Connection

News for our Participating Provider Partners

November 2023

Excellus BlueCross BlueShield

Everybody Benefits

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Stay in the Know!

Visit the Provider News and Updates page on our website to review recent communications. Be sure to log into our provider portal with your username and password to view all news updates.

To view topic specific bulletins, select one of the available categories or enter a keyword in the Search area. While viewing an article, you can click "Email this article" to share it with a friend or co-worker! Save our Provider News and Updates page as an online "favorite" for easy access.

Thank you for your continued Connection readership. We welcome your suggestions, questions and comments. Email Maria Valvo, editor, at maria.valvo@excellus.com.

2023 APEX® AWARDS FOR PUBLICATION EXCELLENCE

Sign Up for our Virtual Fall Seminar!

We invite you to join a session of our 2023 fall seminar, which will be held virtually. Morning and afternoon sessions are available on November 8,9,14 and 16. Choose the date and time that works best for your schedule!

Topics include:

- 2024 Medicare Advantage benefit updates
- Enrollment process updates
- Understanding hybrid products
- Much more!

Please visit the Staff Training area of our website to register.

Preauthorization Lookup Tool Enhancements Coming Soon

We are pleased let you know about our improved web preauthorization lookup tool expected to be available to you on November 18, 2023. The tool enhancements are intended to improve your office team's experience when researching medical preauthorization information.

The Authorizations page at Provider.ExcellusBCBS.com that is familiar to you will not change; however, beginning November 18, you will notice the following enhancements:

- The PDF display will be updated for easier and more direct navigation. PDFs will be organized into current, future, and previous sections. Member specific lookup and line of business lookup features will be added.
- A new Authorization Lookup Tools feature will enable users to search by member-specific lookup or line of business lookup.
- An authorization lookup option will be added to the Eligibility & Benefits landing page.

Please see our tip sheet for additional information about the tool. If you need assistance, please contact your Provider Relations representative.

Provider Satisfaction Survey Open Until October 31 – Your Opinion Matters!

Our annual Provider Satisfaction Survey was mailed to practices on pink paper, so it is easy to spot! Your opinion and suggestions are very important to us as we strive to improve the service that we provide to you.

We hope that you'll take a moment to complete and return the survey in the postage-paid envelope provided.

Thank you!

Provider Demographic Update Process Changing December 1

- ***More demographics news, pg.7***

The accuracy of the demographic information that we have on file for you is very important to our members and our ability to conduct business with you. We are working diligently to ensure that all demographic changes you provide to us are processed correctly and in a timely manner.

We will make the following procedural changes to help improve the Health Plan's demographic update process effective December 1, 2023:

- If the Health Plan receives a provider application or demographic change form that is missing documentation or other information, or if there is a discrepancy in the information, the form will be returned to the provider with an explanation as to what is missing or incorrect and the request will be cancelled. Resubmission of a complete and accurate form/application will be required.
- The Health Plan will return any outdated applications that are submitted. We have recently updated our enrollment forms, so be sure to check Provider.ExcellusBCBS.com for the current versions.

Thank you for your cooperation.

Don't Keep the Latest News and Updates to Yourself

Share this newsletter with your coworkers via the "Forward this email to a Friend" option in the eAlert!

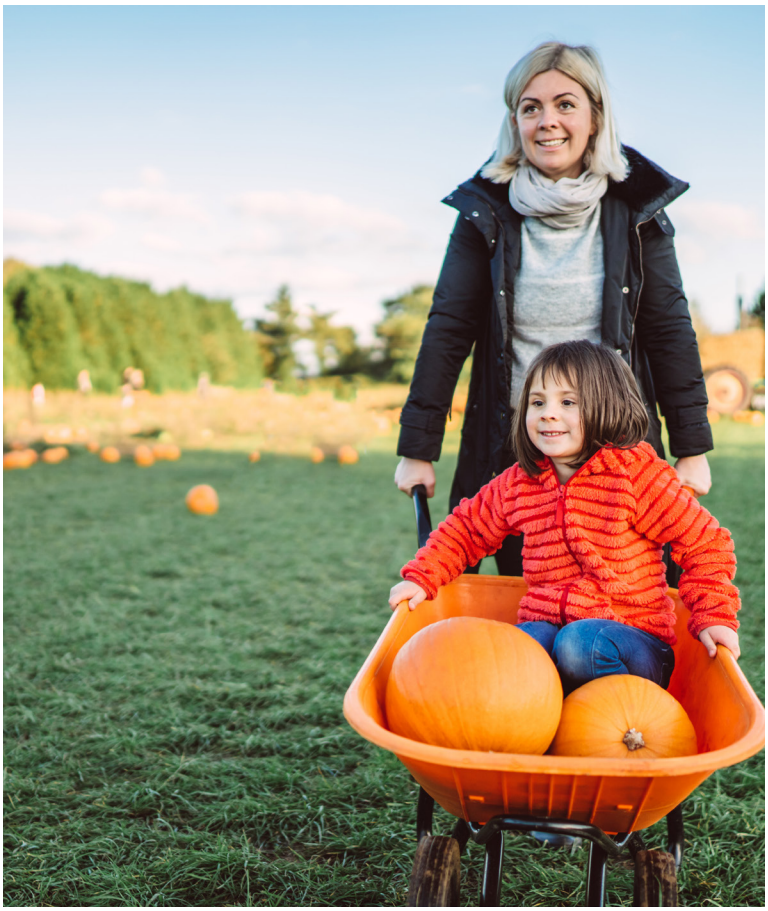
Home and Community Based Services Notification Form Required Prior to Service

Please submit the Children's Home and Community-Based Services (HCBS) Authorization and Care Management Notification form prior to the start of services to prevent potential gaps in care for the following services:

- H2014HA – Skill training and development, per 15 minutes
- H2015HA – Comprehensive community support services, per 15 minutes
- H2023HA – Supported employment, per 15 minutes

The fastest, most convenient way to submit your HCBS Notification form is electronically through our Smart Data Solutions portal.

If you are unable to submit your documentation electronically, call our Intake department at 1-844-694-6411: Option 2, then Option 4 for assistance or fax your documentation to our Intake department at 1-844-878-6989.



Web Self-Service Tools

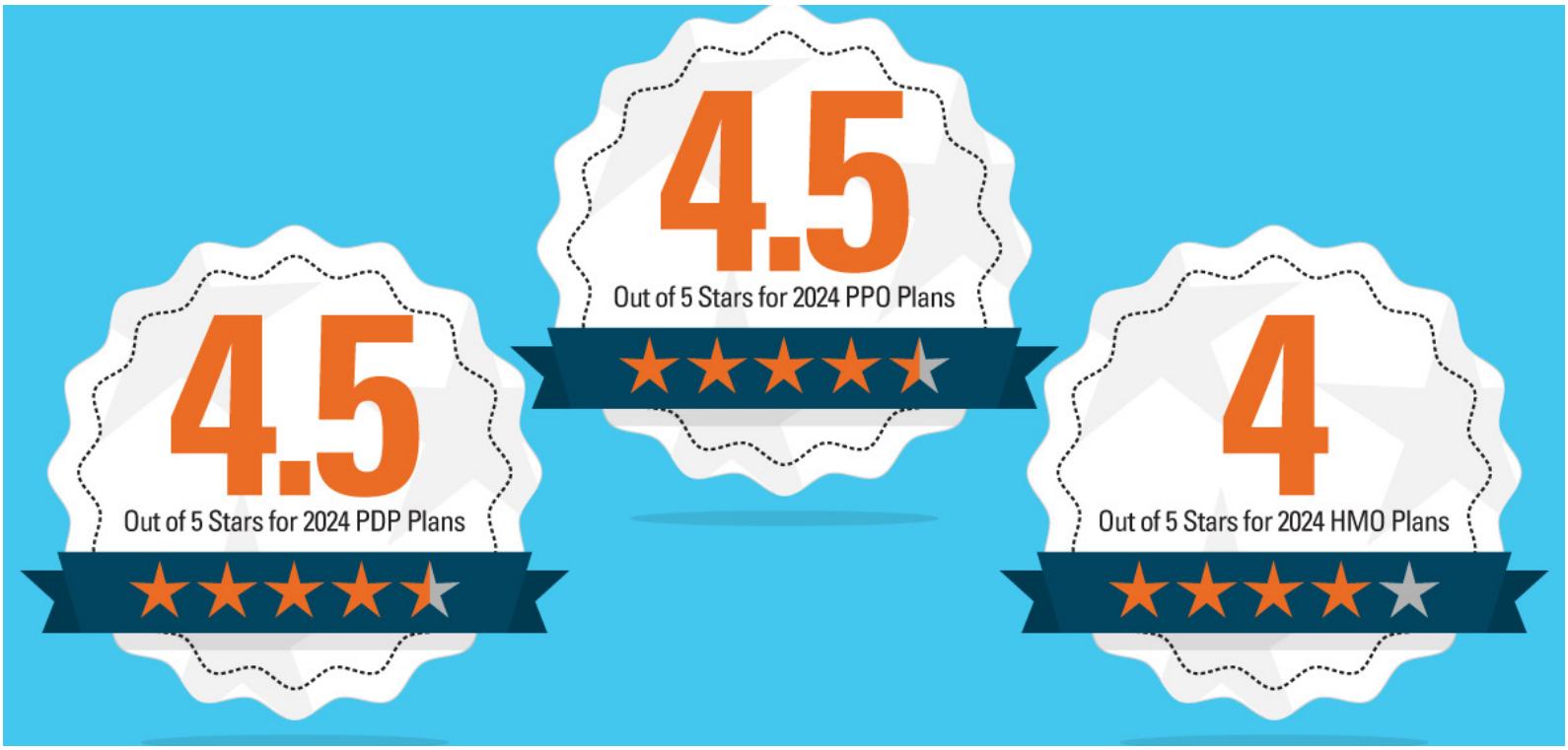
We know how busy your work day can be. That's why we remind you of the time-saving tools and information available on our website. They are quick, convenient and available 24/7!

We require the use of our web self-service tools to check member eligibility and benefits. Keep your web account active by logging in at least every 30 days.

Help Stop Fraud, Waste, and Abuse

To report potential fraud, waste or abuse, please call our Fraud Hotline at 1-800-378-8024 or visit our website to complete and submit our Fraud Reporting form. For federal employees, call 1-800-337-8440.

All fraud, waste and abuse referrals are confidential and can be made anonymously. Those who report wrongdoing are protected from retaliation.



Medicare Recognized Excellus BlueCross BlueShield for Quality

The Centers for Medicare and Medicaid Services (CMS) announced its 2024 quality ratings, and again this year recognized Excellus BlueCross BlueShield for its Medicare Advantage plans. This is the eleventh consecutive year the Health Plan has ranked above average or higher for its Medicare Advantage plans for member satisfaction and quality performance in clinical care. Recognition from CMS comes in the form of Medicare Star ratings.

CMS awarded the Excellus BCBS Medicare Advantage PPO plan 4.5 out of 5 stars, the Medicare Part D prescription drug plan 4.5 stars out of 5 stars, and the Medicare HMO plan 4 stars out of 5 stars.

"When CMS recognizes the performance of our Medicare Advantage Plans, it's really recognizing the local commitment and service our employees provide to our members," says Ankit Garg, MD, vice president of medical affairs at Excellus BCBS. "We are grateful to have members who are satisfied with our Health Plan and recognize the dedication and hard work our people provide every day."

Medicare Stars reflect member satisfaction with the Health Plan and its providers. They also recognize its success in caring for its members by meeting specific health care benchmarks, including how a Medicare member's chronic conditions are being managed; if Medicare members are receiving their preventive screenings and vaccines; and how the Health Plan is helping members to take their medications as prescribed.

For example, Excellus BCBS clinical pharmacists reach out to members to conduct comprehensive reviews of their prescriptions to assure they are taking the right medications in the right dose, at the right time, and in the right way. The pharmacists also help identify opportunities to reduce out-of-pocket spending on prescription medications, such as finding opportunities to save by switching from a brand-name drug to an equally effective and lower cost generic alternative.

"The Medicare stars are a sign of our shared commitment with local health care providers to deliver high quality, and affordable care to our Medicare members," says Dr. Garg.

Ankit Garg, M.D.
Vice President
Medical Affairs

Excellus BCBS Medicaid HMO Rated Among the Nation's Best

Excellus BlueCross BlueShield is one of just 13 health plans nationwide to earn 4.5 stars (out of a possible five) and accreditation for its Medicaid HMO from the National Committee for Quality Assurance. NCQA is a private, nonprofit organization dedicated to improving health care quality.

The good news continues as each plan offered by Excellus BCBS, including Medicaid, Medicare, and commercial health insurance, earned accreditation from NCQA.

The following ratings (based on a five-star rating system) reflect 2022 Health Plan performance across all Excellus BCBS products.

- 4.0 stars Accredited - Commercial HMO/POS/PPO/EPO combined
- 4.0 stars Accredited - Medicare PPO
- 4.0 stars Accredited - Medicare HMO
- 4.5 stars Accredited - Medicaid HMO

NCQA ratings are based on a health plan's combined HEDIS® and CAHPS® scores and NCQA accreditation status. Plans are also evaluated on quality of care, patient satisfaction, and the health plans' efforts toward continuous improvement.

November is National Marrow Awareness Month

November is National Marrow Awareness Month. Excellus BlueCross BlueShield is launching an awareness campaign to educate the community around the importance of joining the Blood Stem Cell Donor Registry for bone marrow transplants.

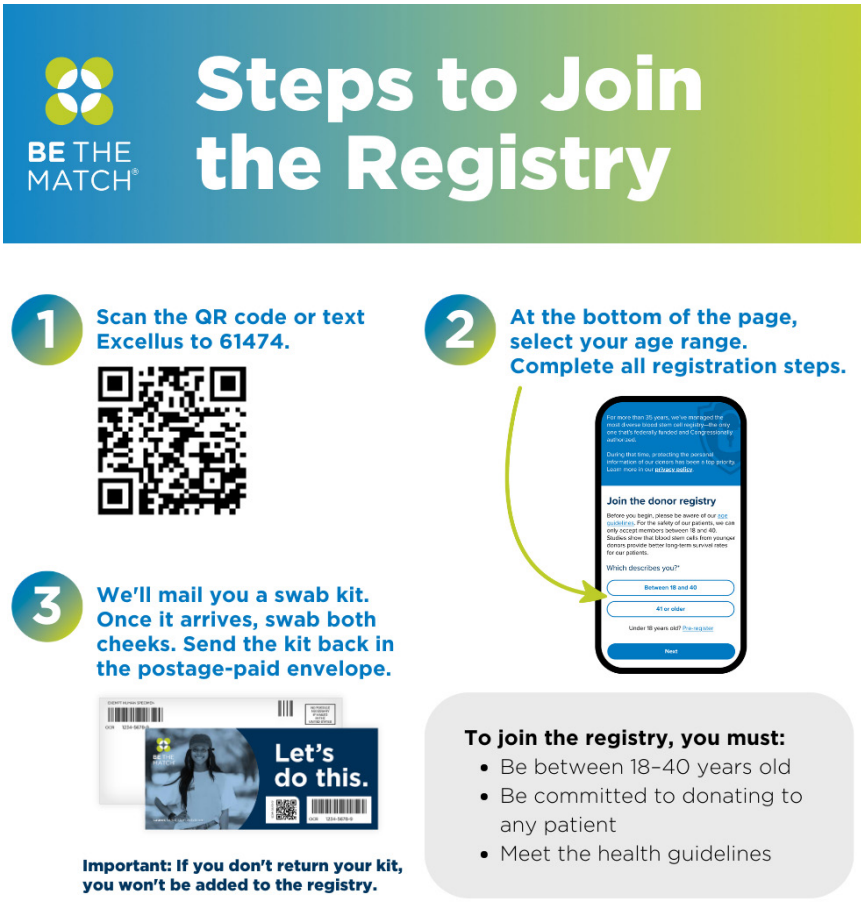
According to Be the Match, every year in the U.S., more than 18,000 patients are diagnosed with life-threatening blood cancers or other blood disorders that could be cured or treated with a blood stem cell transplant. But 70% of them don't have a fully matched donor in their family. This is where we need your assistance.

Help us spread the word! During this month and beyond, please speak to your staff and patients about the importance joining the registry and bone marrow transplantation. There is no cost to be part of the registry. We've included Instructions for getting started in the accompanying graphic.

To participate, potential donors will need to be between the ages of 18-40, a resident of the U.S. or Puerto Rico, and able to meet Be the Match's medical guidelines.

To learn more, visit https://bethematch.org.

Together, we can make a difference!



Practitioner Race, Ethnicity to be Available to Members

We are committed to improving health equity for our members and the communities we serve. By making health care more personal, we can identify barriers and improve health outcomes. We hope you will join us on this journey. Part of this work is ensuring that our network meets the cultural and linguistic needs of our members.

You are likely aware that the demographic information we ask practitioners to provide includes race and ethnicity, and any languages spoken. The languages spoken are included in our provider directories to assist members in selecting a practitioner that meets their needs. Historically, the race and ethnicity information provided has only been used for assessing our network's ability to meet the diverse cultural needs of our network.

The Health Plan will soon be sharing this information with members seeking a provider that shares their cultural experience. While making race and ethnicity information available to members is completely voluntary, we encourage you to consider doing so to help members receive the best care possible. You can specify your preference using our online Practitioner Demographic Changes form. Username and password are required. You still have the option to download a PDF version of this form if you choose.

Please contact your Provider Relations representative with questions.

Nerve Block Injection Policy Reminder

We remind you that Administrative Policy (AP-44) Nerve Block Injections for Post-operative Pain Control became effective on July 15, 2023. The policy outlines the appropriateness and billing guidance for the administration of Nerve Blocks during anesthesia time.

I. The Health Plan considers nerve block injections, given during anesthesia time, inclusive to the anesthesia services when:
   a. the anesthesia services are rendered by the same anesthesiologist (or his/her associate) on the same day.
   b. the anesthesia services are rendered by the operating physician.

II. The appropriate use of modifier 59 is acceptable and may be appended to nerve block injections when the nerve block is given **outside of the anesthesia time** on the same day.

III. When used, modifier 59 should be appended to the epidural catheter, local infiltration, digital block, or nerve block CPT codes to indicate that a significant, separately identifiable service was provided by the same physician or physician group, on the same day as the anesthesia service.

Medical records should support the distinct, significant, or separately identifiable nature of the nerve injection service, the location of the injection, the drug used for the injection, and the time the injection occurred.

Potential reasons for upholding the denials (not limited to):

a. illegible documentation
b. inconclusive start and stop time of anesthesia
c. time of nerve block not provided or is administered within start and stop time of anesthesia

Tips for Prenatal and Postpartum Care

The prenatal and postpartum care measure is based on the percentage of live deliveries on or between October 8 of the year prior to the HEDIS measurement year, and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care:

- Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date of within 42 days of enrollment in the Health Plan.
- Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

For multiple births: Women who had two separate deliveries (different dates of service) between October 8 of the year prior to the measurement year and October 7 of the measurement year count twice. Women who had multiple live births during one pregnancy count once.

First trimester is defined as 280-176 days prior to delivery (or EDD).

Patients are excluded from this measure if they are in hospice or using hospice services anytime during the year.

Supplement your current HEDIS improvement programs with these CPT II Coding Guidelines

Improve your coding practices:

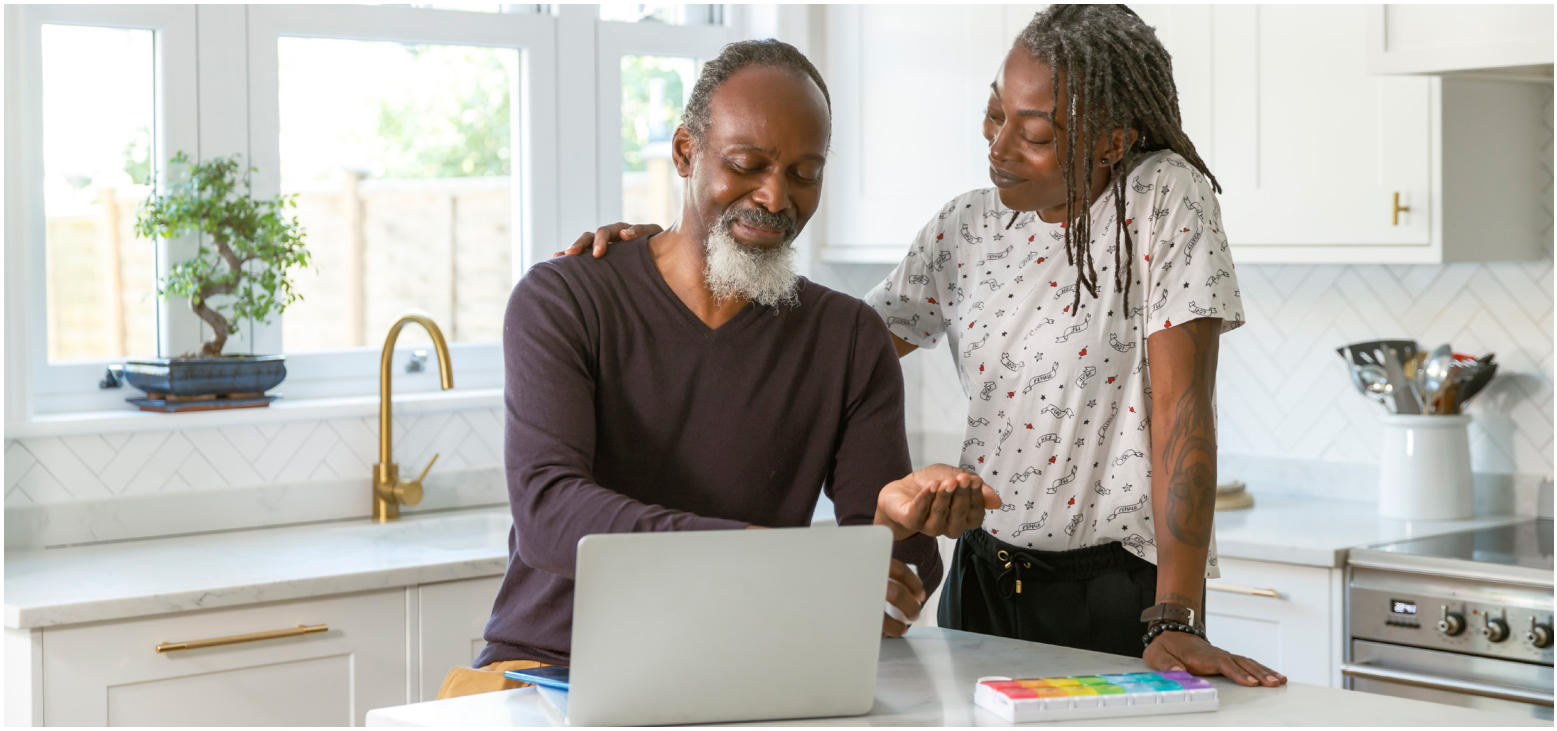
- Adding CPT II codes to your claims for services will provide better documentation of care. Better documentation of care boosts your HEDIS rates.
- Using these CPT II codes for care may eliminate the need to provide patient medical records if selected for a health plan's HEDIS sample. This will minimize the need for chart reviews during HEDIS season.
- Time spent on expanded coding translates to a more accurate comparison of your practice to other practices that are not using the codes.
- For Value-Based contracted practitioners: Using these CPT II codes may improve your scores maximizing your contract reimbursement rate.
- Using expanded CPT II coding leads to improved HEDIS scores, and it considered a best practice.

Use the following CPT II codes to increase capture of the visit and reduce the need for medical record requests:

Service Category	CPT II Codes	Description
Prenatal/Postpartum	0500 or 0501F	Initial prenatal care visit or prenatal flow sheet, must include date of LMP
	0503F	Postpartum care visit

*Prenatal and postpartum codes (0500F or 0501F and 0503 only) are eligible to earn a $15 financial incentive if billed with a $15 charge.

Note: This program is subject to change.



2024 Medicare Part D Medication Coverage Changes

- In 2024, Medicare members with a Part D deductible will have a maximum limit of $545 out-of-pocket cost.
  - Not every member will have a deductible.
- The Initial Coverage Phase limit will increase to $5,030, at which time the patient will enter the Coverage Gap Phase with a 25% copayment for each covered medication.
- The Catastrophic Coverage Phase limit will increase to $8,000, which will cap total Medicare member actual out-of-pocket spending at $3,250.
  - The difference is paid by the manufacturer Coverage Gap Discount, also known as the Donut Hole Discount.
  - **Medicare Part D members in the 2024 Catastrophic Coverage Phase will no longer have a copay or coinsurance and will pay $0 for covered Part D drugs once they reach this amount of out-of-pocket spending.**
- Coming in 2025: The maximum out-of-pocket spending limit for members with Medicare Part D will be lowered to $2,000. There will no longer be a Coverage Gap/Donut Hole Phase.

1. Cubanski J, Neuman T. Changes to Medicare Part D in 2024 and 2025 Under the Inflation Reduction Act and How Enrollees Will Benefit. https://www.kff.org/medicare/issue-brief/changes-to-medicare-part-d-in-2024-and-2025-under-the-inflation-reduction-act-and-how-enrollees-will-benefit/
2. CMS. Reduced Drug Prices, Enhanced Medicare Benefits Under the Inflation Reduction Act Frequently Asked Questions (FAQs) October 5, 2022. https://www.cms.gov/files/document/10522-external-faqs-about-inflation-reduction-act.pdf
3. What is catastrophic coverage (Medicare Part D) https://www.medicareresources.org/glossary/catastrophic-coverage/

Provider Documentation Accuracy Reminders

Documenting and reporting each health condition accurately is important to the quality, access, and outcomes, of patient care. Our Health Plan uses information on our members' health conditions to identify the need for health care services and/or care management.

The following are examples of how to improve or update documentation as you meet with patients throughout the year:

Dates of Service

- It is important to include the month, day, and year to avoid any misinterpretation.
  - For example, if 12/23 is documented, it could be read as December 23 or December of 2023.

Use of Standard Abbreviations/Acronyms

- Abbreviations should be limited to the use of approved and standard abbreviations when documenting in the patient's chart.
  - For example, AKI – it is important to indicate if the provider means acute kidney injury (N17.9) or acute kidney insufficiency (N28.9).

Medication List Updates

- It is important to update the patient's medication lists by both adding and removing any medications as changes are made in the patient's care.
  - Linking a medication to the condition in the medical record supports that the condition is being treated.

Pathology and Laboratory Results

- Medical records should be updated with the most current diagnostic and laboratory results such as a glomerular filtration rate and hemoglobin A1C, etc.

Punctuation

- A misplaced punctuation mark such as a comma or period can impact the way the record is read and coded.

Definitive Statements

- When a diagnosis has been confirmed, use direct and definitive language.
  - Terms such as probable, suspected, questionable, consistent with, etc., can indicate uncertainty.

Important Reminders

- All diagnoses submitted on a claim should be supported by the **M**onitoring, **E**valuation, **A**ssessment and/or **T**reatment of the condition in the medical record documentation
- "Unspecified" codes should only be reported when a more specific diagnosis cannot be determined

For more information on how to receive coding and documentation tips specific to your office please contact Risk.Adjustment.Provider.Contact@excellus.com

Medical Policy Updates

Excellus BlueCross BlueShield works to ensure that the development of corporate medical policies occurs through an open, collaborative process. We encourage participating providers to become actively involved in medical policy development. Each month, draft policies are available on our website for review and comment. To access the draft policies, click here. Providers may now attach supporting documentation related to their comments.

The following new and updated medical policies have been reviewed and were approved in **September 2023** by the Corporate Medical Policy Committee, including practitioner representatives from all our regions. A complete library of our medical policies can be found on our website.

Current Policies – Significant Updates

- **(#2.02.46)** Whole Exome and Whole Genome Sequencing for Diagnosis of Genetic Disorders utilizes next-generation or massively parallel sequencing technology which allows multiple genes to be analyzed at one time and may return a pathogenic variant that is associated with a gene-causing disease. A potential major indication for whole exome or whole genome sequencing is for a molecular diagnosis of patients with a phenotype that is suspicious for a genetic disorder or for patients with known genetic disorders that have a large degree of genetic heterogeneity involving substantial gene complexity. Such patients may be left without a clinical diagnosis of their disorder, despite a lengthy diagnostic workup involving a variety of traditional molecular and other types of conventional diagnostic tests. For some of these patients, whole exome or whole genome sequencing (WES/WGS), after initial conventional testing has failed to make the diagnosis, may return a likely pathogenic variant. Whole exome sequencing may now be considered medically necessary for the evaluation of unexplained congenital or neurodevelopmental disorder in children less than 21 years of age when a genetic cause is suspected to be the origin of the disorder, the clinical presentation does not fit a single well-described syndrome, or may describe two or more syndromes, the affected individual is faced with invasive procedures or testing as the next diagnostic step, and there is potential for a change in management and clinical outcome for the individual being tested. Whole genome sequencing continues to be considered investigational. WES/WGS are considered investigational for prenatal diagnosis or preimplantation testing of an embryo. *With this year's update, an investigational statement was added for repeat WES/WGS testing requests and medically necessary criteria was added for mitochondrial disease testing. These updates will require a 90-day provider notification.*

- **(#2.02.48)** Gene Expression Analysis for Prostate Cancer Management (e.g., Prolaris and Oncotype-Prostate)//New Policy Title: Laboratory Testing for Prostate Cancer Management currently includes the Oncotype DX® test for prostate cancer (Genomic Health, Redwood City, CA) and Prolaris® (Myriad Genetics, Salt Lake City, UT). The Oncotype DX® test is a multigene RT-PCR assay designed to analyze underlying tumor biology in tumor tissue from diagnostic formalin-fixed parafilm-embedded (FFPE) core needle biopsies. The Prolaris test is a gene expression-based assay that directly measures tumor cell growth characteristics specific genes related to cell cycle progression. A cell cycle progression (CCP) score is determined which is used to predict 10-year prostate cancer specific disease progression and mortality. Oncotype Dx Genomic Prostate Score, the Prolaris Assay, Decipher Prostate Cancer Classifier Assay, and ProMark during initial risk stratification to guide the management of prostate cancer is medically appropriate in men with low- or favorable intermediate-risk disease and life expectancy of 10 or more years. The Prolaris Assay or Decipher Prostate Cancer Classifier Assay is considered medically appropriate in men with unfavorable intermediate- or high-risk disease and life expectancy of 10 or more years. The policy criteria follow current NCCN guidelines. *This year's update merges existing content from CMP#10.01.05 and adds new investigational criteria for AteraAI. These updates will require a 90-day provider notification.*

- **(#6.01.24)** Intensity Modulated Radiation Therapy (IMRT) is a form of external beam radiation therapy that uses multiple beam angles and non-uniform beam intensities along with CT based computer planning to conform the radiation to the target organ to spare normal adjacent structures. IMRT is given for certain indications to reduce the amount of radiation to

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Current Policies – Significant Updates

surrounding adjacent tissue. *With this policy update, revisions were made to align with eviCore's V.1.2023 Radiation Oncology Guidelines updates, which include the expansion of coverage criteria for IMRT in the treatment of breast, lung, and rectal cancers.*

(#6.01.44) Radiopharmaceuticals//New Policy Title: Radiopharmaceuticals for the Treatment of Cancer are a way of providing radiation delivery to cancer cells within their microenvironment, providing a more targeted approach. This is done either by using delivery vehicles that bind preferentially to a specific target or may be taken up by a tumor based on its environment. Radiopharmaceuticals have different emission properties which deliver radiation using either alpha or beta particles. Response to treatment with radiopharmaceuticals is much quicker than chemotherapy which may occur after many months or cycles and may occur after one single injection or up to five injections. Adverse events from treatment may also be less. The policy covers criteria for the following radiopharmaceuticals: Radium-223, Lutetium-177 vipivotide tetraxetan, Samarium (Sm-153) lexidronam pentasodium and Strontium-89. *With this policy update, revisions were made to address four other radiopharmaceuticals: Lutathera, Azedra, HICON, and Zevalin, which increases our alignment with eviCore V1. 2023 Radiation Oncology Guidelines. Lutathera is currently addressed on CMP#7.01.78 Peptide Receptor Radionuclide Therapy (PRRT) which is planned for deletion in early 2024. The updates to the policy will require a 90-day provider notification.*

(#7.01.92) Percutaneous Left Atrial Appendage Closure Devices//New Policy Title: Left Atrial Appendage Closure Devices are being investigated as minimally invasive techniques for stroke prevention in patients with non-valvular atrial fibrillation who are at an increased risk for bleeding from anticoagulant medications. Percutaneous left atrial appendage closure devices with U.S. Food and Drug Administration (FDA) approval (e.g., the Watchman, Amplazter Amulet) for the prevention of stroke in patients with nonvalvular atrial fibrillation are considered medically necessary for the prevention of stroke in patients with nonvalvular atrial fibrillation when certain criteria are met. The devices are considered investigational for any other indications. *With this year's update, a new investigational statement was added for the use of surgical left atrial appendage occlusion devices, including the AtriClip device, for stroke prevention as a stand-alone procedure, or undergoing an open or thoracoscopic cardiac procedure in individuals with atrial fibrillation. This update will require a 90-day provider notification.*

(#7.01.104) Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) is a policy which addresses two new minimally invasive procedures, prostatic urethral lift (i.e., UroLift System) and water vapor thermal therapy (i.e., Rezūm) used to treat BPH. One prostatic urethral lift (PUL) system received FDA approval for treatment of urinary outflow obstruction secondary to BPH. The UroLift System® (NeoTract Inc., Pleasanton, CA) is a minimally invasive, PUL system that provides mechanical traction of the lateral lobes of the prostate through a preloaded implant that pulls the lateral lobe of the prostate away from the urethra, opening the urethral lumen and reducing urinary obstruction. The number of implants vary based on the size and shape of the prostate, but typically four to five implants are inserted. The Rezūm System (NxThera, Inc., Maple Grove, MN), transurethral water vapor thermal therapy, is a minimally invasive alternative to transurethral resection of the prostate to relieve symptoms and obstruction caused by BPH. Sterile water vapor (~103 degrees C) is injected into the enlarged prostate tissue by a transurethral needle ablation technique. The water vapor condenses, releasing large amounts of thermal energy and causes prostate tissue death. After approximately 3 months the body reabsorbs the dead tissue leading to a decreased prostate volume and relief of symptoms of LUTS. The procedure is performed under local anesthesia in an office or outpatient setting. The prostatic urethral lift (e.g., UroLift) and transurethral water vapor thermal therapy (i.e., Rezūm) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when specific criteria listed for each indication in the policy are met. *With this year's update, a medically appropriate statement was added for the coverage of waterjet ablation therapy (Aquabeam) when certain criteria are met.*

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Current Policies – Minor Updates

The following policies have been updated to reflect minor changes, such as applicable references, criteria, or system pend, and are available on our website.

- **(#1.01.38)** Negative Pressure Wound Therapy (Vacuum Assisted Closure)
- **(#2.02.48)** Fecal Bacteriotherapy//New Title: Fecal Microbiota Transplantation
- **(#2.02.52)** Gene Expression Profiling for Cutaneous Melanoma
- **(#4.01.10)** Ovarian and Internal Iliac Vein Endovascular Occlusion as a Treatment of Pelvic Congestion Syndrome
- **(#7.01.75)** Interspinous and Interlaminar Stabilization/Distraction Implants (Spacers)
- **(#7.01.91)** Implantable Cardiac Hemodynamic Monitoring for Heart Failure
- **(#7.01.101)** Balloon Dilation of Eustachian Tube

Policies are archived either because the criteria for evaluating the procedure/technology have not changed or because there has been little utilization or few requests. Archived policies are available on our website.

Previously Archived

- **(#1.01.51)** Limb Pneumatic Compression Devices for Venous Thromboembolism Prophylaxis
- **(#6.01.43)** Superficial Stereotactic Radiation Therapy for Treatment of Skin Cancers
- **(#11.01.10)** Clinical Trials

Note: When policy criteria change, Excellus BCBS' requirements related to medical records may also change. Medical record requirements are available here. Failure to submit required records with the claim submission could delay claim processing and payment.

Although medical policies are effective, services may not be reviewed until our systems are updated.

Questions regarding medical policies should be directed to your Provider Relations representative.