BLUE REVIEW℠

For Providers

MAY 2024

BEHAVIORAL HEALTH

Filing Claims for Behavioral Health Services – Use the Correct Place of Service Code

Remember to use the correct Place of Service code when filing professional claims for Applied Behavioral Analysis services. Place of Service codes designate where the patient is located when they received services from you.

Remember: If you use the wrong POS code your claim may be denied, or payment may be delayed. Familiarize yourself with POS codes using guidance from the Centers for Medicare & Medicaid Services. Also, for more information review our Clinical Payment and Coding Policies on Applied Behavior Analysis CPCP011 and Telemedicine and Telehealth CPCP033.

When filing claims, follow these examples of POS code guidance from CMS:

- **POS 3** is for use on claims for services provided in a school
- **POS 11** is for use on claims for services provided in the office
- **POS 12** is for use on claims for services provided in the patient's home
- **POS 49** is for use on claims for services provided in an independent clinic
- **POS 53** is for use on claims for services provided in a community mental health center
- **POS 99** is for use on claims for services provided in all other settings not listed above, including community and daycare locations

Note: claims are subject to the terms of a member's coverage and medical necessity review.

CLAIMS & ELIGIBILITY

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

Before referring a Blue Choice PPO or Blue Advantage HMO (for Blue Advantage Plus HMO point-of-service benefit plan) member to an out-of-network provider for non-emergency services, when such services are also 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** (when TDI is on the member's ID card) or **Non-Regulated Business** (no TDI on member's ID card). The forms are on our provider website.

Note: Referring network physicians must provide a copy of the completed form to enrollees and retain a copy in their medical record files.

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

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:

- CPCP025 Corrected Claim Submission Updated Including Changes for Late/Added Charges
- CPCP006 Preventive Services Policy Update – Effective 04/01/2024
- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services (EIU) Updated Versions – Effective 04/01/2024 & 05/15/2024
- CPCP028 Non-Reimbursable, Experimental, Investigational and/or Unproven Services (EIU) Updates – Effective 07/01/2024

EDUCATION & REFERENCE

Sanitas Medical Center Name Changes to Innovista Medical Center

We value your partnership in patient care and want to remind you of a change that has occurred at all Sanitas Medical Center locations in Texas. As of April 1, 2024, all clinics are now rebranded as Innovista Medical Center.

HEALTH & WELLNESS

ImmTrac2: Shot Records in One Secure Place

More than nine million Texans have already signed up for ImmTrac 2 and it's easy for your patients to join them. A record of all vaccines can be stored in one secure and convenient place — the ImmTrac2 Texas Immunization Registry.

What is the Texas Immunization Registry?
ImmTrac 2 is a free service offered by the Texas Department of State Health and Human Services. It keeps an electronic record of your patient's shot history in one secure and convenient place. Every time a BCBSTX member gets a vaccine, a record of it is recorded in the registry by signing a one-time consent form.

- Vaccine info is gathered from many sources, including:
- Health care providers
- Public health clinics
- Women, Infants and Children (WIC) clinics
- Medicaid claim administrators
- Texas Department of State Health Services

The registry is voluntary and confidential.
Encourage your patients and legal guardians of patients to enroll children under the age of 18. After an enrolled child turns 18, they can choose to enroll as an adult or no longer participate. Records can be kept until the age of 26.

Your patients can fill out and submit the following forms available in both English and Spanish to declare their preferences or any changes:

- Adult Consent Form
- Minor Consent Form
- Authorization to Release Official Immunization History
- Registry Withdrawal Form

While the registry is designed to update and store a person's vaccine information, individuals can opt-out at any time.

Who can access the registry? Once enrolled, doctors, nurses and other health care providers can check the registry as needed to see vaccine history. In addition, in certain cases, private and public schools may access the registry to verify vaccine status**.**

Send reminder notices directly to your patients. As a registered health care provider, you may send reminders through ImmTrac2 about specific vaccines needed by your patients.

Ready to register?

- Register online if your organization has never accessed ImmTrac2.
- Renew your organization's access by logging in and selecting "registration/renewal" in the menu bar.
- Once completed, the access agreement is only required every two years.

For more information, visit ImmTrac2 Texas Immunization Registry.

Supporting Maternal Quality Care

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.

We track the following Healthcare Effectiveness Data and Information Set (HEDIS®) measures related to our members' maternal health:

Prenatal and Postpartum Care measures the percentage of deliveries in which members:

- Had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment with Blue Cross and Blue Shield of Texas.
- Had a postpartum visit on or between seven and 84 days after delivery.

Prenatal and Postpartum Depression Screening and Follow-Up measures the percentage of deliveries in which members:

- Were screened for clinical depression during pregnancy and the postpartum period using a standardized instrument, and
- Received follow-up care within 30 days if the screening was positive.

Tips to Close Gaps in Prenatal and Postpartum 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 physician or other prenatal practitioner.
- A postpartum visit must take place on or between **seven and 84 days after delivery.** Be aware that post-operative visits within six days after discharge don't count as a postpartum visit. Members who have cesarean sections 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.

Tips to Close Gaps in Prenatal and Postpartum Depression Screening and Follow-Up

- Ask members during their pregnancy and postpartum to complete an age-appropriate depression screener, such as the Patient Health Questionnaire (PHQ)-9 or -2, or the Edinburgh Postnatal Depression Scale.
- If the depression screening is positive, follow up within 30 days with one or more of the following, as appropriate:
    - Additional evaluation for depression
    - Suicide risk assessment
    - Referral to a practitioner qualified to diagnose and treat depression
    - Pharmacological interventions
    - Other interventions or follow-up for the diagnosis or treatment of depression
- Coordinate care between behavioral health and other health care providers. Consider case management.

Resources

- Preventive Care Guidelines for providers
- Perinatal Wellness Guidelines for members
- **Earn** continuing education credit**:** Watch a recording of our webinar Maternal Mental Health: Pregnancy and Postpartum. Sign in here (registration required) to access the recording.

MEDICARE ADVANTAGE PLANS

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

What's changing: Blue Cross and Blue Shield of Texas 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. 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 July 1, 2024, include:

- **Addition of Lab codes to be** reviewed by eviCore
- **Removal of Lab codes previously** reviewed by eviCore
- **Addition of Sleep codes to be** reviewed by eviCore
- **Addition of Specialty Drug codes 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.

BCBS Medicare Advantage PPO Network Sharing

Applies to: Blue Cross Medicare Advantage (PPO)[SM]

All Blue Cross and Blue Shield Medicare Advantage[SM] plans participate in reciprocal network sharing, which allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in a service area of any other BCBS MA PPO plan if the member sees a contracted BCBS MA PPO provider. For more information, refer to the Blue Cross Medicare Advantage PPO Supplement. If you have any questions, contact Customer Service at **1-877-774-8592**.

PHARMACY

Pharmacy Program Quarterly Update Changes Effective April 1, 2024 – Part 2

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

UTILIZATION MANAGEMENT

Prior Authorization Code Changes for Commercial Members Effective July 1, 2024

What's new: Blue Cross and Blue Shield of Texas 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 or Healthcare Common Procedure Coding System changes from the Centers for Medicaid & Medicare Services.

Changes effective July 1, 2024, include:

- Addition of Specialty Pharmacy codes to be reviewed by BCBSTX
- Replacement of Medical Oncology codes reviewed by Carelon
- Addition of Medical Oncology codes to be reviewed by Carelon
- Addition of Genetic Testing codes to be reviewed by Carelon
- Removal of Genetic Testing codes previously reviewed by Carelon
- Addition of Cardiology codes to be 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® 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, 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 certificate of 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, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

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