BLUE REVIEW℠

A Provider Publication

MARCH 2023

NOTICES & ANNOUNCEMENTS

How to Identify UT CARETM Members

As of Jan. 1, 2023, approximately 30,000 retirees from the University of Texas System (UTS) converted to UT CARE™ Medicare PPO **(UT CARE)**. UT CARE is a Blue Cross and Blue Shield of Texas (BCBSTX) **open access** Medicare Advantage PPO plan for UTS retirees.

ID Card Reminders

The **front** of a **UT CARE** member ID card includes:

- The **UT CARE** plan name **UT CARE Medicare PPO**
- **Group #:** No group number is on the ID Card. It is **not** needed to verify benefits.

ID Card Quick Reference Tips

- Each member receives a **NEW** member ID number and card.
- The **entire member ID** number including prefix must be updated to verify benefits and successfully process claims.
- Be sure to **replace** the patient's previous member number with the new **UT CARE** number in your records.

Verification of Benefits

- Use the Availity Essentials or your preferred vendor to check eligibility and benefits **or**
- Call Customer Service: 1-877-842-7562 to provide the following:
    - **Full Member** ID number with alpha prefix letters: ZZTU12345678 **on front** of member ID card
    - Member date of birth **MM/DD/YYYY** format

Verify Your Directory Details Every 90 Days

As a reminder, the Consolidated Appropriations Act (CAA) of 2021 requires that certain directory information be verified every 90 days. It must 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® if the information isn't verified.

What to Verify
Verify your name, address, phone, specialty, and digital contact information (website) every 90 days. You also must update your information when it changes, including if you join or leave a network. See our Verify and Update Your Information page on our Provider website.

How to Verify - Professional Providers

- We recommend the **Availity® Essentials Provider Data Management feature** to quickly verify your information with us and other insurers every 90 days. Availity allows one transaction to verify for multiple insurers. See the Provider Data Management webpage 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 reminders from us. The email has a unique link to verify information.

How to Verify – Professional Provider Groups
Groups can verify individual providers through Availity Provider Data Management or our Demographic Change Form.

How to Verify – Professional Provider Groups Who Submit Changes by Roster
Medical groups who update their provider information by roster can verify all their providers' information every 90 days with their roster. When you submit a roster, all providers affiliated with this group and not listed with an update **are verified as correct with no changes**.

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

How to Update Your Information – All Facilities and Professional
If you need to change your data, you may continue to use the Demographic Change Form. Professional providers may update some data through Availity Provider Data Management. See our Verify and Update Your Information page for details. Updating your data will count as your 90-day verification.

To enable us to meet the two-day directory update requirement defined by the CAA, we won't accept demographic changes by email, phone or fax. Any demographic updates requested through these channels will be rejected and closed.

BEHAVIORAL HEALTH

Quality Care: Screening for Depression

Screening patients for depression is an important part of outpatient visits. We created a video about depression screening tools, procedure codes and following up on positive screening. You can **watch the video here**.

We encourage you to **talk with our members about mental health and getting help** if needed. More than half of Americans will be diagnosed with a mental illness or disorder at some point in their lives, according to the Centers for Disease Control and Prevention. Patients often **rely on their primary care physicians** for behavioral health care, according to the American Academy of Family Physicians.

Supporting Quality Behavioral Health Care

We track claims data for quality measures to help assess and improve our members' behavioral health care. See our tip sheets to learn more about the following measures and closing gaps in members' care:

Antidepressant Medication Management (AMM)

AMM captures the percentage of members ages 18 and older with major depression who are **newly treated with antidepressant medication and remain on it**. We track two treatment phases:

- Effective acute treatment phase: Adults who remain on antidepressant medication for at least 84 days (12 weeks)
- Effective continuation treatment phase: Adults who remain on antidepressant medication for at least 180 days (six months)

Follow-up after Hospitalization for Mental Illness (FUH)

FUH applies to members ages 6 and older who had a follow-up visit with a mental health provider after they were hospitalized for the treatment of mental illness or intentional self-harm. FUH captures the percentage of discharges for which members had a **follow-up visit**:

- Within 30 days of discharge (31 total days)
- Within seven days of discharge (eight total days)

Follow-up after Emergency Department Visit for Mental Illness (FUM)

FUM captures the percentage of emergency department visits for which members ages 6 and older with a diagnosis of mental illness or intentional self-harm had a **follow-up visit**:

- Within 30 days of the emergency department visit (31 total days)
- Within seven days of the emergency visit (eight total days)

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

SSD tracks the number of people 18 to 64 years old with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had an **annual diabetes screening**.

CLAIMS & ELIGIBILITY

Prior Authorization and Claim Reconciliation for Neonatal Intensive Care Unit Services Effective

What's changing: Beginning **April 16, 2023**, Blue Cross and Blue Shield of Texas (BCBSTX) will begin reviewing claims **as they are received** to verify the claim is billed consistent with its prior authorization, including number of days by level. Claims **will only pay for the days billed at the level approved on the prior authorization.**

Previously this review was done on a post-payment basis, resulting in refund requests when claims were inconsistent with the prior authorization. Now, the Provider Claim Summary (PCS) will explain how the claim was paid upon adjudication.

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:

- CPCP003 Emergency Department Evaluation and Management (E/M) Services Coding – Facility Services – Effective Feb. 22, 2023
- CPCP017 Wasted/Discarded Drugs and Biologicals Policy – Effective May 16, 2023
- CPCPCP022 Pneumatic Compression Devices – Outpatient Use – Effective May 17, 2023

EDUCATION & REFERENCE

Closing Gaps in Colon Care

Preventive screenings are the most effective way to reduce the risk of colorectal cancer, according to the Centers for Disease Control and Prevention (CDC). The CDC and the U.S. Preventive Services Task Force (USPSTF) recommend that **everyone 45 to 75 years old get a screening**.
Studies show colorectal cancer is becoming more common in people younger than 50. We encourage you to discuss screenings and colon health with our members. We've created resources that may help.

Recommended Screening

USPSTF recommends screening with any of the following tests for adults ages 45 to 75:

- Annual guaiac fecal occult blood test (gFOBT)
- Annual fecal immunochemical testing (FIT)
- DNA-FIT every one to three years
- Flexible sigmoidoscopy every five years
- Flexible sigmoidoscopy every 10 years with annual FIT
- Computed tomography (CT) colonography every five years
- Colonoscopy every 10 years

See our preventive care guidelines for more information about screening. Providers may want to discuss earlier testing with members with a family history of colorectal disease or other risk factors.

Closing Care Gaps

Colorectal Cancer Screening is a quality measure developed by the National Committee for Quality Assurance (NCQA) that tracks appopriate screenings. To help close gaps in care, consider these tips:

- In our members' records, document the date a colorectal cancer screening is performed or include the pathology report indicating the type and date of screening.

- Encourage members to stay up to date on their screenings as well as all screening options available.
- Reach out to members who cancel screenings and help them reschedule.

Addressing Health Disparities
Black Americans are 20% more likely to get colon cancer than other racial and ethnic groups, and 40% more likely to die from it, according to the American Cancer Society. They also are more likely to develop colon cancer at younger ages. Talk with our members about the **importance of regular screening and the unique risks** Black people may face. See our Health Equity and Social Determinants of Health page for more information.

Checking Eligibility and Benefits
Check member eligibility and benefits using Availity® Essentials or your preferred vendor before every scheduled appointment. Eligibility and benefit quotes include members' coverage status and other important information, such as applicable copays, coinsurance, and deductibles.
For most of our members, **preventive colorectal cancer screening** is covered **at no cost share**. For **diagnostic tests for colorectal cancer**, our members **may have out-of-pocket costs**. This includes diagnostic tests for members who have signs of health problems or a family history of disease. Learn more.

Some screenings involve a member's **pharmacy benefits** in addition to their medical benefits, such as the prep kit for colonoscopies. For details about pharmacy benefit coverage, call the number on the member's ID card. A member's pharmacy benefit may be managed by a company other than Blue Cross and Blue Shield of Texas (BCBSTX).

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.

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.

MEDICARE ADVANTAGE PLANS

Survey to Assess Medicare Advantage Members' Experiences

Every year some of our members receive a survey to collect information about their experiences with their health care providers, their Blue Cross Medicare Advantage℠ plans, and their prescription drug plans.

The Centers for Medicare & Medicaid Services (CMS) sends the **Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey** to a random sample of our members from **March through June**. Members are asked to rate their last six months of care. If your patients receive a CAHPS survey, **please encourage them to respond**.

Why the CAHPS survey is important

The survey identifies opportunities to improve member satisfaction. Results also affect the Centers for Medicare & Medicaid Services (CMS) Star Ratings, which rate Medicare Advantage plans on a scale from one to five stars. Our goal is to achieve the highest possible Star rating for our plans. Learn more about the survey from CMS.

How you can help

The survey evaluates how our members interact with their health plan and with you, their provider. Here are tips to help improve members' experiences year-round:

Provide needed care quickly and coordinate care with specialists.

- Leave openings for sick visits and urgent appointments
- Discuss how to access telehealth services and after-hours care
- Follow up with members' specialists to ensure continuity of care

Communicate clearly.

- Ask members about their top health concerns
- Keep conversations clear and simple
- Follow up after urgent or emergency care

Keep members healthy.

- Recommend and/or administer the flu shot during flu season
- Educate members on preventive services, chronic conditions and ongoing care
- Let members know whether you offer telehealth services that allow them to access care from home
- Discuss the COVID-19 vaccine
- Screen members for risk factors, like tobacco use, and recommend appropriate lifestyle changes
- Complete and document any health assessments
- Identify and follow up with members who haven't visited in the past year

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

What's changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Medicare members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

Medicare: Refer to **Prior Authorization Lists** on the **Utilization Management** section of our provider website. The revised lists can be found on the Prior Authorization Lists for Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ page.

Changes effective 04/01/2023 include:

- Addition of lab codes to be reviewed by eviCore
- Addition of musculoskeletal codes to be reviewed by eviCore
- Addition of radiation oncology codes to be reviewed by eviCore
- Removal of a musculoskeletal code previously reviewed by eviCore
- Addition of a Specialty Pharmacy code to be reviewed by BCBSTX

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.

Closing Gaps in Care for Group Medicare Advantage Members

Through the Blue Cross and Blue Shield (BCBS) National Coordination of Care program, we can work with you to help close gaps in care for **Blue Cross Group Medicare Advantage (PPO)℠** (Group MA PPO) members. These include Blue Cross and Blue Shield of Texas (BCBSTX) members with Group MA PPO coverage, as well as Group MA PPO members enrolled in other BCBS plans who are living in Texas.

What This Means for Medicare Providers

If we need medical records for Group MA PPO members, you will receive requests only from BCBSTX or our vendor, Change Healthcare. You won't receive requests from multiple BCBS plans or their vendors. We may request medical records for:

- Risk adjustment gaps related to claims submitted to BCBSTX
- Healthcare Effectiveness Data and Information Set (HEDIS®) measures
- Centers for Medicare & Medicaid Services (CMS) Star Ratings

Important Reminders

- Respond quickly to requests related to risk adjustment, HEDIS and other government-required activities as your contract requires.
- You don't need patient-authorized information releases to fulfill medical records requests and risk adjustment gaps through this program.
- Use the Availity® Essentials or your preferred vendor to verify BCBSTX and other BCBS members' eligibility and benefits before every appointment. Eligibility and benefit quotes include:
    - Membership verification
    - Coverage status
    - Prior authorization requirements
    - Provider's network status for the patient's policy
    - Applicable copayment, coinsurance, and deductible amounts
- Ask to see the member's ID card and a photo ID to help guard against medical identity theft.
- Notify members that they may be billed directly when services may not be covered.

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

PHARMACY

Pharmacy Program Updates: Quarterly Pharmacy Changes Effective April 1, 2023 – Part 1

Review important pharmacy benefit reminders, drug list updates and Utilization Management program changes. 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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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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