September 2023

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Member Search Feature Enhancement: **Search for Patient Without Using Member ID in Availity® Essentials**

Starting mid-September, you can search for patient information in the Availity Essentials **Eligibility and Benefits** menu without having a member ID. Availity LLC is an independent company providing administrative support services on behalf of BlueChoice HealthPlan. We've updated the process to eliminate the need for the member ID while maintaining the highest privacy standards. Easily search for patient eligibility and benefits details using the **Patient Search** option. Search by patient last name, patient first name, date of birth and patient ZIP code.

Find **Eligibility and Benefits Inquiry** on Availity's top menu bar under **Patient Registration**. Use the new search feature when you need to find member information and do not have access to the member ID.

Need the member ID for something else in Availity Essentials? When you use the new search option in **Eligibility and Benefits Inquiry** and see the eligibility and benefits details, the member's current ID details will be available. This will let you do other things that require the member ID.

Watch for more information on the Availity Essentials homepage under **News and Announcements** to see when this feature is available.

Get access to Availity Essentials now

If you and your organization aren't currently registered for Availity Essentials, now is the time to make that happen. Availity Essentials offers secure online access for working together and is free to our providers. To register, visit the Registration Information page at www.Availity.com*.

2023 Healthy Blue Annual **Provider Training Registration**

Registration is now open for the 2023 Healthy Blue Annual Provider Training. The trainings will be held virtually on the following dates:

Tuesday, Oct. 3 – Thursday, Oct., 5, 2023 | 9 a.m. – noon
Tuesday, Oct. 10 – Thursday, Oct. 12, 2023 | 9 a.m. – noon

Register today to join one of our many sessions.

Pharmacists To Be Reimbursed **for Certain Medical Services**

Beginning Oct. 1, 2023, pharmacists can be reimbursed for these medical services for patients 18 years of age and older or patients under 18 years of age who have evidence of a previous prescription from a physician. This change is due to a new state law. The implementation will require pharmacists to enroll as South Carolina Department of Health and Human Services (SCDHHS) providers.

Medical Code	Medical Service
99202	New patient office visit 20 minutes
99203	New patient office visit 30 – 44 minutes
99211	Evaluation and management of established patients 5 minutes or less
99212	Evaluation and management of established patients 10 – 19 minutes
99213	Evaluation and management of established patients 20 – 29 minutes
99214	Evaluation and management of established patients 30 – 39 minutes
96372	Injection of drug/substance under skin or into muscle
81025	Urine pregnancy test

Submitting claims

To ensure proper reimbursement, make sure your claim meets these criteria:

- The pharmacy must be the billing provider.
- The place of service should be pharmacy (01).
- The modifier FP must be appended.
- You must include one of the diagnosis codes in the chart.

Contraceptive	Initial Rx	Repeat Rx
Oral Contraceptive	Z30.011	Z30.41
Contraceptive Patch	Z30.016	Z30.45
Contraceptive Ring	Z30.015	Z30.44
Depo Shot	Z30.013	Z30.42
General counseling only will be billed with a Z30.09.		

The reimbursement rate will be the same as the one for physician assistants and nurse practitioners. If you have questions, please contact the Customer Care Center at 866-757-8286.

Prior Authorization Updates for Medications **Billed Under the Medical Benefit**

Effective for dates of service on and after Sept. 1, 2023, these medication codes billed on medical claims from current or new clinical criteria documents will require prior authorization.

Please note, inclusion of a national drug code on your medical claim is necessary for claims processing.

Visit the Clinical Criteria website to search for specific clinical criteria.

Note: Prior authorization requests for certain medications may require additional documentation to determine medical necessity.

Clinical criteria	HCPCS or CPT® code(s)	Drug name
CC-0002	Q5130	Fylnetra® (pegfilgrastim-pbbk)
CC-0002	J1449	Rolvedon® (eflapegrastim-xnst)
CC-0002	Q5127	Stimufend® (pegfilgrastim-fpgk)

Pharmacotherapy Management of COPD **Exacerbation HEDIS Measure**

Healthcare Effectiveness Data Information Set (HEDIS®) is a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). These are used to drive improvement efforts surrounding best practices.

The Pharmacotherapy Management of COPD Exacerbation (PCE) measure assesses chronic obstructive pulmonary disease (COPD) exacerbations for adults 40 years of age and older who had appropriate medication therapy to manage an exacerbation. A COPD exacerbation is defined as an acute inpatient discharge or emergency department visit with a primary discharge diagnosis of COPD. Two rates are reported:

- Dispensed a systemic corticosteroid (or there is evidence of an active prescription) within 14 days of the event
- Dispensed a bronchodilator (or there is evidence of an active prescription) within 30 days of the event

COPD is a debilitating lung condition that affects 1 in 8 Americans ages 45 and older. More than 16 million Americans have been diagnosed with COPD, and millions more have it without knowing.

COPD exacerbations make up a significant portion of the costs associated with the disease.

Appropriate prescribing of medication following exacerbation can prevent future flare-ups, improve health outcomes and reduce the health care burden of COPD.

Who has COPD?

Prevalence by ethnicity					
12% American Indian and Alaska Native	**7%** Non-Hispanic Black	**7%** White	4% Hispanic	**3%** Native Hawaiian/ Pacific Islander	**2%** Asian

COPD action plan

A COPD action plan is a personalized patient tool that includes the important steps to help manage COPD. It allows patients to track how they are doing and note any concerns to discuss with their provider. It addresses medications, exercise, diet, and avoidance of triggers such as tobacco products and other inhaled irritants. The plan should be discussed at each visit and updated as needed.

HEDIS helpful tips:

- Schedule a follow-up appointment after discharge and confirm the patient has the appropriate medications.
- Reconcile patients' medications with those prescribed at discharge when you get the discharge summary.
- Ask the patient if he or she has any barriers that prevent him or her from filling prescriptions.
- Assure patients with COPD are up to date on their vaccinations, including flu, pneumococcal and COVID-19.
- Provide a COPD action plan for the patient, including daily medications, trigger avoidance and what to do when flare-ups do occur:
  - American Lung Association COPD Action Plan and Management Tools*

You're Invited

Thriving, Not Just Surviving: Youth Mental Health Forum

Register today for the youth mental health forum hosted by Healthy Blue and Motivo for Healthy Blue providers on Sept. 27, 2023. Motivo is an independent company providing a virtual forum on behalf of BlueChoice HealthPlan.

Wednesday, Sept. 27, 2023 | 3:30 p.m. to 5 p.m. Eastern time

This important event will address the critical need to engage young people in leading their mental health. By deepening the discussion on youth mental health, we can do our part to foster a culture of understanding and support for youth and young adults. Authentic conversations lead to reducing implicit bias and improving the health and well-being of all Americans and the communities in which we live and serve.

Please join us to hear from a diverse panel of experienced professionals and young leaders as we explore the challenges experienced by today's youth, amplify the experiences and ideas of young people, and equip attendees with practical tools and innovative approaches to create meaningful change.

Each forum will continue the exploration of ways we can reduce disparities in health care, demonstrate cultural humility, address and deconstruct bias, have difficult and productive conversations, learn about valuable resources, increase inclusion, and advance equity in health care.

– Please register for this event by visiting this link*.

Duplicate **J-Code Billing**

The following J-codes have been identified as those that continue to be billed under both the pharmacy and medical benefit. To avoid duplicate J-code billing, it is important to review the formulary drug list(s) at www.HealthyBlueSC.com or the prior authorization lookup tool to identify whether drugs should be covered under the pharmacy benefit or the medical benefit. If the drug is listed on the formulary, it should be filed to the pharmacy benefit. If not, it should be filed to the medical benefit.

J1631-HALDOL DECANOATE TO 50 MG IM
J2680-PROLIXIN DECANOATE FLUPHENAZINE UP TO 25
J2794-INJ. RISPERDAL CONSTA 0.5 MG
J1050-INJECTION, MEDROXYPROGESTERONE ACETATE
J1726-MAKENA 10 MG

What If I Need Assistance? If you have questions about this communication or need help with any other item, contact your local Provider Relations representative or call Provider Services at 866-757-8286.

Clinical **Criteria Updates**

On Aug. 19, 2022, and March 23, 2023, the Pharmacy and Therapeutic (P&T) Committee approved the following clinical criteria applicable to the medical drug benefit for Healthy Blue. These policies were developed, revised or reviewed to support clinical coding edits.

To view the clinical criteria, visit www.HealthyBlueSC.com and select Providers. For questions or additional information, use this email.

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

- New: Newly published criteria
- Revised: Addition or removal of medical necessity requirements, new document number
- An asterisk (*): Notes the criteria 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 has been adopted by Healthy Blue only. It does not include details regarding any authorization requirements. Authorization rules are communicated via a separate notice.

Effective Date: Aug. 19, 2023

Clinical criteria number	Clinical criteria title	New or revised
*CC-0235	Revcovi (elapegademase-lvlr)	New
*CC-0236	Signifor LAR (pasireotide)	New
CC-0125	Opdivo (nivolumab)	Revised
CC-0072	Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised
CC-0038	Human Parathyroid Hormone Agents	Revised
CC-0066	Monoclonal Antibodies to Interleukin-6	Revised
*CC-0197	Jemperli (dostarlimab-gxly)	Revised
*CC-0119	Yervoy (ipilimumab)	Revised
CC-0092	Adcetris (brentuximab vedotin)	Revised
*CC-0065	Hemophilia A and von Willebrand Disease	Revised
*CC-0034	Agents for Hereditary Angioedema	Revised
CC-0061	GnRH Analogs for the Treatment of Non-Oncologic Indications	Revised
CC-0008	Subcutaneous Hormonal Implants	Revised
CC-0026	Testosterone, Injectable	Revised

DME Procedure Code B9998 **Prior Authorization Requirement Removed**

Following the end of the public health emergency, which expired May 11, 2023, durable medical equipment (DME) providers may have noticed an increase in denials for claims that were filed with HCPCS code B9998. The increase in claim denials were a result of the prior authorization (PA) requirement being reinstated. This affected both members and providers.

For members to get the supplies needed, the PA requirement has been removed for HCPCS code B9998 for the dates of service on or after May 11, 2023. Providers should continue to use code B9998 with medically necessary services according to guidelines to be reimbursed for covered services.

SCDHHS is reviewing and reprocessing the claims. Providers will receive updated remittances to reflect changes. The agency is working hard to ensure the temporary flexibilities that were put into place during the public health emergency do not affect medically necessary services for the members.

If there are questions, call the SCDHHS Provider Service Center at 888-289-0709 Monday – Thursday from 7:30 a.m. – 5 p.m. and Friday from 8:30 a.m. – 5 p.m. Direct questions related to claims that were denied as a result of the PA requirement update to MedicaidWaiver@scdhhs.gov.

Clinical Laboratory **Improvement Amendments**

Claims submitted for laboratory services subject to the Clinical Laboratory Improvement Amendments of 1988 (CLIA) statute and regulations require additional information to be considered for payment.

To be considered for reimbursement of clinical laboratory services, a valid CLIA certificate identification number must be reported on a 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent for clinical laboratory services. The CLIA certificate identification number must be submitted in one of these ways.

Claim format and elements	CLIA number location options	Referring provider name and NPI number location options	Servicing laboratory physical location
CMS-1500 (formerly HCFA-1500)	The number must be represented in field 23.	Submit the referring provider name and NPI number in fields 17 and 17b, respectively	Submit the servicing provider name, full physical address and NPI number in fields 32 and 32A, respectively, if the servicing address is not the same as the billing provider address. The servicing provider address must match the address associated with the CLIA ID entered in field 23.
HIPAA 5010 837 Professional	The number must be represented in the 2300 loop, REF02 element, with qualifier of X4 in REF01.	Submit the referring provider name and NPI number in the 2310A loop, NM1 segment.	The physical address of the servicing provider must be represented in the 2310C loop if it is not to the same as the billing provider address and must match the address associated with the CLIA ID submitted in the 2300 loop, REF02.

To be considered for reimbursement of reference laboratory services, the referring laboratory must be an independent clinical laboratory. Modifier 90 must be submitted to denote the referred laboratory procedure. Per the Centers for Medicare & Medicaid (CMS), an independent clinical laboratory that submits claims in paper format may not combine nonreferred or self-performed and referred services on the same CMS-1500 claim form. When the referring laboratory bills for both nonreferred and referred tests, it must submit two separate paper claims: one claim for nonreferred tests and the other for referred tests. If you submit electronically, the reference laboratory must be represented in the 2300 or 2400 loop, REF02 element, with a qualifier of F4 in REF01.

Providers with a CLIA Waiver or Provider Performed Microscopy Procedure accreditation must include the QW modifier when any CLIA-waived laboratory service is reported on a CMS-1500 claim form.

Laboratory procedures must be rendered by an appropriately licensed or certified laboratory having the appropriate level of CLIA accreditation for the particular test performed. Thus, any claim that does not contain the CLIA ID, has an invalid ID, has a lab accreditation level that does not support the billed service code, or does not have complete servicing provider demographic information and applicable reference laboratory provider demographic information will be considered incomplete and rejected or denied. ***If you have questions, please contact your Provider Relations representative.***

Prior Authorization Updates for **Medications Billed Under the Medical Benefit**

Effective for dates of service on and after Sept. 1, 2023, these medication codes billed on medical claims will require prior authorization in accordance with the requirements of current or new clinical criteria documents. Please note, a national drug code on your medical claim is necessary for claims processing.

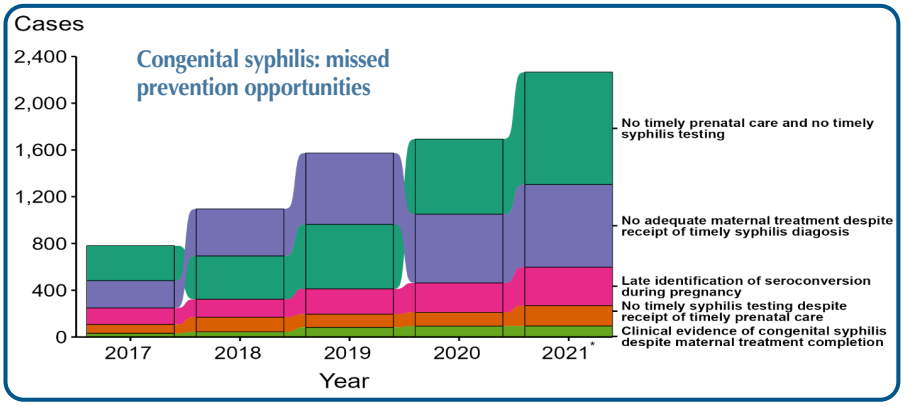
Clinical criteria	HCPCS or CPT® code(s)	Drug name
CC-0065	C9399, J7199	Altuviiio (antihemophilic factor (recombinant)

Visit the Clinical Criteria website to search for specific clinical criteria. ***Note:*** Prior authorization requests for certain medications may require additional documentation to determine medical necessity.

Congenital Syphilis **Is a Sentinel Health Event**

The problem | In 2021, there were 2,677 cases of congenital syphilis reported for a rate of 74.1 per 100,000 live births. From 2012 to 2021, the number of cases of congenital syphilis increased 701.5 percent (334 to 2,677 cases), concurrent with a 642.9 percent increase (2.1 to 15.6 per 100,000 live births) in the rate of primary and secondary syphilis among women ages 15 to 44 years.

Maternal syphilis is associated with a 21 percent increased risk for stillbirth, 6 percent increased risk for preterm delivery, and 9 percent increased risk for neonatal death. Optimal treatment of syphilis during pregnancy is estimated to reduce the risk of congenital syphilis by 98 percent, stillbirth by 82 percent, preterm birth by 64 percent, and neonatal mortality by 80 percent. Syphilis is treatable and curable with penicillin. One in 2 newborn syphilis cases in the U.S. occur due to gaps in testing and treatment during prenatal care.



Submitting Prior Authorizations **Is Getting Easier**

Healthy Blue is transitioning to the Availity Essentials Authorization application.

You may already be familiar with the Availity multipayer authorization app because thousands of providers are already using it to submit prior authorizations for other payers. Healthy Blue is eager to make it available to our providers, too. In September, you can begin using the same authorization app you use for other payers for Healthy Blue.

Interactive care reviewer (ICR) is still available: If you need to refer to an authorization that was submitted through ICR, you will still have access to that information. We've developed a pathway to access your ICR dashboard. You will simply follow the prompts provided through the Availity Authorization app. To make it even more convenient, you can pin your authorizations from the ICR application to your Availity Authorization app dashboard.

Innovation in process: While we grow the Availity Authorization app to provide you with Healthy Blue-specific information, you will still need to access ICR for:

- Appeals.
- Behavioral health authorizations and inquiries.
- Federal Employee Program® authorizations and inquiries.
- HealthLink authorizations and inquiries.
- Medical specialty prescription authorizations and inquiries.

Notices in the Availity Authorization app will guide you through the process for accessing ICR for other authorization and appeals functions.

Training is available: If you aren't already familiar with the Availity Authorization app, training is available. Visit the training site to enroll for an upcoming live webcast or to access an on-demand recording at the Availity Authorization training site.*

Now, give it a try: Accessing the Availity Authorization app is easy. Ask your organization's Availity administrator to make sure you have the Authorization role assignment. Without the role assignment, you will not be able to access the Authorization application. Then, just log in to www.Availity.com* to access the app through the Patient Registration tab by selecting Authorizations and Referrals.

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