BLUE REVIEW℠

For Providers

APRIL 2024

CLAIMS & ELIGIBILITY

ClaimsXten™ Quarterly Update Effective June 17, 2024

Blue Cross and Blue Shield of Texas will implement its second quarter code updates for the ClaimsXten auditing tool on or after June 17, 2024.

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 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.

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:

- Annual Review: CPCP038 Outpatient Services Prior to an Inpatient Admission Updated
- Annual Review: CPCP022 Pneumatic Compression Devices – Outpatient Use Updated
- Annual Review: CPCP002 Inpatient/Outpatient Unbundling Policy- Facility Updated
- CPCP033 Telemedicine and Telehealth/Virtual Health Care Services Policy Updated Effective 05/01/2024

- See Our Revised Clinical Payment and Coding Policy for Billing Anesthesia Services Effective 06/01/2024

EDUCATION & REFERENCE

Medical Necessity Review of Observation Services

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

HEALTH & WELLNESS

Continuity and Coordination of Eye Care

We appreciate the care and services you provide to our Blue Cross and Blue Shield of Texas (BCBSTX) members. Many Primary Care Providers refer diabetic patients to eye care specialists for annual eye examinations. PCPs need to know details about the care their patients receive and to receive communications from their patients' eye care specialists. We want to encourage eye care specialists to share results routinely and promptly with PCPs.

How can you help?

1. **Communicate** the date and results of diabetic patient eye exams to the referring practitioner as one of the essentials for quality care.

2. **Educate your patients by helping** them understand why a retinal exam for diabetics is different than an eye exam for glasses and is essential to help prevent future problems with vision. Many patients without vision problems feel they don't need an exam.

3. **Reassure your patients with diabetes** that a yearly retinal exam may be covered by medical insurance.

4. **Submit claims correctly** for a diabetic patient eye exam, be sure to include "diabetes" as a diagnosis to ensure correct payment. Code your claims with the appropriate code.

We applaud those practices that have processes in place to send exam reports to the referring practitioners. We encourage those who do not routinely share results to consider adopting this practice. Thank you for collaborating with us in the care of our members. With your help, we can improve the care of people with diabetes.

Caring for Substance Use Disorders

Providers can play an important role in our members' care by discussing the signs of substance use disorder and encouraging them to seek help, if appropriate. We've created resources for members that may help.

To monitor our members' care, we track the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures related to substance use disorders:

Initiation and Engagement of SUD Treatment

This measure applies to members ages 13 and older with a new episode of SUD. We capture two stages of adequate and timely follow-up treatment:

- **Initiation of SUD treatment:** One treatment within 14 days of the diagnosis
- **Engagement of SUD treatment:** Two or more additional treatment sessions within 34 days of the initiation visit

Treatment may occur in an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication-assisted treatment.

Follow-up after Emergency Department Visit for Substance Use

This measure captures ED visits for members ages 13 and older with a principal diagnosis of SUD, or any diagnosis of drug overdose, who had a follow-up visit for SUD. We track:

- ED visits for which the member received follow-up within 30 days (31 total days)
- ED visits for which the member received follow-up within seven days (eight total days)

Follow-Up After High-Intensity Care for Substance Use Disorder

This measure tracks the percentage of discharges for members ages 13 and older who were hospitalized, received detoxification or residential treatment for a diagnosis of SUD and who had a follow-up visit or service for SUD. The follow-up visit must be on a different date than the discharge date. We track:

- Discharges that had a follow-up visit within 30 days after discharge
- Discharges that had a follow-up visit within seven days after discharge

Pharmacotherapy for Opioid Use Disorder

We capture the percentage of new pharmacotherapy treatment events for OUD among our members 16 and older with a diagnosis of OUD. The treatment of OUD with medication must continue for at least 180 days.

Tips to consider:

- Discuss the importance of timely follow-up visits with our members.
- Use the same diagnosis for substance use at each follow-up.
- Coordinate care between behavioral health and primary care providers. Share progress notes and include the diagnosis for substance use.
- Reach out to members who cancel appointments and help them reschedule as soon as possible.

MEDICARE ADVANTAGE PLANS

Webinar on Coding for Medicare Advantage Annual Wellness Visits

Join us for our quarterly webinar on coding for annual wellness visits for Medicare Advantage members. The webinar is **April 12, 2024**, from 12 to 12:30 p.m. CT. Register here.

Members of our Coding Compliance team will present information from the Official ICD-10-CM Coding Guidelines, the American Hospital Association Coding Clinic and the Centers for Medicare & Medicaid Services. The webinar includes information on:

- Components of annual health assessments and wellness visits
- Documentation standards and general coding requirements
- Coding for chronic conditions

- Common coding errors

If you're unable to view the Teams registration site, you may need to use a different web browser or clear your browser history. After you register, you'll receive an email with a calendar reminder and link to the webinar.

This webinar doesn't offer continuing education credit.

Medicare Advantage HEDIS Records Collection through June 2024

Medicare Advantage providers may receive requests from Blue Cross and Blue Shield of Texas or our vendor Advantmed from **January through June 2024** to collect data for Healthcare Effectiveness Data and Information Set (HEDIS®) measures. The data you provide helps us monitor the quality of our members' care and their health outcomes.

How You Can Help

Either BCBSTX or Advantmed may contact you by fax or phone to provide details about the records needed and how you can return them to us. When requested, please promptly provide complete and accurate records.

Patient authorization isn't required to release these records, as their collection and review is considered a component of health care operations under the Health Information Portability and Accountability Act.

The Data We're Seeking

We collect data for HEDIS measures developed by the National Committee for Quality Assurance, including:

- Controlling High Blood Pressure
- Colorectal Cancer Screening
- Comprehensive Diabetes Care
- Transitions of Care

Please contact your Provider Network Representative if you have questions.

Other Records Requests

For our Blue Cross Group Medicare Advantage (PPO)℠ members, you will receive requests from BCBSTX or vendor Change Healthcare as part of the Blue Cross and Blue Shield National Coordination of Care program.

We also request medical records throughout the year for risk adjustment, focusing on chart reviews and the accuracy of risk-adjustable codes submitted to the Centers for Medicare & Medicaid Services.

PHARMACY

Pharmacy Program Quarterly Update, Part 1: Changes Effective April 1, 2024

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

Introducing Smart RxAssist via HealthSmartRx®

Addition of Keytruda effective May 1, 2024, to the provider-administered specialty drug list.

Blue Cross Blue Shield of Texas (BCBSTX) is working with HealthSmartRx (HSRx), an independent company, to implement the Smart RxAssist program for certain eligible Teacher Retirement System of Texas (TRS) participants effective **Oct. 16, 2023**.

What Is Smart RxAssist?

Smart RxAssist offers assistance with enrolling in pharmaceutical manufacturer copay assistance programs to eligible participants who are prescribed specific provider-administered specialty drugs*. The manufacturer copay assistance ensures continued access to these drugs with a significantly reduced copay, which can improve adherence and clinical outcomes. This copay assistance applies only to the cost of the provider administered drug(s) and does not apply to office visits or any other associated costs.

Enrollment is optional for eligible TRS participants and participation is voluntary for providers. The resulting payments from the copay assistance, TRS participant's cost sharing, and the health plan will equal the Allowable Amount that applies today. Participants who choose to participate are required to enroll in the Smart RxAssist program per their group benefits for in-scope provider-administered drugs.

HealthSmartRx Smart RxAssist Process

- If your patient has not yet enrolled in Smart RxAssist, an HSRx Patient Advocate will reach out to your patient by phone to facilitate enrollment and answer any questions they may have.
- Your office may be contacted by HSRx via phone or fax for enrollment and/or to provide documentation required by the manufacturer for the copay assistance program.
- Once your patient is enrolled, an HSRx Patient Advocate will contact your office to provide additional details on copay assistance claim submission and how you will receive copay assistance funds from the manufacturer.
- If required, initiate prior authorization and follow utilization review requirements in the Provider Manual. You will receive notification if the prior authorization is approved.
- Submit a medical claim to BCBSTX for primary payment.
- Follow applicable manufacturer program reimbursement procedures to obtain copay assistance funds.

More Information

- Review the TRS participant Smart RxAssist FAQs.
- If you have questions, call 1-833-798-6741 or visit SmartRxAssist.

STANDARDS & REQUIREMENTS

Medical Policy Updates

When Policies are Posted

New or revised medical policies, when approved, may be posted on our provider website (under Standards and Requirements) on the 1st or 15th of each month. 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 review process, you can view medical policy drafts and provide your feedback online. When there are draft medical policies to review, they will be posted around the 1st or 15th of each month with a review period of approximately two weeks.

Related Information

To request a review of your services (before rendering the service), refer to the Recommended Clinical

Review Option webpage. Also, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies webpage.

UTILIZATION MANAGEMENT

Recommended Clinical Review Services and Code List Changes for Certain Members

Periodically, (as often as monthly), we update our lists of services and procedure codes that require Recommended Clinical Review (for some commercial members) to reflect new, replaced or removed codes. These changes are based on updates from our Utilization Management team's prior authorization assessment, Current Procedural Terminology (CPT®) code changes released by the American Medical Association, or Healthcare Common Procedure Coding System changes from the Centers for Medicare & Medicaid Services.

Accessing RCR Lists

To avoid post-service medical necessity reviews and minimize delays in claim processing, providers should refer to the RCR inpatient services and outpatient code lists on our Recommended Clinical Review Option web page prior to rendering services. If services are performed that do not meet medical necessity criteria, they may be denied for payment and the rendering provider may not seek reimbursement from the member.

Check Eligibility and Benefits

Providers should check eligibility and benefits through Availity® Essentials or their preferred vendor and may also indicate if a service requires a prior authorization or recommended clinical review.

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 independentcompany that provides utilization review for select health care services on behalf of BCBSTX.CPT copyright 2021 American Medical Association (AMA). All rights reserved. CPT is a registeredtrademark of the AMA.

ClaimsXten and Clear Claim Connection are trademarks of Change Healthcare, an independent company providing coding software to BCBSTX. Change Healthcare is solely responsible for the software and all the contents.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Prime Therapeutics LLC is a pharmacy benefit management company. BCBSTX contracts with Primeto provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime.

Change Healthcare is an independent third-party vendor that is solely responsible for the products orservices they offer.

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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