BLUE REVIEW℠
A Provider Publication

MAY 2023

NOTICES & ANNOUNCEMENTS

How to Correctly Use Our Claim Review Form

Blue Cross and Blue Shield of Texas (BCBSTX) has revised our Claim Review Form. This form is available on the provider website under Education and Reference/Forms.

Below are reminders for how to correctly use the Claim Review form.

When to use the Claim Review Form:

- This form is only to be used for review of a previously adjudicated claim
- Original claims should not be attached when submitting this form

When Not to Use the Claim Review Form:

- Do not use this form to appeal on behalf of a member
- Do not use this form to submit a corrected claim or respond to a request for additional information. Refer to separate forms for these submissions on our Forms page on the website.

Other Reminders:

- Inquiries without the required information (denoted by an *asterisk on the form) may not be reviewed
- You must include the completed form, even when submitting your inquiry electronically

Learn More

Review information on the Claim Form and refer to the Texas Provider Manuals for more information and detail on claim reconsiderations and how to use the Claim Review form.

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.

BEHAVIORAL HEALTH

Behavioral Health Consultations During Hospitalization Can Improve Outcomes

Coexisting physical and behavioral health conditions can be difficult to manage. Studies have found that people hospitalized for physical health conditions who also have mental illness are more likely to be readmitted than people who don't have mental illness. Proper follow-up care for behavioral health after a hospitalization is often lacking, according to the National Committee for Quality Assurance (NCQA).

Behavioral health consultations during a hospital stay can help our members who have physical and behavioral health conditions. Addressing behavioral health care with timely follow-ups can help **reduce hospital readmissions** and improve health outcomes, according to NCQA.

We encourage hospital staff/attending physicians to discuss behavioral health with our members during a hospital stay and **to consider consultations and follow-up care coordination** when appropriate.

Tips for Behavioral Health Consultations and Follow-Up Care

To help improve outcomes for our members receiving inpatient care, we encourage hospital staff/attending physicians to consider the following:

- Discuss with our members and their medical teams how medical and behavioral health diagnoses are important and **can be intertwined**.
- Facilitate **behavioral health consultations** for our members when they're admitted to a medical unit for a medical concern and also display behavioral health symptoms.
- Coordinate care with our members' medical and behavioral health providers and social support to help ensure **timely follow-ups**. A behavioral health follow-up within 30 days after discharge can be in the form of:
    - Behavioral health inpatient admission
    - Partial hospitalization program
    - Intensive outpatient program
    - Behavioral health outpatient appointment
- When a member receives a psychiatric consultation while medically inpatient and receives a secondary behavioral health diagnosis, the claim should include the **behavioral health diagnosis** and the correct Current Procedural Terminology (CPT®) **codes for a psychiatric consult**.

How We Can Help

Call the number on our member's ID card to connect them with a **case manager support service** or other referral resources after discharge to help with ongoing treatment and follow-up.

CLAIMS & ELIGIBILITY

Enrollee Notification Form Required for Out-of-Network Care for Blue Choice PPO℠ and Blue Advantage HMO℠ (for Blue Advantage Plus)

Prior to referring a Blue Choice PPO or Blue Advantage HMO member (for Blue Advantage Plus point-of-service benefit plan) to an out-of-network provider for non-emergency services (when such services are available through an in-network provider), the referring participating network provider must complete the appropriate Out-of-Network Care – Enrollee Notification forms for Regulated Business (used when "TDI is on the member's ID Card) or Non-Regulated Business (No "TDI on member's ID card). Locate them under Forms on our provider website.

Also, the referring network physician must provide a copy of the completed form to the enrollee and retain a copy in the enrollee's medical record files.

It is essential that Blue Choice PPO and Blue Advantage Plus enrollees fully understand the financial impact of an out-of-network referral to a health care provider that does not participate in their BCBSTX provider network. They have out-of-network benefits and may choose to use out-of-network providers, however, they will be responsible for an increased cost-share under their out-of-network benefits.

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 and does not 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:

- Annual Review: CPCP024 Evaluation and Management Coding: Professional Provider Services – Effective 04/20/2023
- New CPCP038 Outpatient Services Prior to an Inpatient Admission, Three-day Payment Policy – Effective 08/01/2023
- CPCP028 Non-Reimbursable Experimental, Investigational and/or Unproven Services Update – 07/01/2023

EDUCATION & REFERENCE

Webinar on Coding for Chronic Kidney Disease

Join us for a webinar, **Coding Stages and Treatment for Chronic Kidney Disease (CKD)**. We will offer it three times*:

- **April 21, 2023,** from noon to 12:30 p.m. Central time. Register here.
- **May 19, 2023,** from noon to 12:30 p.m. Central time. Register here.
- **June 16, 2023,** from noon to 12:30 p.m. Central time. Register here.

*If you're unable to view the registration site, you may need to clear your web browser history.
The webinar is free to providers and coding professionals. Members of our Coding Compliance team will present coding information from the Official ICD-10-CM Coding Guidelines, American Hospital Association Coding Clinic and Centers for Medicare & Medicaid Services. The webinar includes information on:

- Specificity, accuracy and completeness in documentation
- Coding for CKD with diabetes mellitus, hypertension and hypertensive heart
- Closing gaps in care for patients with CKD

Visit our Provider website for more training opportunities.

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.

Track Care Visits During and After Pregnancy

Prenatal and postpartum care contributes to the long-term well-being of new mothers and their infants, according to the American College of Obstetricians and Gynecologists. We encourage you to talk with our members about the importance of **attending all care visits** during and after pregnancy.

Addressing Health Disparities

The rate of women who die from maternal health causes continues to rise in the U.S., according to the Centers for Disease Control and Prevention (CDC). Rates rose to 32.9 deaths per 100,000 live births in 2021, up from 20.1 in 2019. The rate for Black women was more than twice as high as the rate for white women. Rates also are higher for American Indian and Alaska Native women than white women. Maternal Mortality Review Committees found that 80% of pregnancy-related deaths could be prevented. Consider talking with our members about the unique risks and barriers to care they may face. See our Health Equity and Social Determinants of Health page for more information. The Blue Cross and Blue Shield of Texas (BCBSTX) Preventive Care Guidelines and Perinatal Wellness Guidelines for members also may be helpful.

Tracking Prenatal and Postpartum Care Visits

We track the quality measure Prenatal and Postpartum Care (PPC) to help assess and improve our members' care. PPC captures:

- **Timeliness of prenatal care,** or the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with BCBSTX
- **Postpartum care,** or the percentage of deliveries in which women had a postpartum visit on or between seven and 84 days after delivery

We also track two quality measures focused on maternal mental health: Prenatal Depression Screening and Follow-Up (PND-E) and Postpartum Depression Screening and Follow-Up (PDS-E). Read more about maternal mental health here.

Tips to Close Gaps in Care:

- Check with our members to ensure that **initial prenatal visits** are scheduled in the first 12 weeks of pregnancy with an OB-GYN, primary care provider (PCP) or other prenatal practitioner.
- Be aware that **post-operative visits**, which typically occur within a couple of days of discharge or during an inpatient stay after a cesarean section, don't count as a postpartum visit. A postpartum visit must take place on or between **seven and 84 days** after delivery. Members should be reminded to schedule their postpartum care visit during the C-section post-op visit.
- Data for this measure is collected from claims and chart review for services performed by an OB-GYN, midwife, family practitioner or other PCP. Services provided during telehealth visits, e-visits and virtual check-ups are eligible for reporting to meet the measure
    - **When documenting a prenatal visit**, include diagnosis of pregnancy, last menstrual period or estimated date of delivery, prenatal risk assessment, complete obstetrical history, fetal heart tone and screening tests.

- **When documenting a postpartum visit**, notate postpartum care, check or six-week check. Document the pelvic exam and evaluation of weight, blood pressure, breasts and abdomen.

New Support Program for Members with Kidney Disease

We are offering a new support program to certain Blue Cross and Blue Shield of Texas (BCBSTX) **members who have chronic kidney disease (CKD) or end-stage kidney disease (ESKD),** or who are at risk for these diseases. We are working with Somatus®, a leading value-based kidney care organization, to deliver this program at no extra cost to **eligible Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠** members.

How This Program Can Help

This program provides eligible members with a personal support team of health professionals to help them manage their kidney disease and actively follow their providers' treatment plans. The goal is to **help improve members' clinical outcomes and quality-of-life measures**, and to slow or stop disease progression. The program offers members:

- One-on-one care to help manage their kidney disease and comorbidities, and to address social determinants of health
- Personal health coaching based on their condition, treatment options, and diet
- Help transitioning safely from hospital to home
- Guidance exploring transplant options, if appropriate
- A 24/7 Care Line staffed by Somatus nurses at **1-855-851-8354**, ext. 9

How You Can Help

To find out which patients in your practice are eligible for this program, email Somatus. Please help us help our members by **encouraging your eligible patients to participate**.
If you have questions, call Somatus at **1-855-851-8354** Monday through Friday from 7 a.m. to 7 p.m. Central Time.

Somatus is an independent company that provides care management services for BCBSXX members with CKD and ESKD. Somatus is wholly responsible for its own products and services. BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.

PHARMACY

Pharmacy Program Quarterly Update, Part 2: Changes Effective April 1, 2023

Review important pharmacy benefit reminders, drug list and dispensing limit changes, and Utilization Management program changes. Read More

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PRIOR AUTHORIZATION

Update to Prior Authorization Codes for Commercial Members, Effective July 1, 2023

What's new: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes. These

changes are based on updates from Utilization Management prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) changes from the Centers for Medicaid & Medicare Services.

Changes effective July 1, 2023, include:

- Addition of Medical Oncology* codes to be reviewed by Carelon Medical Benefits Management (Carelon) formerly AIM Specialty Health®
- Replacement and removal of Musculoskeletal Joint and Spine codes reviewed by Carelon
- Addition of Genetic Testing codes to be reviewed by Carelon
- Replacement of an Infusion Site of Care drug code reviewed by BCBSTX
- Addition of Advanced Imaging codes to be reviewed by Carelon

*Watch our provider website for training sessions beginning in May 2023 related to enhancements to Medical Oncology prior authorization submissions to the Carelon Provider Portal.

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** page.

Note: Effective July 1, 2023, the prior authorization list will include a link to the medical policy website for review of the specific medical policies associated with the procedure code rather than listing the medical policy number and title for each code. The list will continue to include information on whether prior authorization for the procedure code is managed by BCBSTX or Carelon.

Check Eligibility and Benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® or your preferred vendor.

Avoid post-service medical necessity reviews and delays in claim processing by obtaining prior authorization before rendering services. If prior authorization is required, services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

UTILIZATION MANAGEMENT

Utilization Management Decisions

We are dedicated to serving our customers through the provision of health care coverage and related benefit services. Utilization Management (UM) determinations are made by licensed clinical personnel based on the:

- benefits policy (coverage) of a member's health plan,
- evidence-based medical policies and medical necessity criteria, and the
- medical necessity of care and service.

All UM decisions are based on the appropriateness of care and service, and the existence of coverage. We prohibit decisions based on financial incentives, nor do we specifically reward practitioners or clinicians for issuing denials of coverage. In addition, financial incentives for UM decision-makers do not encourage decisions that result in underutilization. The criteria used for

UM determinations are available upon request. Please call the customer service or health advocate number on the back of a member's ID card.

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.

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (BCBSTX).

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Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Prime to 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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