is needed.

More information: Learn more about submitting FEP Claims. Access the IVR system at 1-800-451-0827. Learn more about the IVR system with this caller guide here.

Genetic Testing Prior Authorizations via AIM Submission Tip

When submitting prior authorization requests for genetic testing through AIM Specialty Health® (AIM), please use the resources available on their website. They can help you submit "complete" requests and prevent delays due to incomplete information. As an example, tests submitted as "unknown" cannot be reviewed due to lack of information. Reviewing available resources will provide you with the information needed to submit a complete genetic testing request. For more information on submitting requests through AIM, visit the AIM page on our provider website.

Update to Prior Authorization Codes for Commercial Members, Effective Oct. 1, 2022

What's new: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of Current Procedural Terminology® (CPT) codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA).

Changes effective Oct. 1, 2022, include:

- Addition of one Musculoskeletal Joint and Spine code to be reviewed by AIM Specialty Health® (AIM)
- Addition of Molecular Genetic Lab Testing codes to be reviewed by AIM
- Addition and replacement of Medical Oncology drugs to be reviewed by AIM
- Addition of Sleep codes to be reviewed by AIM
- Removal of Musculoskeletal Joint and Spine and Pain codes previously reviewed by AIM
- Addition of Specialty Pharmacy codes to be reviewed by BCBSTX

More information: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website, Revised lists can be found on the **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans.**

Check eligibility and benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® or your preferred vendor.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Contact Us

View our quick directory of contacts for BCBSTX.

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.

Material presented is for informational purposes only and is not intended to be a substitute for the independent medical judgment of a physician. Physicians and other health care providers are encouraged to use their own best medical judgment based upon all available information and the condition of the patient in determining the best course of treatment. The fact that a service or treatment is described is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

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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 Prime to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Change Healthcare is an independent third-party vendor that is solely responsible

for the products 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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