BLUE REVIEW℠

A Provider Publication

JULY 2022

REGULATORY & REQUIREMENTS

The following includes regulatory or mandated information that Blue Cross and Blue Shield of Texas (BCBSTX) is required to provide in all published correspondence with health care providers. It also includes a collection of articles to assist provider offices in servicing BCBSTX patients. For additional information, visit the BCBSTX provider website.

Note: When "Commercial plans" is referenced, it includes Blue Choice PPO®, Blue Advantage HMO℠, Blue Advantage Plus℠, Blue Essentials℠ (including TRS-ActiveCare Primary and TRS-ActiveCare Primary+ participants), Blue Essentials Access℠, Blue Premier℠, Blue Premier Access℠, MyBlue Health℠ and Blue High Performance℠.

Note: When "Commercial plans" is referenced, it includes:

- Blue Choice PPO® and Blue High Performance Network℠ (BlueHPN)
- Blue Advantage HMO℠
- Blue Advantage Plus℠
- Blue Essentials℠ (including TRS-ActiveCare Primary and TRS-ActiveCare Primary+ participants) and Blue Essentials Access℠
- Blue Premier℠ and Blue Premier Access℠
- MyBlue Health℠ and Blue High Performance℠

Topics:

REGULATORY AND REQUIREMENTS CORNER

Billing and Documentation Information and Requirements

Billing and Documentation Information and Requirements
BCBSTX has implemented changes to clarify existing policies related to billing and documentation requirements for the Commercial, Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM plans. These updates are reflected in the Blue Choice PPO and BlueHPN Provider Manual and the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Heath Provider Manual in Section F Filing Claims posted on bcbstx.com/provider under Standards and Requirements/Manuals.

Contracted Providers Must File Claims

As a reminder, health care providers must file claims for any covered services rendered to a patient enrolled in a BCBSTX health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your provider contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA (Health Insurance Portability and Accountability Act of 1996) to add a requirement that if a patient self pays for a service in full and directs a provider to not file a claim with the patient's insurer, the provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

After-hours Access Is Required

BCBSTX requires that primary care and specialty care health care providers provide urgent, and emergency coverage for care 24 hours a day, seven days a week. Providers must have a verifiable mechanism in place, for immediate response, for directing patients to alternative after-hours care based on the urgency of the patient's need.

Acceptable after-hours access mechanisms may include:

- an answering service that offers to call or page the physician/provider or on-call physician/provider,

- a recorded message that directs the patient to call the answering service and the phone number is provided, or
- a recorded message that directs the patient to call or page the physician/provider or on-call physician/provider and the phone number is provided.

For more detail, refer to the provider manuals (Section B).

After-hours or weekend care is reimbursable, within limitations, for services provided by an individual physician or other health care professional who is required to provide office-based services outside of regular posted office hours to treat a patient's urgent illness or condition.

BCBSTX does not reimburse facility-based or non-office-based providers for CPT Codes 99053, 99056 and 99060. These codes will be considered inclusive of the primary procedure.

Medical Policy Disclosure

New or revised medical policies, when approved, will be posted on the BCBSTX provider website on the 1st or 15th day of each month. Those 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 medical policy review process, you can view draft medical policies and provide your feedback online. If there are any draft medical policies to review, these documents will be made available for your review around the 1st and the 15th of each month with a review period of approximately two weeks. To view medical policies, go to Medical Policies. After reviewing and agreeing to the disclaimer, you will then have access to active and pending medical policies.

Rights and Responsibilities Notification

Your Rights

As a participating practitioner of our network, you have the right to review information submitted to support your credentialing application and receive the status of your credentialing (or recredentialing) application, upon request.

Providers have the responsibility to work directly with the reporting entity(ies) to correct erroneous information and/or conflicting information within 30 calendar days. All corrections must be submitted in writing to our Enterprise Credentialing Department, your assigned Network Management Consultant or a Medical Director to avoid future delays in processing your information for consideration in BCBSTX networks.

Mail: 1001 E. Lookout Drive Richardson, Texas 75082
Fax: 972-766-2137
Email: CredentialingCommittee@bcbstx.com

Note: Credentialing decisions will not be made until the applicant has responded or if the response has exceeded the 30 calendar days allocated.

Applicants who only see patients in an office setting and do not have hospital admitting privileges at a network hospital may attest to having coverage for hospital admissions by submitting a signed Hospital Coverage letter. You can find a copy of this letter by visiting the Forms section under Education and Reference on the BCBSTX provider website.

Care Management Programs: Case Management and Disease Management

BCBSTX Case Management (CM) and Disease Management (DM) staff work with enrolled members to increase their knowledge about their condition and help them better manage crisis events when they occur. CM and DM staff support the member and practitioner relationship, and aid communication between them. Members are encouraged to discuss issues and questions with their practitioner, develop a “shared decision making”

partnership with their practitioner and take an active role in managing their own health.

Member compliance with physician treatment plans is monitored, including keeping appointments, compliance with medications and completing ordered tests. Program interventions are designed to coordinate with the activities of a member's treating practitioners, specifically their primary care physician and/or appropriate specialist.

As a practitioner, you may refer a member for these care management programs at any time by calling the number on the back of the member's identification (ID) card. A clinician will collaborate with you to provide our members with available resources and additional support.

Member Rights and Responsibilities
As a BCBSTX practitioner, it is important that you are aware of our members' Rights and Responsibilities. Our health plan members can find their Rights and Responsibilities in their benefit booklet or on our website.

Member Rights and Responsibilities include:

- A right to receive information about BCBSTX, our services, our providers and facilities, and member rights and responsibilities.
- A right to be treated with respect and recognition of the member's dignity and right to privacy.
- A right to participate with providers in making decisions about the member's health care.
- A right to have a candid discussion of appropriate or medically necessary treatment options for the member's condition, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about BCBSTX or the care we provide.
- A right to make recommendations regarding our members' Rights and Responsibilities policy.
- A responsibility to provide, to the extent possible, information that BCBSTX and the provider and facility need to provide care.
- A responsibility to follow the plans and instructions for care that the member has agreed to with their provider. A responsibility to understand their health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.

BENEFITS & ELIGIBILITY

No articles this month. Refer to the Claims & Eligibility section or the Provider Manuals section on our provider website.

CLAIMS

ClaimsXten™ Quarterly Updates
New and revised Current Procedural Terminology (CPT®) and HCPCS codes are periodically added to or deleted from the ClaimsXten code auditing tool software on a quarterly basis and are not considered changes to the software version.

BCBSTX will normally load this additional data to the claim processing system within 60 to 90 days after receipt from the vendor and will confirm the effective date via the News and Updates section of the BCBSTX provider website.

Advance notification of updates to the ClaimsXten software version also will be posted on the BCBSTX provider website.

To help determine how coding combinations on a claim may be evaluated during the claim adjudication process,

you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software.

For more details regarding ClaimsXten, including answers to frequently asked questions, refer to the C3 page under the Education and Reference then Provider Tools or in the Claims Filing Tips/Coding Billing and Bundling Information under Claims and Eligibility on the BCSTX website. Additional information may also be included in upcoming issues of *Blue Review*.

Cotiviti Code-Auditing Software

BCBSTX uses Cotiviti code-auditing software to further enhance the auditing of professional and outpatient facility claims for correct coding according to the Healthcare Common Procedure Coding System (HCPSC), Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services guidelines. Providers may use the Claim Research Tool (CRT), which is available on the Availity Essentials (formerly Availity Provider Portal) to research specific claim edits.

Note: The above notice does not apply to government program claims (Medicare Advantage and Texas Medicaid).

CLINICAL RESOURCES

BCBSTX HEDIS® Tip Sheets

We created quality improvement and behavioral health tip sheets to help you satisfy Healthcare Effectiveness Data and Information Set (HEDIS) measures and code appropriately. These measures from the National Committee for Quality Assurance (NCQA) help ensure our members receive appropriate care.

The tip sheets include measurement requirements, medical record best practices and billing codes. Compliance with HEDIS measures reduces the need for you to send medical records later for review. Review tip sheets below:

- Quality Improvement HEDIS Tip Sheets
- Behavioral Health HEDIS Tip Sheets

BCBSTX Lab Guidelines

Providers can use any in-network clinical laboratory for commercial and retail plans. Statewide in-network clinical labs for PPO and HMO members include the following:

- Clinical Pathology Laboratory at 800-595-1275 or cpllabs.com
- LabCorp at 800-845-6167 or labcorp.com
- Quest Diagnostics at 888-277-8772 or questdiagnostics.com/patient

Refer to Provider Finder® for additional participating clinical laboratory providers.

EDUCATION & REFERENCE

No articles this month. Refer to the Education & Reference section on our provider website.

ELECTRONIC OPTIONS

Electronic Options Available in Availity®

BCBSTX offers you multiple enrollment opportunities for electronic options through the Availity Essentials (formerly Availity Provider Portal) with single sign-on access. You can complete the online options listed below through Availity at no cost, securely and conveniently. Refer to Provider Tools and Electronic Commerce Solutions on our provider website for additional information on the following services and tools:

- Authorizations & Referrals
- Availity Attachments (submit predetermination requests)
- Claim Status Tool – available for all Plans
- Clinical Quality Validation (CQV)
- Electronic Clinical Claim Appeal Requests
- Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA)
- Electronic Quality and Risk Adjustment Medical Record Requests
- Electronic Refund Management(eRM)
- Eligibility and Benefits (including viewing member ID cards)
- Fee Schedule Tool
- Patient ID Finder
- Provider Data Management

For assistance or customized training, contact a BCBSTX Provider Education Consultant at PECS@tx.com.

MEDICARE ADVANTAGE

Blue Cross Medicare Advantage (PPO)SM Lab Guidelines

Quest Diagnostics, Inc., Clinical Pathology Laboratory (CPL) and LabCorp, Inc. are the preferred outpatient clinical reference laboratory providers for Blue Cross Medicare Advantage (PPO) members.

Note: This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free-standing ambulatory surgery centers).

For locations or questions contact:

- Clinical Pathology Laboratory at 800-595-1275 or cpllabs.com
- LabCorp at 800-845-6167 or labcorp.com
- Quest Diagnostics at 888-277-8772 or questdiagnostics.com/patient

As previously indicated, if lab services are performed at the participating physician's or other professional provider's office, the physician or professional provider may bill for the lab services. However, if the physician's or other professional provider's office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Cross Medicare Advantage (PPO) for the lab services.

CMS Notifications for Blue Cross Medicare Advantage (PPO)SM and Blue Cross Medicare Advantage (HMO)SM

The Centers for Medicare and Medicaid Services (CMS) routinely publishes notifications that provide CMS guidance to all Medicare physicians, providers and suppliers, including those serving beneficiaries enrolled in Original Medicare and one of the Blue Cross Medicare Advantage (PPO) or Blue Cross Medicare Advantage (HMO) plans. These CMS notifications are located in the Medicare Learning Network (MLN Matters) on CMS.gov. They may include informational regulatory updates and reminders, as well as required actions or changes by the

provider rendering services. As such, it is important for providers to review these notifications and ensure your staff are aware of them.

Medicare Advantage Prior Authorization Requests through eviCore®

BCBSTX contracts with eviCore (eviCore), an independent specialty medical benefits management, for select specialty utilization management services for Medicare Advantage members.

After you check Availity®, or your preferred vendor, and determine the service requires prior authorization through eviCore, submit prior authorization requests through eviCore's provider portal. Using the eviCore provider portal to submit requests for prior authorization allows you to view and print information, review clinical to determine what is needed, and schedule consultations for questions.

To begin managing eviCore authorizations, go to eviCore.com and register. Training sessions are available through the eviCore training center. For provider portal help, portal.support@evicore.com or call 1-800-646-0418 and select option 2.

PHARMACY

Refer to the Pharmacy Program section on our provider website.

UTILIZATION MANAGEMENT

Importance of Obtaining a Prior Authorization/Referral

A prior authorization/referral is required for certain types of care and services. Prior authorizations may be managed by BCBSTX Medical Management or a vendor such as AIM Specialty Health®, eviCore healthcare® or Magellan Health®. Although BCBSTX participating health care providers are required to obtain prior authorizations/referrals, it is also the responsibility of the member to confirm that this action has been taken for services that require a prior authorization/referral.

To determine if a service requires a referral or prior authorization and who to contact, it is imperative that providers check eligibility, benefits, and prior authorization requirements through Availity® or your preferred vendor and also reference Utilization Management (Prior Authorizations & Predeterminations). In addition, providers can submit prior authorizations managed by BCBSTX via Availity Authorizations & Referrals or find links to the AIM and eviCore sites for services they manage on Availity.

Prior authorizations/referrals may be required for any services provided by someone other than the member's primary care physician/provider (PCP) (i.e., specialist, ambulatory surgery centers, ancillary, etc.). A prior authorization/referral is also needed for an initial stay in a facility and any additional days or services added on.

Prior authorizations are required to allow for medical necessity review. If a member does not obtain a prior authorization/referral for initial facility care or services, or additional days or services added on, the benefit for covered expenses may be reduced. Retrospective reviews for medical necessity will not be performed for any HMO plans except in limited special circumstances.

A prior authorization/referral does not guarantee payment. All payments are subject to determination of a member's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations and other provisions of the policy at the time services are rendered.

If a prior authorization/referral request is received from an out-of-network (OON) provider and the member does not have an OON benefit, BCBSTX will contact the ordering provider to discuss network options. However, if a member has an OON benefit, OON benefits will apply, which could result in a higher cost sharing.

AIM Prior Authorizations and RQI Programs

AIM Specialty Health® administers prior authorization review and the radiology quality initiative (RQI) program for certain services and BCBSTX commercial members. Providers should check eligibility, benefits and prior authorization or prenotification requirements through Availity® or your preferred vendor members when ordering or scheduling the below outpatient services when performed in a health care provider's office, the outpatient department of a hospital or a freestanding imaging center.

Services that may require prior authorization:

- Advanced Imaging
- Cardiology
- Sleep Medicine
- Joint and Spine Surgery
- Pain Management
- Radiation Therapy
- Genetic Testing services
- Medical Oncology

Services that may require an RQI:

- CT/CTA
- MRI/MRA
- SPECT/nuclear cardiology study
- PET scan

If prior authorization or an RQI are required, providers can submit them by logging into AIM's provider portal at aimspecialtyhealth.com. If criteria are met, you will receive an approved order request number RQI. If criteria are not met, or if additional information is needed, the case will automatically be transferred for further clinical evaluation.

For more information refer to the AIM Specialty Health page on our provider website.

CONTACT US

View our directory of contacts for BCBSTX.

UPDATE YOUR INFORMATION

Remember, per the Consolidated Appropriations Act, you must verify your demographic information every 90 days. Refer to the Verify and Update Your Information page for more details on using Provider Data Management via Availity or our online Demographic Change Form. You can also use the Demographic Change Form to include up to 10 of your office email addresses to receive the *Blue Review* newsletter by email.

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 applicableon the date services were rendered. If you

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue

Cross and BlueShield of Texas (BCBSTX).

eviCore is a trademark of eviCore health care, LLC, formerly known as CareCore, an independent company that provides utilization review for selecthealth 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.

HEDIS is a registered trademark of NCQA. Use of this resource is subject to NCQA's copyright, found here. The NCQA HEDIS measure specification has been adjusted pursuant to NCQA's Rules for Allowable Adjustments of HEDIS. The adjusted measure specification may be used only for quality improvement purposes.

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

BCBSTX makes no endorsement, representations or warrantiesregarding third party vendors and the products and services they offer.

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 finaldecision about any medication is between the member and their health care provider.

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