BLUE REVIEW℠

A Provider Publication

AUGUST 2023

NOTICES & ANNOUNCEMENTS

Free Tools & Resources Available via Availity® Essentials

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to providing you with a one-stop shop of complimentary tools and resources through our partnership with Availity.

Availity is a secure, web-based, full-service information exchange that offers a claims clearinghouse and real-time transactions **at no charge** to our providers. Through one sign on, you can access resources and complete transactions such as:

- Eligibility and benefits
- Claim status
- Claim submission
- Electronic remittance
- Submission of BCBSTX prior authorizations and referrals requests as well as links to other prior authorization vendors.
- Access to prior authorization exemption communications.
- Message boards about upcoming changes and important information

We would like to take this opportunity, to invite you to sign up now for this free service by going to Availity or contacting Availity Client Services at **1-800-282-4548**.

Important! When you access Availity, make sure your administrator **adds or edits all providers within your organization** using **Manage My Organization**. If a provider is not added, access to above transactions will not be available to those providers. For more information, refer to Manage My Organization via Availity® Essentials.

Why not take this opportunity to explore all the services that Availity has to offer at no cost to you? For more information on the Availity tools refer Provider Self Service Tools via Availity® Essentials.

Reminder: Physician Performance Insight (PPI) Reports are Coming Soon

On or around Aug. 21, PPI reports will be available. Review who should retrieve their reports, how they could impact you and how to request a reconsideration. After PPI reports are posted, our Physician Efficiency, Appropriateness and Quality℠ team will offer PEAQ 101 webinars for physicians to learn more about the program. Read more.

BEHAVIORAL HEALTH

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. [1] 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. [2]

Treating Depression with Telemedicine

Telehealth use increased by 556 percent between March 11 and April 22, 2020, primarily due to the COVID-19 pandemic.[3] Telehealth usage for mental health and substance abuse visits peaked at 40% between March and August of 2020 and fell only 4% a year later.[4] 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.

References:

1. https://www.nimh.nih.gov/health/statistics/major-depression
2. https://www.jmcp.org/doi/full/10.18553/jmcp.2021.27.2.223
3. Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders published by SAMHSA in 2021.
4. https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/

Antidepressant Medical Management

Major Depression is one of the most common mental illnesses affecting more than 21 million American adults each year. [1] Approximately 60% of those treated for depression are cared for by Primary Care Physicians (PCPs) and almost 80% of antidepressants are prescribed by non-mental health professionals. [2]

Studies conducted in primary care and psychiatric settings show that more than half of patients suffering with Major Depression have poor adherence. Patient-related reasons for discontinuation may include stigma, lack of understanding how the drug works, worries about side effects, or cost. Clinician-related reasons for poor adherence can include lack of shared decision-making with the patient, insufficient education about how the medication works or side effects, or lack of follow-up. [3]

A checklist can be a valuable tool to help practitioners improve adherence with an additional emphasis on patient education about the importance of medication adherence, opportunities for shared decision-making, and 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.

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
- Antidepressant Medication Management (AMM)
- Behavioral Health - Earn Continuing Education Credit
- Anti-Depression Medication Management PCP Packet
- AMM Provider Packet
- American Medical Association

References:

1. https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6727965/
3. https://link.springer.com/article/10.1186/s12991-020-00306-2#citeas
4. https://annals-general-psychiatry.biomedcentral.com/articles/10.1186/s12991-020-00306-2

CLAIMS & ELIGIBILITY

Technical and Professional Components

Modifier 26 denotes professional services for lab and radiological services. **Modifier TC** denotes technical components for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only. **Note:** When a health care provider performs both the technical and professional services for a lab or radiological procedure, they must submit the total service, not each service individually.

CLINICAL RESOURCES

Statin Therapy for Patients with Cardiovascular Disease and Diabetes

Cardiovascular disease is the **leading global cause of death,** according to the World Health Organization. It accounts for 17.9 million deaths per year.

Statin therapy is recommended:

- To prevent cardiovascular disease in diabetics, according to the American Diabetes Association
- To treat cardiovascular disease in adults with established clinical atherosclerotic cardiovascular disease (ASCVD), according to the American Heart Association
- To prevent cardiovascular disease in adults with certain risk factors, according to the U.S. Preventive Services Task Force

Statin Therapy Quality Measures

To help monitor and improve our members' care, we track the quality measures Statin Therapy for Patients with Cardiovascular Disease (SPC) and Statin Therapy for Patients with Diabetes (SPD). You can help ensure quality care by following these guidelines from the National Committee for Quality Assurance (NCQA):

- Men aged 21-75 and women age 40-75 with clinical ASCVD should be dispensed at least one high-or moderate-intensity statin medication.
- Adults aged 40-75 with diabetes who do not have clinical ASCVD should be dispensed at least one statin medication of any intensity.
- All patients prescribed statin therapy should remain on prescribed statin medications for at least 80% of their treatment period.

Tips to Close Gaps in Care

- Discuss lifestyle changes with our members to **lower serum cholesterol**. These can include exercise, adequate sleep and good nutrition, as well as stopping smoking and substance use. We've created resources that may help. When diet and exercise aren't enough, statins may be needed to achieve lower cholesterol levels and reduce the risk of heart disease.
- Emphasize to our members **the importance of staying on statin medication.** Educate them on the proper dose and frequency. Consider converting their medication to a 90-day supply through mail order or a retail pharmacy to encourage adherence.
- Discuss **common side effects** of statin use and what to do if our member has problems with the medication. Remind our members to contact you if they think they are experiencing side effects.
- Review our member's medication profile to confirm statin use history at follow-ups. **Clearly document** any diagnosis indicating an intolerance to statin therapy and any drug interactions with current medications.

For coding tips related to statin therapy, look for this article in the BCBSTX Payer Space resources section in Availity.

Clinical Payment and Coding Policy Updates

Our website's Clinical Payment and Coding Policies 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 and does not address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions during our policy review process. The following policies were added or updated:

- CPCP006 Preventive Services Policy Update, Effective 07/01/2023
- CPCP021 Laboratory Panel Billing Updated, Effective 09/28/2023
- CPCP014 Global Surgical Package – Professional Providers Updated, Effective 10/01/2023
- CPCP031 Trauma Activation – Facility Services Updated, Effective 10/18/2023

EDUCATION & REFERENCE

Webinar on Coding for Morbid and Severe Obesity

Join us for a webinar on coding for morbid and severe obesity. We will offer it three times:

- **July 21, 2023,** from 12 to 12:30 p.m. CDT. Register here.
- **Aug. 18, 2023,** from 12 to 12:30 p.m. CDT. Register here.
- **Sept. 15, 2023,** from 12 to 12:30 p.m. CDT. Register here.

If you're unable to view the registration site, you may need to clear your web browser history.
The webinar is free to providers and coding professionals. Members of our Coding Compliance team will present coding information from the Official ICD-10-CM Coding Guidelines, American Hospital Association Coding Clinic and Centers for Medicare & Medicaid Services. The webinar includes information on:

- Obesity classification levels based on body mass index
- ICD-10-CM guidelines and case studies
- Closing gaps in care for patients

Visit our Provider website for more training opportunities.

HEALTH & WELLNESS

To support quality care, we provide information to providers and members to encourage discussions on health topics. Watch for more about health care quality in our website's News and Updates section and our *Delivering Quality Care* web page.

In-Home Test Kits for Colorectal Cancer Screening

We're providing in-home test kits this summer to certain Blue Cross and Blue Shield of Texas (BCBSTX) members who, based on our data, need a colorectal cancer screening. We're working with vendors to send Fecal Immunochemical Test (FIT) kits to certain MyBlue Health℠ and Blue Advantage HMO℠ members at no additional charge.

As a trusted provider, you may want to **encourage our members who are your patients to take advantage of this opportunity to learn more about their health** with a FIT kit**.** In 2022 we provided 55,227 FIT kits to BCBSTX members:

- 7,999 members returned their kits and closed this gap in their care
- Test results were sent to the members and their health care providers. There were 411 abnormal or positive kit results, meaning the sample contained blood when collected.

Why Use FIT
The U.S. Preventive Services Taskforce recognizes annual FIT testing for **colorectal cancer screening starting at age 45**.

- FIT testing is appropriate screening for people with an average risk for colorectal cancer. Average risk means no family history of colorectal cancer, no personal history of inflammatory bowel disease, no previous polyps and no previous colorectal cancer.
- When compared to stool DNA tests, FIT kits have fewer false positives, which reduces unnecessary colonoscopies, according to the National Cancer Institute. Unlike stool DNA tests like Cologuard®, FIT kits require only a swab rather than a stool sample.

How In-Home Testing Works
The in-home testing process is quick and easy for members:

- Vendors send the kits to a sample of eligible members who have a gap in care for colorectal cancer screening. Completing the kit is voluntary.
- The kits don't require fasting, dietary restrictions or preparation. Members may take medications according to their normal schedule.
- Members complete the test kit at home, provide the name of their health care provider, if available, and **mail the test for processing to the vendor by Dec. 31, 2023**. An addressed, postage-paid envelope is included with the kit.
- The vendor sends results to the member and to their provider in three to four weeks.

How You Can Help

- Consider discussing the importance of colorectal cancer screening and healthy lifestyle choices with your patients. If one of your patients receives a kit and calls your office with questions, **discuss their screening options**.
- Document any test results in your patient's medical record and discuss the results with your patient.

Colorectal Cancer Screening Options and Statistics: Get the Conversation Started Today

The second of a four-part series on Colorectal Cancer (CRC) Screenings

Thank you for your continued support and interest in colorectal cancer screenings for our members. Please refer to the June 2023 *Blue Review* publication for first article titled, Colon Cancer Screenings Goal: 80% In Every Community.

Colorectal Cancer screening can save lives only if it gets done.

- In 2023, there will be an estimated 153,020 new cases of colorectal cancer diagnosed in the US and 52,550 people will die from the disease.
- Colorectal cancer is the second-leading cause of cancer death in the US when men and women are combined
- 1 in 23 men and 1 in 26 women will be diagnosed with colorectal cancer in their lifetime.
- Colorectal cancer is estimated to become the leading cause of cancer-related deaths for 20-49-year-olds by 2030. [1]

Almost all major guidelines recommend screenings start for average risk individuals at age 45 and continue through to age 75. Those screenings include the most accurate and thorough screening, the colonoscopy, followed by other recommendations, the guaiac fecal occult blood test [FOBT], fecal immunochemical test [FIT], mt-sDNA, CT colonoscopy, and sigmoidoscopy. Based on the patient's risk,

any out-of-pocket-costs, and mutually agreed upon appropriateness based on the patient's circumstances, any of the recommended screenings are better than none at all.

Be very attentive to the following populations, who are most likely NOT to be screened?

- Ages 50-54, followed by ages 45-49
- Equally, American Indian or Native Alaskan and Hispanic
- Less than a high school education
- Income of <100% Federal Poverty Level[1]

Start the Conversation!
What has the greatest influence on someone getting screened? The one-on-one conversation between the provider and the patient.

In 2023, it is estimated there will be 12,220 new cases of colorectal cancer and an estimated 4,350 Texas residents will die of that cancer in 2023.[2]

Your recommendation that your patients get screened for colorectal cancer carries the greatest impact for colorectal cancer screening compliance.

Thank you for your continued support and interest in colorectal cancer screenings for our members.

References

1. National Colorectal Cancer Roundtable. 2023. https://nccrt.org/
2. Society A. C. (2023) Cancer Statistics Center, Retrieved from https://cancernstatisticscenter.cancer.org/#!/state/Texas

---

MEDICARE ADVANTAGE PLANS

Update to Prior Authorization Codes for Medicare Members, Effective Oct. 1, 2023

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare 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.

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 Oct. 1, 2023, include the following codes reviewed by eviCore healthcare:

- Addition of Specialty Drug codes
- Addition of Lab codes
- Removal of Lab codes

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 Quarterly Update, Part 2: Changes Effective July 1, 2023

Review important pharmacy benefit reminders, drug list and dispensing limit changes, and Utilization Management program changes. Read more.

Introducing Smart RxAssist via HealthSmartRx®

Blue Cross Blue Shield of Texas (BCBSTX) is working with HealthSmartRx (HSRx), an independent company, to implement the Smart RxAssist program for certain eligible Teacher Retirement System of Texas (TRS) participants effective **October 16, 2023**.

What Is Smart RxAssist?

Smart RxAssist offers assistance with enrolling in pharmaceutical manufacturer copay assistance programs to eligible participants who are prescribed specific provider-administered specialty drugs**.** The manufacturer copay assistance ensures continued access to these drugs with a significantly reduced copay, which can improve adherence and clinical outcomes. This copay assistance applies only to the cost of the provider administered drug(s) and does not apply to office visits or any other associated costs. Enrollment is optional for eligible TRS participants and participation is voluntary for providers. The resulting payments from the copay assistance, TRS participant's cost sharing, and the health plan will equal the Allowable Amount that applies today. Participants who choose to participate are required to enroll in the Smart RxAssist program per their group benefits for in-scope provider-administered drugs.

HealthSmartRx Smart RxAssist Process

- If your patient has not yet enrolled in Smart RxAssist, an HSRx Patient Advocate will reach out to your patient by phone to facilitate enrollment and answer any questions they may have.
- Your office may be contacted by HSRx via phone or fax for enrollment and/or to provide documentation required by the manufacturer for the copay assistance program.
- Once your patient is enrolled, an HSRx Patient Advocate will contact your office to provide additional details on copay assistance claim submission and how you will receive copay assistance funds from the manufacturer.
- If required, initiate prior authorization and follow utilization review requirements in the Provider Manual. You will receive notification if the prior authorization is approved.
- Submit a medical claim to BCBSTX for primary payment.
- Follow applicable manufacturer program reimbursement procedures to obtain copay assistance funds.

More Information

- Review the TRS participant Smart RxAssist FAQs.
- If you have questions, call **1-833-798-6741** or visit SmartRxAssist.

PRIOR AUTHORIZATION

Update to Prior Authorization Codes for Commercial Members, Effective Oct. 1, 2023

What's New: Updates are being made to the Blue Cross and Blue Shield of Texas (BCBSTX) lists of codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes. These changes are based on 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.

Changes effective Oct. 1, 2023, include:

- Addition of Specialty Pharmacy codes to be reviewed by BCBSTX
- Removal of a Radiation Oncology drug code previously reviewed by Carelon Medical Benefits Management (Carelon)
- Addition of a Musculoskeletal joint and spine code to be reviewed by Carelon
- Replacement of Genetic Testing codes reviewed by Carelon

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, limitationsand exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through 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.

HealthSmart RX is an independent company that has been contracted by BCBSTX on behalf of TRS to provide TRS patient support services for certain covered drugs. HealthSmart RX does not offer Blue Products or Services.

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.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual LegalReserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

bcbstx.com/provider