May 2023

BlueBlast℠

News Providers Can Use

Healthy Blue℠

BlueChoice® HealthPlan of SC

BlueBlast℠
News Providers Can Use

All Providers

2023 Healthy Blue Frequently Asked Questions 2-3
Clinical Criteria Updates 4-5
New Specialty Pharmacy Medical Step Therapy Requirements 6
Reminder: Medicaid Annual Eligibility Reviews Resumed on April 1, 2023 6
Help Reduce Delays by Submitting Attachments 7
Moving Toward Equity in Asthma Care Continuing Medical Education (CME) Training and Asthma Medication Ratio HEDIS Measure Update 8
Statin Therapy Exclusions for Patients With Cardiovascular Disease or Diabetes HEDIS® Measures 9
Update on the Use of Modifier 25 for Visits That Include Preventive Problem-Oriented Evaluation and Management Services 10
Inpatient Admission Request Form for Emergent Admissions and the ICR 11
Healthy Blue Provider Office Manual 11

www.HealthyBlueSC.com

2023 Healthy Blue **Frequently Asked Questions**

Authorizations

What is the prior authorization fax number? The Utilization Management department fax number is 800-823-5520.

How do I get the Carelon Medical Benefits Management Inc. authorization number? Carelon Medical Benefits Management Inc. is an independent company providing utilization management services on behalf of BlueChoice®. Healthy Blue gives the authorization number to you once authorization has been approved.

If authorization is approved for a code, does that mean it is covered? Prior authorization is not a guarantee of payment. Prior authorization is in place to show that the service meets medical necessity. You will still need to check eligibility and benefits to see if the member's plan covers the specific service.

What would be the reason an approved prior authorization would be revoked? Once an authorization has been approved and the provider notified, it cannot be revoked. As a reminder, authorization approval does not guarantee payment. Payment is based on coverage and eligibility at the time of service.

Why are prior authorizations needed if they aren't guarantees of payment? These are guidelines set forth by Healthy Blue to show medical necessity. Prior authorizations indicate a service is deemed covered based on the member's policy.

Benefits

Does Healthy Blue still offer free breast pumps? Yes, Healthy Blue does offer free breast pumps as an added benefit. To view Medicaid benefits, visit www.HealthyBlueSC.com and select Providers.

Does Healthy Blue cover CPT® J2057? Healthy Blue follows the same fee schedule as SCDHHS. The covered codes are listed on specific fee schedules based on the specialty of the provider. Therefore, if the code(s) are listed on the SCDHHS specific provider's specialty fee schedule, then Healthy Blue would also cover it.

If a service is not on the SCDHHS fee schedule, are providers allowed to bill the patients? Only applicable Medicaid copayments and services not covered by Medicaid may be billed to the beneficiary.

Is the New Baby, New Life℠ program still available? Yes, it is still available. To view the New Baby, New Life Program, visit www.HealthyBlueSC.com and select Providers.

Is Healthy Blue listed on our Availity Payer Space? Yes, log in to Availity Essentials and choose South Carolina as the state. Under Payer Spaces, you will see the Healthy Blue South Carolina tile with several applications available for your organization. For help with Availity registration, contact Availity Support at 800-282-4548.

Where are the guidelines that state a licensed master social worker is not covered? This is in the SCDHHS Licensed Independent Practitioners (LIPs) manual, section 2. This manual provides a list of approved providers that can render behavioral health specific services. In addition, to view the Behavioral Health Training, visit www.HealthyBlueSC.com and select Providers.

Would neuropsychological testing rendered by a Ph.D. neurophysiologist be covered under behavioral health? No, it would not be covered under behavioral health. We encourage all providers to verify benefits and eligibility before rendering services.

Claims

Can providers submit a claim with an attachment to Availity? You can submit attachments electronically using electronic data interchange (EDI), upload them using the web claim submission on Availity Essentials or attach them to an existing claim. Locate your claim using Claim Status by navigating to **Claims & Payments** > **Claim Status** > Select the **Attachment** button. Upload your documents. Work with your EDI vendor or reach out to Availity Support at 800-282-4548 if you are having issues attaching documents on Availity Essentials.

Can G9153 be billed with a well-child visit? Yes, G9153 should be filed with the well-child exam. To view the BlueBlast March 2022 edition, visit www.HealthyBlueSC.com and select Providers.

What is the address for mailing provider reconsiderations and claim payment appeals? Healthy Blue, Payment Dispute Unit, P.O. Box 100124, Columbia, SC 29202

Once an overpayment has been identified, how long will it take for an offset to be completed? If Healthy Blue does not hear back from the provider or receive payment within 30 days, the offset process will begin.

What should providers do if the overpayment has not been recouped after 30 days? You should contact the Provider Care Call Center at 866-757-8286. Also, for refunds, you may reach out to the Cost Containment department at 818-234-3289 from 8 a.m. to 5 p.m. Pacific time.

Is filing a verbal dispute with a representative on the phone considered a level one dispute? Yes, that is considered a level one dispute. View the Healthy Blue Provider Manual for more specific details on claim payment disputes.

Whom should providers contact about claim report cards? Please reach out to the Provider Relations representative for your specific county.

Who is my Provider Relations representative? To find your Provider Relations representative, visit www.HealthyBlueSC.com and select **Providers**.

Will the Provider Reconsideration form be required for reconsiderations done on Availity Essentials? No, it will not be needed.

Other health insurance

If a member has another primary health insurance, but it has expired, is there a form providers can submit to Healthy Blue to update the member's other health insurance information? No, the managed care organizations receive other health insurance information and updates directly from SCDHHS. Members must provide and update other health insurance information to SCDHHS as soon as possible so the most up-to-date information is sent to the managed care organizations.

If the member's primary insurance carrier denies a claim because the patient needs to update his or her other health insurance, are providers allowed to bill the patient since the patient has not completed or updated other health insurance information? You cannot balance bill members for covered services. You must appeal to the primary insurance. If the request is denied again, then you can appeal to us with the determination letter and Explanation of Benefits denial, which we will need to review for possible payment. If you have questions, contact the Customer Care Center at 866-757-8286.

Provider enrollment

How long should it take to credential a provider? Please allow up to 120 days for clean applications to be completed. Be aware that missing information and delays in receiving information can delay the process.

Even though we are BlueChoice providers, why are we not Healthy Blue providers? Healthy Blue is separate from BlueChoice. Please reach out to your Provider Relations representative to verify participating networks.

Quality

Are quality audits and reviews with quality stipulations happening to all providers in Healthy Blue networks? Quality audits are conducted randomly for providers with 200 or more members.

General questions

Where can I find contact numbers or addresses for different areas within Healthy Blue? To view the Quick Reference Guide, visit www.HealthyBlueSC.com and select **Providers**.

Clinical Criteria **Updates**

On Sept. 12, 2022, and Nov. 18, 2022, the Pharmacy and Therapeutic (P&T) Committee approved these clinical criteria applicable to the medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

Visit the Clinical Criteria page to search for policies. If you have questions or need more information, use this email.

Please see the explanation/definition for each category of clinical criteria:

- New: newly published criteria
- Revised: addition or removal of medical necessity requirements, new document number
- Asterisk (*): criteria that may be perceived as more restrictive

Please share this notice with other providers in your practice and office staff.

Please note:

- The clinical criteria listed apply only to the medical drug benefits contained within the member's medical policy. This does not apply to pharmacy services.
- This notice is meant to inform the provider of new or revised criteria that have been adopted by Healthy Blue only. It does not include details about authorization requirements. Those are in a separate notice.

Effective Date: April 27, 2023

Document number	Clinical criteria title	New or revised
*CC-0222	Tecvayli (teclistamab-cqyv)	New
*CC-0223	Imjudo (tremelimumab-actl)	New
*CC-0224	Pedmark (sodium thiosulfate injection)	New
*CC-0225	Tzield (teplizumab)	New
CC-0130	Imfinzi (durvalumab)	Revised
*CC-0107	Bevacizumab for Non-Ophthalmologic Indications	Revised
CC-0148	Agents for Hemophilia B	Revised
CC-0149	Select Clotting Agents for Bleeding Disorders	Revised
CC-0065	Agents for Hemophilia A and von Willebrand Disease	Revised
*CC-0124	Keytruda (pembrolizumab)	Revised
*CC-0168	Tecartus (brexucabtagene autoleucel)	Revised
*CC-0150	Kymriah (tisagenlecleucel)	Revised
*CC-0151	Yescarta (axicabtagene ciloleucel)	Revised
*CC-0187	Breyanzi (lisocabtagene maraleucel)	Revised
*CC-0214	Carvykti (ciltacabtagene autoleucel)	Revised
CC-0133	Aliqopa (copanlisib)	Revised
*CC-0041	Complement Inhibitors	Revised
*CC-0071	Entyvio (vedolizumab)	Revised
*CC-0064	Interleukin-1 Inhibitors	Revised
*CC-0042	Monoclonal Antibodies to Interleukin-17	Revised
*CC-0066	Monoclonal Antibodies to Interleukin-6	Revised
*CC-0050	Monoclonal Antibodies to Interleukin-23	Revised
*CC-0078	Orencia (abatacept)	Revised
*CC-0063	Stelara (ustekinumab)	Revised
*CC-0062	Tumor Necrosis Factor Antagonists	Revised
*CC-0003	Immunoglobulins	Revised
CC-0072	Selective Vascular Endothelial Growth Factor (VEGF) Antagonists	Revised
*CC-0100	Istodax (romidepsin)	Revised
*CC-0204	Tivdak (tisotumab vedotin-tftv)	Revised
*CC-0205	Fyarro (siroliumus albumin bound)	Revised
*CC-0182	Iron Agents	Revised

New Specialty Pharmacy Medical **Step Therapy Requirements**

Effective for dates of service on and after May 1, 2023, these specialty pharmacy codes from current or new clinical criteria documents will be included in our existing specialty pharmacy medical step therapy review process. Step therapy review will apply upon prior authorization initiation or renewal in addition to the current medical necessity review of all drugs noted below. The list of clinical criteria is publicly available on our provider website. Visit the Clinical Criteria website to search for specific clinical criteria.

Clinical criteria	Status	Drug(s)	HCPCS codes
ING-CC-0002	Preferred	Zarxio	Q5101
ING-CC-0002	Nonpreferred	Granix	J1447
ING-CC-0002	Nonpreferred	Neupogen	J1442
ING-CC-0002	Nonpreferred	Nivestym	Q5110
CC-0182	Nonpreferred	Releuko*	Q5125
CC-0182	Nonpreferred	Infed (iron dextran)	J1750
CC-0182	Nonpreferred	Injectafer (ferric carboxymaltose)	J1439
CC-0182	Nonpreferred	Monoferric (ferric derisomaltose)	J1437
CC-0182	Preferred	Feraheme (ferumoxytol)**	Q0138
CC-0182	Preferred	Ferrlecit (sodium ferric gluconate/sucrose complex)	J2916
CC-0182	Preferred	Venofer (iron sucrose)	J1756
CC-0107	Nonpreferred	Alymsys***	C9399, J3490, J3590, J9999

*Releuko is being added to the existing Step Therapy for Short-Acting Colony-Stimulating Factor Agents;
all other drug statuses remain the same.

**Feraheme (ferumoxytol) will change to preferred for both brand-name and generic.

***Alymsys is being added to the existing Step Therapy for Bevacizumab for Non-Ophthalmologic Indications.

Reminder: Medicaid Annual Eligibility Reviews **Resumed on April 1, 2023**

The South Carolina Department of Health and Human Services (SCDHHS) resumed Medicaid annual eligibility reviews on April 1, 2023. This complies with terms of the Consolidated Appropriations Act of 2023. SCDHHS paused annual reviews during the COVID-19 pandemic.

This federally required process ensures those in the state's Medicaid program continue to meet eligibility criteria. In February 2023, SCDHHS began reaching out to gather information on members who are likely no longer eligible for the Medicaid program. Members can visit the SCDHHS website to learn more about Medicaid annual reviews.

Members should keep their information up to date with SCDHHS. If they move and fail to tell SCDHHS, they may miss important information they need to keep their Medicaid coverage. To update or add contact information, members can:

- Visit apply.scdhhs.gov*.
- Call SCDHHS at 888-549-0820 Monday through Friday from 8 a.m. to 6 p.m.
- Visit an SCDHHS local eligibility office. A list of locations* is available on the website.

To share the importance of making updates, you can share any SCDHHS communication materials*. After selecting the link, scroll down to the Healthy Connections Medicaid Communications Toolkit section. You will find flyers, social media graphics and more.

Help Reduce Delays by **Submitting Attachments**

The best way to send supporting documents when disputing, appealing or sending us additional information about a claim is to use the digital applications available at www.Availity.com.* Using www.Availity.com to send attachments, such as medical records or an itemized bill, is:

- Faster. We'll get the documents needed faster than through the mail.
- Less expensive. No need to pull records, copy them and then mail them. You can upload digital submissions directly to the claim.
- Easier. Submitting attachments digitally is the easiest way to send them and the best way for us to receive them.
- More accurate. The information needed to identify the claim is automated, so the risk associated with submitting incorrect information on paper is eliminated.

However, if you choose to send documentation through the mail, it is important you include at least one of the three following elements; otherwise, we will not be able to match the document to the claim, and the correspondence will be returned to you, causing further delays:

- Valid claim number and valid member ID
- Valid enrollee ID with prefix and correct dates of service
- Valid enrollee ID with prefix and billed charges

For a clinical appeal, ensure these elements are included:

- Valid claim number and valid member ID
- Valid enrollee ID with prefix and correct dates of service
- Valid enrollee ID with prefix and billed charges
- Enrollee name, enrollee date of birth and correct dates of service
- Enrollee name, enrollee date of birth, and either an authorization or reference number

***Important:* We cannot match the attachment to the correct claim or enrollee if these elements are not included with your fax or mail submission. We prefer you submit supporting documentation digitally. That way, the documents are attached directly to the claim. This reduces the possibility that incorrect information is included on the paper submission.**

To attach documents to your claim digitally, go to www.Availity.com and use the Claims & Payments tab to access Claims Status. Enter the necessary information to find your claim and use the Submit Attachments button to upload your supporting documentation.

For a claim dispute or an appeal, at www.Availity.com, use the Claims & Payments tab to access Claims Status. Enter the necessary information to find your claim, use the Dispute button, and upload your supporting documentation. If the Dispute button is not available, refer to the Provider Manual for information about how to file a claim dispute or appeal.

If you do send supporting documentation by mail or fax, you must include the elements noted above. We prefer you include this information on the first page of the correspondence you send to us. If this information is not included on your paper correspondence, we will return the correspondence to you because we are not able to validate the documentation.

For information about submitting attachments digitally, access Availity: Learn about the new claim attachments workflow*.

Diameter Health is now part of Availity. Harness the power of bi-directional data intelligence to reduce costs, improve care quality, and drive innovation.

Read More

Moving Toward Equity in Asthma Care Continuing Medical Education (CME) Training and **Asthma Medication Ratio HEDIS Measure Update**

Healthy Blue is committed to achieving health equity in asthma outcomes with diverse populations. As part of this commitment, we offer an online training, Moving Toward Equity in Asthma Care*. You can access this course from any mobile device or computer. It provides one CME credit at no cost to you. Visit www.MyDiversePatients.com*.

Asthma Medication Ratio (AMR) HEDIS measure

National Committee for Quality Assurance (NCQA) is also working to identify and reduce gaps in care. As part of this effort, race and ethnicity stratifications were added to the AMR HEDIS metric this year. The AMR metric measures the percentage of members ages 5 to 64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.5 or greater during the measurement year.

Did you know:

- Hispanic and African American people with asthma are less likely to take daily controllers. They are also more likely to visit the emergency room (ER) and be hospitalized for asthma-related conditions than non-Hispanic white people? [1]
- Asian American people are more likely to die from asthma than non-Hispanic white people?[2]
- Appropriate medication management for patients with asthma could reduce the need for rescue medication and the costs associated with ER visits, inpatient admissions, and missed days of work or school?[3]

Helpful tips:

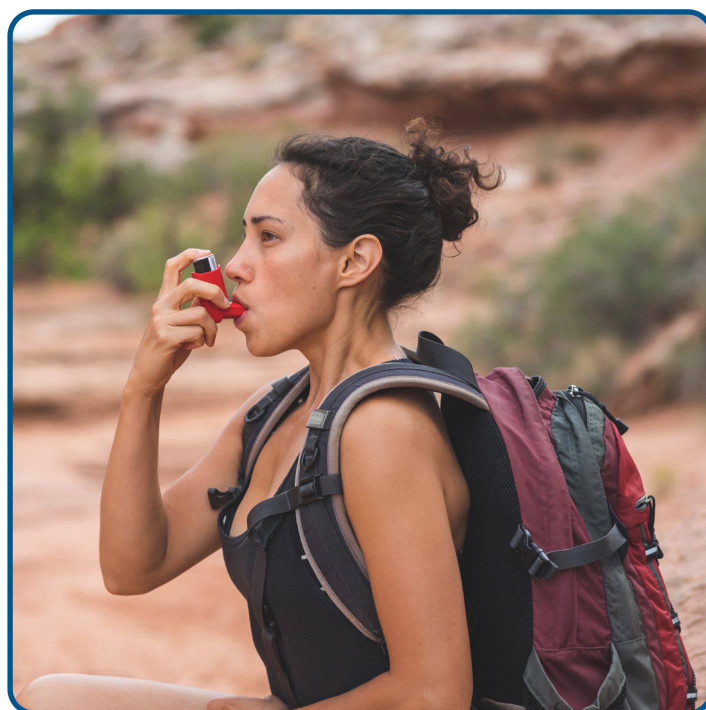
- Ensure at least half of the medications dispensed to treat asthma are controller medications throughout the measurement period.
- Talk to the patient about the importance of controller medication compliance. Remind them not to use rescue medications on a regular basis unless it's part of asthma action plan.
- Encourage patients to fill their prescriptions on a regular schedule rather than waiting until they are symptomatic.
- Create a written asthma action plan in language the patient understands, and schedule follow-up appointments with patients. Ask patients questions to assess asthma control and adherence to the action plan and identify triggers.
- Use evidence-based asthma assessment tools to assess asthma control and adherence to the action plan and identify triggers.
- Take the Moving Toward Equity in Asthma Care* CME course at no cost for more helpful tips.

Additional resources:

Also available is the Asthma & Me* training. Do your patients have asthma? Show them the pathophysiology of asthma in their preferred language.

References:

1. Asthma a nd Allergy Foundation of America and National Pharmaceutical Council. (2005). Ethnic Disparities in the Burden and Treatment of Asthma. Retrieved from www.aafa.org/media/Ethnic-Disparities-Burden-Treatment- Asthma-Report.pdf*.
2. U.S. Department of Health and Human Service, Office of Minority Health. (2016, May 9). Asthma and Asian Americans. Retrieved Aug. 8, 2016, from www.MinorityHealth.hhs.go*.
3. Asthma and Allergy Foundation of America. (2020). Asthma Disparities in America: A Roadmap to Reducing Burden on Racial and Ethnic Minorities. Retrieved from www.aafa.org/wp-content/uploads/2022/08 asthma-disparities- in-america-burden-on-racial-ethnic-minorities.pdf*.



Statin Therapy Exclusions for Patients With **Cardiovascular Disease or Diabetes HEDIS® Measures**

The Statin Therapy Exclusions for Patients with Cardiovascular Disease (SPC) HEDIS measures examine the percentage of patients with atherosclerotic cardiovascular disease (SPC) who received and adhered to statin therapy throughout the measurement year. Statin therapy does not work for everyone. Some people need alternative therapies to minimize their risk for complications. If you have patients who cannot tolerate statin therapy, be sure to document and notify us each year so we can exclude the patients from your list of open care gaps. Refer to NCQA guidelines for a complete list of exclusion criteria.

How to submit exclusion data:

- Indicate the appropriate ICD-10 code for encounters.
- Use standard data file submission or EMR/EHR access for supplemental data collection.

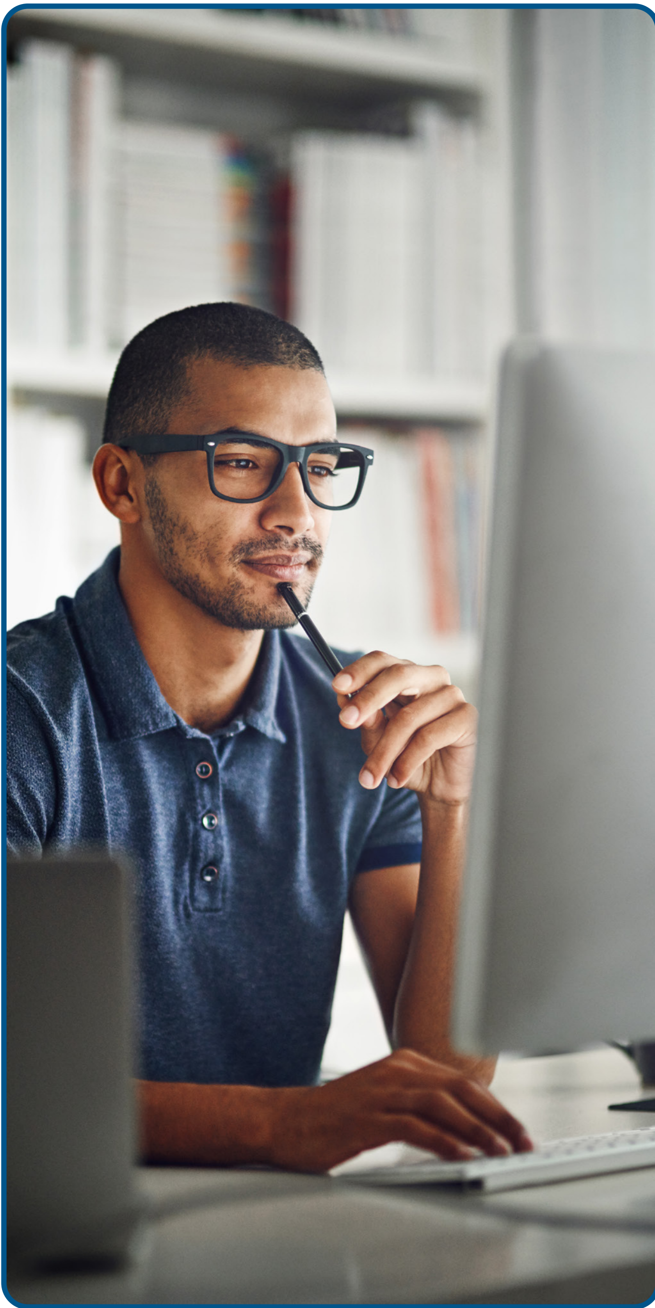
Exclusions are applied based on diagnosis codes on the date of service provided on the claim or through supplemental data collection. Based on the timing of your data submission and when reports are generated, it may take several weeks for exclusions to be reflected on your reports.

Please note, if exclusions are not coded properly or given to Healthy Blue in the proper format, the care gap will remain open until the failure reason is corrected. Patients listed on the open care gap report are assumed to tolerate statin therapy. They will have their care gaps closed after claims for moderate- to high-intensity statins are adjudicated by Healthy Blue.

Tips for applying best practices and improving your quality scores:

- Teach your patients the importance of sticking to their statin therapy regime. Educate them on potential side effects. If they start to have muscle pain or weakness, have them contact you to discuss their options.
- Statin therapy should be accompanied by lifestyle modifications, such as a healthy diet and exercise. Work with your patients to proactively identify and overcome any barriers that may prevent lifestyle modifications. Discuss a realistic, custom exercise routine based on the patient's ability and interests. Encourage a healthy diet based on the patient's culture and locally available produce, stores and resources.

If you have questions or concerns about Healthy Blue, call Customer Service at 866-757-8286.



Update on the Use of Modifier 25 for Visits That Include Preventive **Problem-Oriented Evaluation and Management Services**

In January, we told you Healthy Blue would start taking additional steps to review claims for evaluation and management (E/M) services submitted by professional providers when a preventive service is billed with a problem-oriented E/M service and appended with modifier 25. We have since decided to limit this review for claims for members ages 22 and older. Subsequently, we have updated the affected CPT codes. For your convenience, we are including an updated communication below:

Healthy Blue will implement additional steps to review claims for evaluation and management (E/M) services submitted by professional providers when a preventive service (CPT codes 99385 – 99387 or 99395 – 99397) is billed with a problem-oriented E/M service (CPT codes 99202 – 99215) and appended with modifier 25 (for example, CPT code 99395 billed with CPT code 99213-25). This review is limited to claims for members ages 22 and older.

According to the American Medical Association (AMA) CPT Guidelines, E/M services must be significant and separately identifiable to appropriately append modifier 25. Based on review of the submitted claim information, if the problem-oriented E/M service is determined not to be a significant, separately identifiable service from the preventive service, the problem-oriented E/M service will be bundled with the preventive service.

Providers who believe their medical record documentation supports a significant and separately identifiable E/M service should follow the claims payment dispute process, including submission of such with the dispute, outlined in the Provider Manual.

Availity Chat with Payer is available during normal business hours. Get answers to your questions about eligibility, benefits, authorizations, claims status and more. To access Availity Essentials, go to www.Availity.com* and select the appropriate payer space tile from the drop-down menu. Then select **Chat with Payer** and complete the pre-chat form to start your chat.

Inpatient Admission Request Form for **Emergent Admissions and the ICR**

When you fax a request for authorization, send all the information we need to create an emergent authorization. This helps us make medical necessity decisions quickly. The Healthy Blue website has an authorization form for inpatient admissions. Filling out this form in full will help members get the care they need sooner. You'll need to fill out:

- Sender's name, telephone number and fax number.
- Hospital's name, network status, address, telephone number, National Provider Identifier (NPI) and tax ID.
- Attending physician's name, NPI, tax ID, address and telephone number.
- Admission and discharge dates, ICD-10 codes, admission type, and level of care.
- Member's name, date of birth, gender and Medicaid number.

You can also send requests through the Interactive Care Reviewer (ICR). Providers can submit online prior authorization requests for Healthy Connections members quickly and easily with the ICR tool. It is available through the Availity® Portal. It's a streamlined way to request inpatient and outpatient procedures and find information on past requests.
Learn how to access and use the ICR and find out about its many benefits in the Provider Manual under Availity Essentials: The Secure Portal for Providers.

For help with the Inpatient Request Form or the ICR, please call Customer Service at 866-757-8286. They will be happy to help you.

Healthy Blue Provider **Office Manual**

Healthy Blue offers resources to make sure its providers have all the information they need for seamless processes. One of the key resources is the Provider Manual. It has information on covered services, NCQA standards and much more.

The manual is meant to be informative and help you navigate all aspects of participation with Healthy Blue. Unless otherwise noted in the provider contract, the information in the manual is not binding upon Healthy Blue.

It is subject to change. For this reason, please do not print the Provider Manual. Instead, visit www.HealthyBlueSC.com to review the most up-to-date information. The latest updates were made in February 2023.

If you have questions, please contact the Customer Care Center at 866-757-8286.

Hello

SPRING

BlueChoice HealthPlan is an independent licensee of the Blue Cross Blue Shield Association. BlueChoice HealthPlan has contracted with Amerigroup Partnership Plan LLC, an independent company, for services to support administration of Healthy Connections. Amerigroup Corporation, an independent company, administers utilization management services for BlueChoice HealthPlan.

*Some links in this newsletter lead to third-party sites. Those organizations are solely responsible for the content and privacy policies on these sites.

The codes listed are for informational purposes only and are not intended to suggest or guide reimbursement. If applicable, refer to your provider contract or health plan contact for reimbursement information.

To report fraud, call our confidential Fraud Hotline at 877-725-2702. You may also call the South Carolina Department of Health and Human Services Fraud Hotline at 888-364-3224 or email Fraudres@scdhhs.gov.

216850-05-2023