BLUE REVIEW℠

A Provider Publication

January 2021

Please distribute this newsletter, which contains claims, billing, Medical Policy, reimbursement, and other important information, to all health care providers, administrative staff, and billing departments/entities. This version of Blue Review is based on the electronic version that was distributed in January 2021 but because it is a summary copy, **it may not have all the information contained in the electronic version. To sign up to receive the Blue Review electronically, complete the** request form **that can be found on the BCBSOK provider website.**

You can find the *Blue Review* online at bcbsok.com/provider/news and update

News & Updates

COVID-19 Vaccines and Coverage

In the face of the COVID-19 pandemic, pharmaceutical companies have moved to produce vaccines. The Food and Drug Administration (FDA) has given Pfizer and Moderna an Emergency Use Authorization (EUA) for its vaccine.

Federal and state health officials are working with the medical community to distribute the COVID-19 vaccine.

Rollout Projections: The federal government is working with drug companies to have 300 million doses by the end of January 2021. Health care workers and long-term care facility residents have priority access. The Centers for Disease Control and Prevention (CDC) projected rollout is below:

Phase	Access	Projected Start Date

1a	Health care workers	December 2020
1b	Long-term care facility residents via federal partnership with Walgreens and CVS	December 2020
2	Vaccinate broader population with the help of retail pharmacies	January 2021
3	Integrate vaccination into routine vaccine programs like influenza vaccine	Fall 2021

Initially, the federal government will pay for the vaccine. Blue Cross and Blue Shield of Oklahoma (BCBSOK), or self-funded groups, will cover administration of the vaccine as noted below:

Fully insured:

- Vaccine and administration covered as a preventive service with no cost-share to members at in-network providers
- Vaccine and administration covered as a preventive service with no cost-share to members at in-network providers
- Vaccine and administration covered with no cost-share to members if delivered at out-of-network providers through the end of the public health emergency

Self-funded employer groups:

- Non-grandfathered self-funded employer groups - vaccine and administration covered as a preventive service with no cost-share to members at in-network providers
- Vaccine and administration covered at no cost-share to members at out-of-network providers through the end of the public health emergency
- Self-funded employer groups that don't cover preventive vaccines through their pharmacy benefit must cover the vaccine through their medical benefit
- Grandfathered plans are not required to cover preventive services, including the COVID-19 vaccine

Medicare Advantage and Medicare Supplement

- For 2020 and 2021, Medicare payment for the COVID-19 vaccine and its administration will be through the original fee-for-service Medicare program.
- Submit claims for administering the COVID-19 vaccine to the CMS Medicare Administrative Contractor (MAC) using product-specific codes for each vaccine approved.
- Members will have no cost-sharing on vaccines through Dec. 31, 2021.

Reimbursement:

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

Balance billing: Providers are prohibited from billing patients for the vaccine or its administration, including balance billing, if the provider received the vaccine at no cost from the government.

Coding claims: CMS and the American Medical Association (AMA) have identified the codes to use in submitting claims. For more information, see CMS' guidance.

Code	Use	Description
91300	Vaccine	Pfizer-Biontech Covid-19 Vaccine SARSCOV2 VAC 30MCG/0.3ML IM
0001A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 30MCG/0.3ML 1ST
0002A	Admin	Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 30MCG/0.3ML 2ND

91301	Vaccine	Moderna Covid-19 Vaccine SARSCOV2 VAC 100MCG/0.5ML IM
0011A	Admin	Moderna Covid-19 Vaccine Administration – First Dose ADM SARSCOV2 100MCG/0.5ML1ST
0012A	Admin	Moderna Covid-19 Vaccine Administration – Second Dose ADM SARSCOV2 100MCG/0.5ML2ND

Dosage: Candidate vaccines may require one or two doses. The Pfizer and Moderna vaccines require two doses.

More information:

- CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations
- Provider Relief Fund – for reimbursement for administering the COVID-19 vaccine to the uninsured
- CMS guidance on Medicare billing for the COVid-19 vaccine administration

We continue to monitor information provided by the CDC and other government and health officials. We'll provide updates when we have them. For the latest information on COVID-19, we recommend visiting the CDC's COVID-19 website.

COVID 19 Initiatives Updates

Learn More

Clinical Practice and Preventive Care Guidelines Updated for 2020-2021

Our medical directors and Quality Improvement Committee have updated our Clinical Practice Guidelines and Preventive Care Guidelines for 2020-2021. The guidelines are built on evidence-based standards of care and nationally recognized medical authorities

to **direct our quality and health management programs** and improve member care. They can help **guide your decision-making** as you care for our members.

We update our guidelines at least **every two years** or when new significant findings or major advancements in evidence-based care are established. The **guidelines are on our website under** Clinical Resources.

Use the AIM ProviderPortal for Pre & Post-Service Reviews

Effective Jan. 1, 2021, use the AIM ProviderPortal to request preauthorization and respond to post-service review requests by AIM. **Do not submit medical records to Blue Cross and Blue Shield of Oklahoma (BCBSOK) for prior authorization or post-service reviews for the care categories managed by AIM.** Medical records may or may not be needed for pre- or post-service reviews using the AIM portal due to the smart clinical algorithms within the portal.

Benefits of the AIM ProviderPortal for Pre- & Post-Service Reviews

- Medical records for pre- or post-service reviews are not necessary unless specifically requested by AIM.
- AIM's ProviderPortal offers self-service, smart clinical algorithms and in many instances real-time determinations
- Check prior authorization status
- Increase payment certainty
- Faster pre-service decision turnaround times than post-service reviews

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.

AIM Specialty Health (AIM) is an operating subsidiary of Anthem, Inc., an independent specialty medical benefits management company that provides utilization management services for BCBSOK.

Availity is a trademark of Availity, L.L.C., a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSOK.

The vendors are solely responsible for the products or services they offer. If you have any questions regarding any of the products or services they offer, you should contact the vendor(s) directly.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

2021 HHS-Risk Adjustment Data Validation Program (RADV)

In 2021, the Centers for Medicare and Medicaid Services (CMS) will conduct another Initial Validation Audit (IVA), now known as Department of Health and Human Services (HHS) Risk Adjustment Data Validation Program (RADV), to validate the data used when assessing the payment transfers for the Affordable Care Act (ACA). Your role is essential to the success of the HHS-RADV audit. Therefore, if any of your patients are selected to be included in the audit, Blue Cross and Blue Shield of Oklahoma (BCBSOK) is asking for your cooperation and participation to fulfilling the requirements of the HHS-RADV.

The HHS-RADV is expected to begin in January 2021. As BCBSOK providers, you're required to provide medical records to validate diagnosis codes used in the ACA Risk Adjustment risk score calculation. If you're selected to participate in the HHS-RADV audit, you'll be notified by mail and receive a follow-up phone call from our network representatives.

Please respond to these requests in a timely manner. It's important to have a successful audit to improve the health care delivery system.

Medical Record Submission Standards for the HHS-RADV program must include the following documents for **ALL visits for the 2019 and the subsequent request for the 2020 year:**

- Demographic/Face sheet, ER notes, history and physical, progress notes, discharge summary, consultation reports, anesthesia reports, radiology reports, interventional radiology reports, and operative/procedure notes. Nephrology providers must include DIALYSIS notes.
- Pathology reports, physician orders, medication list and radiology may substantiate a diagnosis and be submitted, but only in conjunction with other medical documentation

The requested medical records must be signed and credentialed within 180 days of the date of service. **Please note:** If the credentialed signature is missing or is ineligible if handwritten, we will contact you for a Signature Statement Attestation.

HHS-RADV will be performed on a sample of members enrolled in ACA-compliant individual and small group plans, both on and off-exchange. The HHS-RADV team will validate medical claims of the sampled members from the previous calendar year. In 2021, we will be requesting ALL medical records tied to the 2019 calendar year and within three months all records tied to the 2020 calendar year for dates of service for the selected members. For example, this HHS-RADV will be conducted in 2021, but will review claims with dates of service in 2019 and 2020.

We understand that this is a very busy time. However, in an effort to comply with CMS' requirements, we appreciate your full support and cooperation as you receive requests from BCBSOK and deliver the requested medical record(s) in a timely manner.

If you have any questions, please contact your Provider Network Representative.

Medicare adds benefit for members with inherited ovarian or breast cancer

The Centers for Medicare & Medicaid Services (CMS) added a benefit this year for Medicare members with germline, or inherited ovarian or breast cancer. The benefit covers a laboratory diagnostic test using **Next Generation Sequencing (NGS)**. These tests provide genetic analysis of a patient's cancer.

What is covered

For services performed **on or after Jan. 27, 2020**, Medicare covers NGS when:

- Performed in a Clinical Laboratory Improvement Amendments (CLIA)-certified laboratory
- Ordered by a treating physician
- And the patient has all the following:
    - Ovarian or breast cancer

- A clinical indication for germline testing for hereditary breast or ovarian cancer
- A risk factor for germline breast or ovarian cancer
- Has not been previously tested with the same germline test using NGS for the same germline genetic content

For more information, see CMS' national coverage determination on NGS.

Check eligibility and benefits

Use the Availity® Provider Portal or your preferred web vendor to check eligibility and benefits for all patients before providing services. This step will help you confirm coverage and other important details, such as prior authorization requirements.

Checking eligibility and/or benefit information and/or the fact that a service has been preauthorized/pre-notified 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 have any questions, call the number on the member's ID card.

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 BCBSOK. BCBSOK makes no endorsement, representations or warranties regarding any products or services provided by third-party vendors such as Availity. If you have any questions about the products or services provided by the vendor, you should contact the vendor directly.

Patients in the Qualified Medicare Beneficiary (QMB) Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage℠ plans, you may not bill our members enrolled in QMB, 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:

- 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 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.

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

The information provided here is only intended to be a summary of the law that has been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

Hospitals Must Provide Medicare Outpatient Observation Notice (MOON)

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 inpatients 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.
- 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.

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

Learn more from CMS' Notice Instructions.

Behavioral Health Tip Sheets

We've added two additional **behavioral health tip sheets** to help you provide quality care to our members. The tip sheets include **measurement requirements, medical record best practices and billing codes**:

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- Follow-Up After Emergency Department Visit for Mental Illness

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

This measure evaluates members **13 years old and older who had an emergency department (ED) visit with the principal diagnosis of alcohol and other drug**

(AOD) abuse or dependence. It evaluates the percentage of members who had **follow-up visits within 7 and 30 days** of the ED visit.

Follow-Up After Emergency Department Visit for Mental Illness

This measure evaluates members 6 years old and older who had an ED visit for mental illness. It evaluates the percentage of members who had follow-up visits within 7 and 30 days of the ED visit.

Feature Tip

BCBSOK will update CPT® codes for some outpatient services

What's New: On March 15, 2021, Blue Cross and Blue Shield of Oklahoma (BCBSOK) will update its list of Current Procedural Terminology (CPT) codes requiring preauthorization, for some commercial members, to reflect new, replaced or removed codes due to a BCBSOK Utilization Management update.

More information about prior authorization: visit the Utilization Management section on the BCBSOK website.

Provider Data and Directory Updates

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is required by the Center for Medicare and Medicaid Services to contact our providers on a quarterly basis requesting verification of information, such as: provider name, organization name, accepting new patients, street address, phone number, hospital affiliations and other changes that affect availability to patients.

Maintaining accurate provider data and directories are an important part of providing BCBSOK members with the information they need to manage their health. Our online provider directory, Provider Finder helps members find in-network doctors and hospitals. The directory is also a helpful tool for you to refer your BCBSOK patients to other participating providers.

Please review your information in Provider Finder to ensure it's correct. To update your directory information please visit our Information Change Request section on our

website. If your information is correct as listed on our website no further action or response is needed.

Please submit your changes at least 30 days ahead of the effective date. If you have any questions or if you need additional information, please Email provider inquiries or call the Provider Contract Support Unit at **800-722-3730, Option 2**.

Web Changes

- Posted: *December Blue Review* to Education and Reference Center/News and Updates/Blue Review webpage.
- Updated: Clinical Payment and Coding Policies/Standards and Requirements
- Updated: Clinical Practice Guidelines to the Clinical Resources/ Clinical Practice Guidelines webpage.
- Updated: Preventive Care Guidelines to the Clinical Resources/ Preventive Care Guidelines for Oklahoma Commercial, Marketplace and Medicare plans webpage.

Stay Informed!

Watch News and Updates for important announcements.

Provider Training

For dates, times and online registration, visit the Provider Training page.

ClaimsXten™ Quarterly Updates

New and revised Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes are periodically added to, or deleted from, the ClaimsXten code auditing tool software by the software vendor on a quarterly basis and are not considered changes to the software version. Blue Cross and Blue Shield of Oklahoma (BCBSOK) will normally load this additional data to the BCBSOK claim processing system after receipt from the software vendor and will confirm the effective date via the News and Updates section of the BCBSOK Provider website. Advance notification of updates to the ClaimsXten software version also will be posted on the BCBSOK Provider website.

To help determine how some coding combinations on a particular claim July be evaluated during the claim adjudication process, you July continue to use Clear Claim Connection™ (C3). C3 is a free, online reference tool. Refer to the Clear Claim Connection page on our website for more information on gaining access to C3, as well as answers to frequently asked questions about ClaimsXten. Updates July be included in future issues of the Blue Review. Note: C3 does not contain all of the claim edits and

processes used by BCBSOK in adjudicating claims, and the results from use of the C3 tool are not a guarantee of the final claim determination.

ClaimsXten and Clear Claim Connection are trademarks of McKesson Information Solutions, Inc., an independent company providing coding software to BCBSOK. McKesson Information Solutions, Inc. is solely responsible for the software and all the contents. Contact the vendor directly with any questions about the products, software and services they provide.

BCBSOK Online Provider Orientation

The Online Provider Orientation is a convenient and helpful way to learn about the online resources available to you.

Medical Policy Reminder

Approved new or revised BCBSOK medical policies and their effective dates are posted on the BCBSOK website the first and fifteenth day of each month. These policies July impact your reimbursement and your patients' benefits. You July view all active and pending policies or view draft Medical Policies and provide comments. These can be accessed on the Standards and Requirements page of our provider website.

While some information on new or revised medical policies July occasionally be published for your convenience, please visit bcbsok.com/provider for access to the most complete and up-to-date information.

On-demand Training

An eRM tutorial is available to show you how to navigate the features of the eRM tool. Log in at your convenience to complete the tutorial and use it as a reference when needed.

We Want Your Feedback

Do you have a helpful suggestion or feedback about our website? Fill out our Feedback Survey.