BLUE REVIEW℠

For Providers

OCTOBER 2024

CLAIMS & ELIGIBILITY

Texas Senate Bill 1040 Prohibits Organ Transplants Associated with China

What's changed: Per Senate Bill 1040, effective September 1, 2023, which applies to plans delivered, issued for delivery or renewed on or after Jan. 1, 2024, Blue Cross and Blue Shield of Texas prohibits coverage of a human organ transplant if the operation is performed or if the organ was procured by a sale or donation originating, in China or a country known to have participated in organ harvesting. "Organ harvesting" is the removal of one or more organs from a living person by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

Why the change: This prohibition helps to combat the practice of forcibly harvesting organs from living persons for transplant without free, voluntary consent and curb illicit transplant tourism and prevent residents of this state from unknowingly involving themselves in forced organ harvesting. For additional details, refer to Texas Senate Bill 1040.

What's not covered: BCBSTX will not cover the transplant procedure or post-transplant.

This change applies:

- Fully insured BCBSTX plans
- Medicaid
- Individual health benefit plans offered by BCBSTX
- ERS
- TRS
- UT/TAMU

Check eligibility and benefits: As with all our members, it's important to ask to see the member's ID card before all appointments and to check eligibility and benefits through Availity® Essentials or your preferred vendor.

If you have questions, call the customer service number on the member's ID card.

ClaimsXten™ Quarterly Update Effective Dec. 9, 2024

We will implement fourth quarter code updates for the ClaimsXten auditing tool on or after Dec. 9, 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, we 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 our 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 tools page for a user guide, rule descriptions and other details.

Register for a Coding Webinar on Coagulation Defects and Other Hematological Disorder

Join our Coding Compliance team for a webinar on coding and documentation for coagulation defects. The webinar is free for providers and coding professionals.

We'll review ICD-10-CM documentation and guidelines, coding case study samples and tips on closing gaps in care for members. This is an informational webinar – it doesn't offer continuing education credits.

Coding Webinar for Coagulation Defects and Other Hematological Disorders
Select your preferred session date to register now:

- Oct. 25, 2024 (noon to 12:30 p.m., CT)
- Nov. 22, 2024 (noon to 12:30 p.m., CT)
- Dec. 13, 2024 (noon to 12:30 p.m., CT)

Visit our website for more training opportunities.

Updated Claims Referral Form for American Indian/Alaska Native Limited Cost Share Plans

When Indian Health, Tribal and Urban Indian facilities refer American Indian and Alaska Native members who are on limited cost-sharing plans to a non-I/T/U provider they need to submit the Limited Cost-sharing Referral Form to Blue Cross and Blue Shield of Texas. You can access the form on the Forms page on our website. If you have a previous version of this form, please replace with new version. (The previous fax number for pharmacy referrals was changed to an email address.)

Note: The form has one page for medical referrals and second page for pharmacy. Be sure to submit the appropriate form based on type of service.

Background: American Indians and Alaska Natives on limited cost-sharing plans can get treatment from Indian health care providers at Indian Health Service, Tribal and Urban Indian facilities. But if they need services unavailable through I/T/U facilities, they can get care from a different provider without paying anything out of pocket, **if they have a referral**.

The medical version of the form can be faxed to our Payment Services Claims Processing area at 918-549-7777 or mailed to:

Attn: I/T/U Referral
7777 East 42nd Place
Tulsa Oklahoma 74145

The pharmacy version of the form can be emailed to the Retail Service Coordinators.

Reminder: Pharmacy claims are processed when a member fills the prescription at the pharmacy. Members may have to pay out of pocket for prescriptions filled without an I/T/U referral.

New Laboratory Claims Review for Certain ASO Groups - Jan. 1, 2025

Beginning Jan. 1, 2025, Blue Cross and Blue Shield of Texas will implement new reimbursement policies for certain laboratory, services, tests and procedures for some Administrative Services Only members. You can view our applicable Laboratory Management Clinical Payment and Coding Policies here. A list of impacted ASO groups is coming soon on our website.

Affected claims: This lab program includes a review of claims prepayment and post-service for the following outpatient laboratory claims:

- Outpatient laboratory claims with dates of service beginning Jan. 1, 2025
- Claims for services performed in an outpatient setting (typically office, hospital outpatient or independent laboratory)
- Any claims that meet criteria relevant to one or more of the applicable laboratory services
- Applicable to specific ASO group members

Ordering providers should review the applicable Laboratory Management Clinical Payment and Coding policy when requesting lab services.

Fee Schedule Updates

Reimbursement changes and updates for commercial HMO and PPO providers are posted under the Standards and Requirements/General Reimbursement Information/Reimbursement Schedules and Related Information/Professional Schedules section on our provider website.

Changes resulting in a decrease will become effective no less than 90 days from the posting date. The specific effective date will be noted for each change. To view this information, visit the General Reimbursement Information section on our provider website. The Drug CPT/HCPCS Fee Schedule is updated quarterly on March 1, June 1, Sept. 1 and Dec. 1. The NDC Fee Schedule is updated monthly.

Additional Claim Processing Enhancements for ERS Plans Effective October 21, 2024

Effective 10/21/2024, in addition to post pay audits already in place for the **Employee Retirement System of Texas** (ERS) participants, pre-payment reviews will be implemented for improved facility claim billing and payment accuracy.

CERIS, who currently performs post pay audits on behalf of Blue Cross and Blue Shield of Texas, will begin pre-payment claim reviews effective 10/21/2024 for ERS plan participants. This may help avoid refund requests handled post-pay.

As a part of the pre-pay review process, CERIS may request documentation such as an itemized bill in order to conduct the review. Documentation should be submitted to the address listed on the request letter from CERIS, not to BCBSTX.

For additional information regarding the pre-pay review performed by CERIS on behalf of BCBSTX, watch for a FAQ coming soon on the ERS Tools page.

CERIS, a CorVel Health Corporation, is an independent company contracted with Blue Cross and Blue Shield of Texas to provide medical claim audits for members with coverage through BCBSTX. BCBSTX makes no endorsement, representations or warranties regarding third-party vendors and the products and services offered by them.

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:

- Annual Review: Unlisted/Not Otherwise Classified (NOC) Coding Policy, Effective Aug. 29, 2024

HEALTH & WELLNESS

In-home Test Kits Help Our Members Manage Their Kidney Health

We're providing in-home urine albumin-creatinine ratio test kits to a select number of eligible members who have diabetes and based on our data, need a uACR test for their kidney health. The uACR kits are provided to select MyBlue Health℠ and Blue Advantage HMO℠ members at no additional charge.
If any of your patients receive a kit and contact you with questions, consider discussing their screening options and encouraging them to complete the kit to learn more about their health.

How in-home testing works: The process is quick and easy for members.

- Vendors send the kits to a sample of eligible members who need a uACR test to close a gap in their care. Completing the kit is voluntary.
- The kits don't require fasting, dietary restrictions or preparation. Members may take medications according to their normal schedule.
- Members complete the test kit at home. They provide the name of their health care provider, if available, and mail the test for processing to the vendor by Dec. 31, 2024. An addressed, postage-paid envelope is included with the kit.
- The vendor sends results to the member and to their provider in three to four weeks.

If you receive test results: Please document them in your patients' medical records and discuss the results with them.

Monitoring our members' kidney care: We track the Healthcare Effectiveness Data and Information Set (HEDIS®) measure Kidney Health Evaluation for Patients with Diabetes.

The measure tracks members ages 18 to 85 with diabetes (Type 1 and type 2) who received a kidney health evaluation during the measurement year. An evaluation includes a blood test for kidney function (estimated glomerular filtration rate) and a uACR test for kidney damage.

Coordinating Care after Hospital Discharges Can Help Our Members' Transition

When our members receive inpatient hospital care, it's important for hospital care teams to share information with primary care providers to coordinate care after discharge. Hospital discharge summaries can help our members transition from inpatient care, according to the American College of Physicians and others. Care coordination and planning may in turn help reduce the chances of hospital readmissions, according to the National Committee for Quality Assurance.

If you provide care to our members during or after a hospital discharge, consider the following tips to support care coordination.

For hospital care teams:
Give PCPs timely access to hospital discharge summaries. Discharge summaries should include information on:

- Course of treatment
- Diagnostic test results
- Diagnostic test results pending at discharge
- Discharge medications with reasons for changes and most commonly known side effects

- Discharge disposition with follow-up and self-care instructions

For PCPs:

- Obtain the member's hospital discharge summary within 48 hours and schedule a timely follow-up visit to discuss discharge instructions. Consider telehealth services when available and appropriate.
- Perform a medication reconciliation to compare hospital medication orders to the medications the member has been taking. This is done to prevent drug interactions, duplications or other errors.
- Talk with our members about unique risks and barriers they may face that might have played a role in hospitalization. Our Health Equity and Social Determinants of Health page has information that may be helpful.
- Educate members about the importance of coordination of care for improved outcomes. Encourage them to complete your release of information form authorizing collaboration and disclosure of protected health information between providers of care.

How we can help:

- Let our members know we offer help and information in their language at no additional cost. To speak to an interpreter, members may call the number on their member ID card.
- We have the potential to provide Medicaid members with free non-emergency transportation services.
- Federal Employee Program® members may call 800-462-3275 to connect with a case manager after discharge.

As part of our provider satisfaction survey, we also track responses from PCPs and specialists about the timely sharing of hospital discharge summaries. The survey results help us identify opportunities to improve coordination of care.

Resources

- Preventive care guidelines on immunization schedules
- Texas Immunization Registry ImmTrac2
- For Medicaid providers: Quality Improvement Toolkits and Tip Sheets
- For Medicaid providers: Texas Health Steps

Breast Cancer Screening for Members Ages 40 to 74

In line with new U.S. Preventive Services Task Force recommendations, Blue Cross and Blue Shield of Texas recommends that breast cancer screening for **our members begin at age 40 rather than 50**. We are updating our Preventive Care Guidelines to reflect this change. Screening should continue every other year until age 74.

Routine screening for breast cancer is the best way to detect it early, according to the Centers for Disease Control and Prevention. Breast cancer is easier to treat when it's caught earlier.

Tips to Close Gaps in Our Members' Care

- Talk with our members about breast cancer risk factors and the importance of regular screening for women. We've created resources that may help.
- Breast cancer disproportionately affects Black women, according to the CDC . Talk with our members about the unique risks and barriers they may face, which can result in poorer outcomes than other women.
- Document screenings in members' electronic medical record. Indicate the specific date and result. This helps us track member progress on the quality measure Breast Cancer Screening from the National Committee for Quality Assurance.
- Document medical and surgical history in the medical record, including dates. Use correct diagnosis and procedure codes. Submit claims and encounter data in a timely manner.
- Offer telehealth services when available and appropriate for preventive care appointments.
- Follow up with members if they miss their appointment and help them reschedule.

- For members who need language assistance, let them know we offer help and information in their language at no cost. To speak to an interpreter, members may call the customer service number on their member ID card.
- For members who have transportation barriers, let them know that we provide Medicaid members with free non-emergency transportation services.
- See our Health Equity and Social Determinants of Health page for more information on health equity.

For men who are at high risk, the American Cancer Society recommends discussing with them how to manage risks.

MEDICARE ADVANTAGE PLANS

Acquisition of Cigna Healthcare Medicare Business in 2025

Earlier this year, the company of which BCBSTX is a division and The Cigna Group entered into a definitive agreement whereby it will acquire Cigna Healthcare's Medicare Advantage, Supplemental Benefits, Medicare Part D and CareAllies businesses. We expect the transaction to be completed in the first quarter of 2025, subject to customary closing conditions and required regulatory approvals.

We are excited about this transaction and the value it will deliver to those we serve once it is finalized. We want to assure you that we appreciate your continued partnership and remain committed to supporting you during this transition.

Continuing our work together in 2024

- It's important to know that BCBSTX and Cigna Healthcare's Medicare Advantage businesses remain separate companies until the transaction is finalized.
- The announcement of the transaction does not impact either company's partnerships with you or how we continue to conduct business together — it remains business as usual.
- You should continue to see and treat patients with a Cigna Healthcare Medicare Advantage benefit plan as you do today, as the announcement has not caused any changes to their coverage, plan services or benefits.
- Since the transaction is expected to close in early 2025, each company will sell their products under their respective brands for the 2025 plan year through the annual enrollment period from Oct. 15 through Dec. 7, 2024. People who purchase Cigna Healthcare or BCBSTX plans during open enrollment will remain enrolled in and covered by the plan they selected for the duration of the 2025 plan year.

Looking forward to 2025

- For products purchased during the 2024 annual enrollment period, **there will be no changes to Medicare Advantage plan benefits or premiums in plan year 2025 for either company (Medicare Supplement plans will follow state filings).** BCBSTX and Cigna Healthcare Medicare Advantage customers will remain enrolled in and covered by their existing BCBSTX or Cigna Healthcare Medicare Advantage plan upon the close of the transaction in 2025 for the duration of the 2025 plan year.
- Therefore, you will continue to see patients in the 2025 plan year with Cigna Healthcare Medicare Advantage benefit plans.
- The terms of current Provider Services Agreements with Cigna Healthcare Medicare Advantage, including reimbursement rates, will remain in effect and are not otherwise affected.
- Following finalization of the transaction, you should not expect any changes to your billing, prior authorization or provider network contacts or processes as a result of the transaction. For BCBSTX members, follow BCBSTX processes for providing and billing for care. For Cigna Healthcare Medicare Advantage customers, follow Cigna Healthcare Medicare Advantage processes for providing and billing for care.
- When providing services to BCBSTX members and Cigna Healthcare Medicare Advantage customers, continue to:
    - Ask to see their member or customer ID card before all appointments.
    - Check eligibility and benefits before all appointments.

    - Follow utilization management review requirements and guidelines.
    - Follow the billing instructions on the member or customer ID card.
- **Contacts for BCBSTX and Cigna Healthcare Medicare Advantage will remain the same for 2025**. For BCBSTX contacts, see our contact us page.
- Independent of the transaction, we continue to evaluate opportunities to enhance the tools and platforms we use, and you may experience changes as part of normal business operations. If there are any changes, we will inform you with plenty of notice.

Both BCBSTX and Cigna Healthcare Medicare Advantage are committed to a smooth transition and ensuring continuity of service. If you have any questions, please continue to work with your assigned points of contact.

We appreciate the quality of care that you provide and will keep you informed of any updates as they become available. You may also refer to our FAQs.

PHARMACY

Abiraterone Drug Coverage Changes Coming for Many Commercial Members

Starting Oct. 1, 2024, coverage of Abiraterone Acetate will change for many of our commercial members with pharmacy benefits administered by Prime Therapeutics. These members will only have coverage for the CivicaScript® produced, low-cost generic version of Abiraterone Acetate 250 mg. This drug is only available through SortPak Pharmacy.

Zytiga and other generic versions of Abiraterone Acetate 250 mg will no longer be covered on the drug lists for our members with employer group or individual health plan benefits.

This change will not apply for some of our members until or after Jan. 1, 2025.

Send prescriptions to SortPak

Letters about this change will be sent to members with claims for Zytiga or other generic versions of Abiraterone Acetate 250 mg. The letter explains how to receive the medication from SortPak, including where to send the prescription.

If your patient receives this letter and asks for a new prescription, please e-prescribe or fax:

- **SortPak Pharmacy**, 124 S. Glendale Ave., Glendale, CA 91205
- **NCPDP/NABP:** 0524733, **NPI:** 1063407252
- **Fax:** 877-475-2382
- **Phone:** 877-570-7787

Why the change? Our partnership with CivicaScript furthers our initiatives to make prescription drugs more affordable for our members. Lower cost generic drugs help lower members' out-of-pocket costs and improve medication adherence.

Check eligibility and benefits: Treatment decisions are between you and your patients. Coverage is subject to the terms and limits of your patients' benefit plans**. Always check eligibility and benefits for each member at every visit.** This step confirms membership and other details, such as prior authorization requirements and utilization management vendors, if applicable.

If your patients have questions about pharmacy benefits, they can call the number on the back of their member ID card, log in to Blue Access for Members℠ or visit MyPrime.com.

UTILIZATION MANAGEMENT

Site of Care Utilization Management Review for Advanced Imaging Jan. 1, 2025

Effective Jan. 1, 2025, Carelon Medical Benefits Management will do a medical necessity review **including site of care when you request eligible computed tomography, computed tomography angiography, magnetic resonance imaging and magnetic resonance angiography imaging services** that require a prior authorization or are applicable for a recommended clinical review in a hospital-based outpatient setting for certain commercial members. These additional reviews will **help our members get the right care in the right setting**.

Carelon will review your request for medical necessity and determine if the service requires an outpatient hospital setting, or if there are available freestanding alternatives. Carelon will use its "Site of Care for Advanced Imaging" clinical guidelines to conduct its review. You may request a peer-to-peer review from Carelon before or after the determination.

For Advanced Imaging Facilities: If your facility bills as a freestanding imaging center, or bills with the following place of service designations, **we recommend you register with *Opti*Net® by Dec. 1, 2024:**

- Place of service codes 11, 49 or 81 are designated as a Freestanding Imaging Facility / Physician Group
- Place of service codes 19 or 22 are designated as an Outpatient Hospital Department

OptiNet is Carelon's online assessment tool that collects modality-specific data from imaging providers. For more information, refer to our updated prior authorization or recommended clinical review code lists on our Utilization Management page.

Always check eligibility and benefits first through Availity® Essentials or your preferred vendor portal, prior to rendering services. This step will confirm prior authorization requirements or if service is eligible for recommended clinical review and if managed by BCBSTX or a utilization management vendor.

Even if prior authorization isn't required for a commercial member, you still may want to submit a voluntary recommended clinical review request. This step can help avoid post-service medical necessity review. Learn more about Recommended Clinical Review.

Services performed without required prior authorization or optional RCR that do not meet post service medical necessity or site of care criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Note: These changes do not apply to **Federal Employee Program®** or **Medicare Advantage or Medicaid** members.

Utilization Management Decisions

We're dedicated to serving our customers through health care coverage and related benefit services. Utilization Management 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
- 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 and don't 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 members' ID cards as appropriate.

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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