BLUE REVIEW℠

A Provider Publication

JULY 2023

NOTICES & ANNOUNCEMENTS

Annual Notice of Provider and Member Rights and Responsibilities

As a participating provider in our provider networks, you are required to comply with our Provider Rights and Responsibilities and understand our Member Rights and Responsibilities that may affect your practice.

The Physician Performance Insight (PPI) Reports Coming Soon

The Physician Efficiency, Appropriateness, and Quality℠ (PEAQ) program evaluates physician performance in a transparent and multidimensional way. Physicians who meet inclusion requirements are provided with PPI reports that show how they compare to their peers and information to improve future performance. Read more.

Ground and Air Ambulance Overpayment Error

Blue Cross and Blue Shield of Texas (BCBSTX) has identified an overpayment error for certain ground and air ambulance claims. For dates of service between January 2017 through April 2022 the claims were erroneously allowing billed charges for some Commercial, FEP, Fully Insured/Retail and Host members. This error has been corrected and as of March 6, 2023, we have begun requesting applicable overpayments for these claims. This includes pursuing overpayments for claims within the last 24-month payment period for ASO and Blue Card and 5 years for FEP as required by these plans. Payments for Fully Insured and retail claims are not being pursued.

Claims will be adjusted upon receipt of the refund. Where applicable, BCBSTX will utilize its standard recoupment process described in the applicable provider manuals.

CLAIMS & ELIGIBILITY

New Availity® Eligibility & Benefits Experience

The Availity Eligibility and Benefits (E&B) tool has been redesigned based on your provider feedback to make it easier to locate the needed patient information in one consolidated view. The refreshed Eligibility and Benefits entry and response screens offer you a clearer and more concise workflow, as well as flexible options for adding providers, expandable sections, and other toggle/filtering options.
Education & Training Opportunities

- We host instructor-led weekly webinars called '**Orientation: Save Time and Go Online**' for providers to learn how to accurately use the **Availity Eligibility and Benefits** transaction, as well as an overview of other electronic options, provider tools and helpful online resources. Providers can register for upcoming sessions by going to Provider Training Webinars on our provider website.
- Availity also offers an on-demand demo at the top of the E&B request page to view how to complete a request and understand the detailed response.
- Watch for an updated Eligibility & Benefits User Guide coming soon to **Availity Eligibility and Benefits** page under Provider Tools on the provider website.

If you have additional questions or need customized training, contact our Provider Education Consultants.

Hospitals, and Routine Services and Supplies

Providers usually include routine services and supplies in charges related to other procedures or services. As such, those services/supplies are considered non-billable for separate reimbursement. The following guidelines identify items, supplies and services that are not separately billable. (Note: This is not an all-inclusive list.)

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over the counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable.

Medical Necessity Review of Observation Services

As a reminder, it is our policy to provide coverage for observation services when determined to be medically necessary based on the medical criteria and guidelines outlined in the MCG Care Guidelines. Claims for observation services are subject to post-service review, and we might request medical records for the determination of medical necessity.

ClaimsXten™ Announces Software Version Upgrade

Beginning on or after July 10, 2023, we will upgrade to ClaimsXten system software from version 6.0 to 7.0. Key enhancements include a new look for the Clear Claim Connection™ (C3) tool, with new data fields for greater claim specificity. The ICD code set default will now be ICD-10. Note: Clinical edit clarifications and related sources will continue to be available. Refer to our Clear Claim Connection Provider Tools web page for more details regarding ClaimsXten, including a user guide, rule descriptions and other details.

CLINICAL RESOURCES

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. During our policy review process, we regularly add and modify clinical payment and coding policy positions. The following policies were added or updated:

- Update of CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services Update, 04/01/2023 & 07/01/2023
- CPCP011 Applied Behavioral Analysis Updated, Effective 09/01/2023
- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services Update, 09/01/2023
- New CPCP041 Sepsis Policy, Effective 09/06/2023

EDUCATION & REFERENCE

Cultural Awareness Webinars: Earn 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.

Course Offerings

Select the links for course overviews and information on continuing education credits:

- 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)

How to Attend

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

The courses are self-paced. Find instructions and get help online.

Medicare Advantage Annual Wellness Visits: Webinar and Resources

Join us for a free webinar to learn about components of wellness visits, documentation standards, general coding requirements, and more. Our Coding Compliance team will present information from the official ICD-10-CM Coding Guidelines, the American Hospital Association Coding Clinic and the Centers for Medicare & Medicaid Services. Visit our provider website for more training opportunities.

- Date: July 10
- Time: Noon to 12:30 p.m. CT

Register here (If you cannot access the registration site, try clearing your web browser history.)

Provider Learning Opportunities

We offer free webinars for contracted providers who serve our members. Trainings focus on electronic options and other helpful tools and resources. Review upcoming training sessions – including the topics below – on our Provider Training Webinars page. Also, if you are a new provider or have new staff, refer to our Provider Orientation information.

- Availity Essentials Orientation – Save Time and Go Online
- Availity® Essentials Authorization and Referral Tools
- Availity Essentials Claim Status, Clinical Claim Appeals & Message This Payer
- Remittance Viewer & Reporting On-Demand via Availity Essentials
- eviCore® Healthcare Training
- Carelon™ ProviderPortal Training for Prior Authorizations

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.

Catch Up on Routine Vaccines and Well-Child Visits

Many children missed routine childhood immunizations and well-child visits during the last several years, according to the Centers for Disease Control and Prevention (CDC). The CDC recommends doctors and health care professionals encourage families to **schedule vaccines and visits to help children catch up**. See our Children's Wellness Guidelines for a **routine immunization schedule**.

Tracking our Members' Care

We track these Healthcare Effectiveness Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance to help close gaps in our members' care:

Child Immunization Status tracks the percentage of 2-year-olds who received the following vaccines by their 2nd birthday:

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA)
- Two or three rotavirus (RV)
- Two influenza (flu)

Immunizations for Adolescents tracks the percentage of 13-year-olds who received by their 13th birthday:

- One dose of meningococcal vaccine
- One tetanus, diphtheria and pertussis (Tdap)
- The complete human papillomavirus vaccine (HPV) series

Child and Adolescent Well-Care Visits

- Well-Child Visits in the First 30 Months of Life measures the percentage of children who had at least six well-child visits with a primary care physician (PCP) during their first 15 months, and two or more well-child visits during their next 15 months
- Child and Adolescent Well-Care Visits tracks the percentage of children ages 3 to 21 who received at least one well-care visit with a PCP or OB-GYN during the measurement year

Tips to Consider

- Identify members who have missed vaccines or well-child visits. Contact their caregivers to schedule appointments.
- Check at each visit for any missing immunizations. Address common misconceptions about vaccines.
- **To document well-child visits,** note that the visit was with a PCP and include in the medical record date of visit; health history; physical and mental development history; physical exam; height, weight and body mass index percentile; health education or anticipatory guidance, including physical activity, diet and nutrition
- We collect immunization data through claims and chart review. **To document immunizations,** you may include in the medical record any of the following: certificates of immunizations; diagnostic reports; Subjective, Objective, Assessment and Plan (SOAP) notes; office or progress notes

Resources

- BCBSTX preventive care guidelines on immunization schedules
- Information on childhood vaccines and well-visits for our members
- CDC recommendations on COVID-19 vaccines and boosters for children and teens

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MEDICARE ADVANTAGE

BCBS Medicare Advantage PPO Network Sharing

All Blue Cross and Blue Shield Medicare Advantage℠ (BCBS MA PPO) plans participate in reciprocal network sharing, which allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO plan if the member sees a contracted BCBS MA PPO provider. For more information, refer to the Blue Cross Medicare Advantage (PPO) Provider Supplement. If you have questions regarding the BCBS MA PPO program or products, please contact BCBS MA PPO Customer Service at 1-877-774-8592.

Additional Changes to Prior Authorization Codes for Medicare Members, Effective July 1, 2023

What's Changing: In addition, to new codes added as indicated in the previous notice, Blue Cross and Blue Shield of Texas (BCBSTX) removed prior authorization requirements for some ultrasound codes and replaced a specialty drug code for Medicare members to reflect updates from Utilization Management or the American Medical Association (AMA) **effective July 1, 2023**. The impacted codes were previously reviewed by eviCore healthcare.

The **Prior Authorization Lists** previously posted for 07/01/2023, on the **Utilization Management** section of our provider website on the Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ page, reflect these changes.
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.

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.

PHARMACY

Pharmacy Benefits

As a participating practitioner, you are given a list of drugs that we review and update throughout the year. For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines. For more information, visit the Pharmacy Program section on our provider website. For Federal Employee Program® members, information can be found at fepblue.org/pharmacy. We encourage you to check our provider website regularly and watch for updates in this newsletter. The following information is available on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits and quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step-therapy protocols

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PRIOR AUTHORIZATION

Additional Changes to Prior Authorization Codes for Commercial Members, Effective July 1

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 the replacement of certain Medical Oncology codes reviewed by Carelon Medical Benefits Management. These changes are based on updates from 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.

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 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.

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.

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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