BLUE REVIEW℠

A Provider Publication

JUNE 2023

NOTICES & ANNOUNCEMENTS

Medical Policy Updates

Recently Blue Cross and Blue Shield of Texas updated our Medical Policy page and link. Be sure to change your bookmark to the updated link. After reviewing and agreeing to the disclaimer, the new page provides navigation on the left-hand panel to:

- Home
- Government Program Policies
- Active Policies
- Pending Policies
- Updates
- Draft Policies

When Policies are Posted

New or revised medical policies, when approved, may be posted on the BCBSTX provider website on the 1st or 15th day of each month. Those medical policies requiring disclosure will become effective 90 days from the posting date. Medical policies that do not require disclosure will become effective 15 days after the posting date. The specific effective date will be noted for each medical policy that is posted. To streamline the medical policy review process, you can view draft medical policies and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks.

Related Information

Refer to the Recommended Clinical Review Option page for information on submitting a request for review of your services prior to rendering the service. In addition, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies page.

Language Line Supporting Cultural Competence

BCBSTX offers translation services for hundreds of languages to providers and members free of charge through our Language Line.

Where do I call and how does this work?

- Call 1-800-874-9426 for Group insurance members. When asked supply code 704322
- Call 1-866-874-3972 for Retail insurance members. When asked supply code 706640
- Provide the needed language and within 5 minutes a translator will be on the phone to assist you and your patient.

Cultural Competence

- More than 67 million people in the United States speak a language other than English at home. (1) The American Academy of Family Physicians reported this population is least likely to access care or be satisfied with the care they receive. (2)
- Limited English proficiency complicates communication which increases the risk of adverse effects from medications and misunderstanding physician instructions or diagnosis information as noted in the American Family Physician Journal article Appropriate Use of Medical Interpreters (2).
- Results for the 2021 and 2022 BCBSTX Enrollee Experience Survey (EES) revealed a significant drop (5 percentage points) in member satisfaction with Cultural Competence directly related to translation services during a doctor or clinic appointment when compared to 2020 scores.

We encourage you:

- To use the language line as an additional resource for you and your office staff as you care for your patients.
- Watch News and Updates (http://www.bcbstx.com/provider/education/education/news) for more information and future announcements.

(1) U.S. Census Bureau. American community survey. http://www.census.gov/acs/www. Accessed March 20, 2023
(2) https://www.aafp.org/afp/2014/1001/p476.html

Fee Schedule Updates

We will post reimbursement changes and updates for commercial HMO and PPO practitioners in the Reimbursement Schedules and Related Information section under Standards and Requirements / General Reimbursement Information on our BCBSTX provider website. In-network providers can obtain the password from their Network Management Office.

Changes resulting in a decreased reimbursement will not become effective until at least 90 days from the posting date. We will post the specific effective date for each change. To view this information, visit the General Reimbursement Information section on our BCBSTX provider website.

The Drug CPT®/HCPCS Fee Schedule is updated quarterly on March 1, June 1, Sept. 1 and Dec. 1 each year. The NDC Fee Schedule is updated monthly.

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

ClaimsXten™ Quarterly Update Effective August 21, 2023

Blue Cross and Blue Shield of Texas (BCBSTX) will implement its second and third quarter code updates for the ClaimsXten auditing tool on or after August 21, 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.

More Outpatient Surgery Codes With Increased Reimbursement When Performed in Ambulatory Surgery Center

In March 2023, Blue Cross and Blue Shield of Texas (BCBSTX) increased the maximum allowable standard fee schedule reimbursement for 63 additional outpatient surgery services when performed at in-network Ambulatory Surgery Centers (ASC) for commercial members*.

This initiative creates an opportunity to increase your reimbursement by 15%-50% on each qualifying procedure while allowing patients to receive the same quality of care they would get in a hospital but at a significantly lower cost.

More Information

For more information and a full list of codes visit our website.
In addition, participating providers may use the Fee Schedule Viewer tool via Availity Essentials to electronically receive the incentive price allowance, as applicable, for up to 20 procedure codes at a time by selecting **Other Place of Service**.

*Please note, this does not apply to BCBSTX Medicare Advantage or Medicaid members.

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:

- CPCP034 Unbundling Policy – Professional Providers, Effective 08/15/2023
- CPCP0013 Increased Procedural Services (Modifier 22), Effective 08/15/2023
- CPCP012 Hernia Repair, Effective 08/18/2023
- Annual Review: CPCP026 Therapeutic Prophylactic Diagnostic Injection Infusion, Effective 05/17/2023

EDUCATION & REFERENCE

Webinar on Coding for Chronic Kidney Disease

Join us for a webinar on how to code stages and treatments for chronic kidney disease (CKD). The webinar is free to providers and coding professionals. Our Coding Compliance team will present coding 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: June 16
- Time: Noon to 12:30 p.m. CT
- Register here (If you cannot access the registration site, try clearing your web browser history.)

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.

The Need for Better, Improved Continuity and Coordination of Care

Electronic health record (EHR) systems are capable of facilitating the timely distribution of integrated and organized patient health information. These can reduce the fragmentation that can surround the continuum of care. Reducing fragmented care leads to better continuity and coordination of care. Leveraging this tool in every episode of care allows for:

- notification to all authorized providers when a patient has been in the hospital or seen in the ED
- every provider involved in a patient's care to have the same up-to-date information including medications, allergies, and other medical conditions
- timely follow up with the patient

Technology has advanced to give us better availability and accuracy of patient information. This improved information sharing is especially important for patients:

- getting emergency treatment
- seeing multiple providers
- transitioning between care settings

Blue Cross Blue Shield of Texas (BCBSTX) annually surveys a sample of our providers about their satisfaction. The BCBSTX Provider Satisfaction Survey includes questions about PCPs' satisfaction with inpatient hospital discharge summaries and emergency department visit summaries. In 2022, there was a nice improvement in the overall satisfaction with continuity of care and receiving hospital discharge summaries, although we did not meet our goal of 85%. There was a 2-percentage point decrease in adequate information about medications at discharge, but it still met our goal. There were no changes in the timeliness of receipt of summaries, and this area still needs some improvement. The results demonstrate opportunities for improvement, most importantly making sure the PCP receives an inpatient discharge summary and an ED visit summary.

BCBSTX Provider Satisfaction Survey Results

Survey Questions	Goal 85%	2021	2022
Overall satisfaction with continuity of care		73%	79%
When your patients are seen by the following, are you sent summary information following the discharge or visit? Inpatient Setting Emergency Dept.		64% 59%	69% 59%
When you receive the summary information, does it reach your office in a timely manner (within 10 business days)? Inpatient Setting Emergency Dept.		78% 71%	78% 71%
When you receive hospital discharge information, does it contain adequate information about medications at discharge?		88%	86%

If every episode of care is captured electronically and every effort is made to identify all providers involved in the care of a patient, authorized information sharing can be critical in avoiding miscommunication or delays in care. EHRs are an invaluable resource that may improve patient outcomes by providing better quality of care and better continuity and coordination of care between care settings and providers.

Helping Our Members Manage Diabetes

More than 37 million Americans have diabetes, according to the Centers for Disease Control and Prevention (CDC). Because symptoms can develop slowly, one in five of them don't know they have it. You may play an important role in supporting our members through regular screenings, tests and office visits.

Monitoring Our Members' Care

We track Healthcare Effectiveness Data and Information Set (HEDIS®) measures from the National Committee for Quality Assurance (NCQA) related to diabetes care, including:

- **Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)** captures the percentage of our members ages 18 to 75 with diabetes (type 1 and type 2) whose HbA1c level during the measurement year is:
    - Less than 8.0%, indicating controlled
    - Greater than 9.0%, indicating uncontrolled. A lower rate on this measure indicates better performance.
- **Eye Exam for Patients with Diabetes (EED)** tracks members ages 18 to 75 with diabetes (type 1 and type 2) who have a retinal eye exam by an eye care professional to screen or monitor for diabetic retinal disease.
- **Blood Pressure Control for Patients with Diabetes (BPD)** captures members ages 18 to 75 with diabetes (type 1 and type 2) whose blood pressure was controlled (<140/90 mm Hg).
- **Kidney Health Evaluation for Patients with Diabetes (KED)** tracks members ages 18 to 85 with diabetes (type 1 and type 2) who received a kidney health evaluation during the measurement year. An evaluation includes a blood test for kidney function (estimated glomerular filtration rate, or eGFR) and a urine test for kidney damage (urine albumin-creatinine ratio, or uACR).
- **Statin Therapy for Patients with Diabetes (SPD)** tracks members ages 40 to 75 who have diabetes and don't have clinical atherosclerotic cardiovascular disease (ASCVD), and who received and adhered to statin therapy.

Tips to Close Gaps in Care

- Identify care gaps and schedule lab tests before office visits to review results and adjust treatment plans if needed.
- Document medication adherence to angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB) when applicable.
- Repeat abnormal lab tests later in the year to document improvement.
- Monitor blood pressure status at each visit and adjust medications as needed for control.
- Encourage members with diabetes to have annual retinal or dilated eye exams by an eye care specialist.
- For our members on statin therapy, discuss the proper dose, frequency and the importance of staying on the medication.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.

Resources

We encourage you to talk with our members about diabetes. We've created information that may help, including:

- Type 1 and Type 2 symptoms
- Regular eye exams to avoid vision loss, or diabetic retinopathy
- Screenings for kidney disease, or diabetic nephropathy
- Making a care plan

See our preventive care and clinical practice guidelines for more information on diabetes.

Colon Cancer Screenings Goal: 80% In Every Community

What is 80% in Every Community? While the 80% by 2018 national colorectal cancer (CRC) screening campaign led by the National Colorectal Cancer Roundtable (NCCRT), brought about progress in reducing CRC as evidenced by increased screening rates, there is still work to be done. The 80% in

Every Community Strategic Plan (2020-2024) provides a variety of recommended activities to use toward achieving 80% CRC screening rates in all communities.[i] The goal is to reduce disparities in screening for marginalized populations including racial/cultural minorities, those with low education levels, and the uninsured. In the U.S., CRC is still the 2nd leading cause of cancer death in the U.S. among men and women combined.[ii]

What is the Vision of the plan? Everyone has access to a quality screening at the right time.
What are the Core Values of the plan? Collaboration of resources and emphasizing health equity to address disparities in screenings, incidence, and mortality.

What are the Desired Impacts of the plan? Screening rates meet or exceed 80% in communities, reduction in screening rate disparities, and declines in mortality.

How far away are we from reaching this goal? In 2022, the national Healthcare Effectiveness Data and Information Set (HEDIS®) PPO average was 63.4 percent compared to BCBSTX's Commercial PPO HEDIS result of 53.37 percent. BCBSTX Quality Improvement CRC screening efforts were numerous and included shipping out over 54K FIT Kits directly to members with gaps in care which resulted in a 14.8% gap closure rate. BCBSTX mailed over 7K advanced notification letters to PCPs with a list of which of their patients would be receiving a kit. In that letter, we asked to outreach these patients and encourage them to take part in the free at home screening.

We need your help to reach this goal! Over the next few months, we will provide a series of **'80% in Every Community'** articles that will provide more information on efforts to increase CRC screenings and identify barriers. These articles will supply useful information such as:

- 80% In Every Community - Resources
- Data & Progress

What influences these results? YOU DO! The biggest influencer to motivate patients to get screened is YOU and your staff. Identify your patients who need it, talk to them about the importance of CRC screenings and then get them screened! Once this happens, they can be easily tracked for annual follow-up.

What actions can you take to make a difference?

- Flag the EMR for those ages 45-75 and start that conversation.
- Have standing orders for CRC screenings for those ages 45-75 and follow through with them.
- Direct your most persuasive and educated staff to answer questions and concerns, and help patients commit and complete CRC screenings.

Remember: The best CRC screening test is the one that gets done! Thank you in advance for your commitment to this important preventive screening!

[i] National Colorectal Cancer Roundtable. 2023. https://nccrt.org/
[ii] Cancer Facts & Figures. American Cancer Society. 2023. https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/2023-cancer-facts-figures.html

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MEDICARE ADVANTAGE

Medical Records Reminder for Out-of-Area Medicare Advantage Members

If we need medical records for Blue Cross Group Medicare Advantage (PPO)SM members, you will receive requests from BCBSTX or our vendor, Change Healthcare. Please respond quickly to our requests, including those related to risk adjustment gaps and HEDIS measures. Additionally, you may receive requests from CERiS of CorVel Health Corporation for select inpatient diagnosis-related group claims for out-of-area Blue Cross Medicare AdvantageSM members.

Preventive Services Reminder: Zero Copay for Blue Cross Medicare Advantage

We want to remind you that there are no copays for preventive services for Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO)SM. Blue Cross Medicare Advantage covers a full range of preventive services to help keep patients healthy, help find problems early and determine when treatment is most effective. Access the Medicare Learning Network's Medicare Preventive Services for detailed information.

Medicare Advantage Annual Wellness Visit Resources

We're providing resources to help you track Medicare wellness visit requirements. As you know, wellness visits provide opportunities to screen for health conditions and manage chronic ones, so please encourage our members to schedule a visit this year if they haven't already. Note: These resources are optional and you don't need to return anything to us.

- Our Annual Wellness Visit Guide has a checklist and information on coverage, coding, preventive services and closing gaps in care.
- Our Annual Wellness Visit Form includes sections for members' medical history, risk factors, conditions, treatment options, coordination of care and advance care planning.

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.

PRIOR AUTHORIZATION

Update to Prior Authorization Codes for Medicare Members, Effective July 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)SM and Blue Cross Medicare Advantage (HMO)SM page.

Changes **effective July 1, 2023** include the following codes reviewed by eviCore healthcare:

- Addition of Lab codes
- Addition of Specialty Pharmacy Drug

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

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Contact Us

View our quick directory of contacts for BCBSTX.

Verify and Update Your Information

Verify your directory information every 90 days. Use the Provider Data Management feature on Availity® or our Demographic Change Form. You can also use this form to submit email addresses for you and your staff to receive the *Blue Review* each month.

Checking eligibility, benefit information and/or if a service has been prior authorized is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

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

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 independent company 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 registered trademark 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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