BLUE REVIEW℠
A Provider Publication

FEBRUARY 2023

NOTICES & ANNOUNCEMENTS

Important Benefit Changes to 2023 Fully Insured Texas Group Plans

Texas law permits insured group contracts to be modified during coverage renewal if the modification is effective uniformly among all employer groups covered by the benefit plan. Since all BCBSTX Fully Insured group health plans were amended on Jan. 1, some laboratory services may not be covered. Read more.

FEP Annual Medical Record Data Collection for Quality Reporting – HEDIS

Begins Feb. 1, 2023, through April 27, 2023

Blue Cross and Blue Shield Federal Employee Program (FEP®) collects performance data using specifications published by the National Committee for Quality Assurance (NCQA) for Healthcare Effectiveness Data and Information Set (HEDIS®). HEDIS is a comprehensive set of standardized performance measures that assess quality of care and outcomes HEDIS is the most widely used and nationally accepted effectiveness of care measurement available and is used to ensure compliance with the Federal Employees Health Benefits Program (FEHBP) requirements.

To meet this annual quality reporting requirement, BCBS FEP will be collecting medical records using internal resources and leveraging an independently contracted third-party vendor Episource. This medical retrieval process will begin in February 2023 and run through the end of April 2023.

If you receive a request for medical records, we ask that you reply within five (5) business days of receipt of this request. Your cooperation is crucial to ensure that data is reported completely, accurately, and timely. BCBS FEP or Episource may be contacting your office or facility in February 2023 to identify a key contact person and to ascertain which data collection method your office or facility prefers (fax, secure email, sFTP or onsite). (Appointments for onsite visits will be scheduled with your staff, if applicable.) You will then receive a letter outlining the information that is being requested, and the medical record request list with members' names and the identified measures that will be reviewed.

Patient authorization for release of medical record data is not required. These reporting activities are considered health care operations under the Health Information Portability and Accountability Act (HIPAA) of 1996 and its **implementing regulations (45 C.F.R. Parts 160 and164), and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as**

incorporated in the American Recovery and Reinvestment Act (ARRA) of 2009, and its implementing regulations, each as issued and amended.

We appreciate your time and continued collaboration. If you have any questions about medical record requests, please contact the BCBS FEP Quality Improvement (HEDIS) Department at **1-(888) 907-7918**.

Episource LLC is an independent third-party vendor that is solely responsible for the products or services they offer. BCBS FEP makes no endorsement, representations or warranties regarding any products or services offered by independent third-party vendor. If you have any questions regarding the services they offer, you should contact the vendor directly.

Annual HEDIS/QRS Reports

Because our Quality Improvement Program aims to monitor and improve the care and services our members receive, we're providing a chart that summarizes how we're performing on selected HEDIS and Quality Rating System (QRS) measures, along with key interventions and key accomplishments. Read more.

BEHAVIORAL HEALTH

Psychiatry Reimbursement Increase

Effective January 1, 2023, Blue Cross and Blue Shield of Texas (BCBSTX) will increase the maximum allowable standard fee schedule reimbursement for the following specialties for commercial members in certain networks*.

Provider Specialties Included:

- Child & Adolescent Psychiatry
- Psychiatry

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

What's Changed?

Eligible services with a Relative Value Unit (RVU) or certain laboratory procedures that are specifically identified under Relative Values, Clinical & Other Lab Codes on the Reimbursement and Schedules and Related Information (Secure Content) area of the General Reimbursement Information page on the provider website.

Note: To enter the "Secure Content" area of the General Reimbursement Information section of the provider website, a password is required. You may obtain the password from your Network Management Office. As a reminder, this 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.

CLAIMS & ELIGIBILITY

ClaimsXten™ Quarterly Update Effective April 17, 2023

Blue Cross and Blue Shield of Texas (BCBSTX) will implement its first quarter code update for the ClaimsXten auditing tool on or after April 17, 2023.

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.

Prior Authorization and Claim Reconciliation for Neonatal Intensive Care Unit Services Effective 03/20/2023

What's changing: Beginning March 20, 2023, Blue Cross and Blue Shield of Texas (BCBSTX) will begin reviewing claims **when they are received** for Neonatal Intensive Care Unit (NICU) services with the approved services on the prior authorization. This real-time verification will reconcile the claim to the authorization including number of days by level with what the provider submits for payment on their claim. We will allow only the levels billed that correspond to the actual or greater level of care prior authorized.

This is not a new process. Previously, this review was done on a post-payment basis resulting in refund requests. With the new process, the initial Provider Claim Summary (PCS) will explain how the claim was paid.

Reconciliation Process
The following are examples of how the claim may be adjudicated to match the prior authorization:

Example 1

- Provider's prior authorization is approved for authorization for a Level **II** NICU bed for 10 days
- Provider bills 10 of Level **III** NICU
- The system will allow 10 days of Level **II** NICU instead of the Level **III** NICU billed

Example 2

- Provider's prior authorization is approved for authorization for a Level **IV** NICU bed for 5 days and 5 days at Level **III** NICU
- Provider bills 10 of Level **IV** NICU
- The system will allow 5 days of Level **IV** NICU instead of 10 that was billed and allow the additional 5 days at Level **III** NICU

In both examples, a message will appear on the PCS indicating that the claim was paid at the level authorized, not the level that was billed.

Please note, if there is no prior authorization on file for NICU services, the claim will follow normal no authorization processing guidelines.

When qualified, providers can submit an appeal if you do not agree with the payment.

CLINICAL RESOURCES

Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding Policies on our website describe payment rules and methodologies for CPT®, HCPCS and ICD-10 coding for claims submitted as covered services. This information is a resource for our payment policies. It is not intended to address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review process. The following policies were added or updated:

- CPCP006 Preventive Services – effective Jan. 1, 2023
- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – effective Jan. 1, 2023

- CPCP019 Home Infusion – effective Jan. 5, 2023
- CPCP036 Paravertebral Facet Injection Procedure Coding & Billing Policy – effective Jan. 6, 2023
- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services (EIU) – effective April 1, 2023
- CPCP026 Therapeutic, Prophylactic and Diagnostic Injection and Infusion Coding – effective April 5, 2023

EDUCATION & REFERENCE

2023 Holiday Schedule Reminders (for 835 and 837 transactions)

We're providing the 2023 holiday schedule to help plan around scheduling variances that may affect electronic claims (837) and/or electronic claims payment and remittance (835) transactions. We encourage you to download, keep and distribute the PDF calendar (embedded in the Read More link) to the appropriate staff. Read more.

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.

Supporting Heart Health Equity

Social determinants of health can play a significant role in cardiovascular health, according to the Centers for Disease Control and Prevention (CDC). Social determinants of health are non-medical factors that influence health outcomes. They include the social, economic, and physical conditions where people live, learn, work, play, worship, and age.

You and your staff may support our members who have risk factors for heart attacks or strokes. We encourage you to ask our members about their needs related to social determinants of health, such as issues with transportation or access to healthy food. They may need to be prompted to discuss non-medical issues that impact their health. On the claims you submit to us, you can include ICD-10 Z codes for social determinants of health so that we can help address barriers.

Why It Matters

Heart disease and stroke are among the leading causes of death in the U.S., according to the CDC. However, heart disease, stroke and their risk factors disproportionately affect some populations. According to the American Heart Association:

- Black adults have higher rates of severe high blood pressure, and it develops earlier in life.
- Low-income adults are less likely to be screened for cardiovascular disease.
- Adults living in less walkable neighborhoods have a higher risk of cardiovascular disease.

See our Health Equity and Social Determinants of Health webpage for more information.

Other Tips to Close Gaps in Cardiovascular Care

- Talk with our members about reducing and managing their risks for heart disease and stroke. This may include taking medications as prescribed, smoking cessation, increasing physical activity, and eating a low-sodium diet. We've created resources for members, including information on high blood pressure and cholesterol.
- The U.S. Preventive Services Task Force (USPSTF) recommends blood pressure checks for adults age 18 and older at every visit. Ensure that screenings and results are documented in our members' electronic medical records. See our preventive care and clinical practice guidelines for more information.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Encourage members to return for follow-up visits. Reach out to those who cancel or miss appointments and help them reschedule as soon as possible.
- 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.

Tracking Our Members' Progress

For the quality measure Controlling High Blood Pressure, we measure the percentage of members ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled. The National Committee for Quality Assurance (NCQA) defines controlling blood pressure as:

- Systolic blood pressure < 140 mmHg
- Diastolic blood pressure < 90 mmHg

We also track Statin Therapy for Patients with Cardiovascular Disease. It measures the percentage of male members ages 21 to 75 and female members ages 40 to 75 who:

- Have atherosclerotic cardiovascular disease, and
- Were dispensed at least one high- or moderate-intensity statin medication and remained on the medication for at least 80% of the treatment period

Learn more about statin therapy recommendations.

MEDICARE ADVANTAGE PLANS

Inflation Reduction Act to Impact Insulin and Vaccine Costs for Medicare Members

Starting Jan. 1, 2023, the Inflation Reduction Act (IRA) of 2022 will affect the costs of insulin and adult vaccines for Medicare members. The act requires:

- The cost of a covered insulin to be capped at $35 for a month's supply for those enrolled in a Medicare prescription drug plan.
- No out-of-pocket costs for adult vaccines covered under Medicare Part D.

In January 2023, some Medicare members may be charged more than $35 per month for a covered insulin. If that happens, we will reimburse members for any amount paid over $35. Reimbursement checks would be mailed by Jan. 31, 2023.

Frequently Asked Questions About the Changes

Q: What insulin products are included in the $35 per month cap?

A: Included in the cap are insulin products covered under Medicare prescription drug plans and dispensed at a network retail or mail order pharmacy, according to the Centers for Medicare & Medicaid Services.

Q: What vaccines are covered by Medicare Part D at a $0 copay?

A: There is no cost sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC). This includes the shingles and Tetanus-Diphtheria-Whooping Cough vaccines. ACIP is a group of medical and public health experts that is part of the CDC.

Q: Do the insulins or vaccines need to be included in the plan's formulary to be eligible for the cost reductions?

A: Insulins and vaccines that are included on the formulary are eligible. Any vaccine or insulin that is approved in transition or due to a formulary coverage exception request is also eligible.

Q: What if a Medicare member has a coverage determination for a non-formulary product?

A: If a Medicare member has requested a formulary exception for insulin or vaccine and has received an approval, those products are subject to the $35 cap (insulins) or the $0 copay (vaccines).

For more information, you can read the CMS fact sheet.

PRIOR AUTHORIZATION

Correction - Prior Authorization Codes for Commercial Members Updated Effective April 1, 2023

Please Note- *A correction was made to the prior authorizations lists indicated below on 1/17/2023. Be sure to review the lists for changes.*

What's New: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its 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 April 1, 2023, include:

- Addition of Specialty Pharmacy: Site of Care codes to be reviewed by BCBSTX
- Addition of a Medical Oncology code to be reviewed by AIM Specialty Health® (AIM)
- Replacement of Medical Oncology codes to be reviewed by AIM

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.

UTILIZATION MANAGEMENT

'Predetermination' Is Changing to 'Recommended Clinical Review'

On Oct. 1, 2022, we introduced Recommended Clinical Review (RCR) for **inpatient services** that no longer required prior authorization. Then on Jan. 1, 2023, we also changed the name of our longstanding **outpatient preservice review** from "Predetermination" to "Recommended Clinical Review." Key points and the RCR submission process are included.
Read More

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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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.

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The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Physicians are to exercise their own medical judgment. Pharmacy benefits and limits are subject to the terms set forth in the member's 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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