BLUE REVIEW℠

For Providers

MARCH 2024

BEHAVIORAL HEALTH

Follow-up Care for Mental Health

Among Americans ages 18 to 44, nearly 600,000 are hospitalized yearly for mental health-related conditions, according to the National Alliance on Mental Illness. A recent study found that mental health-related visits to emergency departments have increased among children and young adults. Timely follow-up care after these visits is linked to **improved health outcomes and fewer repeat hospital visits**, according to the National Committee for Quality Insurance. You can help our members by encouraging follow-up care with behavioral health care providers when appropriate.

We track data for the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures to help assess our members' care:

Follow-up after Hospitalization for Mental Illness

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 captures the percentage of ED 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 ED visit (31 total days)
- Within seven days of the ED visit (eight total days)

Tips to Close Gaps in Care

For EDs and hospitals:

- Help our members schedule an in-person or telehealth follow-up visit with a mental health provider within seven days of discharge. The follow-up visit must be on a different date than the discharge date.
- Consider member preference for treatment, allowing members to take ownership of the treatment process.

For providers:

- Encourage members to bring their hospital discharge paperwork to their first appointment.
- Educate members about following up and adhering to treatment recommendations.
- Use the same diagnosis for mental illness at each follow-up visit. A non-mental illness diagnosis code won't fulfill this measure.

Coordinate care between behavioral health and primary care providers:

- Share progress notes and updates
- Include the diagnosis for mental illness
- Reach out to members who cancel appointments and help them reschedule as soon as possible

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Avoiding the Inappropriate Use of Antipsychotic Medication in Anxiety Disorders

Most antipsychotic medications aren't approved for the treatment of anxiety disorders, such as panic disorder and generalized anxiety disorder. Because antipsychotics can have adverse effects, we encourage prescribing providers to **carefully assess symptoms, risks and benefits in prescribing medications** for our members with anxiety disorders.

Our Behavioral Health Clinical Practice Guidelines have evidence-based information from nationally recognized sources. These are intended to provide a framework for patient care but not substitute for clinical judgment in individual cases. Following are guidelines related to anxiety disorder:

- Practice Guideline for the Treatment of Patients with Panic Disorder, Second Edition (2009) American Psychiatric Association
- Clinical Practice Review for GAD (2015) Anxiety and Depression Association of America
- Diagnosis and Management of Generalized Anxiety Disorder and Panic Disorder in Adults (2015) American Family Physician
- Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders (2020) American Academy of Child & Adolescent Psychiatry
- VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder (2023) Department of Veterans Affairs/Department of Defense

For more information on medications in behavioral health care, see our Quick Reference on Potential Side Effects.

Closing Gaps in Our Members' Care

People with serious mental illness who use antipsychotic medications are at increased risk of diabetes, according to the National Committee for Quality Assurance. Regular screening for diabetes is important for detecting, monitoring and in the treatment of the disease. We track the NCQA quality measure Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**.** 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

Recommended Clinical Review Procedure Code List Changes for Certain Members Effective May 15, 2024

BCBCSTX is updating its lists of codes requiring Recommended Clinical Review, 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.

More Information: Refer to **Recommended Clinical Review Lists** on the Utilization Management section of our provider website. Revised lists can be found on the Recommended Clinical Review (CR) Option page on the provider website.

- **Check Eligibility and Benefits:** Providers should check eligibility and benefits through Availity® Essentials or their preferred vendor. This may also indicate if a service requires a prior authorization or recommended clinical review.
- Avoid post-service medical necessity reviews and delays in claim processing by obtaining RCR before rendering services. If services are performed that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Fighting Fraud, Waste and Abuse

Every year analysts and investigators for Blue Cross and Blue Shield of Texas review claims data, industry trends and investigative results to identify potential areas of fraud, waste and abuse.
We share this information with you in letters mailed to your office. The current letters show instances of potential billing abuse around COVID-19 testing and vaccinations. The letters will remind you to comply with BCBSTX's policies and requirements.

For more information refer to these BCBSTX informational resources:

- Provider Standards and Requirements
- Medical Policies
- Fraud and Abuse

If you encounter potential fraud, waste and/or abuse:

- Please file a report online.
- Call our Fraud Hotline at 1-800-543-0867. *All online reports and calls are confidential, and you may remain anonymous.*

HealthSelect of Texas® In-Area Participants PCP Referral Requirement for In-Network Benefits

Participants enrolled in the HealthSelect of Texas In-Area medical plan are required to have a designated PCP on file with BCBSTX to receive in-network benefits. Prior authorization is also required for some services. For in-network benefits to apply, specialty providers must have a valid referral on file with BCBSTX before submitting a prior authorization. If a referral and a prior authorization are required, and the participant does **not** have a valid referral on file from their PCP with BCBSTX before rendering the authorized services, claims may be processed at the lower out-of-network benefit level. For more information, refer to the ERS Tools page.

Hospitals, Routine Services and Supplies

Providers usually include routine services and supplies in charges related to other procedures or services. As such, those services/supplies are considered non-billable for separate reimbursement. The following guidelines identify items, supplies and services that are not separately billable. (Note: This is not an all-inclusive list.)

- Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and not separately billable in the inpatient and outpatient environments.
- All items and supplies that may be purchased over the counter are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients during an inpatient or outpatient admission are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients admitted to a given treatment area or units are not separately billable.
- All reusable items, supplies and equipment that are provided to all patients receiving the same service are not separately billable

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Technical and Professional Components

Modifier 26 denotes professional services for lab and radiological services. **Modifier TC** denotes technical components for lab and radiological services. These modifiers should be used in conjunction with the appropriate lab and radiological procedures only. **Note:** When a health care provider performs both the technical and professional services for a lab or radiological procedure, they must submit the total service, not each service individually.

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 policy was added or updated:

- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services (EIU) Update - Effective 05/15/2024

HEALTH & WELLNESS

Closing Gaps in Colon Care

Adults ages 45 to 75 should have preventive screenings to reduce their risk of colorectal cancer, according to the U.S. Preventive Services Task Force and Centers for Disease Control and Prevention. Colorectal cancer is becoming more common in people younger than 55. We encourage you to discuss colon health and screening options with our members. We've created resources for members to 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 (Cologuard®) every 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 Healthcare Effectiveness Data and Information Set (HEDIS®) measure that tracks appropriate screenings for adults ages 45 to 75. To help close gaps in our members' care, consider these tips:

- In our members' medical 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.

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.

MEDICARE ADVANTAGE PLANS

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)SM 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.

Prior Authorization Code Updates for Medicare Advantage Members Effective April 1, 2024

What's changing: BCBSTX is changing prior authorization requirements for Medicare Advantage members to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association effective April 1, 2024. A summary of changes is included below. 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 April 1 include:

- Addition of lab codes reviewed by eviCore healthcare

Check Eligibility and Benefits: To identify if a service requires prior authorization for our members, check eligibility and benefits through Availity® Essentials 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 Benefits

As a participating practitioner, you are given a list of drugs that we review and update throughout the year. For certain drugs, we have quantity limits and/or may require prior authorization before we approve any benefits for the drug. Prior approval and quantity limits are in place to ensure we are following current medically appropriate drug guidelines. For more information, visit the Pharmacy Program section on our provider website. For Federal Employee Program® members, information can be found at fepblue.org/pharmacy. We encourage you to check our provider website regularly and watch for updates in this newsletter.

The following information is available on our website:

- Formulary lists, including restrictions and preferences
- How to use our pharmacy procedures
- An explanation of limits and quotas
- How you can provide information to support an exception request
- The process for generic drug substitutions, therapeutic interchange and step-therapy protocols

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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.

PRIOR AUTHORIZATION

Reminder: Prior Authorization Changing to Recommended Clinical Review for Certain Services for TRS Participants

Effective March 1, 2024, certain inpatient services for Teacher Retirement System of Texas participants are moving from prior authorization to the Recommended Clinical Review Option (RCR). Refer to the notice posted Nov. 30, 2023, for more information.

Update to Prior Authorization Code Changes for Commercial Members Effective April 1, 2024

In addition to the changes effective April 1, 2024 to the Prior Authorization Codes announced on 12/15/2023, the following change is being added:

- Addition of Gene Therapy codes to be reviewed by BCBSTX for certain member plans

What's new: BCBCS is 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 April 1, 2024, include:

- Addition of Genetic Testing codes reviewed by Carelon Medical Benefits Management
- Addition of Infusion Site of Care codes to be reviewed by BCBSTX
- Addition of Medical Oncology drug codes to be reviewed by Carelon
- Removal of Medical Oncology drug codes previously reviewed by Carelon
- Addition of Gene Therapy codes to be reviewed by BCBSTX for certain member plans (Added 01/08/2024)

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® Essentials 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.

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, limitationsand 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.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual LegalReserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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