BLUE REVIEW℠
A Provider Publication

SEPTEMBER 2023

NOTICES & ANNOUNCEMENTS

Future Blue Cross Blue Shield Association Provider Performance Program

The Blue Cross Blue Shield Association (BCBSA) has partnered with Blue Health Intelligence (BHI) and Motive Medical Intelligence to deliver a Provider Performance Program for efficiency, appropriateness, and quality evaluations for physicians **across all Blue plans** in a variety of medical, surgical, and primary care specialties.

What Does This Mean for Physicians?

Blue-contracted physicians will be fairly and consistently evaluated to peers across a common set of industry-standard measurements in the following specialties:

Medical	Cardiology Endocrinology Gastroenterology Nephrology	Neurology Pulmonary Rheumatology Obstetrics/Gynecology
Surgical	Cardiothoracic Surgery General Surgery Ophthalmology Orthopedic Surgery	Otolaryngology Urology Vascular Surgery
Primary Care	Family Medicine Internal Medicine Pediatrics	

Each Blue plan will have access to this information, which may be used for member steerage, tiering, network optimization, and other use cases. Notably, members may be able to see a summary of physician performance in Provider Finder®.

Q: How Is This Different Than the Current BCBSTX Physician Efficiency, Appropriateness, and Quality℠ (PEAQ℠) program?

A: The current PEAQ program applies to providers contracted with BCBSTX. This program uses principles like PEAQ's, but different analysis to implement it nationally. BCBSA is partnering with BHI and Motive which allows BCBSTX to expand PEAQ nationally and consistently. This approach will replace PEAQ's measurements in the future.

The current **PEAQ methodology** is available for review on our PEAQ page but watch for updates in the future.

Check back later for more information coming on our News and Updates and PEAQ page.

Reimbursement Change for Inpatient DRG Claims When Patients Are Transferred Early

What's changing: Effective **Nov. 20, 2023**, Blue Cross and Blue Shield of Texas (BCBSTX) will follow the Centers for Medicare and Medicaid Services' (CMS) transfer policy on inpatient claims reimbursed using the Medicare Severity Diagnostic Related Group (DRG) claims payment methodology.

If a member's hospital stay is shorter than the average length of stay (ALOS) because the member is transferred to another facility, then the DRG claim will pay a prorated amount for the length of the stay. This transfer rule applies:

- to all inpatient DRG claims when the transfer is made to a post-acute setting (with eligible DRG codes) – for the list of qualifying post-acute services, please see the list in Table 5 of the applicable fiscal year Medicare hospital inpatient prospective payment systems (IPPS) Federal Register.
- when a member is moved from an acute care facility to another acute care or post-acute setting as denoted by the following Patient Discharge Status Codes (PDSC):
    - Transfers between acute care hospitals
        - Transfers to another acute care hospital or unit for related care (PDSC 02 or 82)
    - Transfers from acute care hospital to a post-acute setting.
        - Transfer to an inpatient rehabilitation facility or unit (PDSC 62 or 90)
        - Transfer to long term acute care facility (PDSC 63 or 91)
        - Transfer to a psychiatric care facility (PDSC 65 or 93)
        - Transfer to a children's hospital, cancer hospital (PDSC 05 or 85)
        - Transfer to a skilled nursing facility (PDSC 03 or 83)
        - Transfer to Hospice care (PDSC 50 or 51)
        - Transfer to Critical Access (PDSC 66 or 94)
        - Transfer to home, under a written plan of care, for the provision of home health services from a home health agency (PDSC 06 or 86). Please note this does not apply when Condition Code 42 or 43 is on the transferring hospital's claim.

Why change: The CMS transfer rule helps the member avoid paying double for services. For example, if an average length of stay is seven days, but the member is discharged from acute care and admitted to a skilled nursing facility on day five, without these adjustments, then the member would pay twice for days five, six and seven – once at the acute care facility and again at the skilled nursing facility.

More information: see *42 Code of Federal Regulations(CFR) 412.4(a) and (b) and* the Medicare Claims Processing Manual Pub. 100-04, Chapter 3, Section 40.2.4.

Claim Editing Changes for Emergency Department Services Coming Nov. 1, 2023

Blue Cross and Blue Shield of Texas (BCBSTX) will enhance our claims editing and review process with Cotiviti for **emergency department (ED) evaluation and management (E&M)** for some of our commercial members. These editing enhancements for facility and professional claims will help ensure accurate billing and proper reimbursement.

What's changing: when we review your claim, beginning Nov. 1, 2023, your reimbursement may be processed at a lower level of service if we cannot validate the level of E&M services billed. We will follow the American Medical Association guidelines for level of service and medical decision making.

What happens next: if you agree with the level of service reimbursed, no further action is needed. If you do not agree with the level of service reimbursed, you may submit additional medical records to support your claim.

Learn more: For more information on revisions to our ED claims editing process, please review the revised **CPCP003 Emergency Department Evaluation and Management (E/M) Services – for Facility Services** policy and our new **CPCP042 Emergency Department Evaluation and Management (E/M) Services Coding – for Professional Services** policy on our Clinical Payment and Coding Policy page.

BEHAVIORAL HEALTH

See New Enhancements for Behavioral Health Prior Authorizations

Blue Cross and Blue Shield of Texas (BCBSTX) is continuing to make enhancements to its Behavioral Health (BH) prior authorization review process for some commercial members.

When submitting requests for BH reviews the best method is to submit the request electronically via Availity Authorizations and Referrals.

Here's what's new: effective Nov. 1, 2023, if you are unable to submit a request electronically through Availity, call the number on the member ID card and use the interactive voice response (IVR) system to complete a real-time review with customer service and a live clinician.

Beginning Nov. 1, you will be able to use the IVR system to request Inpatient, Residential and Partial Hospitalization services, as well as these outpatient services that will no longer be requested by form: Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT) and Repetitive Transcranial Magnetic Stimulation (TMS).

More Information: watch News and Updates for future announcements on Behavioral Health.

CLAIMS & ELIGIBILITY

Blue Card® Program Reminder

The BlueCard Program links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country and around the world through a single electronic network.
BlueCard enables our members to obtain health care services while traveling or living in the Blue Cross and Blue Shield of Texas (BCBSTX) service area.

It is important to check eligibility and benefits on these Blue Card members to determine if you are eligible to treat them for non-emergency services. Check the Blue Card Manual for information related to "suitcases" as listed on the card and their meaning.

For example, currently, we have Blue Cross and Blue Shield of Oklahoma (BCBSOK) members living in Texas and they may have a Blue Advantage PPO℠ or Native Blue PPO℠ plan. However, their cards indicate a suitcase with PPO inside which means BCBSTX PPO providers can see these members under the Blue Card Program.

Refer to the Blue Card Program page on our website for more information.

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.

Submitting Claims for Infertility Services

When completing claims for infertility services rendered to a **surrogate** or from a **donor**, please **indicate the recipient** on the claim form. Coverage for surrogates and donors may vary by plan. Inclusion of the recipient information on submitted claims will help us to expedite the proper processing of claims for these services, this applies to professional and facility claims.

How to indicate recipient: Simply add "surrogate" or "donor" to the comments or notes field on the claim form. For example:

- On the **UB-04** form, add "surrogate" or "donor" to **Form Field 80** Remarks
- On the **CMS-1500** claim form, add "surrogate" or "donor" to **Form Field 19** Additional Claim Information.

Check eligibility and benefits: To ensure surrogate and donor services are covered, check eligibility and benefits first through Availity® Essentials or your preferred vendor portal, prior to rendering services.

Reporting On-Demand via Availity® Essentials is Now Named Provider Claim Summary

What's Changing

Effective August 2, 2023, Blue Cross and Blue Shield of Texas (BCBSTX) is changing the name of its long-standing Reporting On-Demand tool to Provider Claim Summary (PCS). The tool is still available in the BCBSTX-branded Payer Spaces section via Availity and allows users to readily view, download, save and/or print Provider Claim Summaries. The tool also offers you the opportunity to obtain claim outcome results for multiple patients, in one central location.

PCS Available to View

As a reminder, PCS reports are available in this tool for commercial claims processed after Dec. 1, 2016, and for Medicare Advantage and Texas Medicaid claims processed after April 12, 2019.

Switch from Paper to Electronic PCS
If you currently rely on paper claim summaries, we strongly recommend registering for Availity Essentials to gain access online to the PCS. Providers currently enrolled to receive the Electronic Remittance Advice (ERA) from BCBSTX will continue to receive the Electronic Payment Summary (EPS), but with the additional opportunity to access the PCS as a complimentary option.

Join us for a Webinar
BCBSTX hosts instructor-led educational **"Obtaining Provider Claim Summaries Online"** webinars for you to learn more about the application. New and existing Availity Essentials users are highly encouraged to attend. To register for a complimentary training session, select your preferred date and time below.

- Sept. 7, 2023 – 1 to 2 p.m.
- Sept. 14, 2023 – 1 to 2 p.m.
- Sept. 21, 2023 – 1 to 2 p.m.
- Sept. 28, 2023 – 1 to 2 p.m.

For more information, refer to the updated Provider Claim Summary page and user guide in the Provider Tools section of our website. In addition to the Provider Claim Summary tool, BCBSTX supports an array of online tools that are available to registered Availity Essentials users at no additional cost. To register, simply go to Availity, select "Register," and complete the online application today.

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. We may add and modify clinical payment and coding policies. The following policies were added or updated:

- Revised CPCP003 and New CPCP042 for Emergency Department Evaluation and Management Services Coding for Facility and Professional Services, Effective 10/25/2023

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.

Shared Decision-Making Aids Can Help Guide Care Choices
Shared decision-making is a communications process. It's a way for providers and patients to make informed health care decisions that align with what matters most to patients. Below are resources to help you involve your patients in shared decision-making.

These evidence-based aids provide information about treatment options, lifestyle changes and outcomes. They don't replace your guidance but can help your conversations with patients.

Why it's important: When patients help make decisions about their health care, it can lead to improved patient experience, better outcomes, and quality of life.

- **Mayo Clinic Knowledge and Evaluation Research Unit Care That Fits Tools**
    - Acute Myocardial Infarction Choice
    - Anticoagulation Choice
    - Cardiovascular Primary Prevention Choice
    - Chest Pain Choice
    - Depression Medication Choice
    - Diabetes Medication Choice
    - Graves Disease Treatment Choice
    - Head CT Choice
    - Osteoporosis Choice
    - Percutaneous Coronary Intervention Choice
    - Rheumatoid Arthritis Choice
    - Smoking Cessation Around the Time of Surgery
    - Statin Choice

This information is also on our Clinical Practice Guidelines webpage.

MEDICARE ADVANTAGE PLANS

2024 Blue Cross Medicare Advantage Expansion Service Areas

Effective **Jan. 1, 2024**, Blue Cross Blue Shield of Texas (BCBSTX) announces that **Blue Cross Medicare Advantage (PPO)℠** and **Blue Cross Medicare Advantage Dual Care (HMO SNP)℠** networks are expanding its service areas across Texas. The expansion continues to build on strong networks already in place in Texas and is part of our commitment to providing members with access to affordable health care.

Blue Cross Medicare Advantage (PPO)℠ Expansion Areas:
Andrews, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Carson, Castro, Cochran, Coke, Coleman, Concho, Crane, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Dickens, Donley, Ector, Edwards, Fisher, Floyd, Foard, Frio, Gaines, Garza, Gillespie, Glasscock, Hale, Hall, Hansford, Hardeman, Hartley, Haskell, Hockley, Howard, Hutchinson, Irion, Jeff Davis, Kent, Kimble, King, Kinney, Knox Lamb, Live Oak, Loving, Lubbock, Lynn, Marion, Martin, Menard, Midland, Mitchell Montague, Moore, Motley, Oldham, Pecos, Presidio, Reagan, Red River, Reeves, Roberts, Runnels, San Augustine, Schleicher, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Terry, Upton, Wheeler, Winkler, Yoakum, and Zapata counties.

Blue Cross Medicare Advantage (HMO SNP) ℠ Service Areas
Anderson, Andrews, Armstrong, Bailey, Baylor, Bee, Borden, Brewster, Briscoe, Cameron, Carson, Castro, Chambers, Cherokee, Cochran, Coke, Coleman, Concho, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Delta, Dickens, Donley, Ector, Edwards, Erath, Fisher, Floyd, Foard, Frio, Gaines, Garza, Gillespie, Glasscock, Hale, Hall, Hansford, Hardeman, Hardin, Harrison, Hartley, Haskell, Henderson, Hidalgo, Hockley, Howard, Hutchinson, Irion, Jackson, Jasper, Jeff Davis, Jefferson, Jim Wells, Kent, Kimble, King, Kinney, Kleberg, Knox, Lamb, Liberty, Live Oak, Loving, Lubbock, Lynn, Marion, Martin, Menard, Midland, Mitchell, Montague, Moore, Motley, Nacogdoches, Oldham, Orange, Panola, Pecos, Presidio, Rains, Reagan, Reeves, Roberts, Runnels, San Augustine, Schleicher, Shelby, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Terry, Upton, Uvalde,

Victoria, Willacy, Winkler, Yoakum, Young and Zavala counties.

Remember to view the Blue Cross Medicare Advantage HMO SNP provider training here
Plan highlights for both include:

- Cost-free SilverSneakers® gym membership
- Some plans offer supplemental vision and dental
- Dallas Choice Premier PPO plan offers a supplemental hearing aid allowance
- New Flexible Medicare Advantage PPO Plan

Have questions?
Call **1-972-766-7100**, email Texas Medicare Advantage Network or reference the Medicare Advantage Provider Quick Reference Guide.

†SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

HMO Special Needs Plan provided by Blue Cross and Blue Shield of Texas, which refers to GHS Insurance Company (GHS), an Independent Licensee of the Blue Cross and Blue Shield Association. GHS is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in GHS' plan depends on contract renewal.

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

If we need medical records for Blue Cross Group Medicare Advantage (PPO) members, you will receive requests from us or our vendor, Change Healthcare, as part of the Blue Cross and Blue Shield National Coordination of Care program. Please respond quickly to our requests, including requests related to risk adjustment gaps and Healthcare Effectiveness Data and Information Set (HEDIS®) measures. In addition, you may receive requests from EXL Health for select inpatient, diagnosis-related group claims for any out-of-area Blue Cross Medicare Advantage℠ members.

Update to Prior Authorization Codes for Medicare Members, Effective Oct. 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 Oct. 1, 2023, include the following codes reviewed by eviCore healthcare:

- Addition of Specialty Drug codes
- Addition of Lab codes
- Removal of Lab codes

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.

PHARMACY

Pharmacy Program Quarterly Update, Part 1: Changes Effective Oct. 1, 2023

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

Removal of Select Medication List

Effective Dec. 1, 2023, the Select Medication List will be removed from our provider website. The intent of this list was to show specific medications that may have a higher reimbursement rate versus other medications within the same drug class. Reimbursement rates for these and all other specialty medications will continue to be updated monthly, as applicable, You can find more information about reimbursements on our provider website.

PRIOR AUTHORIZATION

Designating Prior Authorization Requests as "Urgent"

We've recently been inundated with a huge increase in prior authorization (PA) requests. The increase in requests include an unusual number marked **urgent or expedited**. An urgent or expedited request, for members, is only appropriate for a situation that is:

- **life threatening** or
- poses a **risk to maximum function**

The problem: When non-urgent requests are marked urgent, they can over burden the review process by taking precedence over standard requests and creating a backlog, potentially delaying responses for legitimate urgent requests. This impacts your ability to service your patients in a timely manner.

The solution: Submit your PA requests with the appropriate documentation and level of urgency.

More information: Refer to the Utilization Management page on how to submit requestsand **Prior Authorization Lists** section of our provider website for information on what requires PA and how to submit. Always check eligibility and benefits through Availity® Essentials or your preferred vendor. Refer to our Eligibility and Benefits web page for more details.

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

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

What's new: Updates are being made to the Blue Cross and Blue Shield of Texas (BCBSTX) 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 Oct. 1, 2023, include:

- Addition of Specialty Pharmacy codes to be reviewed by BCBSTX
- Removal of a Radiation Oncology drug code previously reviewed by Carelon Medical Benefits Management (Carelon)
- Addition of a Musculoskeletal joint and spine code to be reviewed by Carelon
- Replacement of Genetic Testing codes reviewed by Carelon

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.

UTILIZATION MANAGEMENT

Utilization Management (UM) Decisions

We're dedicated to serving our customers through the provision of health care coverage and related benefit services. 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 appropriateness of care and service, and existence of coverage. We prohibit decisions based on financial incentives, and we do not specifically reward practitioners or clinicians for issuing denials of coverage. 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 the 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.

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 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 or services they offer.

HealthSmart RX is an independent company that has been contracted by BCBSTX on behalf of TRS to provide TRS patient support services for certain covered drugs. HealthSmart RX does not offer Blue Products or Services.

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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