BLUE REVIEW℠

A Provider Publication

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NOTICES & ANNOUNCEMENTS

COVID-19 Provider Preparedness Updates

Check for continuing updates to our COVID-19 Preparedness, COVID-19 Provider Information for ERS Participants and COVID-19 Related News pages.

New Look Ahead for Provider Website

Our provider website will have a new streamlined design by early next year. We're making changes to enhance your online experience and help you easily find the information you need. Information will be in the sections you're used to seeing, such as Claims and Eligibility and Education and Reference. Please watch for future updates.

CLAIMS & ELIGIBILITY

Claim Editing Enhancements Coming April 1, 2022

Effective **April 1, 2022**, Blue Cross and Blue Shield of Texas (BCBSTX) will enhance our claims editing and review process with Cotiviti, Inc. for some of our commercial members to help ensure accurate coding of services and that services are properly reimbursed.

What this means for you: The enhancements require you to continue to follow generally accepted claim payment policies. With your help, the enhanced claims review process will help our members get the right care at the right time and in the right setting.

Note: Inaccurately coded claims will result in denied or delayed payment.

About the guidelines: BCBSTX will continue to follow claim payment policies that are global in scope, simple to understand and come from recognized sources, including:

- ICD-10 coding guidelines
- The Healthcare Common Procedure Coding System (HCPCS)

- Current Procedural Terminology (CPT®) codes as documented by the American Medical Association (AMA)
- Correct Coding Initiatives (CCI)
- Post-Operative Period Guidelines as outlined by the Centers for Medicare and Medicaid Services (CMS)

Using these guidelines will help ensure a more accurate review of all claims.

What's changing: Components of the editing and review enhancements include:

- **Anatomical Modifiers** – CMS-defined anatomical modifiers validate the area or part of the body on which a procedure is performed. Procedure codes that do not specify right or left require an anatomical modifier. This includes procedures on fingers, toes, eyelids and coronary arteries which have specific CMS-defined modifiers.
- **Diagnosis Code Guidelines** - Use of correct ICD-10 codes will be verified. Use of ICD-10 clinical modification (CM) diagnosis coding guidelines, including reporting of inappropriate code pairs, as well as correct coding of secondary, manifestation, sequelae, chemotherapy administration, external causes and factors influencing health status diagnoses. These guidelines are contained in the ICD-10-CM Diagnosis Codes Manual.

Reminder: these new enhancements follow a previous announcement for an edit that will go live Jan. 10, 2022.

More Information: View the Cotiviti, Inc Edit Descriptions for additional guidance. To edit or correct a denied claim, refer to the Claim Forms, Submissions, Responses and Adjustments section under Claims Filing Tips on our provider website. Watch News and Updates for future updates.

2022 Federal Employee Program® Prior Authorization and Benefit Updates

Effective 1/1/2022, our Blue Cross and Blue Shield of Texas (BCBSTX) Federal Employee Program (FEP®) participants will have some changes to their prior authorization requirements and benefits.

Prior Authorization Updates

- Kidney transplants will now require prior approval and are now part of the Blue Distinction Centers for Transplants® (BDCT) Program.
- Pancreas transplants continue to require prior approval but are removed from the BDCT program
- Air Ambulance (non-emergent) transport from one facility to another requires prior approval and falls under the No Surprise Billing Act.

Benefit Changes

Be sure to check eligibility and benefits through FEP Customer Service or Availity® for specifics on FEP member benefits. The following have changes to benefits:

- Gender Reassignment Surgery (GRS)
- EKG will no longer be considered part of the preventive benefit. There must be a medical necessity.
- Specialty drug pharmacy will be administered by CVS Caremark. For Blue Focus members, Walgreens and Duane Reade Pharmacies will no longer be in-network. For more information, refer to the FEP Pharmacy page or call **1-888-346-3731**.
- Emergency medical services performed in the emergency department of a hospital or urgent care centers, licensed as and permitted to provide emergency services that do not contract with our Blue Cross and Blue Shield Plan, will be reimbursed in accordance with federal laws and regulations, such as the No Surprise Billing Act.

If you have any questions, contact our FEP Customer Service at **1-800-442-4607**.

Chiropractic & Mixed Therapy Benefits Contained in IVR Phone System as of Jan. 3, 2022

Beginning **Jan. 3, 2022,** the option to speak to a Customer Advocate will be removed for the chiropractic and mixed therapy (physical, occupational and speech therapies) benefit category within our automated Interactive Voice Response (IVR) phone system. The IVR quotes the same level of patient eligibility and benefits information as a Customer Advocate provides. Remain assured; our Customer Advocates will continue to be available for more complex benefit quotes.

Blue Cross and Blue Shield of Texas (BCBSTX) is committed to providing efficient and secure access to patient information. **To better assist providers with understanding the recent IVR change, a list of the benefit categories that are currently contained in the IVR is included below.** This listing is continually reviewed and may vary across our different BCBSTX networks, products and/or group policies.

Note: *This information/listing is not applicable to Medicare Advantage or Texas Medicaid members. When calling to verify eligibility and benefits for one of these members, refer to the Customer Services phone number on the back of the member's BCBSTX ID card.*

Air Ambulance	Electrocardiogram (EKG)	***Mixed Therapy***	Preventive Care
Allergy	Extended Care Facility	MRI	Private Duty Nursing
Anesthesia	Ground Ambulance	Office Services	Prosthetics

Assistant Surgeon	Hospice	Office Visit	Prostate-specific Antigen (PSA)
CAT Scan	Hospital	Pap Smear	Sterilization
Chiropractic Services	Inhalation Therapy	Pathology	Ultrasound
Colonoscopy	Laboratory	PET Scan	23-Hour Observation
Consultations	Mammogram	Physical Exam	
Dialysis	Medical Supplies	Physical Therapy	

This change does not impact the Federal Employee Program® (FEP®) IVR. Refer to ***page 5*** *of the* ***Eligibility and Benefits Caller Guide*** *to view a listing of contained benefit categories within the IVR for FEP members.*

Chiropractic Services Mixed & Therapy will be contained in the IVR as of Jan. 3, 2022.

For additional help with navigating the IVR, refer to the **Eligibility and Benefit Caller Guide** under the IVR page in the Claims and Eligibility section of our Provider website.

Consider Electronic Options

Checking eligibility and benefits electronically through Availity® or your preferred Web vendor is the quickest way to access information for BCBSTX members. To learn more about online solutions, refer to the Provider Tools section of our website.

Availity® Tools to Support Providers in 2022

As a reminder, the Availity Essentials helps providers and us quickly and securely share information, including information defined by the Consolidated Appropriations Act. Review the many self-service tools you can access through the Availity portal, instructional user guides and important tips. Read More

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Clinical Payment and Coding Policy Updates

The Clinical Payment and Coding policies on our website 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; it is not intended to address all reimbursement-related issues. We regularly add and modify clinical payment and coding policy positions as part of our ongoing policy review process. The following have been recently added or updated:

- Coordinated Home Care /Private Duty Nursing Policy – Effective 12/01/2021
- Applied Behavior Analysis – Effective 03/01/2022

- Emergency Department Evaluation and Management (E/M) Services Coding – Facility Services – Effective 03/20/2022

CLINICAL RESOURCES

Rural Health Clinics and Federally Qualified Health Centers May Meet Quality Measure

Starting Jan. 1, 2022, Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) may meet the requirements for the quality measure **Follow-up After Hospitalization for Mental Illness (FUH).** We track FUH as part of monitoring the quality of our members' care.

Meeting the Measure

For RHCs and FQHCs, the Psychiatric Collaborative Care Model (CoCM) service may satisfy the measure. Psychiatric CoCM must meet all of the following criteria:

- Sixty minutes or more of clinical staff time for psychiatric CoCM services directed by an RHC or FQHC practitioner (physician, nurse practitioner, physician assistant, or certified nurse-midwife), and
- Include services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.

This guidance is for RHCs and FQHCs only. It applies to measurement year 2022.

Why FUH Matters

FUH is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure from the National Committee for Quality Assurance (NCQA). It requires a timely outpatient follow-up visit with a qualified mental health provider, including telehealth visits, or in certain outpatient settings. Timely follow-up care is important for members' health and well-being after hospitalization for mental illness, according to NCQA.

For FUH, we capture the percentage of discharges for members ages 6 and older who were hospitalized for the treatment of selected mental illness or intentional self-harm and had a follow-up visit with a mental health provider. The follow-up visit must be on a different date than the discharge date. Two percentages are measured and reported:

- Discharges for which members had a follow-up visit within 30 days after discharge
- Discharges for which members had a follow-up visit within seven days after discharge

If the first follow-up visit is within seven days after discharge, then both rates are counted for this measure.

Questions? Email or contact your Provider Network Representative.

HEALTH & WELLNESS

To support quality care, we are providing information to providers and members to encourage discussions on health topics. Watch for more on health care quality in the News and Updates section of our website and on our Wellness Can't Wait web page.

MEDICARE ADVANTAGE PLANS

COVID-19 Vaccine Billing for Medicare Advantage Members

Starting Jan. 1, 2022, Blue Cross and Blue Shield of Texas (BCBSTX) will cover the cost of COVID-19 vaccines and their administration for Blue Cross Medicare Advantage members instead of the original Medicare program (also known as Fee-for-Service Medicare). Medicare Advantage members will continue to have no cost-sharing during their 2022 benefit year for COVID-19 vaccines and their administration, including approved booster doses.

What This Means for You

- **Through Dec. 31, 2021:** For Medicare Advantage members you vaccinate through Dec. 31, submit claims for the vaccine and its administration to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved. Payment for the vaccine and its administration is through the Original Medicare program until the end of the year.
- **Starting Jan. 1, 2022:** For Medicare Advantage members you vaccinate on or after Jan. 1, follow your normal submission process to BCBSTX or refer to the member's ID card for billing instructions when submitting vaccine and administration claims.

Reimbursement

- In-network providers will be reimbursed for the COVID-19 vaccine and administration fee based on contracted rates.
- Out-of-network providers will be reimbursed based on the established out-of-network reimbursement policy that follows Medicare rates.

Resources

- Learn more about COVID-19 coverage
- See CMS guidance on Medicare billing for the COVID-19 vaccine administration

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New Flexible Medicare Advantage PPO Plan

We're offering certain Blue Cross Medicare Advantage℠ members a new way to access care. The Blue Cross Medicare Advantage Flex (PPO)℠ Plan is an open access plan that **allows members to see any provider accepting Medicare,** including Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage

(HMO)℠ contracted providers. Members can see providers inside or outside the plan service area or plan network, at no additional cost.

What This Means for You

- Starting Jan. 1, 2022, you can identify Flex Plan members by their member ID card. Look for the Flex Plan name on the front.
- You can see Flex Plan members if you accept Medicare and bill Blue Cross and Blue Shield of Texas (BCBSTX). Follow the billing instructions on the member ID card.
- If you are a Medicare Advantage-contracted provider with Blue Cross and Blue Shield (BCBS), you will be paid at your contracted rate.
- If you are not a Medicare Advantage-contracted provider with BCBS, you will receive the Medicare allowed amount for covered services. You may not balance bill the member for any difference in your charge and the allowance.

Value for Members

Flex Plan members' coverage level is the same whether in or outside the plan service area nationwide. Services must meet medical necessity criteria to be covered. The Flex Plan includes:

- Prescription drug coverage
- MDLIVE® for telehealth and 24/7 Nurseline
- SilverSneakers® fitness program at no cost
- A traveler benefit for members leaving their service area for up to six months

Check Eligibility and Benefits First

Use the Availity® Provider Portal or your preferred vendor to verify members' eligibility and benefits before every appointment. Eligibility and benefit quotes include:

- Membership verification
- Coverage status
- Prior authorization requirements
- Provider's network status for the member's policy
- Applicable copayment, coinsurance, and deductible amounts

Ask to see the member's ID card and a photo ID to help guard against medical identity theft. If services may not be covered, members should be notified that they may be billed directly.

Hospitals Must Provide Medicare Outpatient Observation Notice

Hospitals and Critical Access Hospitals (CAH) are required to give the standardized Medicare Outpatient Observation Notice (MOON) to our Blue Cross Medicare Advantage℠ members who are under outpatient

observation for more than 24 hours. **The notice explains why the members aren't inpatient and what their coverage and cost-sharing obligations will be.**

Steps for Providers to Complete the MOON

- Download the notice from the Centers for Medicare and Medicaid Services (CMS) website
- Fill in the reason the member is outpatient rather than inpatient
- Explain the notice verbally to the member if they are in observation more than 24 hours
- Have the member sign to confirm they received and understand the notice. If the member declines, the staff member who provided the notice must certify that it was presented.
- Document all member communications regarding the MOON process in members' records

If the patient is admitted, transferred, or released, the notice **must be completed no later than 36 hours after observation begins or sooner.**

Learn more from CMS' notice instructions.

Qualified Medicare Beneficiary Program Patients Should Not Be Billed

If you participate in Blue Cross Medicare Advantage℠ networks, you may not bill cost-sharing or out-of-pocket costs to our members enrolled in the Qualified Medicare Beneficiary (QMB) program, a federal Medicare savings program.

QMB patients are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a state Medicaid benefit, QMB covers the Medicare Advantage premiums, deductibles, coinsurance, and copayments of QMB beneficiaries. **QMB beneficiaries are not responsible for Medicare Advantage cost-sharing, or out-of-pocket costs.**

For services you provide to QMB patients, you must:

- Bill both Medicare Advantage and Medicaid
- Accept Medicare Advantage payments and any Medicaid payments as payment in full

Tips to Avoid Billing QMB Patients

Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare Advantage cost-sharing.

To avoid billing QMB patients, please take these precautions:

- Identify QMB patients by looking for **Blue Cross Medicare Advantage Dual Care**℠ on member ID cards
- Check the Texas Medicaid portal to confirm QMB beneficiary status.

- Understand the Medicare Advantage cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare Advantage cost-sharing billing and related collections efforts

Questions?
Call Customer Service at **1-877-774-8592** to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.

Blue Cross Medicare Advantage℠ Prior Authorization Code Update Effective April 1, 2022

What's Changing: Blue Cross and Blue Shield of Texas (BCBSTX) is changing prior authorization requirements for Blue Cross Medicare Advantage members to reflect new, replaced or removed procedure codes due to updates from Utilization Management or the American Medical Association (AMA). A summary of changes is included below.

Changes effective **April 1, 2022** include:

- Addition of Lab codes to be reviewed by eviCore healthcare (eviCore)
- Addition of Specialty Drug codes to be reviewed by eviCore
- Addition of Medical Oncology codes to be reviewed by BCBSTX

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.

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.

Medicare Advantage Provider Manual Supplements Update

Be sure to check out the updated Medicare Advantage PPO and HMO Provider Manual Supplements posted on the Provider Manuals on the BCBSTX provider website. In addition, throughout the year, keep current on changes by visiting the provider website for News and Updates and the *Blue Review* newsletter. You and your staff can also directly receive the newsletter by submitting your email address(es) using the Demographic Change Form. Refer to the User Guide for instructions on which fields to complete.

2022 Blue Cross Medicare Advantage Expansion Service Areas

Effective January 1, 2022, Blue Cross Blue Shield of Texas (BCBSTX) announces that Blue Cross Medicare Advantage HMO, and PPO networks are expanding its service areas across Texas. The expansion builds on strong networks already in place in Texas and is part of our commitment to providing members with access to affordable health care.

Blue Cross Medicare Advantage (HMO)℠ Expansion Areas: Brazoria, Ellis, Johnson, Parker, Rockwall, and Waller counties.

Plan highlights include:

- $0 premiums
- $0 PCP visits
- Over-the-counter quarterly mail order benefit
- Cost-free SilverSneakers® gym membership
- Cost-free transportation for travel to/from doctors' visits
- Some supplemental vision, dental and hearing benefits

Remember to view the Blue Cross Medicare Advantage HMO SNP provider training here.

Blue Cross Medicare Advantage (PPO)℠ Expansion Areas:

Archer, Austin, Bee, Bell, Blanco, Bosque, Brazoria, Brooks, Burleson, Clay, Coryell, Dimmit, Duval, Ellis, Erath, Falls, Freestone, Goliad ,Grimes, Hamilton, Henderson, Hopkins, Houston, Jack, Jim Hogg, Jim Wells, Karnes, Kenedy, La Salle, Limestone, Madison, Mason, McCulloch, McLennan, Mills, Nueces, Orange, Palo Pinto, Parker, Polk, Rains, Refugio, San Jacinto, San Patricio, San Saba, Shackelford, Somervell, Throckmorton, Trinity, Tyler, Van Zandt, Walker, Waller, Washington, Webb, and Zavala counties.

Plan highlights include:

- Cost-free SilverSneakers® gym membership
- Some plans offer supplemental vision and dental
- Dallas Choice Premier PPO plan offers a supplemental hearing aid allowance
- New Flexible Medicare Advantage PPO Plan

Have questions?

Call 1-972-766-7100, Email Texas Medicare Advantage Network or reference the Medicare Advantage Provider Quick Reference Guide.

†SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

HMO Special Needs Plan provided by Blue Cross and Blue Shield of Texas, which refers to GHS Insurance Company (GHS), an Independent Licensee of the Blue Cross and Blue Shield Association. GHS is a Medicare Advantage organization with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in GHS' plan depends on contract renewal.

PHARMACY

Pharmacy Program Updates Effective Jan. 1, 2022

Pharmacy programs have numerous updates effective Jan. 1, 2022. Some members may have new pharmacy networks and/or changes within their current network. Providers can refer to our News and Updates page to review the Pharmacy Program Updates: Quarterly Pharmacy Changes Effective Jan. 1, 2022 – Part 1 for details on the changes.

PRIOR AUTHORIZATION

Prior Authorization Code Update Effective 4/1/22 for Commercial Members

What's New: Blue Cross and Blue Shield of Texas (BCBSTX) will be updating its lists of procedure codes requiring prior authorization, for some commercial members, to reflect new, replaced or removed codes due to updates from Utilization Management or the American Medical Association (AMA).

Changes effective April 1, 2022, include the following codes reviewed by AIM Specialty Health® (AIM):

- Addition of Musculoskeletal codes
- Addition of Molecular Genetic Lab Testing codes
- Removal of one Musculoskeletal code
- Removal of Radiation Therapy/Radiation Oncology
- Addition of Advanced Imaging/Radiology

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® 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.

Revision to Prior Authorization Codes for Commercial Members

On Sept. 29, 2021, Blue Cross and Blue Shield of Texas (BCBSTX) announced changes to the commercial member prior authorization procedure code lists effective Jan. 1, 2022.

Additional Code Removals

We have updated the lists of procedure codes, for some commercial members, to reflect removing some additional codes from requiring prior authorization through BCBSTX or AIM Specialty Health® (AIM) due to updates from Utilization Management or the American Medical Association (AMA).

The revisions effective Jan. 1, 2022 include the removal of some codes in the following categories:

- Reviewed by BCBSTX
    - Spinal Cord Stimulation codes
    - Multiple Stimulation codes
- Reviewed by AIM
    - Cardiology codes
    - Radiation Oncology codes
    - Advanced Imaging codes
    - Medical Oncology codes

More Information:

The **Prior Authorization Lists for Fully Insured and Administrative Services Only (ASO) Plans** page under the Utilization Management section of our provider website include the revised lists. Refer to AIM's website for available training sessions.

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.

Cardiology (Echo) Reminder:

The updates posted Sept. 29, 2021 include the addition of several cardiology (echo) codes to be reviewed by AIM as of Jan. 1, 2022. Be sure to review the list if your practice provides or refers for these services.

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.

Update Your Information

Do you need to update your location, phone number or other important details on file with BCBSTX? Do we have the most current email address for you and your staff? Use our online forms to request information changes. Are you receiving a copy of the Blue Review by email? If not, contact your local BCBSTX Network Management Representative to have up to 10 of your office email addresses added.

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. If you

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.

AIM Specialty Health is an independent medical benefits management company that provides utilization management services for Blue Cross and Blue Shield of Texas (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.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent third-party vendor that is solely responsible for its products and services.

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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.

BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by third party vendors.

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. The vendors are solely responsible for the products or services they offer.

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.

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

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