BLUE REVIEW℠
A Provider Publication

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NOTICES & ANNOUNCEMENTS

Fee Schedule Update for BCBSTX DME, Prosthetic and Orthotics Providers

Effective **March 1, 2023**, Blue Cross and Blue Shield of Texas (BCBSTX) will implement changes in the maximum allowable fee schedule for Blue Choice PPO℠, Blue Essentials℠ (including the Health Select Network), Blue Premier℠, Blue High Performance, Blue Advantage HMO℠, MyBlue Health and ParPlan networks (collectively referred to as "Networks") for in-network BCBSTX Durable Medical Equipment (DME), Prosthetic and Orthotic providers.

All files and fee schedules for the Networks will be posted on the provider website under **Standards & Requirements** then select **General Reimbursement Information**. Locate the **Reimbursement Schedules and Related Information** section. Please contact the Ancillary Network Management Department for the Secure Content password to access the Network fee schedules. The following is a brief description of the changes:

The methodology used to develop the maximum allowable fee schedules will be based on **2022 CMS** values as posted on the website for those services for which the BCBSTX reimbursement is based on CMS values.

BCBSTX provides general reimbursement information policies, fee schedule request forms and fee schedule information on the provider website. Reimbursement changes and updates will be posted under "Reimbursement Changes/Updates" in the Reimbursement Schedules section on the website. The specific effective date will be noted for each change that is posted.

Please be advised the reimbursement information being disclosed within this letter and the attachment contains confidential information proprietary to BCBSTX. The use and disclosure of this information is restricted under Texas Insurance Code Section 1301.136(b), Texas Insurance Code Section 843.321(b) and the terms of your Network agreement(s), as applicable.

We value your participation as a contracted provider. As some Networks are limited in scope or geographic area, if you are not participating in one of the Networks, please disregard the information pertaining to that particular network. If you have questions, please contact the Ancillary Network Management Department.

Reminder: Update Your Demographic Information

Have you had a change in your location, phone number, email or other important details? As indicated in your provider agreement and as required by the Consolidated Appropriations Act (CAA) of 2021, make sure you verify and notify Blue Cross and Blue Shield of Texas (BCBSTX) of these changes **timely**. It's important that your demographic information is current so our members can locate you in our Provider Finder® tool. Be sure to review yourself on Provider Finder to verify the accuracy of your information.

CAA Requirement

As a reminder, the Consolidated Appropriations Act (CAA) of 2021 requires that certain directory information 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 every 90 days, your name, address, phone, specialty, and digital contact information (website) every 90 days and you must update your information when it changes. This includes if you join or leave a network. Refer to the Verify and Update Your Information page on our provider website.

Professional Providers Verification Process

- 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.

Facilities and Ancillary Providers Verification Process

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

We appreciate the care you provide to our BCBSTX members and want to ensure that your current information is available to them.

CLAIMS & ELIGIBILITY

Updates to 'Message This Payer' Option via Availity® Essentials

In September we published an article announcing the new Message This Payer option for sending us secure, electronic claim messages. To ensure timely responses, we've decided to limit the *Message This Payer* capability to BCBSTX member claims only. Therefore, this option will temporarily be

disabled for BlueCard® (out-of-area) claims. Our customer advocates remain available for these complex claim inquiries. For more information, refer to the Message This Payer page on our website. *As a reminder, Message This Payer is also unavailable for Medicare Advantage for Texas Medicaid claims.*

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 ages 21-75 and women ages 40-75 with clinical ASCVD should be dispensed at least one high-or moderate-intensity statin medication.
- Adults ages 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

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 policy was added or updated:

- Coordinated Home Care/Private Duty Nursing Policy – effective 12/13/2022

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 on our website's News and Updates section and on our *Delivering Quality Care* web page.

Cervical and Breast Cancer Screenings

The new year is an opportunity to remind our members to schedule screenings for cervical cancer and breast cancer. Regular screening tests can detect problems early when they're easier to treat.

Recommended Screenings

The U.S. Preventive Services Task Force recommends:

- Screening all women for cervical cancer starting at age 21
- Screening women ages 50 to 74 for breast cancer every two years. You may want to discuss with members the risks and benefits of starting screening mammograms before age 50.

See our preventive care guidelines for more information.

Addressing Health Disparities

According to the American Cancer Society:

- Native American and Hispanic women have the highest rates of cervical cancer.
- Black women are more likely to die from breast and cervical cancer than other racial or ethnic groups. Learn more about disparities in breast cancer.

Other non-medical drivers of health, such as education levels and poverty, are also linked to different health outcomes. See our Health Equity and Social Determinants of Health page for more information on health equity and how you can help.

Closing Gaps in Care

Cervical Cancer Screening and Breast Cancer Screening are Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). We track data from HEDIS measures to help assess and improve our members' care. Cervical Cancer Screening tracks the following:

- Women ages 21 to 64 who had cervical cytology performed within the last 3 years
- Women ages 30 to 64 who had either:
  - Cervical high-risk human papillomavirus (hrHPV) testing within the last 5 years or
  - Cervical cytology/hrHPV cotesting within the last 5 years

Breast Cancer Screening assesses the percentage of women ages 50 to 74 who had at least one mammogram in the past two years.

Tips to Consider

- Talk with our members about risk reduction and prevention.
  - We've created resources on cervical cancer and breast cancer screening that may help.
  - The Centers for Disease Control and Prevention recommends human papillomavirus

(HPV) vaccines for all people up to age 26 to protect against cervical cancers. We have a tip sheet on coding and documenting for HPV and related cancers.

- Document screenings in the medical record. Indicate the date and result.
- Document medical and surgical history in the medical record, including dates.
- For members who have had a hysterectomy, document the type of hysterectomy and date. Discuss with our members they may continue to need cervical cancer screening after their hysterectomy, depending on the procedure previously performed.
- Follow up with members if they miss their appointment and help them reschedule.

MEDICARE ADVANTAGE PLANS

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

Below is an additional update to the Blue Cross and Blue Shield of Texas (BCBSTX) prior authorization requirements for Medicare Advantage members to reflect removed codes due to updates from Utilization Management or the American Medical Association (AMA) effective Jan. 1. 2023.

Updated Changes

The prior authorization list, currently posted for Jan. 1, 2023, includes the below additional change not included in the previous article posted Oct. 20, 2022:

- Removal of Lab codes previously reviewed by eviCore

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® 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.

Home Health Physician Fee Schedule Increase for Medicare Advantage PPOSM Providers

Effective January 1, 2023, Blue Cross and Blue Shield of Texas (BCBSTX) will add new reimbursement rates to your existing Medicare Advantage PPO agreement fee schedule. After January 1st, **Home Health** providers should utilize these Current Procedural Terminology (CPT®) billing codes for Medicare Advantage PPO members who have Private Duty Nursing as a covered benefit and will be reimbursed as follows:

Billing Codes	Private Duty Nursing	Timeframe	Reimbursement
T1000	Private Duty/Independent Nursing	Per 15 minutes	$13.50
T1001	RN Nursing Assessment/Evaluation	Per 15 minutes	$27.00
T1002	RN Services	Per 15 minutes	$27.00
T1003	LPN/LVN Services	Per 15 minutes	$27.00

Fee schedule links are available by selecting the Claims & Payments menu, Fee Schedule Listing, and then choose the appropriate Additional Fee Schedules for Medicare. They can also be found via the Resources tab in the BCBSTX-branded Payer Spaces section in the Availity® Essentials portal.

How to Use the Availity Fee Schedule Listing Tool:
Note: Availity Administrators must assign the "Provider Fee Schedule" role for users to gain access to this tool.

- Log in to Availity
- Select Claims & Payments from the navigation menu
- Select Fee Schedule Listing
- Select BCBSTX as the payer
- Select your organization and Tax ID number
- Enter the Billing National Provider Identifier (NPI) and Rendering NPI (if applicable)
- Select the Network, Place of Service, and Provider
- Enter the procedure code(s) and modifier(s)

You must be registered with Availity to use the new Fee Schedule tool. You can sign up today at no charge. For registration assistance, call Availity Client Services at **1-800-282-4548**. If you do not have online access, you may continue to submit your requests using the Professional Fee Schedule Request form located on our provider website.

If you have any questions or need additional information, please contact your BCBSTX Medicare Network Management Representative.

Hospitals Must Provide Medicare Outpatient Observation Notice

Hospitals and Critical Access Hospitals (CAH) are required to give the standardized Medicare Outpatient Observation Notice (MOON) to our Blue Cross Medicare Advantage℠ members who are under outpatient observation for more than 24 hours. **The notice explains why the members aren't inpatients and what their coverage and cost-sharing obligations will be.**

To Complete the MOON:

- Download the notice from the Centers for Medicare and Medicaid Services (CMS) website.
- Fill in the reason the member is outpatient rather than inpatient.
- Explain the notice verbally to the member if they are in observation more than 24 hours.
- Have the member sign to confirm they received and understand the notice. If the member declines, the staff member who provided the notice must certify that it was presented.
- Document all member communications regarding the MOON process in members' records.

The notice **must be completed no later than 36 hours after observation begins or sooner** if the patient is admitted, transferred or released.

Learn more from CMS's notice instructions.

Patients in the Qualified Medicare Beneficiary Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage℠ plans, you may not bill our members enrolled in the Qualified Medicare Beneficiary (QMB) program, a federal Medicare savings program.
QMB patients are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a state Medicaid benefit, QMB covers the Medicare Advantage premiums, deductibles, coinsurance and copayments of QMB beneficiaries. **QMB beneficiaries are not responsible for Medicare Advantage cost-sharing, or out-of-pocket costs.**

For services you provide to QMB patients, you must:

- Bill both Medicare Advantage and Medicaid
- Accept Medicare Advantage payments and any Medicaid payments as payment in full

Tips to Avoid Billing QMB Patients
Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare Advantage cost-sharing.

To avoid billing QMB patients, please take these precautions:

- Identify QMB patients by looking for **Blue Cross Medicare Advantage Dual Care**℠ on member ID cards
- Check Medicaid eligibility to confirm QMB beneficiary status.
- Understand the Medicare Advantage cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare Advantage cost-sharing billing and related collections efforts

Questions? Call Customer Service at 1-877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.

More Access for Medicare Patients and Providers
If you're a Medicare provider, you may treat Blue Cross Group Medicare Advantage Open Access (PPO)℠, UT CARE™ Medicare PPO (UT CARE) and Blue Cross Medicare Advantage Flex (PPO)℠ members.

You may treat these members regardless of your contract or network status with Blue Cross and Blue Shield of Texas (BCBSTX). That means you don't need to participate in BCBSTX Medicare Advantage networks or in any other BCBSTX networks to see these members.

The **only requirements** are that you:

- Agree to see the member as a patient
- Accept Medicare assignment, and
- Will submit claims to BCBSTX

Flex and Open Access Advantages
These plans cover the same benefits as Medicare Advantage Parts A and B plus additional benefits per plan. Members' coverage levels are the same inside and outside their plan service area nationwide for covered benefits.

- **Blue Cross Medicare Advantage Flex (PPO)** is available to individuals**.** It includes medical coverage and prescription drug coverage. It doesn't require member cost share.
- **Blue Cross Group Medicare Advantage Open Access (PPO)** is available to retirees of employer groups. It includes medical coverage and may include prescription drug coverage.

Plan members may have to pay deductibles, copays and coinsurance, depending on their benefit plan. Call the number on the member ID card for details.

Referrals aren't required for office visits. Prior authorization may be required for certain services from Medicare Advantage-contracted providers with BCBSTX.

To Identify Members
Look for **Blue Cross Medicare Advantage Flex (PPO), UT CARE** or **Blue Cross Group Medicare Advantage Open Access (PPO)** on the front of member ID cards. It's always important to check eligibility and benefits before providing care.

For Reimbursement
Follow the billing instructions on the member's ID card. When you see these members, you'll submit the claims to BCBSTX and not Medicare.

- **If you're a Medicare Advantage-contracted provider with any Blue Cross and Blue Shield (BCBS) plan,** you'll be paid your contracted rate. You're required to follow utilization management review requirements and guidelines.
- **If you're a Medicare provider who isn't contracted for Medicare Advantage with any BCBS plan,** you'll be paid the Medicare-allowed amount for covered services. You may not balance bill the member for any difference in your charge and the allowed amount.* You aren't required to follow utilization management guidelines. However, you may request a review to confirm medical necessity.

Learn more about UT CARE and Blue Cross Group Medicare Advantage Open Access (PPO) on our Provider website**.**

Questions? Call the number on the member's ID card.

MAPD Risk Adjustment Medical Records Request

Recently you may have received a request for medical records from **Change Healthcare** for Medicare Advantage members who used your facility or were treated by your clinical staff during 2021 and 2022.

Change Healthcare, which conducts records retrieval for Blue Cross and Blue Shield of Texas (BCBSTX), is gathering medical records for a **Centers for Medicare & Medicaid mandated risk adjustment** review.

How do I submit medical records? Submit your records to Change Healthcare using any of the methods below:

- Secure email: Change HealthCare Documentation Receipt
- Fax: **1-866-667-5557** or **1-866-686-7771**
- FedEx: Call **1-855-767-2650** or email CRCR Provider Relations at Change Healthcare for help

- Mail paper charts to Change Healthcare, P.O. Box 52122, Phoenix, AZ 85072-2122
- VPN EMR download: Communicate this preference to Change Healthcare upon receipt of the request letter.
- Onsite scanning by a Change Healthcare medical record technician

Didn't I already provide these records? Possibly, because we request medical records throughout the year for different purposes, including:

- **Risk Adjustment** – Chart reviews, focusing on accuracy of risk-adjustable codes submitted to CMS
- **Risk Adjustment Data Validation (RADV)** – Targeted, plan-specific CMS-mandated chart reviews that ensure payment integrity and accuracy in the risk adjustment program
- **Healthcare Effectiveness Data and Information Set (HEDIS®) measures** – Record requests are used to illustrate the completion of specific National Committee for Quality Assurance (NCQA) quality measures

You also may receive medical record requests from Change Healthcare or BCBSTX as part of the Blue Cross and Blue Shield National Coordination of Care program to help close gaps in care for Blue Cross Group Medicare Advantage (PPO)℠ members.

Please note: If your office is enrolled in the Epic Payer Platform, the tax identification numbers associated with that enrollment should not receive records requests. However, there may be outliers where Change Healthcare will need to retrieve documents that we cannot obtain from the Epic Payer Platform.

Expansion of Members Utilizing eviCore for Prior Authorizations for Blue Cross Group Medicare Advantage

Blue Cross and Blue Shield of Texas (BCBSTX) is expanding members enrolled in Blue Cross Group Medicare Advantage (PPO)℠ programs effective Jan. 1, 2023. These members will require prior authorization from eviCore healthcare® for certain services as shown below. Services performed without authorization may not be reimbursed for these healthcare services and you may not seek reimbursement from members.

Authorization is required for:

- Advanced Radiology Imaging
- Musculoskeletal – Pain/Joint/Spine
- Outpatient Medical Oncology
- Outpatient Radiation Therapy
- Outpatient Sleep
- Outpatient Specialty Drug
- Lab Management Solutions – Molecular and Genomic Lab Testing

Services performed in conjunction with an inpatient stay, 23-hour observation, or emergency room visit are not subject to authorization requirements.

As of Dec. 9, 2022, providers can submit eviCore prior authorization requests for services for dates of service Jan. 1, 2023, and after.

To request an authorization:

- Log onto **(preferred method)**
- Call**: 1-855-252-1117** (7 am – 7 pm local time, M-F)
- Fax: **1-800-540-2406**

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please submit a request online at eviCore and indicate the procedure is NOT routine/standard. Providers can also request urgent requests by calling the toll-free number at **1-855-252-1117**. Be sure to tell the representative the request is for medically urgent care.

We recommend ordering physicians request authorization and pass the approval information to the rendering facilities at the time of scheduling. Authorizations contain approval numbers and one or more CPT codes specific to the services authorized. If the service requested and/or performed is different than what was initially authorized, the rendering facility must contact eviCore to make revisions to the authorization prior to claim submission.

Have questions about requesting authorizations? Attend on online orientation session!
The orientation schedule and program training resources are available on the eviCore resources site then select Blue Cross Blue Shield of Texas from drop down list.

eviCore healthcare's Clinical Guidelines and request forms are available on the eviCore website. Please call Client and Provider Services department at **1(800) 646-0418** (Option 4) if you have any questions or need more information.

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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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

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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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